



Abortion care guideline

Supplementary material 1: Evidence-to-Decision frameworks for the law and policy recommendations

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Supplementary material 1: Evidence-to-Decision frameworks for the law and policy recommendations

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Note: Details of all PICO (population, intervention, comparator, outcome) questions are provided in Annex 8 in the main guideline document: *Abortion care guideline (2021)*.¹

¹ The main guideline is available at: <https://www.who.int/publications/i/item/9789240039483>.

Acronyms and abbreviations

CCPR	Covenant on Civil and Political Rights (Treaty monitoring body: Human Rights Committee) ²
CEDAW	Committee on the Elimination of Discrimination against Women/Convention on the Elimination of All Forms of Discrimination against Women
CERD	Committee on the Elimination of Racial Discrimination/Convention on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights/Covenant on Economic, Social and Cultural Rights
CRC	Committee on the Rights of the Child/Convention on the Rights of the Child
CRPD	Committee on the Rights of Persons with Disabilities/Convention on the Rights of Persons with Disabilities
CRR	Center for Reproductive Rights
EtD	Evidence-to-Decision
GC	General Comment
GR	General Recommendation
PICO	population, intervention, comparator, outcome
SRH	sexual and reproductive health

² For further information on the relevant reference information from all these covenants and committees, please refer to Web annex A: Key international human rights standards on abortion, available at: <https://apps.who.int/iris/bitstream/handle/10665/349317/9789240039506-eng.pdf>.

Background: information presented in each EtD framework

A detailed Evidence-to-Decision (EtD) framework has been developed for each intervention. The EtD frameworks contain three types of tables, presented consecutively.

1. The first is the **Findings tables**, which summarizes the findings from individual studies presented by outcome.
2. The second type is the **Human Rights Standards to Evidence tables**, in which human rights standards have been linked to the evidence from the studies, presented by outcome. In some cases, the same human rights standards are linked to all outcomes; in these cases, to avoid repetition, this is presented at the bottom of the *human rights standards* table.
3. Finally, the evidence and human rights standards are presented in a table entitled **Summary table**, which compiles the overall conclusions from the two previous tables and includes a draft recommendation for review.

Explanation of Findings tables

Each Findings table begins with an overview of the human rights standards engaged, that are relevant to the intervention. In addition to the outcomes/sub-outcomes and study information, the Findings tables include symbols representing a directional impact of the intervention on the outcomes/sub-outcome (*Directionality of Evidence*). The definitions of the symbols are:

- ▲ = the intervention leads to **an increase** in the outcome/sub-outcome
- = the intervention leads to **no change** in the outcome/sub-outcome
- ▽ = the intervention leads to **a decrease** in the outcome/sub-outcome

Please note that the symbol does **not** indicate magnitude or certainty of effect.

The column “*What does this mean?*” provides a narrative summary of the study findings related to the specific outcome/sub-outcome.

The “*Overall conclusion*” column provides an overall conclusion of the evidence related to outcome when considering all related sub-outcomes. Regarding setting, studies conducted in the United States of America (USA) are national studies or studies conducted in a large cross-section of states.

Explanation of “Human Rights Standards-to-Evidence” tables

Each Human Rights Standards-to-Evidence table begins with the overall conclusion of the evidence presented in the Findings tables. This is followed by a description of the relevant human rights standards that are engaged and a column illustrating directionality. These table also include directionality symbols representing the link between the negative relationship with rights enjoyment and the impact of the intervention on the outcome. The definitions of the symbols are:

- ▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases)
- = the impact on rights enjoyment between the intervention and the outcome is unclear
- ▽ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases)

The column *Overall: Application of Rights to Evidence* describes the implication for States when human rights standards are applied to the evidence.

1. EtD framework for Criminalization

Recommendation 1: Recommend the full decriminalization of abortion.

PICO 1: The impact of criminalization on abortion-related outcomes (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of criminalization on abortion related outcomes, 22 studies were identified addressing the following outcomes; delayed abortion (n=3), continuation of pregnancy (n=4), opportunity costs (n=12), self-managed abortion (n=4), unlawful abortion (n=8), criminal justice procedures of abortion seekers (n=5), workload implications (n=4), referral to another provider (n=1), system costs (n=9), perceived impact on relationship with patient (n=2), anti-abortion sting operations (n=2), criminal justice procedures of health-care providers (n=4), availability of trained providers (n=3), reporting of suspected unlawful abortion (n=9). No studies were identified that encompassed information related to the outcome stigmatization of health-care providers and harassment. Studies were conducted in Australia, Chile, El Salvador, Ethiopia, Ireland, Northern Ireland, Mexico, Philippines, Rwanda, Senegal, United Republic of Tanzania, Uruguay and Zambia. Study designs in this EtD framework include cross-sectional studies, retrospective cohort studies, case-control studies, times-series design, qualitative interview studies and legal analyses.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion care

Outcome: DELAYED ABORTION

Findings table 1: Impact of criminalization on delayed abortion

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health, right to security of person, right to equality and non-discrimination, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Criminalization contributes to delayed abortion, as women in need of an abortion travel out of the country to access an abortion, or use telemedicine services (where the shipment of medications can sometimes take several weeks, and some packages may be confiscated).	Overall, evidence from 3 studies suggests that criminalization contributes to abortion delay. While evidence from 2 of these studies suggests that criminalization leads to health-care providers delaying care to women who are suffering from severe pregnancy complications, evidence from 1 study suggests that while criminalization does not stop women from having an abortion, it complicates women’s abortion pathways, and thereby delays abortion.
Aitken 2017 ²	▲	Criminalization contributes to delayed abortion when health-care providers must delay treating women with pregnancy complications until their lives are considered to be in danger. Among 33 obstetrics/gynaecology trainees having been involved in the care of women with life threatening pregnancy complications, 27% (n=9) felt they had delayed abortion until a woman’s health had deteriorated and “the pregnancy was deemed a severe risk to life/health”.	
Casas 2014 ¹	▲	Criminalization contributes to delayed abortion by creating and fuelling an unregulated market for abortion medications. Some women are sold counterfeit drugs or poor-quality medications, which leads to a delay in abortion. Criminalization further contributes to delayed abortion, by	

		requiring health-care providers to delay treating women with pregnancy complications until their lives are considered to be in danger.
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable

² The study was not powered to look at this outcome

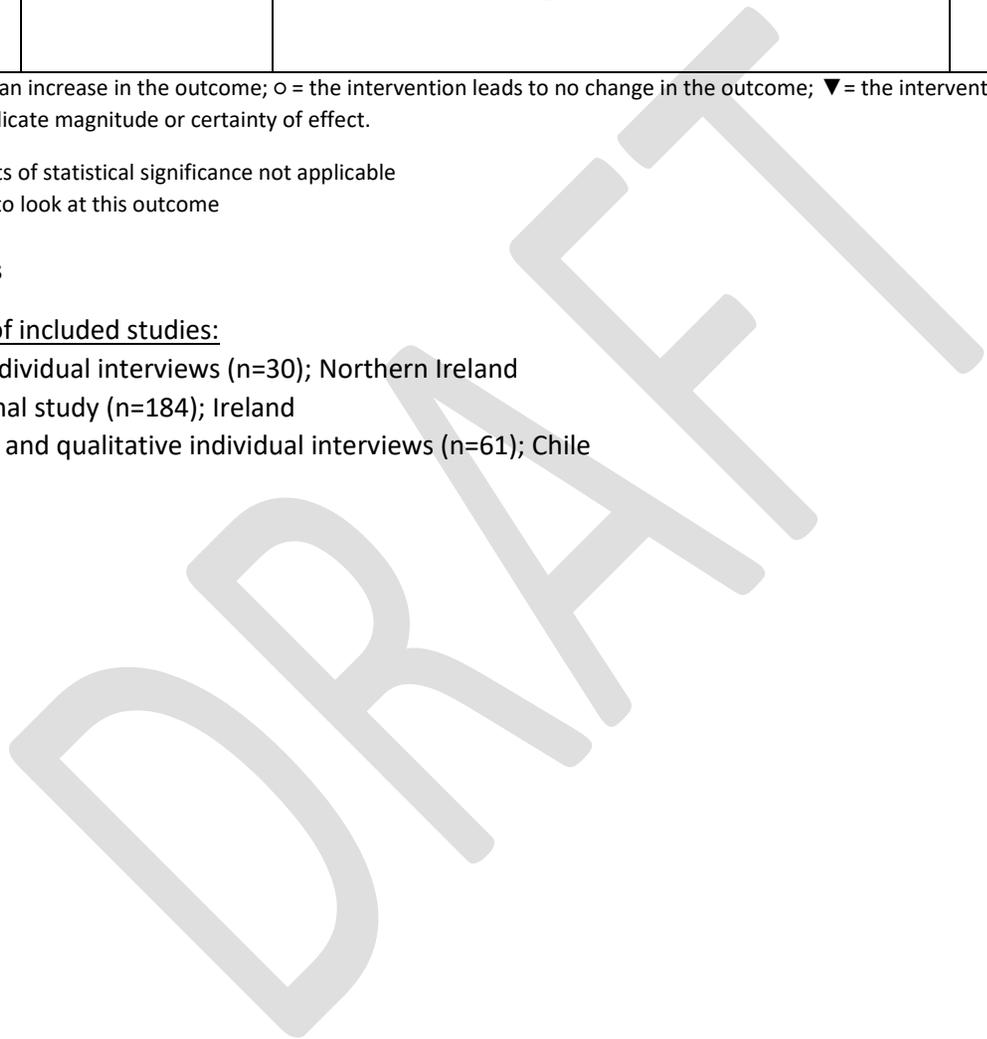
Additional considerations

Study design and setting of included studies:

Aiken 2019; Qualitative individual interviews (n=30); Northern Ireland

Aitken 2017; Cross-sectional study (n=184); Ireland

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile



Findings table 2: Impact of criminalization on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY			
Human rights standards engaged: right to health, right to security of person, right to equality and non-discrimination, right to decide on the number and spacing of children, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Antón 2016	○	Decriminalization of abortion was not associated with a change in adolescent birth rates or birth outcomes (birthweight, prematurity, adequacy of prenatal care).	Overall evidence from 3 studies suggests that criminalization indirectly contributes to increased continuation of pregnancy; decriminalization is associated with reductions in birth rates. While 2 of these studies suggests that criminalization affects the birth rates of women 20–29 and 20–34 years in particular, 1 study points to a greater impact among adolescents. Evidence from 1 study suggests that criminalization does not impact adolescent birth rates.
Antón 2018	▲	Decriminalization of abortion is associated with an 8% decrease in births due to unplanned pregnancies. This decline is driven by a fall in fertility among women 20–34 years old with secondary education.	
Clarke 2016	▲	Decriminalization is associated with reductions in fertility and maternal mortality. Following legal reform that established free of charge, on request, first trimester abortions, maternal mortality and birth rates were reduced. Among women aged 15–44, maternal mortality rates decreased by 8.8% to 16.2% and fertility rates declined by 2.3–3.8%. This trend was more marked among younger women aged 15–19. Maternal death rates decreased by 14.9% to 30.3% and fertility rates by 5.1–7.1% in the first 4 years following legal reform.	
Vasquez 2016	▲	Decriminalization lead to a decrease in the number of births in Mexico City by an additional 4% over what was seen in outlying areas, where legal abortion was not available. Little effect was seen on the fertility of adolescents, for whom parental authorizations remained in place. The greatest reduction in childbearing was among women aged 20–29 (decline of 12–18% probability).	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

Additional considerations

Study design and setting of included studies:

Antón 2016; Time-series design (n=not reported); Uruguay

Antón 2018; Time-series design (n=not reported); Uruguay

Clarke 2016; Time-series design (n=not reported); Mexico

Vasquez 2016; Time-series design (n=not reported); Mexico City, Mexico

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Findings table 3: Impact of criminalization on opportunity cost

OUTCOME: OPPORTUNITY COSTS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Criminalization results in some women having to travel to access an abortion, which is associated with travel costs, emotional distress, time off work, and lost wages. For women who choose to self-manage an abortion, this experience is sometimes associated with significant fear and distress.	Overall, evidence from 10 studies suggests that criminalization contributes to opportunity costs including traveling for abortion, delayed abortion and post abortion care, apprehension of legal repercussions, poor quality post abortion care, emotional distress, financial costs, internalized and experienced stigma, and sexual and financial exploitation. Evidence from 2 studies suggests that although criminalization may create fear among women it does not impact the decision to have an abortion.
Aiken 2017	▲	Where abortion is criminalized, women commonly report serious mental stress caused by their pregnancies and their inability to afford travel abroad to access abortion. The option of telemedicine for abortion services mitigates some of these opportunity costs. The feelings women most commonly report after completing an abortion are “relief” (70%) and “satisfaction” (36%). Women with financial hardship have twice the risk of lacking emotional support (OR = 2.0, <i>P</i> < 0.001).	
Aitken 2017 ²	▲	Some health-care providers perceive that criminalization contributes to isolation, stigma, shame, fear and stress among women in need of an abortion. In addition, some providers report seeing women returning from abroad with preventable infections and that some of these women delayed care seeking when experiencing complications, due to fear of legal repercussions.	
Arambepola 2014	○	Criminalization does not impact the decision to abort. Among women who carry their unintended pregnancies to term, only 4.2% (n=25) mention that the illegal status of abortion influenced their decision to keep the pregnancy.	

Casas 2014 ¹	▲	Criminalization contributes to opportunity costs including travel costs to access abortion and costs for illegal procedures. Further, criminalization creates and fuels an unregulated market for abortion medications. Some women are sold counterfeit drugs or ineffective drugs and thus experience subsequent abortion delays. In addition, some women seeking abortion care are exposed to sexual and financial exploitation but are unable to report it due to criminalization of abortion. They also do not seek out support or information from friends or relatives because they do not want to implicate people in their activities.
Citizens Coalition 2014	▲	Women who are prosecuted for criminal abortion are young (85% below 30 years) and have low levels of education (46.3% illiterate or completed 2 years of primary school; 25.6% attended secondary school or higher education). The majority are single (73%) and have no income or little income (80%).
Center for Reproductive Rights 2010 ¹	▲	Criminalization leads to fear of criminal liability among health-care providers and many hesitate to perform abortion under any circumstances. Criminalization is one factor of many that contributes to internalized stigma and poor quality of post abortion care – some women are abused, threatened, denied care and harassed by health-care providers when seeking care for abortion complications. Some women do not seek care for abortion complications as they fear being imprisoned.
Douglas 2013 ¹	▲	In order to avoid risk of prosecution, some physicians advise women to travel for abortion, acknowledging that this may incur several opportunity costs for the woman including financial costs, lack of support and distress.
Friedman 2019	▲	Living in a municipality where abortion is illegal is associated with less access to safe and legal abortion (reduction in access index = 58.6%; 95% CI 21.5–78.1) compared with living where abortion is legal.

Juarez 2019 ¹	○	Criminalization does not prevent women from having abortions despite awareness of the illegal status of abortion and fear of legal repercussions.
Påfs ¹	▲	Where abortion is criminalized, except in cases of rape or incest, the process to access legal abortion is so costly, laborious and time consuming, that few women attempt this pathway.
Suh 2014 ¹	▲	Where abortion is criminalized, some health-care providers prevent women suspected of induced abortion from leaving the hospital, so they are more easily found in case someone reports her to the police.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable

²These findings were reported by free text answers on a cross-sectional survey. Proportions of respondents not given.

Additional considerations

Study design and setting of included studies:

Aiken 2019; Qualitative individual interviews (n=30); Northern Ireland, United Kingdom of Great Britain and Northern Ireland

Aiken 2017; Retrospective cohort study (n=5650), Ireland and Northern Ireland, United Kingdom

Aitken 2017; Cross-sectional study (n=184); Ireland

Arambepola 2014; Case control study (n=771), Sri Lanka

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Citizens Coalition 2014; Legal case series (n=129); El Salvador

Center for Reproductive Rights (CRR) 2010; Legal review/Qualitative individual interviews (n=53); Philippines

Douglas 2013; Qualitative individual interviews (n=22); Australia

Friedman 2019; Time-series design (n=35 054); Mexico City, Mexico

Juarez 2019; Qualitative individual interviews (n=60); Mexico

Påfs 2019; Qualitative individual interviews (n=50); Rwanda

Suh 2014; Qualitative individual interviews (n=36); Senegal

Outcome: SELF-MANAGED ABORTION

Findings table 4: Impact of criminalization on self-managed abortion

OUTCOME: SELF-MANAGED ABORTION			
Human rights standards engaged: right to life, right to health, right to equality and non-discrimination, right to security of person, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Where abortion is criminalized, some women self-manage their abortions unlawfully.	Overall, evidence from 4 studies suggests that criminalization contributes to self-management of abortion. These abortions are sometimes unsafe.
Aiken 2017	▲	Where abortion is criminalized, women increasingly self-manage their abortions unlawfully with the help of telemedicine services.	
Casas 2014 ¹	▲	Criminalization contributes to self-management of abortion as some women who do not travel abroad for abortion, self-manage their abortions unlawfully, which is sometimes unsafe.	
CRR 2010 ¹	▲	Criminalization contributes to self-management of abortion that is unsafe and sometimes lead to death.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aiken 2019; Qualitative individual interviews (n=30); Northern Ireland, United Kingdom

Aiken 2017; Retrospective cohort study (n=5650), Ireland and Northern Ireland, United Kingdom

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Center for Reproductive Rights (CRR) 2010; Legal review/qualitative individual interviews (n=53); Philippines

Findings table 5: Impact of criminalization on unlawful abortion

OUTCOME: UNLAWFUL ABORTION			
Human rights standards engaged: right to life, right to health, right to equality and non-discrimination, right to security of person, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Where abortion is criminalized, some women self-manage their abortions unlawfully.	Overall, evidence from 8 studies suggests that criminalization contributes to unlawful abortion. These abortions are either self-managed or conducted in health-care facilities. They are sometimes unsafe and may lead to death.
Aiken 2017	▲	Where abortion is criminalized, women increasingly self-manage their abortions unlawfully with the help of telemedicine services.	
Arambepola 2014	▲	Criminalization contributes to unlawful abortion that is sometimes unsafe. Women report avoiding seeking care from health-care facilities or trained professionals due to the illegal status of abortion (100%, n=171). Only 20.5% (25/122) of women who obtain an abortion receive care from a qualified medical professional.	
Casas 2014 ¹	▲	Criminalization contributes to unlawful abortion as some women who do not travel abroad for abortion, engage in self-management of abortion or undergo abortions in health-care facilities unlawfully that are sometimes unsafe.	
CRR 2010 ¹	▲	Criminalization contributes to unlawful abortion that is sometimes unsafe.	
Juarez 2019 ¹	▲	Criminalization contributes to unlawful abortion that is sometimes unsafe.	
Van Dijk 2012 ¹	▲	Criminalization contributes to unlawful and unsafe abortion that sometimes leads to death	
Påfs 2019 ¹	▲	Criminalization contributes to a fear of litigation among health-care providers, denial of abortion and subsequent unlawful abortion, that is sometimes unsafe.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aiken 2019; Qualitative individual interviews (n=30); Northern Ireland, United Kingdom

Aiken 2017; Retrospective cohort study (n=5650), Ireland and Northern Ireland, United Kingdom

Arambepola 2014; Case control study (n=771), Sri Lanka

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Center for Reproductive Rights (CRR) 2010; Legal review/Qualitative individual interviews (n=53); Philippines

Juarez 2019; Qualitative individual interviews (n=60); Mexico

Van Dijk 2012; Review of medical charts (n=12); Mexico City, Mexico

Påfs 2019; Qualitative individual interviews (n=50); Rwanda

Findings table 6: Impact of criminalization on criminal justice procedures

OUTCOME: CRIMINAL JUSTICE PROCEDURES OF ABORTION SEEKERS			
Human rights standards engaged: right to health, right to information, right to equality and non-discrimination, right to security of person, right to be free from torture, and cruel, inhuman and degrading treatment, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Blystad 2019 ¹	○	Prosecutions and convictions of women are extremely rare.	Overall, evidence from 3 studies suggests that criminalization contributes to criminal justice procedures against women and girls, some of which lead to convictions. Evidence from 1 study indicates that criminalization creates fear of legal repercussions among women undergoing abortions; evidence from another study suggests that prosecutions and convictions against women are rare.
Casas 2014 ¹	▲	Criminalization leads to criminal investigations of women and girls. In a few cases, women are prosecuted and charged.	
Casseres 2018	▲	Where abortion is criminalized, some health-care providers report women seeking post abortion care to authorities, leading to criminal lawsuits and public prosecution.	
Citizens Coalition 2014	▲	Where abortion is criminalized, some women are prosecuted for abortion or aggravated homicide. A review of criminal justice procedures showed that out of 129 prosecuted women, 49 were convicted.	
Juarez 2019 ¹	○	Where abortion is criminalized, women undergoing abortions fear unwanted disclosure and subsequent legal justice procedures.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Blystad 2019; Qualitative individual interviews (n=79); Ethiopia, United Republic of Tanzania, Zambia

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile
Casseres 2018; Legal analysis
Citizens Coalition 2014; Legal case series (n=129); El Salvador
Juarez 2019; Qualitative individual interviews (n=60); Mexico

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POPULATION: Medical professionals providing abortion services

Outcome: *WORKLOAD IMPLICATIONS*

Findings table 7: Impact of criminalization on workload implications

OUTCOME: WORKLOAD IMPLICATIONS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
De Costa 2013 ¹	▲	Criminalization contributes to increased workload implications when physicians, in order to comply with the law, have to refer abortion seekers to psychiatrists and other physicians for second opinions. These procedures are perceived by some physicians as unnecessary and time consuming and as placing additional stress upon the woman.	Overall, evidence from 4 studies suggests that criminalization has increased workload implications for health-care providers who, in order to comply with regulations and avoid criminal investigations, have to refer women to other health-care professionals, provide detailed written statements and ensure documentation does not put themselves or their patients at risk.
Douglas 2013 ¹	▲	Criminalization contributes to increased workload implications when physicians, in order to not risk any criminal charges, have to provide written detailed statements that prove why an abortion is legally justified.	
Påfs 2019 ¹	▲	Where abortion is criminalized, the threat of police investigations makes health-care providers cautious about documentation in patient files and means they note all cases as spontaneous abortion.	
Suh 2014 ¹	▲	Where abortion is criminalized, health-care providers are cautious about documentation in patient files and registers, and mindful about how data is reported to the Ministry of Health.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable

Additional considerations

Study design and setting of included studies:

De Costa 2013; Qualitative individual interviews (n=22); Australia

Douglas 2013; Qualitative individual interviews (n=22); Australia

Påfs 2019; Qualitative individual interviews (n=50); Rwanda

Suh 2014; Qualitative individual interviews (n=36); Senegal

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Findings table 8: Impact of criminalization on referral to another provider

OUTCOME: REFERRAL TO ANOTHER PROVIDER			
Human rights standards engaged: Human rights standards engaged: Human rights standards engaged: right to life, right to health, right to security of person, right to equality and non-discrimination, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▲	In settings where abortion is criminalized, including for referral to another provider, 18/52 obstetrics/gynaecology trainees report having referred women to an agency where she can receive information on abortion services abroad, while 29/52 have been asked for a referral by a pregnant woman.	Overall, evidence from 1 study suggests that criminalization of abortion, including abortion referrals, will complicate women’s pathways to a safe and legal abortion.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional study (n=184); Ireland

Findings table 9: Impact of criminalization on system costs

OUTCOME: SYSTEM COST			
Human rights standards engaged: right to health, right to security of person, right to life,			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▲	Criminalization contributes to delayed abortion when health-care providers delay treating women with pregnancy complications until their lives are considered to be in danger. Among 33 physicians involved in the care of women with life threatening abortion complications, 27% (n=9) felt they had delayed abortion until a woman’s health had deteriorated until “the pregnancy was deemed a severe risk to life/health”.	Overall, evidence from 7 studies suggests that criminalization contributes to system costs. Four of these studies do so by showing how decriminalization impacts birth weight positively, decreases unplanned pregnancies and fertility, and decreases maternal mortality and severe abortion morbidity. Evidence from 3 studies shows that criminalization contributes to system costs by creating a black market for abortion medication, by delaying abortion and post abortion care until women are severely ill, by contributing to poor quality of post abortion care, and by preventing women from accessing evidence based, safe and effective treatment. Evidence from 1 study indicates that criminalization does not contribute to any system costs related to adolescent birth rates and finally, evidence from 1 study suggests that factors related to maternal health care and health status impact maternal mortality and not abortion legislation itself.
Antón 2016	○	Criminalization of abortion was not associated with a change in adolescent birth rates or birth outcomes (birthweight, prematurity, adequacy of prenatal care).	
Antón 2018	▲	Decriminalization of abortion is associated with an 8% decrease in births due to unplanned pregnancies. This decline is driven by a fall in fertility among women with secondary education, aged 20–34 years old.	
Casas 2014 ²	▲	Criminalization contributes to system costs by creating and fuelling a black market for abortifacients and facility-based care where providers are free to determine the fees.	
Clarke 2016	▲	Decriminalization is associated with reductions in maternal mortality. Following a law reform that gave women access to first trimester abortions on request, free of charge, maternal mortality fell by 8.8–16.2% among women aged 15–44 and by 14.9–30% among adolescents.	
CRR 2010 ²	▲	Criminalization deters women from seeking post-abortion care, as they fear harassment and legal repercussions. This results in delayed care-seeking for complications and women seeking care only when experiencing severe complications that may risk their health and life.	

		Banning of misoprostol has potential system costs as it prevents women from accessing evidence based, safe and effective means to end their pregnancies including for the treatment of post abortion complications. Furthermore, where therapeutic abortions are not accurately recorded, system readiness is impacted, increasing system costs.
Henderson 2013	▲	Decriminalization is associated with a decrease in the odds of serious abortion complications (aOR = 0.49; CI95% 0.37–0.64). The odds of sepsis are significantly reduced when comparing pre- and post de-criminalization (aOR 0.37; CI 95% 0.29–0.46).
Koch 2015	○	Differences in maternal mortality between settings with more restrictive and less restrictive abortion legislation are attributed to differences in maternal health care, fertility, literacy, intimate partner violence and sanitation, and not the abortion legislation itself.
Vasquez 2016	▲	Decriminalization leads to a decrease in the number of births by an additional 4%. In addition, decriminalization contributes to a reduction in the probability of childbearing by 12–18% among women aged 20–29. No change in adolescent fertility is observed.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ The study was not powered to look at this outcome. The data is limited by a low response rate (< 30%) which introduces risk of bias.

² Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional study (n=184); Ireland

Antón 2016; Time-series design (n=not reported); Uruguay

Antón 2018; Time-series design (n=not reported); Uruguay

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Clarke 2016; Time-series design (n=not reported); Mexico

Center for Reproductive Rights 2010; Legal review/Qualitative individual interviews (n=53); Philippines

Henderson 2013; Retrospective cohort study (n=23 493); Nepal
Koch 2015; Time-series design (n=not reported); Mexico
Vasquez 2016; Time-series design (n=not reported); Mexico City, Mexico

DRAFT

Outcome: IMPACT ON PROVIDER–PATIENT RELATIONSHIP

Findings table 10: Impact of criminalization on perceived impact on relationship with patient

OUTCOME: IMPACT ON PROVIDER–PATIENT RELATIONSHIP			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▲	Some health-care providers perceive that the care they provide is suboptimal, especially in cases of fetal anomaly, as criminalization prevents them from providing abortion care.	Evidence from 2 studies suggests that criminalization negatively impacts the provider–patient relationship.
Casas 2014 ²	▲	³ Where abortion is criminalized, some health-care providers perceive that when reporting is required, this impacts the provider–patient relationship negatively.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ The study was not powered to look at this outcome. The data is limited by a low response rate (< 30%) which introduces risk of bias.

² Qualitative study design: tests of statistical significance not applicable.

³ Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional study (n=184); Ireland

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Outcome: STIGMATIZATION

No studies identified

Outcome: HARASSMENT

No studies identified

Outcome: ANTI-ABORTION STING OPERATIONS

Findings table 11: Impact of criminalization on anti-abortion sting operations

OUTCOME: ANTI-ABORTION STING OPERATIONS			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Douglas 2013 ^a	○	Where abortion is criminalized, some physicians report apprehension of anti-abortion sting operations, which may lead to criminal justice procedures.	Overall, evidence from 2 studies suggests that criminalization contributes to apprehension of anti-abortion sting operations.
Påfs 2019 ¹	○	Where abortion is criminalized, some health-care providers provide abortion care clandestinely to avoid being reported to the police by a spy or someone else.	

^a Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Douglas 2013; Qualitative individual interviews (n=22); Australia
Påfs 2019; Qualitative individual interviews (n=50); Rwanda

Findings table 12: Impact of criminalization on criminal justice procedures

OUTCOME: CRIMINAL JUSTICE PROCEDURES OF HEALTH-CARE PROVIDERS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Douglas 2013 ¹	○	Where abortion is criminalized, some physicians report apprehension of criminal prosecution resulting from their clinical practice.	Overall, evidence from 1 study indicates that criminalization leads to criminal justice procedures against providers of abortion related information; while evidence from 3 studies suggests that health-care providers anticipate criminal justice procedures resulting from their clinical practice. In addition, evidence from one of these studies indicates that fear of criminal justice procedures leads to hesitancy to provide abortion care, including in cases of non-viable pregnancies.
Casas 2014 ¹	▲	² Criminalization leads to criminal investigations of providers of abortion information, including staff at abortion hotlines.	
De Costa 2013 ¹	○	Where abortion is criminalized, some health-care providers report apprehension of criminal prosecution resulting from their clinical practice.	
CRR 2010 ¹	○	Criminalization of abortion creates fear of criminal liability among some health-care providers and hesitation to provide abortion care, even in cases of non-viable pregnancies such as ectopic and molar pregnancies	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Douglas 2013; Qualitative individual interviews (n=22); Australia

De Costa 2013; Qualitative individual interviews (n=22); Australia

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Center for Reproductive Rights (CRR) 2010; Legal review/Qualitative individual interviews (n=53); Philippines

Findings table 13: Impact of criminalization on availability of trained providers

OUTCOME: AVAILABILITY OF TRAINED PROVIDERS			
Human rights standards engaged: right to life, right to health, right to be free from torture, and cruel, inhuman and degrading treatment, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▼	Out of 52 obstetrics/gynaecology trainees, 52% (n=27) would be interested in abortion provision training as part of their curriculum, 30% (n=16) are not interested and 15% (n=8) are unsure.	Overall, evidence from 3 studies suggests that criminalization contributes to lower availability of trained providers and a loss of relevant skills.
CRR 2010 ²	▼	Criminalization contributes to a lack of training opportunities in abortion care for health-care providers and unwillingness among some clinicians to learn about abortion.	
Douglas 2013 ²	▼	Criminalization contributes to a lack of training opportunities in abortion care for physicians, and unwillingness among some clinicians to learn about abortion. This in turn leads to a lack of relevant skills among specialists in obstetrics and gynaecology.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ The study was not powered to look at this outcome. The data is limited by a low response rate (< 30%) which introduces risk of bias.

² Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional study (n=184); Ireland

Center for Reproductive Rights (CRR) 2010; Legal review/qualitative individual interviews (n=53); Philippines

Douglas 2013; Qualitative individual interviews (n=22); Australia

Findings table 14: Impact of criminalization on reporting of suspected unlawful abortion

OUTCOME: REPORTING OF SUSPECTED UNLAWFUL ABORTIONS			
Human rights standards engaged: right to health, right to information, to security of person, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▲	While most health-care providers (74%, n=39/52) would not report a woman who has had an abortion by procuring medications illegally to the police, 14% (n=7/52) are unsure.	Overall, evidence from 7 studies suggests that some health-care providers report or would report a woman suspected of an induced abortion, while evidence from 2 studies indicate that health-care providers generally do not report women to authorities. Where abortion is criminalized, there is not always a consensus among health-care providers about when, whether and if one should report. While some never report in order to avoid being dragged into an investigation, others report to protect themselves from any legal repercussions.
Blystad 2019 ²	○	Where abortion is criminalized, health-care providers generally do not report women to the authorities.	
Casas 2014 ²	▲	Women seeking post abortion care risk being reported to the authorities. Some physicians perceive that some “obvious cases” leave them no option other than to report.	
Casseres 2018	▲	Where abortion is criminalized, some health-care providers report women seeking post abortion care to authorities leading to criminal lawsuits. Women seeking care following a self-induced abortion who are reported are more likely to be Black and to have only completed primary school.	
Citizen’s Coalition 2014	▲	Where abortion is criminalized, some health-care providers at public institutions report women seeking post abortion care to authorities leading to criminal lawsuits. Some reports are made by police officers.	
CRR 2010 ²	▲	Where abortion is criminalized, some health-care providers report women seeking post abortion care to authorities and believe it is their duty to do so. Some threaten to report women and force them to sign statements admitting guilt to protect themselves from any legal repercussions. Others refrain from reporting due to fear of being dragged into a legal investigation.	

Påfs 2019 ²	▲	Where abortion is criminalized, there is a lack of consensus among health-care providers about whether or not one should report women suspected of induced abortion to the police. While most providers do not report women, some do in order to protect themselves from litigation.
Suh 2014 ²	○	Where abortion is criminalized, health-care providers generally do not report women suspected of induced abortion and all cases are recorded as spontaneous abortion.
Van Dijk 2012	▲	Where abortion is criminalized and health-care facilities are obliged to report women suspected of induced abortion, reporting is largely dependent on the physician and the hospital director.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ The study was not powered to look at this outcome. The data is limited by a low response rate (< 30%) which introduces risk of bias.

² Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional study (n=184); Ireland

Blystad 2019; Qualitative individual interviews (n=79); Ethiopia, United Republic of Tanzania, Zambia

Casas 2014; Legal analysis and qualitative individual interviews (n=61); Chile

Casseres 2018; Legal commentary

Citizens Coalition 2014; Legal case series (n=129); El Salvador

Center for Reproductive Rights 2010; Legal review/Qualitative individual interviews (n=53); Philippines

Påfs 2019; Qualitative individual interviews (n=50); Rwanda

Suh 2014; Qualitative individual interviews (n=36); Senegal

Van Dijk 2012; Review of medical charts (n=12); Mexico City, Mexico

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Overall, evidence from 3 studies suggests that criminalization contributes to abortion delay. While evidence from 2 of these studies suggests that criminalization leads to health-care providers delaying care to women who are suffering from severe pregnancy complications, evidence from 1 study indicates that while criminalization does not stop women from having abortion, it complicates women's abortion pathways, and thereby delays abortion.

Continuation of pregnancy

- Overall evidence from 3 studies suggests that criminalization indirectly contributes to increased continuation of pregnancy; decriminalization is associated with reductions in birth rates. While 2 of these studies suggests that criminalization affects the birth rates of women 20–29 and 20–34 years in particular, 1 study points to a greater impact among adolescents. Evidence from 1 study suggests that criminalization does not impact adolescent birth rates.

Opportunity costs

- Overall, evidence from 10 studies suggests that criminalization contributes to opportunity costs including traveling for abortion, delayed abortion and post abortion care, apprehension of legal repercussions, poor quality post abortion care, emotional distress, financial costs, internalized and experienced stigma, and sexual and financial exploitation.
- Evidence from 2 studies suggests that although criminalization may create fear among women it does not impact the decision to have an abortion.

Self-managed abortion

- Overall, evidence from 4 studies suggests that criminalization contributes to self-management of abortion. These abortions are sometimes unsafe.

Unlawful abortion

- Overall, evidence from 8 studies suggests that criminalization contributes to unlawful abortion. These abortions are either self-managed or conducted in health-care facilities. They are sometimes unsafe and may lead to death.

Criminal justice procedures

- Overall, evidence from 3 studies suggests that criminalization contributes to criminal justice procedures against women and girls, some of which lead to convictions. Evidence from 1 study indicates that criminalization creates fear of legal repercussions among women undergoing abortions, and evidence from another study suggests that prosecutions and convictions against women are rare.

Workload implications

- Overall, evidence from 4 studies suggests that criminalization has increased workload implications for health-care providers who, in order to comply with regulations and avoid criminal investigations, have to refer women to other health-care professionals, provide detailed written statements and ensure documentation does not put themselves or their patients at risk.

Referral to another provider

- Overall, evidence from 1 study suggests that criminalization of abortion, including abortion referrals, will complicate women's pathways to a safe and legal abortion.

System costs

- Overall, evidence from 7 studies suggests that criminalization contributes to system costs. Four of these studies do so by showing how decriminalization impacts birth weight positively, decreases unplanned pregnancies and fertility, and decreases maternal mortality and severe abortion morbidity.
- Evidence from 3 studies shows that criminalization contributes to system costs by creating a black market for abortion medication, by delaying abortion and post abortion care until women are severely ill, by contributing to poor quality of post abortion care, and by preventing women from accessing evidence based, safe and effective treatment.
- Evidence from 1 study indicates that criminalization does not contribute to any system costs related to adolescent birth rates and finally, evidence from 1 study suggests that factors related to maternal health-care and health status impact maternal mortality and not abortion legislation itself.

Impact on provider–patient relationship

- Evidence from 2 studies suggests that criminalization negatively impacts the provider–patient relationship.

Stigmatization

- No studies identified

Harassment

- No studies identified

Criminal justice sting operations

- Overall, evidence from 2 studies suggests that criminalization contributes to apprehension of anti-abortion sting operations

Criminal justice procedures

- Overall, evidence from 1 study indicates that criminalization leads to criminal justice procedures against providers of abortion related information providers; while evidence from 3 studies suggests that health-care providers anticipate criminal justice procedures resulting from their clinical practice. In addition, evidence from one of these studies indicates that fear of criminal justice procedures leads to hesitancy to provide abortion care, including in cases of non-viable pregnancies.

Availability of trained providers

- Overall, evidence from 3 studies suggests that criminalization contributes to lower availability of trained providers and a loss of relevant skills.

Reporting of suspected unlawful abortion

- Overall, evidence from 7 studies suggests that some health-care providers report or would report a woman suspected of an induced abortion, while evidence from 2 studies indicate that health-care providers generally don't report women to authorities. Where abortion is criminalized, there is not always a consensus among health-care providers about whether and if so when one should report. While some never report in order to avoid being dragged into an investigation, others report to protect themselves from any legal repercussions.

DRAFT

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Criminalization

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	<p>Overall, evidence from 3 studies suggests that criminalization contributes to abortion delay.</p> <p>While evidence from 2 of these studies suggests that criminalization leads to health-care providers delaying care to women who are suffering from severe pregnancy complications, evidence from 1 study suggests that while criminalization does not stop women from having abortion, it complicates women’s abortion pathways, and thereby delays abortion.</p>	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Criminalization can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions	▲	Criminalization can result in delayed access to abortion care. Where such delays are associated with unsafe abortion, they have negative implications for rights.
		States should protect people seeking abortion	▲	Criminalization can result in delayed access to abortion care. Such delays may be associated with unsafe abortion or increased risks of maternal mortality or morbidity, with negative implications for rights.
		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons’ physical and mental integrity	▲	Criminalization may not result in continued pregnancy, but may be associated with exposure to delayed abortion which might be unsafe. Criminalization that has a disproportionately negative effect on the health and physical and mental integrity of abortion seekers has negative implications for rights.
		Criminalization of abortion may constitute a human rights violation.	▲	Where criminalization is associated with delayed abortion and such abortion is unsafe or associated with increased risks of maternal mortality or morbidity, criminalization has negative implications for rights.

Continuation of Pregnancy	Overall evidence from 3 studies suggests that criminalization indirectly contributes to increased continuation of pregnancy; decriminalization is associated with reductions in birth rates. While 2 of these studies suggests that criminalization affects the birth rates of women 20–29 and 20–34 years in particular, 1 study points to a greater impact among adolescents. Evidence from 1 study suggests that criminalization does not impact adolescent birth rates.	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Criminalization is associated with continuation of pregnancy. Where that is undesired, the impacts on health, physical and mental integrity of continuation of pregnancy may be disproportionate with negative implications for rights.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.	▲	Where criminalization is associated with continuation of pregnancy that may be disproportionately the case for younger women and girls. In such situations, criminalization has negative implications for rights.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, government or health authorities.	▲	Criminalization is associated with continuation of pregnancy. Where that is undesired, criminalization constitutes a limitation on a woman’s decision about whether to have a child with negative implications for rights.
		States should ensure appropriate sexual and reproductive health (SRH) care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest.	▲	Criminalization is associated with continuation of pregnancy. Where abortion is criminalized in situations of sexual violence, this criminalization has negative implications for rights.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Criminalization is associated with continuation of pregnancy. Where abortion is criminalized in situations of therapeutic abortion, this criminalization has negative implications for rights.
Opportunity Costs	Overall, evidence from 10 studies suggests that criminalization contributes to	States should protect people seeking abortion.	▲	Criminalization contributes to opportunity costs for those accessing or seeking abortion, with negative implications for rights.

	<p>opportunity costs including traveling for abortion, delayed abortion and post abortion care, apprehension of legal repercussions, poor quality post abortion care, emotional distress, financial costs, internalized and experienced stigma, and sexual and financial exploitation.</p> <p>Evidence from 2 studies suggests that although criminalization may create fear among women it does not impact the decision to have an abortion.</p>	<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	▲	<p>Criminalization contributes to opportunity costs for those accessing or seeking abortion, but may not deter abortion. Failure to ensure criminalization does not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights.</p>
Self-managed abortion	<p>Overall, evidence from 4 studies suggests that criminalization contributes to self-management of abortion. These abortions are sometimes unsafe.</p>	<p>States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.</p>	▲	<p>Criminalization may be associated with recourse to self-management of abortion. Where self-management of abortion increases risks of maternal mortality or morbidity, criminalization has negative implications for rights.</p>
		<p>States must protect people from the physical and mental health risks associated with unsafe abortions.</p>	▲	<p>Criminalization may be associated with recourse to self-management of abortion. Where such self-management of abortion is unsafe, criminalization has negative implications for rights.</p>
Unlawful Abortion	<p>Overall, evidence from 8 studies suggests that criminalization contributes to unlawful abortion. These abortions are either self-managed or conducted in health-care facilities. They are sometimes unsafe and may lead to death.</p>	<p>States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.</p>	▲	<p>Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.</p>
		<p>States must protect people from the physical and mental health risks associated with unsafe abortions.</p>	▲	<p>Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.</p>

		States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest.	▲	Criminalization is associated with access to unlawful abortion, which may be unsafe. Where abortion is criminalized in situations of sexual violence, this criminalization has negative implications for rights.
		States should protect people seeking abortion.	▲	Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.
		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.
		Criminalization of abortion may constitute a human rights violation.	▲	Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Criminalization is associated with access to unlawful abortion, which may be unsafe. Where abortion is criminalized in situations of therapeutic abortion, this criminalization has negative implications for rights.
Criminal Justice Procedures	Overall, evidence from 3 studies suggests that criminalization contributes to criminal justice procedures against women and girls, some of which lead to convictions. Evidence from 1 study indicates that criminalization creates fear of legal repercussions among women undergoing abortions, and evidence from another study suggests that	Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction.	▲	Where seeking or accessing abortion information exposes an abortion seeker to criminalization, such criminalization has negative implications for rights.
		States must provide post-abortion care in all circumstances including where abortion is illegal.	▲	Where seeking or accessing post-abortion care exposes a woman or girl to criminalization, such criminalization has negative implications for rights.
		States should protect people seeking abortion.	▲	Criminalization exposes women and girls to criminal proceedings, and to the risks associated with not accessing, support, timely information, or timely post-abortion care. This has negative implications for rights.

prosecutions and convictions against women are rare.	Criminalization of abortion may constitute a human rights violation.	▲	Criminalization exposes women and girls to criminal proceedings, and to the risks associated with not accessing, support, timely information, or timely post-abortion care. This has negative implications for rights.
	SRH services including abortion and post-abortion care must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	▲	Criminalization exposes women and girls to involuntary disclosure of seeking to access, or having accessed, abortion with negative implications for rights.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Criminalization

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Workload Implications	Overall, evidence from 4 studies suggests that criminalization has increased workload implications for health-care providers who, in order to comply with regulations and avoid criminal investigations, have to refer women to other health-care professionals, provide detailed written statements and ensure documentation does not put themselves or their patients at risk.	States should protect health-care professionals providing abortion care.	▲	Workload implications arising from criminalization place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Workload implications arising from criminalization may result in reduced or hindered access to comprehensive abortion care. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.
Referral to Another Provider	Overall, evidence from 1 study suggests that criminalization of abortion, including abortion referrals, will complicate women’s pathways to a safe and legal abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Criminalization can result in complications in accessing safe abortion care. Where such complications increase risks of maternal mortality or morbidity, they have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions	▲	Criminalization can result in complications in accessing safe abortion care Where such complications are associated with unsafe abortion, they have negative implications for rights.
		States should protect people seeking abortion	▲	Criminalization can result in complications in accessing safe abortion care. Such complications may be associated with unsafe abortion or increased risks of maternal mortality or morbidity, with negative implications for rights.

		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Criminalization can result in complications in accessing safe abortion care. Criminalization that has a disproportionately negative effect on the health and physical and mental integrity of abortion seekers has negative implications for rights.
		Criminalization of abortion may constitute a human rights violation.	▲	Where criminalization is associated with complications in referral for abortion, and such complications are associated with increased risks of maternal mortality or morbidity, criminalization has negative implications for rights.
System Cost	Overall, evidence from 7 studies suggests that criminalization contributes to system costs. Four of these studies do so by showing how decriminalization impacts birth weight positively, decreases unplanned pregnancies and fertility, and decreases maternal mortality and severe abortion morbidity. Evidence from 3 studies shows that criminalization contributes to system costs by creating a black market for abortion medication, by delaying abortion and post abortion care until women are severely ill, by	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Criminalization is associated with system costs, which may constitute a disproportionate interference with the rights of abortion seekers.
		States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Criminalization is associated with system costs, including those related to access to unlawful abortion, unsafe abortion, and increased maternal morbidity and mortality. Thus, criminalization has negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Criminalization is associated with system costs, including those related to access to unlawful abortion, unsafe abortion, and increased maternal morbidity and mortality. Thus, criminalization has negative implications for rights.

	<p>contributing to poor quality of post abortion care, and by preventing women from accessing evidence based, safe and effective treatment.</p> <p>Evidence from 1 study indicates that criminalization does not contribute to any system costs related to adolescent birth rates and finally, evidence from 1 study suggests that factors related to maternal health-care and health status impact maternal mortality and not abortion legislation itself.</p>	States should protect people seeking abortion.	▲	Criminalization is associated with system costs, including those related to access to unlawful abortion, unsafe abortion, and increased maternal morbidity and mortality. Thus, criminalization has negative implications for rights.
Impact on Provider/Patient Relationship	Evidence from 2 studies suggests that criminalization negatively impacts the provider–patient relationship.	States should protect people seeking abortion.	▲	Criminalization can impact negatively on the doctor–patient relationship, with negative implications for women and girls’ right to health.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Criminalization can impact negative on the doctor–patient relationship and may interfere disproportionately with abortion seekers’ rights to health and to physical and mental integrity.
Stigmatization	No studies identified			
Harassment	No studies identified			
Anti-Abortion Sting Operations	Overall, evidence from 2 studies suggests that criminalization contributes to apprehension of anti-abortion sting operations	States should protect health-care professionals providing abortion care	▲	Where criminalization is associated with anti-abortion sting operations, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.

Criminal Justice Procedures against Health-care Providers	Overall, evidence from 1 study indicates that criminalization leads to criminal justice procedures against providers of abortion related information; while evidence from 3 studies suggests that health-care providers anticipate criminal justice procedures resulting from their clinical practice. In addition, evidence from one of these studies indicates that fear of criminal justice procedures leads to hesitancy to provide abortion care, including in cases of non-viable pregnancies.	States should ensure laws regulating abortion are evidence based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Actual or apprehended criminal justice procedures against health-care providers associated with criminalization may result in reduced or hindered access to comprehensive abortion care. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Actual or apprehended criminal justice procedures against health-care providers associated with criminalization may result in reduced or hindered access to comprehensive abortion care. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.
		States should protect health-care professionals providing abortion care.	▲	Where criminalization is associated with apprehended or actual criminal justice procedures against health-care providers, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.
Availability of Trained Providers	Overall, evidence from 3 studies suggests that criminalization contributes to lower availability of trained providers and a loss of relevant skills.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for the reduction of maternal mortality and morbidity and, thus, for human rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for the availability of competent providers for exceptions to criminalization.

		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for exposure to the physical and mental health risks associated with unsafe abortion and thus, for human rights.
		States should protect people seeking abortion.	▲	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for the reduction of maternal mortality and morbidity, the availability of competent providers for exceptions to criminalization, and exposure to the physical and mental health risks associated with unsafe abortion and thus, for human rights.
		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, which may have disproportionate negative impact on the rights of those seeking comprehensive abortion care.
Reporting of Suspected Unlawful Abortions	Overall, evidence from 7 studies suggests that some health-care providers report or would report a woman suspected of an induced abortion, while evidence from 2 studies indicate that health-care providers generally do not report women to authorities. Where abortion is criminalized, there is not always a consensus among health-care providers about when, whether and if one should report. While some never report in order to avoid being dragged into an investigation, others report to protect themselves from any	Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction.	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may deter women and girls from seeking or safely accessing abortion information with negative implications for rights.
		States must provide post-abortion care in all circumstances including where abortion is illegal.	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may deter women and girls from seeking or safely accessing post-abortion care with negative implications for rights.
		States should protect health-care professionals providing abortion care.	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may put health-care professionals who conscientiously provide comprehensive abortion care and information

	legal repercussions.			at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.
		States should protect people seeking abortion.	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion this may deter people seeking abortion from accessing comprehensive abortion care including information and referral within the formal medical system, with negative implications for rights.
		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion this may have disproportionate impacts on abortion seekers' right to health, and physical and mental integrity.
		SRH services including abortion and post-abortion care must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	▲	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion this exposes women and girls to involuntary disclosure of seeking to access, or having accessed, abortion with negative implications for rights.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON CRIMINALIZATION WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: CRIMINALIZATION: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	Overall, evidence from 3 studies suggests that criminalization contributes to abortion delay. While evidence from 2 of these studies suggests that criminalization leads to health-care providers delaying care to women who are suffering from severe pregnancy complications, evidence from 1 study suggests that while criminalization does not stop women from having abortion, it complicates women’s abortion pathways, and thereby delays abortion.	Criminalization can result in delayed access to abortion care. Such delays may be associated with unsafe abortion or increased risks of maternal mortality or morbidity, with negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Continuation of Pregnancy	Overall evidence from 3 studies suggests that criminalization indirectly contributes to increased continuation of pregnancy; decriminalization is associated with reductions in birth rates. While 2 of these studies suggests that criminalization affects the birth rates of women 20–29 and 20–34 years in particular, 1 study points to a greater impact among adolescents. Evidence from 1 study suggests that criminalization does not impact adolescent birth rates.	Criminalization is associated with continuation of pregnancy. Where that is undesired, this has negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Opportunity Costs	Overall, evidence from 10 studies suggests that criminalization contributes to opportunity costs including traveling for abortion, delayed abortion and post abortion care, apprehension of legal repercussions, poor quality post abortion care, emotional distress, financial costs, internalized and experienced stigma, and sexual and financial exploitation. Evidence from 2 studies suggests that although criminalization may create fear among women it does not impact the decision to have an abortion.	Criminalization contributes to opportunity costs for those accessing or seeking abortion, with negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.

Self-managed Abortion	Overall, evidence from 4 studies suggests that criminalization contributes to self-management of abortion. These abortions are sometimes unsafe.	Criminalization may be associated with recourse to self-management of abortion. Where such self-management of abortion is unsafe, or increase risks of maternal mortality or morbidity, criminalization has negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Unlawful Abortion	Overall, evidence from 8 studies suggests that criminalization contributes to unlawful abortion. These abortions are either self-managed or conducted in health-care facilities. They are sometimes unsafe and may lead to death.	Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of maternal mortality and morbidity, with negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Criminal Justice Procedures	Overall, evidence from 3 studies suggests that criminalization contributes to criminal justice procedures against women and girls, some of which lead to convictions. Evidence from 1 study indicates that criminalization creates fear of legal repercussions among women undergoing abortions, and evidence from another study suggests that prosecutions and convictions against women are rare.	Criminalization exposes women and girls to criminal proceedings, and to the risks associated with not accessing, support, timely information, or timely post-abortion care. This has negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Workload Implications	Overall, evidence from 4 studies suggests that criminalization has increased workload implications for health-care providers who, in order to comply with regulations and avoid criminal investigations, have to refer women to other health-care professionals, provide detailed written statements and ensure documentation does not put themselves or their patients at risk.	Workload implications arising from criminalization place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Referral to Another Provider	Overall, evidence from 1 study suggests that criminalization of abortion, including abortion referrals, will complicate women's pathways to a safe and legal abortion.	Criminalization can result in complications in accessing safe abortion care. Where such complications increase risks of maternal mortality or morbidity, they have negative implications for rights. Criminalization may deter people seeking abortion or who have availed of abortion from accessing comprehensive abortion care including referral within the formal	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.

		medical system, with negative implications for rights.	
System Cost	<p>Overall, evidence from 7 studies suggests that criminalization contributes to system costs. Four of these studies do so by showing how decriminalization impacts birth weight positively, decreases unplanned pregnancies and fertility, and decreases maternal mortality and severe abortion morbidity.</p> <p>Evidence from 3 studies shows that criminalization contributes to system costs by creating a black market for abortion medication, by delaying abortion and post abortion care until women are severely ill, by contributing to poor quality of post abortion care, and by preventing women from accessing evidence based, safe and effective treatment.</p> <p>Evidence from 1 study indicates that criminalization does not contribute to any system costs related to adolescent birth rates and finally, evidence from 1 study suggests that factors related to maternal health-care and health status impact maternal mortality and not abortion legislation itself.</p>	Criminalization is associated with system costs, including those related to access to unlawful abortion, unsafe abortion, and increased maternal morbidity and mortality. Thus, criminalization has negative implications for rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Impact on Provider/Patient Relationship	Evidence from 2 studies suggests that criminalization negatively impacts the provider-patient relationship.	Criminalization can impact negatively on the doctor-patient relationship, with negative implications for women and girls' right to health.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Stigmatization	No studies identified	Criminalization of abortion may lead to stigmatization of abortion care provision with implications for the professional life, health, and well-being of health-care professionals.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.

		The implications for health-care professionals of criminalization may reduce the number of willing providers of lawful abortion, abortion information, or post-abortion care with implications for the health and rights of abortion seekers or persons who have accessed abortion including unsafe abortion.	
Harassment	No studies identified	Criminalization of abortion may expose health-care professionals to risks of harassment, criminal prosecution, or “sting” operations. The implications for health-care professionals of criminalization may reduce the number of willing providers of lawful abortion, abortion information, or post-abortion care with implications for the health and rights of abortion seekers or persons who have accessed abortion including unsafe abortion.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Anti-Abortion Sting Operations	Overall, evidence from 2 studies suggests that criminalization contributes to apprehension of anti-abortion sting operations	Where criminalization is associated with anti-abortion sting operations, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Criminal Justice Procedures against Health-care Professionals	Overall, evidence from 1 study indicates that criminalization leads to criminal justice procedures against providers of abortion related information; while evidence from 3 studies suggests that health-care providers anticipate criminal justice procedures resulting from their clinical practice. In addition, evidence from one of these studies indicates that fear of criminal justice procedures	Actual or apprehended criminal justice procedures against health-care providers associated with criminalization may result in reduced or hindered access to comprehensive abortion care. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.

	leads to hesitancy to provide abortion care, including in cases of non-viable pregnancies.	Where criminalization is associated with apprehended or actual criminal justice procedures against health-care providers, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.	
Availability of Trained Providers	Overall, evidence from 3 studies suggests that criminalization contributes to lower availability of trained providers and a loss of relevant skills.	Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for the availability of competent providers for exceptions to criminalization, for the reduction of maternal mortality and morbidity and, thus, for human rights.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.
Reporting of Suspected Unlawful Abortions	Overall, evidence from 7 studies suggests that some health-care providers report or would report a woman suspected of an induced abortion, while evidence from 2 studies indicate that health-care providers generally do not report women to authorities. Where abortion is criminalized, there is not always a consensus among health-care providers about when, whether and if one should report. While some never report in order to avoid being dragged into an investigation, others report to protect themselves from any legal repercussions.	Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may deter women and girls from seeking or safely accessing abortion information with negative implications for rights. Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.	We recommend against the criminalization of accessing, providing, or assisting in availing of any part of comprehensive abortion care.

DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- Criminalization may not result in continued pregnancy, but may be associated with exposure to delayed abortion which might be unsafe.
- Where criminalization is associated with delayed abortion and such abortion is unsafe or associated with increased risks of maternal mortality or morbidity, criminalization has negative implications for rights.
- Criminalization that has a disproportionately negative effect on the health and physical and mental integrity of abortion seekers has negative implications for rights.

Continuation of pregnancy

- Criminalization is associated with continuation of pregnancy.
- Where continuation of pregnancy is undesired, criminalization constitutes a limitation on a woman's decision about whether to have a child with negative implications for rights.
- Where continuation of pregnancy is undesired, the impacts on health, physical and mental integrity of continuation of pregnancy may be disproportionate with negative implications for rights.
- Where criminalization is associated with continuation of pregnancy that may disproportionately impact younger women and girls, criminalization has negative implications for rights.
- Where abortion is criminalized in situations of sexual violence, this criminalization has negative implications for rights.
- Where abortion is criminalized in situations of therapeutic abortion, this criminalization has negative implications for rights.

Opportunity costs

- Criminalization contributes to opportunity costs for those accessing or seeking abortion, with negative implications for rights. While this may not deter abortion, failure to ensure criminalization does not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights.

Self-managed abortion

- Criminalization may be associated with recourse to self-management of abortion. Where self-management of abortion increases risks of maternal mortality or morbidity, criminalization has negative implications for rights.
- Criminalization may be associated with recourse to self-management of abortion. Where such self-management of abortion is unsafe, criminalization has negative implications for rights.

Unlawful abortion

- Criminalization is associated with access to unlawful abortion. Such unlawful abortion may be unsafe and/or increase risks of

maternal mortality and morbidity, with negative implications for rights.

- Where abortion is criminalized in situations of sexual violence, this criminalization has negative implications for rights.
- Where abortion is criminalized in situations of therapeutic abortion, this criminalization has negative implications for rights.

Criminal justice procedures

- Criminalization exposes women and girls to criminal proceedings, and to the risks associated with not accessing support, timely information, or timely post-abortion care. This has negative implications for rights.
- Criminalization exposes women and girls to involuntary disclosure of seeking to access, or having accessed, abortion, with negative implications for rights.
- Where seeking or accessing abortion information exposes an abortion seeker to criminalization, such criminalization has negative implications for rights.
- Where seeking or accessing post-abortion care exposes a woman or girl to criminalization, such criminalization has negative implications for rights.

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- Workload implications arising from criminalization place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.
- Workload implications arising from criminalization may result in reduced or hindered access to comprehensive abortion care. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.

Referral to another provider

- Criminalization can result in complications in accessing safe abortion care. Such complications may be associated with unsafe abortion or increased risks of maternal mortality or morbidity, with negative implications for rights.
- Criminalization that has a disproportionately negative effect on the health and physical and mental integrity of abortion seekers has negative implications for rights.
- Where criminalization is associated with complications in referral for abortion, and such complications are associated with increased risks of maternal mortality or morbidity, criminalization has negative implications for rights.

System costs

- Criminalization is associated with system costs, which may constitute a disproportionate interference with the rights of abortion seekers. This includes system costs related to access to unlawful abortion, unsafe abortion, and increased maternal morbidity and mortality. Thus, criminalization has negative implications for rights.

Impact on provider–patient relationship

- Criminalization can impact negatively on the doctor-patient relationship, with negative implications for women and girls’ right to health.
- Criminalization can impact negative on the doctor-patient relationship and may interfere disproportionately with abortion seekers’ rights to health and to physical and mental integrity.

Stigmatization

- No studies identified

Harassment

- No studies identified

Anti-abortion sting operations

- Where criminalization is associated with anti-abortion sting operations, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.

Criminal justice procedures

- Where criminalization is associated with apprehended or actual criminal justice procedures against health-care providers, access to comprehensive abortion care may be hindered. Where this is the case, criminalization interferes disproportionately with rights to health and to physical and mental integrity.
- Where criminalization is associated with apprehended or actual criminal justice procedures against health-care providers, this may put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had abortions.

Availability of trained providers

- Criminalization is associated with reduced availability of trained providers and a loss of relevant skills, with implications for the reduction of maternal mortality and morbidity, the availability of competent providers for exceptions to criminalization, and exposure to the physical and mental health risks associated with unsafe abortion and thus, for human rights.
- Where criminalization is associated with reduced availability of trained providers and a loss of relevant skills, this may have disproportionate negative impact on the rights of those seeking comprehensive abortion care.

Reporting of suspected unlawful abortion

- Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion, this may deter women and girls from seeking or safely accessing post abortion care with negative implications for rights. This may also put health-care professionals who conscientiously provide comprehensive abortion care and information at risk of legal or professional sanction, with negative implications for their rights and the rights of abortion seekers or those who have had

abortions.

- Where criminalization requires or results in health-care professionals reporting suspected unlawful abortion this may deter people seeking abortion from accessing comprehensive abortion care including information and referral within the formal medical system, with negative implications for rights. This may also have disproportionate impacts on abortion seekers' right to health, and physical and mental integrity, and exposes women and girls to involuntary disclosure of seeking to access, or having accessed, abortion with negative implications for rights.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes, we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy, and affordable care with as few logistical burdens as possible. We can also assume that health-care providers, regardless if they participate in abortion care or not, value reasonable workloads, and avoidance of harassment and stigmatization. Finally, we can assume that both abortion seekers and health-care providers value avoidance of criminal justice procedures and anti-abortion sting operations.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does the intervention *criminalization*.

Resources:

The studies did not speak to the issue of resources.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability or feasibility.

Equity:

Some studies included in this framework speak to the issue of equity by providing evidence on the disproportionate impact of the intervention on abortion seekers.

Criminalization: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Criminalization
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	Right to Life Right to health	CESCR: General Comment (GC) 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland</i> , <i>Mellet v Ireland</i> , <i>LMR v Argentina</i> CRC: GC 4 CEDAW: General Recommendation (GR) 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report: 2017, 2018 Working Group on Discrimination against Women Report 2016	<ul style="list-style-type: none"> • Criminalization of abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • Criminalization may lead to delays in accessing abortion as people seek to travel to jurisdictions where criminalization does not apply. • Such delays may expose women to risks of maternal mortality or morbidity. • Criminalization of abortion may make persons who have access unlawful abortion reluctant to seek post-abortion care, including in situations of post-abortion complication. • In such cases, criminalization may expose abortion seekers to violations of the right to life and the right to health. • Criminalization of abortion may expose abortion seekers to violence, exploitation, and other forms of harm from persons providing unlawful abortion services with implications for human rights including the rights to life, health, and right to a remedy.

<p>Where it is lawful, abortion must be safe and accessible.</p>	<p>The right to health</p> <p>The right to be free from torture, and cruel, inhuman and degrading treatment</p>	<p>CCPR: GC 36, <i>LMR v Argentina</i>, <i>LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • In some cases criminalization can be partial, e.g. abortion is criminalized only in certain circumstances (“grounds-based” approach), at certain gestational ages, or for certain providers (“provider restrictions”). • In such cases criminalization may result in a chilling effect for persons permitted to provide abortion, overly conservative interpretation or application of law, or reluctance to provide abortions considered to be “close” to criminalized procedures or situations. • Thus, criminalization can operate in conjunction with other limitations and interventions in order to make lawful abortion less accessible in practice.
<p>States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.</p>	<p>Right to health Right to equality and non-discrimination Right of persons with disabilities to retain fertility on an equal basis with others</p>	<p>CCPR GC 36 CRC GC 4; GC 15 CRPD GC 3, GC 6 Special Rapporteur on Health Report, 2016</p>	<ul style="list-style-type: none"> • Criminalization of abortion makes unlawful a medical procedure exclusively required by pregnant people, the vast majority of whom are women and girls, and thus impacts disproportionately on women and girls with possible implications for the right to equality and non-discrimination. • The opportunity costs involved in accessing safe abortion in a context of criminalization are unevenly distributed across different populations of abortion seekers with possible implications for the right to equality and non-discrimination. • Inability to avail of safe abortion in a context of criminalization is unevenly experienced across different populations of abortion seekers with possible implications for the right to equality and non-discrimination.

			<ul style="list-style-type: none"> • Risks of exploitation and violence involved in accessing abortion in the context of criminalization are unevenly distributed across different populations of abortion seekers with possible implications for the right to equality and non-discrimination. • Discriminatory patterns in criminal justice systems, policing, and prosecutions may be replicated in the context of abortion criminalization with possible implications for the right to equality and non-discrimination.
States must protect people from the physical and mental health risks associated with unsafe abortions.	Right to health	<p>CCPR: GC 28, GC 36, GR 34 CESCR: GC 22 CRC: GC 4 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Executions/Killings Report, 2017</p>	<ul style="list-style-type: none"> • Criminalization of abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with associated physical and health risks. • Criminalization of abortion may make persons who have access unlawful abortion reluctant to seek post-abortion care, including in situations of post-abortion complication. • In such cases, criminalization may expose abortion seekers to violations of the right to health. • Criminalization of abortion may expose abortion seekers to violence, exploitation, and other forms of harm from persons providing unlawful abortion services with implications for rights to life, health, a remedy and others.

<p>Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction.</p>	<p>Right to health Right to information</p>	<p>CCPR, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CRPD: GC 3 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2018 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Where the provision of abortion information is criminalized, this criminalization has implications for the rights to health and information. • Criminalization of abortion may result in a chilling effect on the provision of accurate abortion information with implications for the rights to health and information.
<p>States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest.</p>	<p>Right to health</p>	<p>CCPR: GC 36 CESCR: GC 22</p>	<ul style="list-style-type: none"> • Criminalization of abortion without effective, workable exceptions for persons pregnant as a result of rape or incest violates the right to health.
<p>States must provide post-abortion care in all circumstances including where abortion is illegal.</p>	<p>Right to health</p>	<p>CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 14 CRC: GC 15 CEDAW: GC 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2004, 2011, 2016 Special Rapporteur on Torture Report, 2013, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018</p>	<ul style="list-style-type: none"> • Where the provision of post-abortion care is criminalized, this violates the right to health. • Criminalization of abortion may result in a chilling effect on the provision of post-abortion care with implications for the right to health. • Obligations to report suspected unlawful abortion may operate to undermine or hinder access to post-abortion care with negative implications for the right to health. • Criminalization of abortion may make persons who have access unlawful abortion reluctant to seek post-abortion care, with implications for their right to health.

<p>States should protect health-care professionals providing abortion care.</p>	<p>Right to health</p>	<p>Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Criminalization of abortion may lead to stigmatization of abortion care provision with implications for the professional life, health, and well-being of health-care professionals. • Criminalization of abortion may expose health-care professionals to risks of harassment, criminal prosecution, or “sting” operations. • The implications for health-care professionals of criminalization may reduce the number of willing providers of lawful abortion, abortion information, or post-abortion care with implications for the health and rights of abortion seekers or persons who have accessed abortion including unsafe abortion.
<p>States should protect people seeking abortion.</p>	<p>Right to health</p>	<p>CCPR: GC 36 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Criminalization of abortion may lead people to access abortion outside of the formal system.

			<ul style="list-style-type: none"> • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • Criminalization of abortion may make persons who have accessed unlawful abortion reluctant to seek post-abortion care, including in situations of post-abortion complication. • In such cases, criminalization may expose abortion seekers to violations of the right to life and the right to health. • Criminalization of abortion may expose abortion seekers to violence, exploitation, and other forms of harm from persons providing unlawful abortion services with implications for human rights including the rights to life and health, and right to a remedy. • Criminalization of abortion may expose abortion seekers to discriminatory treatment.
States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	Right to health Right to security of person	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	<ul style="list-style-type: none"> • Criminalization of abortion undermines a pregnant person's ability safely to access abortion with disproportionate negative effects on her health, physical and mental integrity, and right to access abortion in cases of sexual violence and therapeutic indication.

<p>Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, Government, or health authorities.</p>	<p>Right to decide on the number and spacing of children Right to equality and non-discrimination Right to privacy</p>	<p>CESCR: GC 22 CCPR: GC 36, <i>LMR v Argentina</i> CEDAW: GR 21, GC 24, GR 34 CRPD: GC 3 Special Rapporteur on Torture Report, 2008</p>	<ul style="list-style-type: none"> • Criminalization of abortion as a result of the application of gestational age limits can result in unwanted continuation of pregnancy. • In such cases criminalization constitutes a limitation on the pregnant person's decision-making about whether or not to have children. • This limitation may violate the right to decide on the number and spacing of children, right to equality and non-discrimination, and right to privacy.
<p>Criminalization of abortion may constitute a human rights violation.</p>	<p>Right to equality and non-discrimination Right to security of person Right to be free from torture, and cruel, inhuman and degrading treatment</p>	<p>CEDAW: GR 33, GR 35 CCPR, GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> Special Rapporteur on Torture Report, 2016 Working Group on Discrimination against Women Report 2016</p>	<ul style="list-style-type: none"> • Criminalization of abortion may result in violations of the right to equality and non-discrimination, right to security of person, right to free from torture and cruel, inhuman and degrading treatment.
<p>SRH services including abortion and post-abortion care must be provided in a way that respects women and girls' privacy and guarantees confidentiality.</p>	<p>Right to privacy</p>	<p>CCPR GC 36 CCPR: GC 28, GC 36 Special Rapporteur on Health Report, 2011, 2016 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Obligations to report suspected unlawful abortion may operate to undermine the right to privacy in the receipt of sexual and reproductive health services including abortion and post-abortion care.
<p>Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.</p>	<p>Right to privacy</p>	<p>CCPR: <i>KNLG v Peru</i></p>	<ul style="list-style-type: none"> • Criminalization of abortion without effective, workable exceptions for therapeutic abortion has negative implications for the right to privacy.

<p>Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.</p>	<p>Right to life</p>	<p>CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017</p>	<ul style="list-style-type: none"> • Criminalization of abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, and may result in death. • In such circumstances criminalization of abortion may result in violation of the right to life.
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2. EtD framework for Grounds-based approaches

Recommendation 2:

- a. **Recommend against** laws and other regulations that restrict abortion by grounds.
- b. **Recommend** that abortion be made available at the request of the woman, girl or other pregnant person.

PICO 2: What is the impact of grounds-based approaches on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of grounds (and grounds-based laws) on abortion related outcomes, 21 studies were identified addressing the following outcomes; delayed abortion (n=6), continuation of pregnancy (n=2), opportunity costs (n=15), unlawful abortion (n=3), self-managed abortion (n=2), reproductive coercion (n=2), disproportionate impact (n=5), workload implications (n=5), referral to another provider (n=1), imposition on conscience or ethics (n=2), stigmatization (n=1), system costs (n=5). No studies were identified that encompassed information related to the outcomes: *family disharmony, exposure to interpersonal violence or exploitation, or perceived impact on relationship with patient*. Studies were conducted in northern Argentina, Australia, Brazil, Chile, Colombia, Ethiopia, Ghana, Islamic Republic of Iran, Ireland, Israel, Mexico, Rwanda, Thailand, United Kingdom, United Republic of Tanzania, Uruguay and Zambia. Study designs in this EtD framework include cross-sectional studies, retrospective cohort studies, case-control studies, times-series design, qualitative interview studies, and legal analyses.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion

Outcome: *DELAYED ABORTION*

Findings table 1: Impact of grounds on abortion delay

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2018 ¹	▲	Grounds-based laws (preserve life and prevent grave and permanent damage to physical or mental health) may contribute to delayed abortion. Out of 30 women interviewed, 18 self-managed their abortions by ordering abortion medications online. Some women had their packages seized in customs and for others the deliveries were delayed by several weeks. One woman experienced long delays while waiting to be deemed legally eligible.	Overall, the findings from 6 studies indicate that grounds-based laws may contribute to abortion delays in different ways due to inconsistencies in interpretation and implementation of the legal grounds. Abortion delays can occur when: abortion medications are seized by customs; the process of obtaining a legal abortion through local ethics committees or courts is protracted; women's rape claims are questioned; health-care providers misapply the right to conscientious objection; there is disagreement among health-care providers about severity of fetal anomaly; medical professionals wait until the health condition is severe enough that the woman's condition is deemed life threatening.
Aitken 2017 ²	▲	Grounds-based laws (real and substantial risk to life only) may contribute to delayed abortion; 33 physicians reported having been involved in the management of women who had an abortion because of severe or life-threatening illness. Of those, 27% reported that they had delayed the abortion until a pregnancy was deemed a "real and substantial risk" to life.	
Amado 2010 ²	▲	Grounds-based laws (life, rape, incest, health, fatal fetal malformations, "unwanted insemination") may contribute to abortion delays due to inconsistencies in the interpretation and implementation of the health indication, when a woman's rape claims are questioned or the right to conscientious objection is misapplied. In a review of 46 cases, 36 women were denied an abortion or obtained an abortion only after a protracted bureaucratic process; of	

		those, 18 (50%) sought abortion on rape grounds and 22 experienced delays. The average delay from date of first request to abortion = 16 days (range 2 to 44) and in cases of rape = 79 days (range 37 to 150).	
Black 2015 ¹	▲	In settings where grounds-based laws apply (threat to life*), and where local ethics committees are assigned the responsibility to determine legal eligibility for pregnancies > 20 weeks or “in complex cases”, the case review process women go through is sometimes lengthy and contributes to abortion delays. *Defined through case law as including threats to physical and mental health, including changes to future social and/or economic circumstances that might affect health.	
Maira 2019 ¹	▲	Where grounds-based laws apply (life, rape, fatal fetal anomaly), access to an abortion may depend on the understanding of the law and its application by health-care professionals. Participants reported that there are sometimes disagreements within a medical team about whether a fetal anomaly is incompatible with life or whether there is a risk to life, despite both being grounds for access. In these cases, abortion is denied or delayed until the health condition is severe enough that health-care professionals can agree that the condition is life threatening.	
Sahin Hodoglugil 2017 ³	▲	Where grounds-based laws apply (life, rape, forced marriage, incest); one health-care provider reported a case where a minor sought an abortion on rape grounds but where she ended up giving birth before the legal process was concluded.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² The study was not powered to look at this outcome.

³ Mixed-methods study design; qualitative component.

Additional considerations

Study design and setting of included studies:

Aiken 2018; Individual in-depth interviews (n=30); Northern Ireland

Aitken 2017; Cross-sectional survey (n=184); Northern Ireland

Amado 2016; Case series (n=36); Colombia

Black 2015; Individual in-depth interviews (n=22); New South Wales and Queensland, Australia

Maira 2019; Individual in-depth interviews (n=62); Chile

Sahin Hodoglugil 2017; Mixed-methods: review of hospital records (n=2644), individual in-depth interviews (n=22) and focus group discussions (n=3); Rwanda

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Findings table 2: Impact of grounds on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY			
Human rights standards engaged: right to health, right to security of person, right to decide on the number and spacing of children, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Antón 2018	▲	Shifting from a grounds-based laws to permitting first trimester abortions on request is associated with a 7.8% (SD 3.7%) decrease in births due to unplanned pregnancies. This decline is driven by a fall in fertility among women 20–34 years old with secondary education.	Overall, the findings from 2 studies indicate that grounds-based laws may indirectly contribute to continuation of pregnancy and thus increased fertility. When grounds-based laws are removed, and first trimester abortion is allowed on request, these studies demonstrated a decrease in fertility, possibly due to a reduction in unplanned births.
Clarke 2016	▲	Shifting from a grounds-based laws to permitting first trimester abortions on request and free of charge, is associated with reductions in fertility. Among women aged 15–44, fertility rates declined by 2.3–3.8% two years following the policy change. This trend was more marked among younger women aged 15–19 among whom fertility rates reduced between 5.1–7.1%.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

Additional considerations

Study design and setting of included studies:

Antón 2018; Time-series design (n=93 762); Uruguay
 Clarke 2016; Time-series design (n=23 155 080); Mexico

Findings table 3: Impact of grounds on opportunity cost

OUTCOME: OPPORTUNITY COSTS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Grounds-based laws (real and substantial risk to life only) may contribute to opportunity costs for women who choose to travel to access an abortion, as well as those who choose self-management of abortion. Out of 38 women interviewed, 27 had chosen self-management of abortion and 11 had chosen to travel abroad. Some women who travelled reported experiencing emotional stress, trauma and financial costs. Women who travelled and those who chose self-management of abortion feared seeking post abortion care in their own country when experiencing complications due to anticipated judgement; those who self-managed also feared being reported to the authorities.	Overall, the findings from 15 studies, suggest that grounds-based laws may contribute to opportunity costs in several ways including: the need to travel for an abortion, increased financial costs, emotional stress and trauma, fear of/experienced judgement and stigma, bureaucratic and costly protracted legal processes, increased morbidity, being subjected to “interrogations” and having one’s rape claim questioned, unsafe abortions, having to carry an unwanted pregnancy or a pregnancy with severe malformations, to term. The findings from some of these studies point to an inconsistency in how grounds are interpreted and applied, which sometimes leads to unpredictability and inequity in terms of abortion access and health care quality for the abortion seeker. The findings from other studies indicate that certain grounds, such as health and rape grounds, are consistently interpreted very restrictively, which ultimately leads to the denial of an abortion.
Aiken 2018 ¹	▲	Grounds-based laws (preserve life and prevent grave and permanent damage to physical or mental health) may force women who do not meet one of the few legal exceptions, to travel abroad for an abortion or to self-manage their abortions. Out of 30 women interviewed, 11 travelled, 18 self-managed and one qualified for a legal abortion. Women who travelled for an abortion reported emotional stress and financial costs. Women who opted for self-management of abortion reported fear of legal repercussions, confiscation of medications by customs and judgement, and emotional stress.	

Amado 2010 ²	▲	<p>Under grounds-based laws (life, rape, incest, health, fatal fetal malformations, “unwanted insemination”), a review of 46 cases show that abortion seekers are sometimes verbally abused, and/or denied services. In 36 cases, the woman was denied an abortion or obtained an abortion only after a protracted bureaucratic process, of those 50% (n=18) sought abortion on rape grounds. Reasons for denial and/or delays were unjustified and included requests for legal or other authorization not required by law, institutional conscientious objection, ignoring court rulings, ignorance of the law, misinterpretation of the life and health ground, and questioning of women’s rape claims.</p>
Arnott 2017 ^{2,4}	▲	<p>Where grounds-based laws apply (life, health, rape, incest, age below 15/unable to consent to sex), abortion services may still be unavailable. Senior medical administrators who do not support abortion may limit access to abortion services by controlling the purchase of equipment and commodities, and by narrowly interpreting the mental health exception. Availability of services may thereby vary considerably between institutions and regions.³</p>
Black 2015 ¹	▲	<p>In settings where grounds-based laws apply (threat to life*) and where local ethics committees are assigned the responsibility to determine legal eligibility for pregnancies > 20 weeks or “in complex cases”, the process women go through in which their case is examined is sometimes lengthy, financially burdensome, and contributes to abortion delays.</p> <p>*Defined through case law as including threats to physical and mental health, including changes to future social and/or economic circumstances that might affect health.</p>

Depiñeres 2017 ¹	○	<p>Where grounds-based laws apply (rape, incest, fatal fetal anomaly, life, health), women report significant challenges in obtaining care when they cannot obtain legal support and counselling. In a study among 21 women who were first denied a legal abortion, 5 out of 8 women who received legal support and counselling reported that they accessed an abortion; they felt that the support was crucial as it allowed them to advocate for themselves and navigate a complex system.</p>
Diniz 2014 ⁵	▲	<p>Where grounds-based laws apply (rape, life), women who are legally eligible for an abortion may not be able to access one. Even when the law provides that a woman's claim of rape is sufficient to satisfy requirements for legal ground, only 13.7% (n=232) of participants (physicians) reported that they required only the woman's narrative to grant her an abortion; almost half (44.1%, n=754) required at least one document not required by law such as a police report, judicial authorization, expert external medical opinion or authorization of institutional ethics committee and 37% (n=625) required a woman to present two or more such documents.</p> <p>Interviews with physicians revealed that some providers frequently tested women's rape claims by subjecting them to several "interviews", requiring them to have multiple ultrasounds to verify the chronology of the rape claim, by requiring women to provide legal documentation, or by requiring that they exhibit signs of psychological trauma in order to verify the "truth" for her to be granted a legal abortion.</p>
Küng 2018 ⁶	▲	<p>In settings where abortion is permitted on health grounds, modes of interpretation and wording of health grounds can result in wide variation in availability under such a ground. This can contribute to opportunity costs through abortion delay or denial.</p> <p>Some participants (providers and NGO workers) reported</p>

		that very restrictive interpretation of the health ground meant that few abortions on this ground were granted. Incorrect interpretation and application of the law by health-care providers may be due to limited knowledge about the law, stigma or personal negative attitudes towards abortion among physicians whose responsibility it is to determine the risk to health.
LaRoche ¹	▲	Across a variety of contexts with grounds-based laws, some in combination with criminalization, abortion seekers report that they are asked to justify their abortion and to fit it into one of the prescribed legal grounds. Some women experienced this as stigmatizing and felt this created a hierarchy of deservingness and imbued a sense of judgement about their decision.
Madeiro 2016 ^{2,4}	▲	Where a grounds-based laws apply (rape, life) abortion accessed on a rape ground may still be very difficult to access. These delays or denials represent important opportunity costs of time and financial costs. Even though not required by law, out of 37 institutions that reportedly provided abortions on rape grounds, 92% (n=34) reported that they required additional documentation to grant the abortion; 14% (n=5) required a police report, 8% (n=3) required a forensic report, 8% (n=3) required a court order, 11% (n=4) required an opinion from an institutional review board, and 8% (n=3) required an order from the department of public prosecutions.
Maira 2019 ¹	▲	Where grounds-based laws apply (life, rape, fatal fetal anomaly), access to an abortion may depend on the understanding of the law and its application by health-care professionals. Participants reported that there are sometimes disagreements within a medical team about whether a fetal anomaly is incompatible with life (ground) or whether there is a risk to life (ground). In these cases, abortion is denied or delayed until the health condition is severe enough that health-care

		<p>professionals can agree that the condition is life threatening.</p> <p>In addition, health-care providers report that in cases of rape, some providers impose additional requirements in order to provide the abortion.</p>
Mclean 2019 ¹	▲	<p>Where grounds-based laws apply (rape, incest, life, health, severe fetal anomaly, “mentally unfit to bring up a child”), some health-care providers perceive it as their task to determine the legitimacy of the abortion. Abortion seekers who are perceived to be lying about being raped or to not have a “good enough” reason to have an abortion even when they are legally eligible, may be denied one.</p>
Påfs 2019 ¹	▲	<p>Where grounds-based laws apply (life, rape, health, life, forced marriage), the abortion seeker has to prove her rape claim. Health-care providers reported that going through the legal process is so time consuming, laborious and costly that few choose to go down this route. None of the interviewed participants had ever heard of a woman obtaining an abortion on the rape ground. In addition, some participating providers had limited knowledge about the law, and several were uncertain about how the law should be interpreted and applied.</p>
Ramos 2014 ^{2,4}	▲	<p>Where grounds-based laws apply (life, health, rape, mental disabilities) some health-care providers have poor awareness and understanding of the law; out of 157 health-care providers, 56.3% were not aware of the mental health ground and 24.1% were unsure/did not respond; 64% did not have a correct understanding of the rape ground and 24.1% were unsure/did not respond.</p> <p>Over half of respondents said that providers do not perform abortions because of restrictive interpretation of the law, hospitals requiring judicial authorizations, and lack of familiarity with the indications.</p>

Sahin Hodoglugil 2017 ⁶	▲	<p>Where grounds-based laws apply (life, rape, forced marriage, incest), the process of obtaining a court order needed to access a legal abortion on rape grounds is so challenging, costly and lengthy that few choose to go down this path and instead end up carrying their pregnancies to term or having unsafe abortions. The evidence burden lies with the person who has been raped who must prove the rape to the courts.</p> <p>Out of 11 reviewed cases where abortion was sought on the rape ground, only one presented a court order and obtained an abortion.</p>
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² The study was not powered to look at this outcome.

³ Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

⁴ Mixed-methods study design; data from quantitative component.

⁵ Mixed-methods study design; data from qualitative and quantitative component.

⁶ Mixed-methods study design; data from qualitative component.

Additional considerations

Study design and setting of included studies:

Aiken 2018; Individual in-depth interviews (n=30); Northern Ireland

Aiken 2019; Individual in-depth interviews (n=38); Northern Ireland

Amado 2016; Case-series study (n=36); Colombia

Arnott 2017; Mixed methods: legal analysis, cross-sectional survey (n=32) and individual interviews (n=6); Thailand

Black 2015; Individual in-depth interviews (n=22); New South Wales and Queensland, Australia

Depiñeres 2017; Individual in-depth interviews (n=21); Colombia

Diniz 2014; Mixed methods: cross-sectional survey (n=1690) and individual in-depth interviews (n=50); Brazil

Küng 2014; Mixed methods: descriptive review of publicly available records and individual in-depth interviews (n=17); Britain, Colombia, Mexico

LaRoche 2014; Individual in-depth interviews (n=22); Australia

Madeiro 2016; Mixed methods: cross-sectional survey (evaluation of n=68 institutions) and individual interviews (n=82); Brazil

Maira 2019; Individual in-depth interviews (n=62); Chile

McLean 2019; Individual in-depth interviews (n=31) and focus group discussions (n=3); Ethiopia
Påfs 2019; Individual in-depth interviews (n=32) and focus group discussions (n=5); Rwanda
Ramos 2014; Mixed methods: cross-sectional survey (n=157) and individual interviews (n=27); Argentina
Sahin Hodoglugil 2017; Mixed methods: review of hospital records (n=2644), individual in-depth interviews (n=22) and focus group discussions (n=3); Rwanda

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Findings table 4: Impact of grounds on unlawful abortion

OUTCOME: UNLAWFUL ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Where grounds-based laws apply (real and substantial risk to life only) some women who do not satisfy one of the prescribed legal grounds, go on to have unlawful self-management of abortion. Out of 38 women interviewed, 27 had chosen self-management of abortion.	Overall, evidence from 3 studies suggest that grounds-based laws may contribute to unlawful abortion.
Aiken 2018 ¹	▲	Where grounds-based laws apply (preserve life and prevent grave and permanent damage to physical or mental health) some women who do not satisfy one of the prescribed legal grounds, may go on to have unlawful self-management of abortion. Out of 30 women interviewed 18 chose to self-manage their abortions unlawfully.	
Payne 2013 ¹	▲	Where grounds-based laws apply (health, life, fetal anomaly, rape), some physicians feel that the ambiguous nature of the law may contribute to unsafe clandestine abortions. ²	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Aiken 2018; Individual in-depth interviews (n=30); Northern Ireland

Aiken 2019; Individual in-depth interviews (n=38); Northern Ireland

Payne 2013; Individual in-depth interviews (n=4) and one focus group discussion; Ghana

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Outcome: SELF-MANAGED ABORTION

Findings table 5: Impact of grounds on self-management of abortion

OUTCOME: SELF-MANAGED ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aiken 2019 ¹	▲	Where grounds-based laws apply (real and substantial risk to life only), some women, who do not satisfy one of the prescribed legal grounds, may prefer and choose to self-manage their abortion over traveling to obtain abortion (27 out of 38 women interviewed).	Overall, evidence from 2 studies suggest that grounds-based laws may contribute to self-management of abortion.
Aiken 2018 ¹	▲	Where grounds-based laws apply (preserve life and prevent permanent damage to physical or mental health), some women, who do not satisfy one of the prescribed legal grounds, may prefer and choose to self-manage their abortion over traveling (18 out of 30 women interviewed). Some choose self-management as they cannot afford to travel.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aiken 2018; Individual in-depth interviews (n=30); Northern Ireland

Aiken 2019; Individual in-depth interviews (n=38); Northern Ireland

Outcome: FAMILY DISHARMONY

No studies identified

Outcome: EXPOSURE TO VIOLENCE OR EXPLOITATION

No studies identified

Outcome: REPRODUCTIVE COERCION

Findings table 6: Impact of grounds on reproductive coercion

OUTCOME: REPRODUCTIVE COERCION			
Human rights standards engaged: right to health, right to be free from torture and cruel, inhuman and degrading treatment, right to decide the number and spacing of children, right to equality and non-discrimination, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Mclean 2019 ¹	▲	Where grounds-based laws apply (rape, incest, life, health, severe fetal anomaly, “mentally unfit to bring up a child”), some health-care providers perceive it as their task to determine the legitimacy of the abortion. Abortion seekers who are perceived to be lying about being raped or to not have a “good enough” reason to have an abortion even when they are legally eligible, may be denied one.	Overall, the findings from 2 studies suggest that grounds-based laws may contribute to reproductive coercion through the denial of an abortion.
Mirlesse 2013 ¹	▲	Where grounds-based laws apply (rape and fetal anomaly) and the ground for abortion in cases of fetal malformations requires the condition to be fatal, women with pregnancies with severe but non-lethal fetal malformations, are not given any other choice than to continue the pregnancy.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

McLean 2019; Individual in-depth interviews (n=31) and focus group discussions (n=3); Ethiopia

Mirlesse 2013; Ethnographic observations (n=80); Brazil

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Findings table 7: Impact of grounds on disproportionate impact

OUTCOME: DISPROPORTIONATE IMPACT			
Human rights standards engaged: right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Arnott 2017 ¹	▲	Where grounds-based laws apply (life, health, rape, incest, age below 15/unable to consent to sex), there are sometimes large variations between regions and institutions with regards to how liberal or restrictive the law is interpreted. This may contribute to disproportionate impact for women seeking an abortion in a setting where the law is interpreted very narrowly and where there is limited use of the mental health ground.	Overall, the findings from 6 studies suggest that grounds and grounds-based laws may have a disproportionate, negative impact on women with fewer resources, rural women and women with lower education, as well as those seeking abortion due to rape and on health grounds.
Casas 2017 ²	▲	Where abortion is not legal on any grounds, women with few resources are disproportionately impacted as they cannot afford to travel abroad for a legal abortion, afford a safe abortion within the private health care sector, or afford professional counselling when experiencing mental health issues related to carrying a pregnancy with severe fetal malformations.	
Diniz 2014 ^{3,4}	▲	Where grounds-based laws apply (rape, life), a study among physicians revealed that women and girls who seek an abortion due to rape are disproportionately disadvantaged as they are more likely (than other grounds) to face difficulties in accessing a legal abortion, particularly as their rape claim is often questioned and services are denied and or delayed. Out of 1690 physicians, only 13.7% (n=232) reported that they only required the woman’s narrative in order to grant an abortion.	

Küng 2018 ⁵	▲	In settings where abortion is permitted on health grounds, modes of interpretation and wording of health grounds can result in wide variation in availability under such a ground, with a resultant disproportionate negative impact on rural and poor women who may not have access to accurate information and are unable to travel for an abortion.
Mirlesse 2013 ²	▲	Where grounds-based laws apply (rape and fetal malformation) and authorization from a court is required, abortion in cases of fatal fetal malformation may be especially difficult to access for women who are poor or have lower education levels.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Mixed-methods study design: unclear if data is based on qualitative or quantitative component.

² Qualitative study design: tests of statistical significance not applicable.

³ The study was not powered to look at this outcome.

⁴ Mixed-methods design; data from quantitative and qualitative component.

⁵ Mixed-methods design; data from qualitative component.

Additional considerations:

Study design and setting of included studies:

Arnott 2017; Mixed methods: legal analysis, cross-sectional survey (n=32) and individual interviews (n=6); Thailand

Casas 2017; Individual in-depth interviews (n=22); Chile

Diniz 2014; Mixed methods: cross-sectional survey (n=1690) and individual in-depth interviews (n=50); Brazil

Küng 2014; Mixed methods: descriptive review of publicly available records and individual in-depth interviews (n=17); Britain, Colombia, Mexico

Mirlesse 2013; Ethnographic observations (n=80); Brazil

POPULATION: Medical professionals providing abortion services

Outcome: WORKLOAD IMPLICATIONS

Findings table 8: Impact of grounds on workload implications

OUTCOME: WORKLOAD IMPLICATION			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Casas 2017 ¹	▲	Where abortion is not legal under any grounds, interviews with health-care providers revealed that some providers express frustration with the fact they can diagnose severe fatal and non-fatal fetal malformations but they cannot help the pregnant woman obtain an abortion when she wants one.	Overall, the findings from 5 studies suggest that grounds and grounds-based laws may have workload implications including: difficulties in interpreting and applying the law, preparing detailed files for court reviews, stress and fear of legal repercussions, and a frustration with the system when a diagnosis of a non-lethal fetal malformation can be made but abortion is not permitted.
Mclean 2019 ¹	▲	Where grounds-based laws apply (rape, incest, life, health, severe fetal anomaly, “mentally unfit to bring up a child”), some health-care providers struggle to interpret and apply the law, especially in cases where the women is legally eligible but the provider does not perceive that the reason is “good enough”.	
Mirlesse 2013 ¹	▲	Where abortion is legal only in cases of rape and fetal malformation, and authorization from a court is required to obtain an abortion, this may have workload implications as the medical referral centre has to prepare a detailed file for the court to review. Where a ground exists for only lethal malformations, severe non-lethal fetal malformations are particularly challenging for physicians; some consider that their “hands and feet are tied” as they are not legally allowed to help the women with an abortion.	

Payne 2013 ¹	▲	Where grounds-based laws apply (health, life, fetal anomaly, rape), some physicians, whose authority it is to determine satisfaction of prescribed grounds, interpret the health ground ambiguously. Ambiguity in how the law should be interpreted caused stress among some physicians who feared legal repercussions in case their judgement was challenged. Other physicians perceived the ambiguity as something positive as it increased access to legal abortion.
Ramos 2014 ²	▲	Where grounds-based laws apply (life, health, rape, mental disabilities) some providers struggle with understanding and applying the mental health ground more than other grounds.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

² Mixed-methods design; from qualitative component.

Additional considerations

Study design and setting of included studies:

Casas 2017; Individual in-depth interviews (n=22); Chile

McLean 2019; Individual in-depth interviews (n=31) and focus group discussions (n=3); Ethiopia

Mirlesse 2013; Ethnographic observations (n=80); Brazil

Payne 2013; Individual in-depth interviews (n=4) and one focus group discussion; Ghana

Ramos 2014; Mixed methods: cross-sectional survey (n=157) and individual interviews (n=27); Argentina

Outcome: REFERRAL TO ANOTHER PROVIDER

Findings table 9: Impact of grounds on referral to another provider

OUTCOME: REFERRAL TO ANOTHER PROVIDER			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Black 2015 ¹	▲	Where grounds-based laws apply (threat to life, but possibly can be interpreted based on case law to include threats to physical and mental health, including changes to social and economic circumstances that might affect health) and where local ethics committees are assigned the responsibility to determine legal eligibility for women with pregnancies > 20 weeks or “in complex cases”, the process women go through in which their case is examined is sometimes protracted. 20 out of 22 providers reported that they or their colleagues had referred women to travel to another state to other providers because of how long the process is to summon the ethics committee and obtain a legal abortion in the present state.	Overall findings from 1 study suggest that grounds-based laws may contribute to referrals to another provider; physicians must make referrals to providers in another state to circumvent existing obstacles including ethics committees and other protracted processes.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Black 2015; Individual in-depth interviews (n=22); New South Wales and Queensland, Australia

Outcome: IMPACT ON PROVIDER–PATIENT RELATIONSHIP

No studies identified

Outcome: IMPOSITION ON CONSCIENCE OR ETHICS

Findings table 10: Impact of grounds on imposition on conscience or ethics

OUTCOME: IMPOSITION ON CONSCIENCE OR ETHICS			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
McLean 2019 ¹	▲	Where grounds-based laws apply (rape, incest, life, health, severe fetal anomaly, “mentally unfit to bring up a child”), some health-care providers struggle to interpret and apply the law, especially in cases where the women is legally eligible but the provider does not perceive that the reason is “good enough” or when the patient is thought to be lying about their rape claim. Providers felt that these cases forced them into ethically challenging situations whether to provide the abortion or not.	Overall, the findings from 2 studies indicate that grounds and grounds-based laws may contribute to providers experiencing an imposition on their conscience or ethics in two ways, either by (a) resulting in the questioning of whether or not a provider should provide a legal abortion, or (b) by preventing providers from giving women diagnosed with a fetal malformations an option to end their pregnancy.
Casas 2017 ¹	▲	Where abortion is not legal under any ground, interviews with health-care providers reveal that some providers express frustration with the fact they can diagnose severe fatal and non-fatal fetal malformations but they cannot help the pregnant woman obtain an abortion when she wants one.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

McLean 2019; Individual in-depth interviews (n=31) and focus group discussions (n=3); Ethiopia

Casas 2017; Individual in-depth interviews (n=22); Chile

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Outcome: STIGMATIZATION

Findings table 11: Impact of grounds on stigmatization

OUTCOME: STIGMATIZATION			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Madeiro 2016 ¹	○	Where grounds-based laws apply (preserve life, rape), providers may still be unwilling to provide abortion care to legally eligible women due to stigmatization of abortion providers. ²	Overall, the findings from 1 study indicate that grounds-based laws may contribute to stigmatization of health-care providers who ultimately choose not to involve themselves in abortion care for this reason.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Mixed-methods study design; data from qualitative component.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants

Additional considerations

Study design and setting of included studies:

Madeiro 2016; Mixed methods: cross-sectional survey (evaluation of n=68 institutions) and individual interviews (n=82); Brazil

Findings table 12: Impact of grounds on system costs

OUTCOME: SYSTEM COSTS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aitken 2017 ¹	▲	Grounds-based laws (real and substantial risk to life only) may contribute to increased system costs; 33 physicians reported having been involved in the management of a women who had an abortion because of severe or life-threatening illness. Of those, 27% reported that they had delayed the abortion until a pregnancy was deemed a “real and substantial risk” to life.	Overall, the findings from 5 studies suggest that grounds and grounds-based laws may contribute to system costs by indirectly contributing to continuation of pregnancy and maternal mortality, and directly by imposing costs on court systems, increased workloads of health-care professionals, and by delaying care for pregnant women with severe health conditions.
Antón 2018 ¹	▲	Shifting from a grounds-based laws to permitting first trimester abortions on request is associated with an 7.8% (SD 3.7%) decrease in births due to unplanned pregnancies. This decline is driven by a fall in fertility among women 20–34 years old with secondary education.	
Casas 2017 ²	▲	Where abortion is not legal under any ground, women are forced to carry non-viable and medically high-risk pregnancies to term. This may contribute to system costs by increasing the health-care resources needed to provide obstetrical care and increasing the risk of maternal morbidity and mortality.	

Clarke 2016	▲	Shifting from a grounds-based laws to permitting first trimester abortions on request and free of charge, is associated with reductions in maternal mortality. Following the policy change maternal mortality fell by 8.8–16.2% among women aged 15–44 and by 14.9–30% among adolescents.
Mirlesse 2013 ²	▲	Grounds-based laws (rape) may contribute to system costs where authorization from a court is required in cases of lethal fetal malformations. A detailed file must be prepared by the medical referral centre which requires significant work.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Study is not powered to look at this outcome and indirectly assesses systems costs. The study uses as a proxy delay in abortion until maternal condition is significantly affected.

²Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aitken 2017; Cross-sectional survey (n=184); Northern Ireland

Antón 2018; Time-series design (n=93 762); Uruguay

Casas 2017; Individual in-depth interviews (n=22); Chile

Clarke 2016; Time-series design (n=23 155 080); Mexico

Mirlesse 2013; Ethnographic observations (n=80); Brazil

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

POPULATION: Pregnant people seeking abortion

Delayed abortion

- Overall, the findings from 6 studies indicate that grounds-based laws may contribute to abortion delays in different ways due to inconsistencies in interpretation and implementation of the legal grounds. Abortion delays can occur when: abortion medications are seized by customs; the process of obtaining a legal abortion through local ethics committees or courts is protracted; women's rape claims are questioned; health-care providers misapply the right to conscientious objection; there is disagreement among health-care providers about severity of fetal anomaly; medical professionals wait until the health condition is severe enough that the woman's condition is deemed life threatening.

Continuation of pregnancy

- Overall the findings from 2 studies indicate that grounds-based laws may indirectly contribute to continuation of pregnancy and thus increased fertility. When grounds-based laws are removed, and first trimester abortion is allowed on requests, these studies demonstrated a decrease in fertility, possibly due to a reduction in unplanned births.

Opportunity costs

- Overall, the findings from 15 studies, suggest that grounds-based laws may contribute to opportunity costs in several ways including: the need to travel for an abortion, increased financial costs, emotional stress and trauma, fear of/experienced judgement and stigma, bureaucratic and costly protracted legal processes, increased morbidity, being subjected to "interrogations" and having one's rape claim questioned, unsafe abortions, having to carry an unwanted pregnancy or a pregnancy with severe malformations, to term. The findings from some of these studies point to an inconsistency in how grounds are interpreted and applied, which sometimes leads to unpredictability and inequity in terms of abortion access and health care quality for the abortion seeker. The findings from other studies indicate that certain grounds, such as health and rape grounds, are consistently interpreted very restrictively, leading to the denial of an abortion.

Unlawful abortion

- Overall, evidence from 3 studies suggest that grounds-based laws may contribute to unlawful abortion.

Self-managed abortion

- Overall, evidence from 2 studies suggest that grounds-based laws may contribute to self-management of abortion, which may

sometimes be unsafe.

Family disharmony

- No studies identified

Exposure to violence or exploitation

- No studies identified

Reproductive coercion

- Overall, the findings from 2 studies suggest that grounds-based laws may contribute to reproductive coercion through the denial of an abortion.

Disproportionate impact

- Overall, the findings from 6 studies suggest that grounds and grounds-based laws may have a disproportionate, negative impact on women with fewer resources, rural women and women with lower education, as well as those seeking abortion due to rape and on health grounds.

POPULATION: Medical professionals providing abortion services

Workload implications

- Overall, the findings from 5 studies suggest that grounds and grounds-based laws may have workload implications including: difficulties in interpreting and applying the law, preparing detailed files for court reviews, stress and fear of legal repercussions, and a frustration with the system when a diagnosis of a non-lethal fetal malformation can be made but abortion is not permitted.

Referral to another provider

- Overall findings from 1 study suggest that grounds-based laws may contribute to referrals to another provider; physicians must make referrals to providers in another state to circumvent existing obstacles including ethics committees and other protracted processes.

Impact on provider–patient relationship

- No studies identified

Imposition on conscience or ethics

- Overall, the findings from 2 studies indicate that grounds and grounds-based laws may contribute to providers experiencing an imposition on their conscience or ethics in two ways, either by (a) resulting in the questioning of whether or not a provider should provide a legal abortion, or (b) by preventing providers from giving women diagnosed with a fetal malformations an option to end their pregnancy.

Stigmatization

- Overall, the findings from 1 study indicate that grounds-based laws may contribute to stigmatization of health-care

providers who ultimately choose not to involve themselves in abortion care for this reason.

System costs

- Overall, the findings from 5 studies suggest that grounds and grounds-based laws may contribute to system costs by indirectly contributing to continuation of pregnancy and maternal mortality, and directly by imposing costs on court systems, increased workloads of health-care professionals, and by delaying care for pregnant women with severe health conditions.

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HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARD TO EVIDENCE TABLE: Grounds-based approaches

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed abortion	Overall, the findings from 6 studies indicate that grounds-based laws may contribute to abortion delays in different ways due to inconsistencies in interpretation and implementation of the legal grounds. Abortion delays can occur when: abortion medications are seized by customs; the process of obtaining a legal abortion through local ethics committees or courts is protracted; women’s rape claims are questioned; health-care providers misapply the right to conscientious objection; there is disagreement among health-care providers about severity of fetal anomaly;	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Grounds-based laws can result in delayed access to abortion care, including waiting until health conditions deteriorate to satisfy a “ground”. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Grounds-based laws can result in delayed access to abortion care. Where such delays are associated with the physical and mental health risks associated with unsafe abortion, such as increased risks of maternal mortality or morbidity they have negative implications for rights.
		States should protect people seeking abortion.	▲	Grounds-based laws can result in delayed access to abortion care. Such delays may be associated with unsafe abortion or increased risks of maternal mortality or morbidity, with negative implications for rights.

	medical professionals wait until the health condition is severe enough that the woman's condition is deemed life threatening.	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Grounds-based laws can result in delayed access to abortion care. Where this has a disproportionately negative effect on the health, and physical and mental integrity of abortion seekers, it has negative implications for rights.
Continuation of Pregnancy	Overall, the findings from 2 studies indicate that grounds-based laws may indirectly contribute to continuation of pregnancy and thus increased fertility. When grounds-based laws are removed, and first trimester abortion is allowed on request, these studies demonstrated a decrease in fertility, possibly due to a reduction in unplanned births.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health and protect persons' physical and mental integrity.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Grounds that have a disproportionately negative effect on the health, and physical and mental integrity of abortion seekers, have negative implications for rights.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State, or health authorities.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Grounds that have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy have negative implications for rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Where abortion is lawful, the operation of grounds to hinder a pregnant person's ability to access safe abortion has negative implications for rights.
		States should ensure appropriate SRH care and services to address sexual violence against women and girls, including making abortion available in cases of rape or incest.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Failure to ensure access to safe abortion in cases of sexual violence, including rape or incest, has negative implications for rights.

		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Failure to ensure grounds do not result in denial of therapeutic abortion has negative implications for rights.
Opportunity Costs	Overall, the findings from 15 studies, suggest that grounds-based laws may contribute to opportunity costs in several ways including: the need to travel for an abortion, increased financial costs, emotional stress and trauma, fear of/experienced judgement and stigma, bureaucratic and costly protracted legal processes, increased morbidity, being subjected to “interrogations” and having one’s rape claim questioned, unsafe abortions, having to carry an unwanted pregnancy or a pregnancy with severe malformations, to term. The findings from some of these studies point to an inconsistency in how grounds are interpreted and applied, which sometimes leads to unpredictability and inequity in terms of abortion access and health-care quality for the abortion seeker. The findings from other studies indicate that certain grounds, such as health and rape grounds, are consistently interpreted very restrictively, which ultimately leads to the denial of an abortion.	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Grounds-based laws may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure grounds do not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights.
		States should protect people seeking abortion.	▲	Grounds-based laws may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure grounds do not expose abortion seekers to harm has negative implications for rights.
		Where it is lawful, abortion must be safe and accessible	▲	Grounds-based laws may operate and be applied in a way that makes lawful abortion inaccessible in practice, with negative implications for rights.

Unlawful Abortion	Overall, evidence from 3 studies suggest that grounds-based laws may contribute to unlawful abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Grounds-based laws may be associated with recourse to unlawful abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity, grounds have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Grounds-based laws may be associated with recourse to unlawful abortion. Where such unlawful abortions are unsafe, grounds have negative implications for rights.
Self-managed Abortion	Overall, evidence from 2 studies suggest that grounds-based laws may contribute to self-management of abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Grounds-based laws may be associated with recourse to unlawful abortion, including unlawful self-management of abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity, grounds have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Grounds-based laws may be associated with recourse to unlawful abortion, including unlawful self-management of abortion. Where such unlawful abortions are unsafe, grounds have negative implications for rights.
Family Disharmony	No studies identified			
Exposure to Interpersonal Violence	No studies identified			
Reproductive Coercion	Overall, the findings from 2 studies suggest that grounds-based laws may contribute to reproductive coercion through the denial of an abortion.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health and protect persons' physical and mental integrity.	▲	Grounds-based laws that do not operate to make lawful abortion accessible fail to protect people's physical and mental integrity.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State,	▲	Grounds-based laws that operate to empower providers, committees, courts or other persons other than the abortion seeker to determine qualification for

		or health authorities.		abortion undermine a women’s decision whether to have a child.
		States should ensure appropriate SRH care and services to address sexual violence against women and girls including making abortion available in cases of rape or incest.	▲	Grounds-based laws that do not operate to make abortion accessible in cases of rape or incest fail to ensure appropriate SRH care and services to address sexual violence against women and girls.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Grounds-based laws that do not operate to make therapeutic abortion accessible fail to protect the right to privacy.
		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Non-rights-compliant interpretation and application of grounds-based laws may result in disqualification from lawful abortion and undermine or hinder access to abortion with negative implications for rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Non-rights-compliant interpretation and application of grounds-based laws and the imposition of onerous procedures for qualification may result in disqualification from lawful abortion and make lawful abortion inaccessible.
Disproportionate Impact	Overall, the findings from 6 studies suggest that grounds and grounds-based laws may have a disproportionate, negative impact on women with fewer resources, rural women and women with lower education, as	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Grounds-based laws impact disproportionately on certain groups of women. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.

	well as those seeking abortion due to rape and on health grounds.	States should ensure appropriate SRH care and services to address sexual violence against women and girls, including making abortion available in cases of rape or incest.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Failure to ensure grounds-based laws do not prevent a woman from accessing abortion in cases of sexual violence, including rape or incest, has negative implications for rights.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Grounds-based laws may result in continuation of pregnancy and unwanted birth. Failure to ensure grounds-based laws do not result in denial of therapeutic abortion has negative implications for rights.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Grounds-based approaches

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Workload Implications	Overall, the findings from 5 studies suggest that grounds and grounds-based laws may have workload implications including: difficulties in interpreting and applying the law, preparing detailed files for court reviews, stress and fear of legal repercussions, and a frustration with the system when a diagnosis of a non-lethal fetal malformation can be made but abortion is not permitted.	States should protect health-care professionals providing abortion care.	▲	Workload implications arising from grounds-based laws may result in significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health and protect persons’ physical and mental integrity.	▲	Workload implications arising from grounds-based laws may result in reduced or hindered access to comprehensive abortion care. Where this is the case, grounds interfere disproportionately with rights to health and to physical and mental integrity.
Referral to Another Provider	Overall findings from 1 study suggest that grounds-based laws may contribute to referrals to another provider; physicians must make referrals to providers in another state to circumvent existing obstacles including ethics committees and other protracted processes.	States should protect people seeking abortion.	○	Referrals to a provider in another jurisdiction may mitigate difficulties of access produced by grounds-based laws for those with resources and capacity to undertake travel.
Impact on Provider–Patient Relationship	No studies identified			

Imposition on Conscience or Ethics	Overall, the findings from 2 studies indicate that grounds and grounds-based laws may contribute to providers experiencing an imposition on their conscience or ethics in two ways, either by (a) resulting in the questioning of whether or not a provider should provide a legal abortion, or (b) by preventing providers from giving women diagnosed with a fetal malformations an option to end their pregnancy.	States should protect health-care professionals providing abortion care.	▲	Grounds-based laws may result in providers being required to deny abortion where provision would align with their conscience or ethics, or to declare a ground to have been satisfied in order to ensure safe abortion provision even where it may not strictly satisfy the requirements of the law. In both cases, there are negative implications for the provider.
Stigmatization	Overall, the findings from 1 study indicate that grounds-based laws may contribute to stigmatization of health-care providers who ultimately choose not to involve themselves in abortion care for this reason.	States should protect health-care professionals providing abortion care.	▲	Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where a grounds-based law differentiates between the lawfulness of “reasons” for accessing abortion, with negative implications for both providers’ rights and the rights of persons seeking to access abortion.
System Costs	Overall, the findings from 5 studies suggest that grounds and grounds-based laws may contribute to system costs by indirectly contributing to continuation of pregnancy and maternal mortality, and directly by imposing costs on court systems, increased workloads of health-care professionals, and by delaying care for pregnant women with severe health conditions.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health and protect persons’ physical and mental integrity.	▲	Grounds-based laws are associated with poor health outcomes with sometimes disproportionate negative implications for rights.
		States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Grounds-based laws are associated with increased rates of maternal mortality and poor health, with negative implications for rights.

		States should protect people seeking abortion.	▲	Grounds-based laws are associated with poor health outcomes and system costs and thus with exposure of abortion seekers to substantial costs and risks, with negative implications for rights.
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▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON GROUNDS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: GROUNDS: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
<p>Delayed abortion</p>	<p>Overall, the findings from 6 studies indicate that grounds-based laws may contribute to abortion delays in different ways due to inconsistencies in interpretation and implementation of the legal grounds.</p> <p>Abortion delays can occur when: abortion medications are seized by customs; the process of obtaining a legal abortion through local ethics committees or courts is protracted; women’s rape claims are questioned; health-care providers misapply the right to conscientious objection; there is disagreement among health-care providers about severity of fetal anomaly; medical professionals wait until the health condition is severe enough that the woman’s condition is deemed life threatening.</p>	<p>Grounds-based laws can result in delayed access to abortion care, including waiting until health conditions deteriorate to satisfy a “ground”. Such delays may be associated with unsafe abortion or increased risks of maternal mortality or morbidity. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.</p>	<p>We recommend against grounds-based laws, and for the provision of abortion without restriction as to reason.</p>
<p>Continuation of pregnancy</p>	<p>Overall, the findings from 2 studies indicate that grounds-based laws may indirectly contribute to continuation of pregnancy and thus increased fertility. When grounds-based laws are removed, and first trimester abortion is allowed on requests, these studies demonstrated a decrease in fertility, possibly due to a reduction in unplanned births.</p>	<p>Grounds-based laws may result in continuation of pregnancy and unwanted birth. Grounds that have a disproportionately negative effect on the health and physical and mental integrity of abortion seekers, including on a woman’s ability to decide whether or not to continue with pregnancy, have negative implications for rights. Failure to ensure grounds do not result in denial of therapeutic abortion has negative implications for rights.</p>	<p>We recommend against grounds-based laws, and for the provision of abortion without restriction as to reason.</p>

<p>Opportunity Costs</p>	<p>Overall, the findings from 15 studies, suggest that grounds-based laws may contribute to opportunity costs in several ways including: the need to travel for an abortion, increased financial costs, emotional stress and trauma, fear of/experienced judgement and stigma, bureaucratic and costly protracted legal processes, increased morbidity, being subjected to “interrogations” and having one’s rape claim questioned, unsafe abortions, having to carry an unwanted pregnancy or a pregnancy with severe malformations, to term. The findings from some of these studies point to an inconsistency in how grounds are interpreted and applied, which sometimes leads to unpredictability and inequity in terms of abortion access and health-care quality for the abortion seeker. The findings from other studies indicate that certain grounds, such as health and rape grounds, are consistently interpreted very restrictively, which ultimately leads to the denial of an abortion.</p>	<p>Grounds-based laws may operate in a way that imposes significant opportunity costs on people seeking abortion, and in a way that makes lawful abortion inaccessible in practice.</p>	<p>We recommend against grounds-based laws, and for the provision of abortion without restriction as to reason.</p>
<p>Unlawful Abortion</p>	<p>Overall, evidence from 3 studies suggest that grounds-based laws may contribute to unlawful abortion.</p>	<p>Grounds-based laws may be associated with recourse to unlawful abortion.</p> <p>Where such unlawful abortions increase risks of maternal mortality or morbidity, grounds have negative implications for rights.</p>	<p>We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.</p>
<p>Self-managed Abortion</p>	<p>Overall, evidence from 2 studies suggest that grounds-based laws may contribute to self-management of abortion.</p>	<p>Grounds-based laws may be associated with recourse to unlawful abortion, including unlawful self-management of abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity grounds have negative implications for rights.</p>	<p>We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.</p>

Family Disharmony	No studies identified		
Exposure to Interpersonal Violence	No studies identified	Grounds-based approaches to the provision of abortion may require the disclosure of personal information to persons or institutions without clinical justification. In some cases, disclosure of such information may expose abortion seekers to risks of interpersonal violence, ostracization or other harms (e.g. where a claim must be disclosed in order to access abortion) with negative implications for her right to privacy, health, and potentially right to life.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.
Reproductive Coercion	Overall, the findings from 2 studies suggest that grounds-based laws may contribute to reproductive coercion through the denial of an abortion.	Grounds-based laws that contribute to reproductive coercion through the denial of lawful abortion (as a result of unnecessary procedures or non-rights compliant interpretation and application), denial of therapeutic abortion, and denial of abortion in case of rape or incest have negative implications for rights.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.
Disproportionate Impact	Overall, the findings from 6 studies suggest that grounds and grounds-based laws may have a disproportionate, negative impact on women with fewer resources, rural women and women with lower education, as well as those seeking abortion due to rape and on health grounds.	Grounds-based laws impact disproportionately on certain groups of women, including women who seek abortion following rape or therapeutic indication. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.

Workload Implications	Overall, the findings from 5 studies suggest that grounds and grounds-based laws may have workload implications including: difficulties in interpreting and applying the law, preparing detailed files for court reviews, stress and fear of legal repercussions, and a frustration with the system when a diagnosis of a non-lethal fetal malformation can be made but abortion is not permitted.	Workload implications arising from grounds-based laws significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.
Referral to Another Provider	Overall findings from 1 study suggest that grounds-based laws may contribute to referrals to another provider; physicians must make referrals to providers in another state to circumvent existing obstacles including ethics committees and other protracted processes.	Referrals to a provider in another jurisdiction may mitigate difficulties of access produced by grounds-based laws for those with resources and capacity to undertake travel.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.
Impact on Provider-Patient Relationship	No studies identified		
Imposition on Conscience or Ethics	Overall, the findings from 2 studies indicate that grounds and grounds-based laws may contribute to providers experiencing an imposition on their conscience or ethics in two ways, either by (a) resulting in the questioning of whether or not a provider should provide a legal abortion, or (b) by preventing providers from giving women diagnosed with a fetal malformations an option to end their pregnancy.	Grounds-based laws may result in providers being required to deny abortion where provision would align with their conscience or ethics, or to declare a ground to have been satisfied in order to ensure safe abortion provision even where it may not strictly satisfy the requirements of the law. In both cases, there are negative implications for the provider.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.
Stigmatization	Overall, the findings from 1 study indicate that grounds-based laws may contribute to stigmatization of health-care providers who ultimately choose not to involve themselves in abortion care for this reason.	Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where grounds-based laws differentiate between the lawfulness of “reasons” for accessing abortion, with negative implications for both providers’ rights and the rights of persons seeking to access abortion.	We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.

<p>System Costs</p>	<p>Overall, the findings from 5 studies suggest that grounds and grounds-based laws may contribute to system costs by indirectly contributing to continuation of pregnancy and maternal mortality, and directly by imposing costs on court systems, increased workloads of health-care professionals, and by delaying care for pregnant women with severe health conditions.</p>	<p>Grounds-based laws are associated with poor health outcomes and system costs and thus with exposure of abortion seekers to substantial costs and risks, with negative implications for rights.</p>	<p>We recommend against grounds-based laws and for the provision of abortion without restriction as to reason.</p>
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DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- Grounds-based laws can result in delayed access to abortion care, including waiting until health conditions deteriorate to satisfy a “ground”. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights. Where such delays are associated with the physical and mental health risks associated with unsafe abortion, such as increased risks of maternal mortality or morbidity, they have negative implications for rights. Where this has a disproportionately negative effect on the health, and physical and mental integrity of abortion seekers, it has negative implications for rights.

Continuation of pregnancy

- Grounds-based laws may result in continuation of pregnancy and unwanted birth. Grounds that have a disproportionately negative effect on the health, and physical and mental integrity of abortion seekers, have negative implications for rights.
- Grounds that have a disproportionately negative effect on a woman’s ability to decide whether or not to continue with pregnancy have negative implications for rights. Where abortion is lawful, the operation of grounds to hinder a pregnant person’s ability to access safe abortion has negative implications for rights. Failure to ensure access to safe abortion in cases of sexual violence, including rape or incest, has negative implications for rights. Failure to ensure grounds do not result in denial of therapeutic abortion has negative implications for rights.

Opportunity costs

- Grounds-based laws may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure grounds do not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights. Failure to ensure grounds do not expose abortion seekers to harm has negative implications for rights.
- Grounds-based laws may operate and be applied in a way that makes lawful abortion inaccessible in practice, with negative implications for rights.

Unlawful abortion

- Grounds-based laws may be associated with recourse to unlawful abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity, grounds have negative implications for rights. Where such unlawful abortions are unsafe, grounds have negative implications for rights.

Self-managed abortion

- Grounds-based laws may be associated with recourse to unlawful abortion, including unlawful self-management of abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity, grounds have negative implications for

rights. Where such unlawful abortions are unsafe, grounds have negative implications for rights.

Family disharmony

- No studies identified

Exposure to violence or exploitation

- No studies identified

Reproductive coercion

- Grounds-based laws that do not operate to make lawful abortion accessible fail to protect people's physical and mental integrity. Grounds-based laws that operate to empower providers, committees, courts or other persons other than the abortion seeker to determine qualification for abortion undermine a women's decision whether to have a child.
- Grounds-based laws that do not operate to make abortion accessible in cases of rape or incest fail to ensure appropriate SRH care and services to address sexual violence against women and girls.
- Grounds-based laws that do not operate to make therapeutic abortion accessible fail to protect the right to privacy.
- Non-rights-compliant interpretation and application of grounds-based laws may result in disqualification from lawful abortion and undermine or hinder access to abortion with negative implications for rights.
- Non-rights-compliant interpretation and application of grounds-based laws and the imposition of onerous procedures for qualification may result in disqualification from lawful abortion and make lawful abortion inaccessible.

Disproportionate impact

- Grounds-based laws impact disproportionately on certain groups of women. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.
- Grounds-based laws may result in continuation of pregnancy and unwanted birth. Failure to ensure grounds-based laws do not prevent a woman from accessing abortion in cases of sexual violence, including rape or incest, has negative implications for rights. Failure to ensure grounds-based laws do not result in denial of therapeutic abortion has negative implications for rights.

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- Workload implications arising from grounds-based laws may result in significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access comprehensive abortion care.
- Workload implications arising from grounds-based laws may result in reduced or hindered access to comprehensive abortion care. Where this is the case, grounds interfere disproportionately with rights to health and to physical and mental integrity.

Referral to another provider

- Referrals to a provider in another jurisdiction may mitigate difficulties of access produced by grounds-based laws for those with resources and capacity to undertake travel.

Impact on provider–patient relationship

- No studies identified

Imposition on conscience or ethics

- Grounds-based laws may result in providers being required to deny abortion where provision would align with their conscience or ethics, or to declare a ground to have been satisfied in order to ensure safe abortion provision even where it may not strictly satisfy the requirements of the law. In both cases, there are negative implications for the provider.

Stigmatization

- Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where a grounds-based law differentiates between the lawfulness of “reasons” for accessing abortion, with negative implications for both providers’ rights and the rights of persons seeking to access abortion.

System costs

- Grounds-based laws are associated with poor health outcomes with sometimes disproportionate negative implications for rights.
- Grounds-based laws are associated with increased rates of maternal mortality and poor health, with negative implications for rights.
- Grounds-based laws are associated with poor health outcomes and system costs and thus with exposure of abortion seekers to substantial costs and risks, with negative implications for rights.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any data-direct evidence pertaining to values, we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy, and affordable care with as few logistical burdens as possible. We can also

assume that health-care providers value reasonable workloads, and avoidance of imposition on conscience or ethics and stigmatization.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does the intervention *grounds*.

Resources:

Some studies included in this framework speak to the issue of resources by providing evidence on the effect of *grounds* on workload implications.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability and feasibility.

Equity:

Some studies included in this framework speak to the issue of equity by providing evidence on the disproportionate impact of the intervention, *grounds*, on abortion seekers.

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Grounds-based approaches: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Grounds-Based Approaches
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	Right to Life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland, Mellet v Ireland, LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report: 2011 Special Rapporteur on Torture Report: 2016 Special Rapporteur on Extrajudicial Killings Report: 2017, 2018 Working Group on Discrimination against Women Report 2016	<ul style="list-style-type: none"> • Grounds-based approaches to abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • Grounds-based approaches may lead to delays in accessing abortion as people seek to travel to jurisdictions where criminalization does not apply. • Such delays may expose women to risks of maternal mortality or morbidity.
Where it is lawful, abortion must be safe and accessible.	The right to health The right to be free from torture, and cruel, inhuman and degrading treatment	CCPR: GC 36, <i>LMR v Argentina, LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Where there is a grounds-based approach to abortion provision, provider and/or legal interpretation of grounds may fail to reflect a rights-based approach and/or the WHO definition of health and thus be overly restrictive, meaning lawfully available abortion is not accessible in practice. • Where there is a grounds-based approach to abortion provision, formal or informal requirements for additional certifications and “evidence” of fulfilling a ground (e.g. court order in cases of rape) can operate to make lawful abortion less accessible in practice. • Where grounds-based approaches operate in conjunction with other limitations (e.g. criminalization) this can have a chilling effect on interpretation and application of grounds.

States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.	Right to health Right to equality and non-discrimination Right of persons with disabilities to retain fertility on an equal basis with others	CCPR GC 36 CRC GC 4; GC 15 CRPD GC 3, GC 6 Special Rapporteur on Health Report, 2016	Grounds-based approaches may have a disproportionate impact on people seeking abortion on particular grounds (e.g. rape), marginalized women, or people living in underserved areas where personnel and institutions required to satisfy requirements produced by a grounds-based approach (e.g. certification) are less accessible.
States must protect people from the physical and mental health risks associated with unsafe abortions.	Right to health	CCPR: GC 28, GC 36, GR 34 CESCR: GC 22 CRC: GC 4 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Executions/Killings Report, 2017	<ul style="list-style-type: none"> • Grounds-based approaches to abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • Grounds-based approaches may lead to delays in accessing abortion as people seek to travel to jurisdictions where criminalization does not apply. • Such delays may expose women to risks of maternal mortality or morbidity, and other physical and mental health risks associated with unsafe abortion.
Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction.	Right to health Right to information	CCPR, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CRPD: GC 3 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2018 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Where there is a grounds-based approach to abortion provision, women and girls may not be provided with accurate information about abortion in situations where their circumstances do not satisfy prescribed grounds (e.g. where a fetal impairment is detected but the grounds do not permit abortion for that or any fetal impairment).
States should ensure appropriate SRH care and services to address sexual violence against women and girls including making	Right to health	CCPR: GC 36 CESCR: GC 22	<ul style="list-style-type: none"> • Grounds-based approaches that do not allow abortion in cases of rape or incest fail to ensure appropriate SRH care and services to address sexual violence against women.

abortion available in cases of rape or incest.			<ul style="list-style-type: none"> • Even where rape or incest grounds are stipulated in law, unnecessary procedures, overly restrictive definitions or interpretations, and provider refusal may operate to mean abortion is not actually available in these settings and there is a failure to ensure appropriate SRH care and services to address sexual violence against women.
States should protect health-care professionals providing abortion care.	Right to health	Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Grounds-based approaches to the provision of abortion may lead to stigmatization of abortion care provision with implications for the professional life, health, and well-being of health-care professionals. • The implications for health-care professionals of grounds-based approaches may reduce the number of willing providers of lawful abortion, abortion information, or post-abortion care with implications for the health and rights of abortion seekers or persons who have accessed abortion including unsafe abortion.
States should protect people seeking abortion.	Right to health	CCPR: GC 36 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Grounds-based approaches to abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • Grounds-based approaches may lead to delays in accessing abortion as people seek to travel to jurisdictions where criminalization does not apply. • Such delays may expose women to risks of maternal mortality or morbidity, and other physical and mental health risks associated with unsafe abortion.

			<ul style="list-style-type: none"> • Grounds-based approaches may expose abortion seekers to discriminatory treatment, stigma, and opportunity costs. • Grounds based approaches may require the disclosure of personal information, which may expose abortion seekers to risks of interpersonal violence, ostracization or other harms (e.g. where a claim must be disclosed in order to access abortion) with negative implications for her right to privacy, health, and potentially right to life.
States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	Right to health Right to security of person	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	<ul style="list-style-type: none"> • Grounds-based approaches to abortion that do not ensure the availability of abortion in at least the minimum circumstances laid down by international human rights law, applied and interpreted in a rights-based manner, are prima facie disproportionate interferences with abortion seekers' rights.
Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, Government, or health authorities.	Right to decide on the number and spacing of children Right to equality and non-discrimination Right to privacy	CESCR: GC 22 CCPR: GC 36, <i>LMR v Argentina</i> CEDAW: GR 21, GC 24, GR 34 CRPD: GC 3 Special Rapporteur on Torture Report, 2008	<ul style="list-style-type: none"> • Grounds-based approaches to abortion provision can result in unwanted continuation of pregnancy. • In such cases a grounds-based approach limits the pregnant person's decision making about whether or not to have children. • This limitation may violate the right to decide on the number and spacing of children, right to equality and non-discrimination, and right to privacy.
SRH services including abortion and post-abortion care must be provided in a way that respects women and girls'	Right to privacy	CCPR GC 36 CCPR: GC 28, GC 36 Special Rapporteur on Health Report, 2011, 2016 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Grounds-based approaches to the provision of abortion may require the disclosure of personal information to persons or institutions without clinical justification.

<p>privacy and guarantees confidentiality.</p>			<ul style="list-style-type: none"> • Such unnecessary disclosure of information may interfere negatively with abortion seekers' right to privacy. • In some cases, disclosure of such information may expose abortion seekers to risks of interpersonal violence, ostracization or other harms (e.g. where a claim must be disclosed in order to access abortion) with negative implications for her right to privacy, health, and potentially right to life.
<p>Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.</p>	<p>Right to privacy</p>	<p>CCPR: <i>KNLG v Peru</i></p>	<ul style="list-style-type: none"> • Grounds-based approaches that do not allow therapeutic abortion may interfere arbitrarily with the right to privacy. • Even where therapeutic grounds are stipulated in law, unnecessary procedures, overly restrictive definitions or interpretations, and provider refusal may operate to mean abortion is not actually available in these settings and there is an arbitrary interference with the right to privacy.
<p>Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.</p>	<p>Right to life</p>	<p>CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017</p>	<ul style="list-style-type: none"> • Grounds-based approaches to the provision of abortion may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, and may result in death. • In such circumstances grounds-based approaches may result in violation of the right to life.

3. EtD framework for Gestational age limits

Recommendation 3: **Recommend against** laws and other regulations that prohibit abortion based on gestational age limits.

PICO 3: What is the impact of gestational age limits on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of gestational age limits on abortion-related outcomes, 21 studies were identified addressing the following outcomes; delayed abortion (n=5), continuation of pregnancy (n=6), opportunity costs (n=15), unlawful abortion (n=2), self-managed abortion (n=2), disqualification from lawful abortion (n=5), disproportionate impact (n=7), referral to another provider (n=1), system costs (n=5). No studies were identified that encompassed information related to the outcomes workload implications, impact on provider–patient relationship or stigmatization. Studies were conducted in Australia, Belgium, Nepal, Mexico, South Africa, United Kingdom and USA. Study designs in this EtD framework include cross-sectional studies, prospective and retrospective cohort studies, qualitative in-depth interviews, mixed-methods studies and a cost effectiveness analysis.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion

Outcome: **DELAYED ABORTION**

Findings table 1: Impact of gestational age limits on abortion delay

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Greene Foster 2013	▲	In settings where most clinics offer only first trimester abortions, gestational age limits contribute to abortion delays for women seeking second trimester abortions.	Overall evidence from 5 studies suggests that gestational age limits may lead to abortion delays. The effects of gestational age limits are greatest among specific populations: women seeking second trimester abortions, those living in areas where clinics are limited and remote, and women closest to gestational age cut offs.
Jerman 2017 ¹	▲	Gestational age limits lead to abortion delays when available clinics are few and far apart, and where gestational age limits set by clinics vary between clinics/providers.	
Purcell 2014 ¹	▲	Gestational age limits, in combination with potentially complicated referral pathways, and the need to travel for an abortion, may lead to abortion delays.	
Puri 2015 ¹	▲	Abortion delays are experienced among women (12/25) who continue to seek abortion after an initial denial due to gestational age limits. Many of these women receive multiple referrals and visit multiple facilities until they find a provider who is willing to perform the abortion.	
Upadhyay 2014	▲	Gestational age limits may delay access to abortion care especially for women seeking an abortion near the point at which abortion is no longer allowed.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Greene-Foster 2013; Cross-sectional study (n=441); USA

Jerman 2017; Qualitative in-depth interviews (n=29); USA

Purcell 2014; Qualitative in-depth interviews (n=23); Scotland, United Kingdom

Puri 2015; Qualitative in-depth interviews (n=25); Nepal

Upadhyay 2014; Prospective cohort study (n=683); USA

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Findings table 2: Impact of gestational age limits on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY			
Human rights standards engaged: right to health, right to security of person, right to decide on the number and spacing of children, right to privacy, right to equality and non-discrimination, right to be free from torture and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Bullard 2018 ²	▲	A ban on abortions at 20 weeks or later may increase the number of live births among women with pregnancies affected by congenital diaphragmatic hernia.	Overall, evidence from 6 studies suggests that gestational age limits contribute to women continuing pregnancies after being denied an abortion due to their gestational age.
Burgen 2010	▲	Gestational age limits may contribute to continuation of pregnancy among women with cognitive impairment.	
Cameron 2016	▲	Gestational age limits are significantly more likely to lead to continuation of pregnancy among women who present at or beyond 20 weeks, compared with women presenting between 16–19 weeks (OR 6.37, 95% CI 3.07–13.2).	
Harries 2015 ¹	▲	Some women who are denied an abortion due to gestational age limits will continue their pregnancies.	
Puri 2015 ¹	▲	Among women who are denied an abortion due to gestational age limits, half end up continuing the pregnancy (12/25).	
Upadhyay 2014	▲	In 2008, an estimated 5278 US women were denied an abortion due to gestational age limits and among those, 4143 (78%) carried their pregnancies to term.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Cost effectiveness model using a theoretical cohort of women in the USA.

Additional considerations

Study design and setting of included studies:

Bullard 2018; Cost-effectiveness analysis (n=921); USA

Burgen 2010; Retrospective cohort study (n=20); Melbourne, Australia

Cameron 2016; Cross-sectional study (n=267); Scotland, United Kingdom

Harries 2015; Qualitative in-depth interviews (n=8); Cape Town, South Africa

Puri 2015; Qualitative in-depth interviews (n=25); Nepal

Upadhyay 2014; Prospective cohort study (n=683); USA

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Outcome: OPPORTUNITY COST

Findings table 3: Impact of gestational age limits on opportunity cost

OUTCOME: OPPORTUNITY COSTS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aztlán 2018	○	Women who are denied an abortion due to gestational age limits and go on to parent do not have a higher rate of subsequent unintended pregnancy within 5 years, as compared with women who receive an abortion near the gestational age limit (adjusted HR 0.79, (5% CI 0.59–1.06).	Overall, evidence from 14 studies suggests that gestational age limits contribute to opportunity costs, including financial and emotional opportunity costs, time and travel, and reduced quality of life. Being denied an abortion due to a gestational age limit may have negative financial consequences that persist for years after the denial and may also negatively impact a woman’s educational opportunities. Evidence from 1 study indicates that denial of abortion due to gestational age limits do not impact the risk of subsequent unintended pregnancy.
Bullard 2018 ¹	▲	A 20 week ban on abortions increases opportunity costs for women with pregnancies complicated by fetal anomalies, including out of state travel for abortion, increased financial costs, and lower quality of life.	
Burgen 2010	▲	Gestational age limits are associated with opportunity costs for women with cognitive impairment seeking abortion care after passing the gestational age limit.	
Cooney 2017	▲	Genetic counsellors perceive that gestational age limits restrict women’s access to abortion and place additional stress on abortion seekers.	
Gerdts 2016	▲	A total of 37.9% (n=22) of all women who travel for abortion report gestational age limits as the reason for not having the abortion in their country of residence. Travelling is associated with significant financial costs and time away from work and care taking.	
Hall 2020	▲	Implementation of a 22-week gestational age limit significantly decrease abortions performed at > 21 weeks (from 809 to 7, $P = 0.02$). The decline is larger among non-resident women (-31.3 abortions/year, $P = 0.02$) compared with resident women (-13.9 abortions/year, $P = 0.06$), indicating potential added opportunity costs for women who need to travel for an abortion.	

Harries 2015 ²	▲	Denial of abortion due to gestational age limits causes emotional distress among abortion seekers. Opportunity costs are especially large for women who have travelled far, but are then denied the procedure due to gestational age limits.
Jerman 2017 ²	▲	Varying gestational age limits at clinics that are few and far apart may lead to opportunity costs for abortion seekers, including travel, financial costs, loss of income, and emotional distress.
Miller 2020	▲	Among women denied an abortion due to gestational age limits, financial distress, as measured by a validated index, increases significantly, as does overdue debts; bankruptcies; and evictions; as compared with women who receive an abortion near to the gestational age limit. Differences in financial outcomes remain for at least 4 years.
Purcell 2014 ²	▲	³ Gestational age limits contribute to emotional distress and sometimes the need to travel for abortion, which requires significant resources and time. Some women who seek abortions near gestational age limits feel that the mere existence of a gestational age limit is judgemental.
Puri 2015 ²	▲	Being denied an abortion because of gestational age limits causes distress and frustration among abortion seekers. ³ Many women who are denied an abortion because of gestational age limits receive multiple referrals and visit multiple facilities until they find a provider who is willing to perform the abortion, markedly increasing opportunity costs. Referrals to other providers that may be able to perform the abortions are sometimes accompanied by judgement and misinformation. ²
Ralph 2019	▲	There is no statistically significant difference in the rate of graduating or dropping out of school between women who are denied an abortion due to Gestational age limits and go on to parent versus women who obtain a wanted abortion (aHR 0.76, 95% CI 0.36–1.61). However, women

		who are denied an abortion due to the gestational age limit who parent, are more likely to seek a high school degree than a higher degree compared with women who received a wanted abortion (67% vs 24% $P = 0.05$). Among women who graduate high school, women who are denied an abortion due to the gestational age limit, are less likely to complete a postsecondary degree compared to women who receive a wanted abortion (27% vs 71% $P = 0.02$).
Rocca 2013	▲	Compared with women who receive a near gestational age limit abortion, women turned away due to gestational age limits feel significantly less relief (mean group difference on a 4-point scale) -1.38, 95% CI -1.61 to -1.13), increased regret (0.46, 95% CI 0.24–0.67), and increased anger (0.43, 95% CI 0.22–0.63).
Upadhyay 2014	▲	Gestational age limits may contribute to opportunity costs, including travel, multiple clinic visits and financial costs, especially for those women seeking an abortion near the gestational age limit.
White 2019	▲	When a law that includes gestational age limits with other regulatory requirements, its implementation may contribute to opportunity costs by increasing mean gestational age at which women undergo abortions (from 7.3 to 8.3 weeks, $P = 0.001$), increasing second trimester abortions (OR 1.45, CI 95% 1.1–1.25), decreasing the number of first trimester medication abortions (from 27.3% to 8.6% of all procedures), and reducing abortions performed above 22 weeks (from 0.3% to 0.1%).

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Cost effectiveness model using a theoretical cohort of women in the USA.

² Qualitative study design: tests of statistical significance not applicable.

³ Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Aztlan 2017; Prospective cohort study (n=798); USA
Bullard 2018; Cost effectiveness analysis (n=921); USA
Burgin 2010; Retrospective cohort study (n=20); Melbourne, Australia
Cooney 2017; Cross-sectional study (n=268); USA
Gerdtts 2016; Cross-sectional study (n=58); United Kingdom
Hall 2020; retrospective cohort study (n=360 972); Georgia, USA
Harries 2015; Qualitative in-depth interviews (n=8); Cape Town, South Africa
Jerman 2017; Qualitative in-depth interviews (n=29); USA
Miller 2020; Retrospective cohort study (n=828); USA
Purcell 2014; Qualitative in-depth interviews (n=23); Scotland, United Kingdom
Puri 2015; Qualitative in-depth interviews (n=25); Nepal
Ralph 2019; Prospective cohort study (n=876); USA
Rocca 2013; Prospective cohort study (n=843); USA
Upadhyay 2014; Prospective cohort study (n=683); USA
White 2019; Cross-sectional study (n=64 902); Texas, USA

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Outcome: UNLAWFUL ABORTION

Findings table 4: Impact of gestational age limits on unlawful abortion

OUTCOME: UNLAWFUL ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Harries 2015 ¹	▲	Some women who are denied an abortion due to gestational age limits will go on to have unlawful abortions.	Evidence from 2 studies suggests that when gestational age limits are in place, some women will seek out unlawful abortion.
Jerman 2017 ¹	▲	When a law that includes gestational age limits is combined with other regulatory requirements, some of which may act as barriers, access to safe abortion may decrease, potentially contributing to unlawful abortion.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Harries 2015; Qualitative in-depth interviews (n=8); Cape Town, South Africa
 Jerman 2017; Qualitative in-depth interviews (n=29); USA

Findings table 5: Impact of gestational age limits on self-management of abortion

OUTCOME: SELF-MANAGED ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Jerman 2017 ¹	▲	Where a gestational age limit is combined with other policies, access to safe abortion may decrease, potentially contributing to self-management of abortion that is sometimes unsafe.	Overall, findings from 2 studies suggests that gestational age limits may contribute to attempts by women to self-manage an abortion.
Puri 2015 ¹	▲	Gestational age limits may contribute to attempts to self-manage their abortions among women who are denied abortion due to gestational age limits.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Jerman 2017; Qualitative in-depth interviews (n=29); USA

Puri 2015; Qualitative in-depth interviews (n=25); Nepal

Findings table 6: Impact of gestational age limits on disqualification of lawful abortion

OUTCOME: DISQUALIFICATION FROM LAWFUL ABORTION			
Human rights standards engaged: right to health, right to be free from torture and cruel, inhuman and degrading treatment, right to decide the number and spacing of children, right to equality and non-discrimination, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Burgen 2010	▲	Gestational age limits contribute to the disqualification from lawful abortion among women with cognitive impairment.	Overall, findings from 5 studies find that gestational age limits may contribute to disqualification from lawful abortion.
Gerds 2016	▲	Gestational age limits contribute to the disqualification from lawful abortion, thereby resulting in more women travelling (if able) for abortion.	
Harries 2014 ¹	▲	Gestational age limits contribute to the disqualification from lawful abortion, leading some women to continue their pregnancies, and others to have unlawful abortions.	
Van de Velde 2019	▲	Over 3 years, 3.9% (n=972) of women at an outpatient abortion centre network were disqualified from legal abortion due to gestational age limits. Of those, 293 women were denied an abortion because the 6-day waiting period pushing them over the gestational threshold.	
Upadhyay 2014	▲	In the USA, 5278 women are estimated to be disqualified from lawful abortion annually due to gestational age limits.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Burgen 2010; Retrospective cohort study (n=20); Melbourne, Australia
 Gerds 2016; Cross-sectional study (n=58); United Kingdom
 Harries 2015; Qualitative in-depth interviews (n=8); Cape Town, South Africa

Ven de Velde 2019; Retrospective cohort study (n=28 741); Belgium
Upadhyay 2014; Prospective cohort study (n=683); USA

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Findings table 7: Impact of gestational age limits on disproportionate impact

OUTCOME: DISPROPORTIONATE IMPACT			
Human rights standards engaged: right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Burgen 2010	▲	Gestational age limits disproportionately impact women with cognitive disabilities, who often present after the legal threshold for abortion.	Evidence from 7 studies suggests that gestational age limits disproportionately impact abortion access for key populations; adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income are more likely to be turned away due to gestational age limits.
Greene Foster 2012	▲	Gestational age limits disproportionately impact adolescents, who are more likely than adults to present beyond clinics' gestational age limits.	
Greene Foster 2013	▲	Demographic characteristics of women presenting for abortions after 20 weeks vary by key characteristics. Young women aged 20–24, compared with 25–34, are significantly more likely to have an abortion at or beyond 20 weeks (OR 2.7, 95% CI 1.46–5.04). Being employed (OR 0.48, 95% CI 0.28–0.83) and discovering the pregnancy at < 8 weeks (OR 0.07, 95% CI 0.04–0.11) significantly decreased the likelihood of having an abortion at or beyond 20 weeks, while < 3 h travel time to a clinic (OR 4.61, 1.89–11.26) increased the odds. This suggests that younger women, and women living further from abortion clinics are more likely to be disproportionately impacted by gestational age limits.	
Hall 2020	▲	Implementation of a gestational age limit of 22 weeks leads to a significant decrease in abortions performed at > 21 weeks (from 809 to 7, $P = 0.02$). The decline is larger among non-resident women (-31.3 abortions/year, $P = 0.02$) compared with resident women (-13.9 abortions/year, $P = 0.06$), indicating that the gestational age limit disproportionately impacts women who need to travel for an abortion.	
Saavedra-Avenando 2018	▲	Adults aged 30–39 have significantly lower odds of presenting past gestational age limits compared with adolescents aged 12–17 (aOR 0.58, 95% CI 0.425–0.783). Women with higher levels of education (greater than high school) have significantly reduced odds of presenting past the gestational age limit (a) 0.40 95%CI 0.343–0.455). Adolescents, regardless of educational attainment, have a significantly higher probability of not receiving an abortion due to gestational age limits.	

Upadhyay 2014	▲	Gestational age limits disproportionately impact young women and poor women, who are more likely than older women and non-poor women to present beyond a gestational age limit, when compared with women who obtain a desired abortion.
Van de Velde 2019	▲	<p>Women presenting for abortion past the gestational age limit vary based on key demographic characteristics, suggesting that gestational age limits disproportionately impact key populations.</p> <p>Younger women (age < 18) are significantly more likely (aOR 1.72 1.22–2.41) to present past the gestational age limit than women over age 20.</p> <p>Women with less education (primary or less) are significantly more likely (OR 1.95, 95% CI 1.26–3.02) to present past the gestational age limit than women with higher education. Women with special needs education (OR 3.12, 95% CI 1.63–5.97), lower secondary (OR 2.07, 95% CI 1.54–2.79) and upper secondary level education (OR 1.84, 95% CI 1.47–2.31) are also negatively impacted by gestational age limits.</p> <p>Women who are unemployed are also more likely to be affected by gestational age limits than women who are employed (OR 1.31, 95% CI 1.06–1.62).</p>

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

Additional considerations

Study design and setting of included studies:

Burgen 2010; Retrospective cohort study (n=20); Melbourne, Australia
Greene-Foster 2012; Cross-sectional study (n=5109); USA
Greene-Foster 2013; Cross-sectional study (n=441); USA
Hall 2020; retrospective cohort study (n=360 972); Georgia, USA
Saavedra Avenando 2018; Cross-sectional study (n=52 391); Mexico
Upadhyay 2014; Prospective cohort study (n=683); USA
Ven de Velde 2019; Retrospective cohort study (n=28741); Belgium

Findings table 8: Impact of gestational age limits on referral to another provider

OUTCOME: REFERRAL TO ANOTHER PROVIDER			
Human rights standards engaged: right to health, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Puri 2015 ¹	▲	² For women who are successful in obtaining an abortion (12/25) after being denied one due to gestational age limits, multiple referrals and visits to more than one facility were required to find a provider who was willing to perform an abortion.	Overall, evidence from 1 study suggests that women who are denied an abortion, due to gestational age limits, may experience multiple challenges in obtaining a referral to another provider.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Puri 2015; Qualitative in-depth interviews (n=25); Nepal

POPULATION: Medical professionals providing abortion services

Outcome: *WORKLOAD IMPLICATIONS*

No studies identified

Outcome: *SYSTEM COSTS*

Findings table 9 Impact of gestational age limits on system costs

OUTCOME: SYSTEM COST			
Human rights standards engaged: right to health, right to security of person, right to life			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Bullard 2018 ¹	▲	A 20-week abortion ban contributes to system costs by restricting access to abortion to women with pregnancies affected by severe foetal anomalies (congenital diaphragmatic hernia). This is associated with worsened health outcomes, decreased quality of life, and increased health care costs.	Overall evidence from 5 studies suggests that gestational age limits increase system costs by leading to increased rates of maternal mortality and poor health outcomes, increased travel, bankruptcies, overdue bills and evictions.
Hall 2020	▲	Implementation of a 22-week gestational age limit results in an abrupt decrease in abortions performed after 21 weeks while the rate of abortions at < 20 weeks remains stable. The decline is larger among non-resident women (-31.3 abortions/year, <i>P</i> = 0.02) compared with resident women (-13.9 abortions/year, <i>P</i> = 0.06). This suggests that there may be increased system costs due to women either travelling further to obtain desired abortion or continuing the pregnancy.	
Hawkins 2020	▲	In states that enacted gestational age limits, maternal mortality increases by 38%, compared with states that do not (IRR 1.38, CI 95% 1.03–1.84).	
Miller 2020	▲	Women who are denied an abortion due to gestational age limits experience negative economic effects that persist over at least 4 years. Women who are denied an abortion experience significantly increased financial distress using a validated index, increased rates of past due debts, bankruptcies and evictions.	

White 2019	▲	Gestational age limit restrictions that are implemented as part of a package of laws restricting abortion access may contribute to system costs by increasing second trimester abortions (OR 1.45, CI 95% 1.1–1.25) and decreasing the proportion of first trimester medication abortions (from 27.3% to 8.6% of all procedures).
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Cost effectiveness model using a theoretical cohort of women in the USA.

Additional considerations

Study design and setting of included studies:

Bullard 2018; Cost effective analysis (n=921); USA
 Hawkins 2020; Prospective cohort study (n=4767); USA
 Hall 2020; retrospective cohort study (n=360 972); Georgia, USA
 Miller 2020; Retrospective cohort study (n=828); USA
 White 2019; Cross-sectional study (n=64 902); Texas, USA

Outcome: PERCEIVED IMPACT ON RELATIONSHIP WITH PATIENT

No studies identified

Outcome: STIGMATIZATION OF HEALTH-CARE PROVIDERS

No studies identified

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Overall evidence from 5 studies suggests that gestational age limits may lead to abortion delays. The effects of gestational age limits are greatest among specific populations: women seeking second trimester abortions, those living in areas where clinics are limited and remote, and women closest to gestational age cutoffs.

Continuation of pregnancy

- Overall, evidence from 6 studies suggests that gestational age limits contribute to women continuing pregnancies after being denied an abortion due to their gestational age.

Opportunity costs

- Overall, evidence from 14 studies suggests that gestational age limits contribute to opportunity costs, including financial and emotional opportunity costs, time and travel, and reduced quality of life. Being denied an abortion due to a gestational age limit may have negative financial consequences that persist for years after the denial and may also negatively impact a woman's educational opportunities. Evidence from 1 study indicates that denial of abortion due to gestational age limits do not impact the risk of subsequent unintended pregnancy.

Unlawful abortion

- Evidence from 2 studies suggests that when gestational age limits are in place, some women will seek out unlawful abortion.

Self-managed abortion

- Overall, findings from 2 studies suggests that gestational age limits may contribute to attempts by women to self-manage an abortion.

Disqualification from lawful abortion

- Overall, findings from 5 studies find that gestational age limits may contribute to disqualification from lawful abortion.

Disproportionate impact

- Evidence from 7 studies suggests that gestational age limits disproportionately impact abortion access for key populations; adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income are more likely to be turned away due to gestational age limits.

Referral to another provider

- Overall, evidence from 1 study suggests that women who are denied an abortion, due to gestational age limits, may experience multiple challenges in obtaining a referral to another provider.

Workload implications

- No studies identified

System costs

- Overall evidence from 5 studies suggests that gestational age limits increase system costs by leading to increased rates of maternal mortality and poor health outcomes, increased travel, bankruptcies, overdue bills and evictions.

Perceived impact on relationship with patient

- No studies identified

Stigmatization

- No studies identified

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HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARD TO EVIDENCE TABLES: Gestational age limits

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Overall evidence from 5 studies suggests that gestational age limits may lead to abortion delays. The effects of gestational age limits are greatest among specific populations: women seeking second trimester abortions, those living in areas where clinics are limited and remote, and women closest to gestational age cut offs.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Gestational age limits can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Gestational age limits can result in delayed access to abortion care. Delays relating to gestational age limits may particularly affect women in rural areas, those seeking second trimester abortions, and those close to gestational age limit cut offs, with implications for their exposure to increased risks of maternal mortality or morbidity, resulting in reduced rights enjoyment.
Continuation of Pregnancy	Overall, evidence from 6 studies suggests that gestational age limits contribute to women continuing pregnancies after being denied an abortion due to their gestational age.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Gestational age limits that have a disproportionately negative effect on the health and physical and mental integrity of abortion seekers have negative implications for rights.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State, or health authorities.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Gestational age limits that have a disproportionately negative effect on a woman’s ability to decide whether or not

				to continue with pregnancy has negative implications for rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Where abortion is lawful, the operation of gestational age limits to hinder a pregnant person's ability to access safe abortion has negative implications for rights.
		States should ensure appropriate SRH care and services to address sexual violence against women and girls, including making abortion available in cases of rape or incest.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Failure to ensure gestational age limits do not prevent a woman from accessing abortion in cases of sexual violence, including rape or incest, has negative implications for rights.
		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Failure to ensure gestational age limits do not undermine or hinder access to abortion has negative implications for rights.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Gestational age limits may result in continuation of pregnancy and unwanted birth. Failure to ensure gestational age limits do not result in denial of therapeutic abortion has negative implications for rights.
Opportunity Costs	Overall, evidence from 14 studies suggests that gestational age limits contribute to opportunity costs, including financial and emotional opportunity costs, time and travel, and reduced quality of life. Being denied an abortion due to a gestational age limit may have negative financial	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Gestational age limits may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure gestational age limits do not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights. These negative implications may endure and have long-term effects.

	<p>consequences that persist for years after the denial and may also negatively impact a woman's educational opportunities.</p> <p>Evidence from 1 study indicates that denial of abortion due to Gestational age limits do not impact the risk of subsequent unintended pregnancy.</p>	States should protect people seeking abortion.	▲	Gestational age limits may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure gestational age limits do not expose abortion seekers to harm, including long-term harm, has negative implications for rights.
Unlawful abortion	Evidence from 2 studies suggests that when gestational age limits are in place, some women will seek out unlawful abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Gestational age limits may be associated with recourse to unlawful abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity gestational age limits have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Gestational age limits may be associated with recourse to unlawful abortion. Where such unlawful abortions are unsafe, gestational age limits have negative implications for rights.
Self-managed Abortion	Overall, findings from 2 studies suggests that gestational age limits may contribute to attempts by women to self-manage an abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Gestational age limits may be associated with recourse to self-management of abortion. Where self-management of abortion increases risks of maternal mortality or morbidity, gestational age limits have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Gestational age limits may be associated with recourse to self-management of abortion. Where such self-management of abortion is unsafe, gestational age limits have negative implications for rights.
Disqualification from Lawful Abortion	Overall, findings from 5 studies find that gestational age limits may contribute to disqualification from lawful abortion.	States should protect people seeking abortion.	▲	Gestational age limits may result in disqualification from lawful abortion and lead to unlawful abortion and/or self-management of abortion. Where such abortion is unsafe, gestational age limits have negative implications for rights.

		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Provider-imposed gestational age limits may result in delay and subsequent disqualification from lawful abortion and undermine or hinder access to abortion with negative implications for rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Provider-imposed gestational age limits may result in delay and subsequent disqualification from lawful abortion with implications for safety and accessibility and, thus, negative implications for rights.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State, or health authorities.	▲	Gestational age limits may result in disqualification from lawful abortion and resultant continuation of pregnancy and unwanted birth. Gestational age limits that have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy have negative implications for rights.
Disproportionate Impact	Evidence from 7 studies suggests that gestational age limits disproportionately impact abortion access for key populations; adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income are more likely to be turned away due to gestational age limits.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Gestational age limits impact disproportionately on adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.
Referral to Another Provider	Overall, evidence from 1 study suggests that women who are denied an abortion, due to gestational age limits, may experience multiple challenges in obtaining a referral to another provider.	States should protect people seeking abortion.	▲	Failure to regulate gestational age limits so that their application does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services) has negative implications for rights.

		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Failure to regulate gestational age limits so that their application does not undermine or hinder access to abortion has negative implications for rights.
		Where it is lawful, abortion must be safe and accessible.	▲	Where abortion is lawful, failure to regulate gestational age limits so that their application does not hinder a pregnant person's ability to access safe abortion has negative implications for rights.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Gestational age limits

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Workload Implications	No studies identified			
System Costs	Overall evidence from 5 studies suggests that gestational age limits increase system costs by leading to increased rates of maternal mortality and poor health outcomes, increased travel, bankruptcies, overdue bills and evictions.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.	▲	Gestational age limits are associated with poor health outcomes and substantial opportunity costs, with sometimes disproportionate negative implications for rights.
		States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Gestational age limits are associated with increased rates of maternal mortality and poor health, with negative implications for rights.
		States should protect people seeking abortion.	▲	Gestational age limits are associated with poor health outcomes and substantial opportunity costs and thus with exposure of abortion seekers to substantial costs and risks, with negative implications for rights.
		Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.	▲	Where deaths are associated with gestational age limits, such limits may violate the right to life.
Impact on Provider–Patient Relationship	No studies identified			
Stigmatization	No studies identified			

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON GESTATIONAL AGE LIMITS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: GESTATIONAL AGE LIMITS: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	Overall evidence from 5 studies suggests that gestational age limits may lead to abortion delays. The effects of gestational age limits are greatest among specific populations: women seeking second trimester abortions, those living in areas where clinics are limited and remote, and women closest to gestational age cut offs.	Gestational age limits can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.	We recommend against gestational age limits for access to abortion care.
Continuation of pregnancy	Overall, evidence from 6 studies suggests that gestational age limits contribute to women continuing pregnancies after being denied an abortion due to their gestational age.	Gestational age limits may result in continuation of pregnancy and unwanted birth. Gestational age limits can have a disproportionately negative effect on the health and physical and mental integrity of abortion seekers, on a woman's ability to decide whether or not to continue with pregnancy, and on access to safe abortion in cases of sexual violence or therapeutic abortion with negative implications for rights.	We recommend against gestational age limits for access to abortion care.
Opportunity costs	Overall, evidence from 14 studies suggests that gestational age limits contribute to opportunity costs, including financial and emotional opportunity costs, time and travel, and reduced quality of life. Being denied an abortion due to a gestational age limit may have negative financial consequences that persist for years after the denial and may also negatively impact a woman's educational opportunities. Evidence from 1 study indicates that denial of abortion due to gestational age limits do not impact the risk of subsequent unintended pregnancy.	Gestational age limits may operate in a way that imposes significant opportunity costs on people seeking abortion. Failure to ensure gestational age limits do not expose abortion seekers to harm, including long-term harm, has negative implications for rights.	We recommend against gestational age limits for access to abortion care.

<p>Unlawful Abortion</p>	<p>Evidence from 2 studies suggests that when gestational age limits are in place, some women will seek out unlawful abortion.</p>	<p>Disqualification from lawful abortion as a result of the application of gestational age limits may lead people to seek abortion outside of the formal medical system. This may include recourse to unlawful abortion, which may be unsafe and thus have a negative impact on rights. Disqualification from lawful abortion as a result of the application of gestational age limits can result in criminal liability where a pregnant person seeks abortion outside the formal system including availing of unlawful abortion. In such cases gestational age limits may operation as <i>de facto</i> criminalization provisions.</p> <p>Criminalization of abortion may result in a violation of the right to equality and non-discrimination, right to security of person, or right to be free from torture, and cruel, inhuman and degrading treatment.</p>	<p>We recommend against gestational age limits for access to abortion care.</p>
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Self-managed Abortion	Overall, findings from 2 studies suggests that Gestational age limits may contribute to attempts by women to self-manage an abortion.	<p>Disqualification from lawful abortion as a result of the application of gestational age limits may lead people to seek abortion outside of the formal medical system. This may include recourse to unlawful abortion, which may be unsafe and thus have a negative impact on rights. Disqualification from lawful abortion as a result of the application of gestational age limits can result in criminal liability where a pregnant person seeks abortion outside the formal system including availing of unlawful abortion. In such cases gestational age limits may operation as <i>de facto</i> criminalization provisions.</p> <p>Criminalization of abortion may result in a violation of the right to equality and non-discrimination, right to security of person, or right to be free from torture, and cruel, inhuman and degrading treatment.</p>	We recommend against gestational age limits for access to abortion care.
Disqualification from Lawful Abortion	Overall, findings from 5 studies find that gestational age limits may contribute to disqualification from lawful abortion.	<p>Gestational age limits may result in disqualification from lawful abortion and consequent recourse to unlawful abortion and/or self-management of abortion.</p> <p>Where such abortion is unsafe, Gestational age limits have negative implications for rights. Gestational age limits may result in disqualification from lawful abortion and undermine or hinder access to abortion including in cases of sexual violence or therapeutic abortion.</p>	We recommend against gestational age limits for access to abortion care.

Disproportionate Impact	Evidence from 7 studies suggests that gestational age limits disproportionately impact abortion access for key populations; adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income are more likely to be turned away due to gestational age limits.	Gestational age limits have a disproportionate impact on particular populations including teenagers, women with cognitive impairments, women living in areas that are poorly served by abortion services, and women who are more susceptible to later detection of pregnancy. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.	We recommend against gestational age limits for access to abortion care.
Referral to Another Provider	Overall, evidence from 1 study suggests that women who are denied an abortion, due to gestational age limits, may experience multiple challenges in obtaining a referral to another provider.	Failure to regulate gestational age limits so that their application does not undermine or hinder access to abortion has negative implications for rights.	We recommend against gestational age limits for access to abortion care.
Workload Implications	No studies identified	Gestational age limits may hinder or undermine access to abortion and have associated workload implications. This may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.	We recommend against gestational age limits for access to abortion care.
System Costs	Overall evidence from 5 studies suggests that gestational age limits increase system costs by leading to increased rates of maternal mortality and poor health outcomes, increased travel, bankruptcies, overdue bills and evictions.	Gestational age limits are associated with poor health outcomes and substantial opportunity costs and thus with exposure of abortion seekers to substantial costs and risks, with negative implications for rights.	We recommend against gestational age limits for access to abortion care.
Impact on Provider-Patient Relationship	No studies identified	Failure to regulate provider-level-imposed gestational age limits may expose abortion seekers to a negatively impacted relationship with their health-care provider, with negative implications for rights.	We recommend against gestational age limits for access to abortion care.
Stigmatization	No studies identified	Disqualification from lawful abortion as a result of the application of gestational age limits can expose abortion seekers to	We recommend against gestational age limits for access to abortion care.

		stigmatization and indignity, significant opportunity costs at the time and in the future, impediments to their access to safe abortion, and lack of access to accurate pre- and post-abortion information and care.	
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DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- Gestational age limits can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.
- Delays relating to gestational age limits may particularly affect women in rural areas, those seeking second trimester abortions, and those close to gestational age limit cut-offs, with implications for their exposure to increased risks of maternal mortality or morbidity, resulting in reduced rights enjoyment.

Continuation of pregnancy

- Gestational age limits may result in continuation of pregnancy and unwanted birth.
- Gestational age limits that have a disproportionately negative effect on the health and physical and mental integrity of abortion seekers have negative implications for rights.
- Gestational age limits that have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy has negative implications for rights.
- Where abortion is lawful, the operation of gestational age limits to hinder a pregnant person's ability to access safe abortion has negative implications for rights.
- Failure to ensure gestational age limits do not prevent a woman from accessing abortion in cases of sexual violence, including rape or incest, has negative implications for rights.
- Failure to ensure gestational age limits do not undermine or hinder access to abortion has negative implications for rights.
- Failure to ensure gestational age limits do not result in denial of therapeutic abortion has negative implications for rights.

Opportunity costs

- Gestational age limits may operate in a way that imposes significant opportunity costs on people seeking abortion.
- Failure to ensure gestational age limits do not have a disproportionately negative effect on health and physical and mental integrity has negative implications for rights. These negative implications may endure and have long-term effects.
- Failure to ensure gestational age limits do not expose abortion seekers to harm, including long-term harm, has negative implications for rights.

Unlawful abortion

- Gestational age limits may be associated with recourse to unlawful abortion. Where such unlawful abortions increase risks of maternal mortality or morbidity gestational age limits have negative implications for rights. Where such unlawful abortions are unsafe, gestational age limits have negative implications for rights.

Self-managed abortion

- Gestational age limits may be associated with recourse to self-management of abortion. Where self-management of abortion increases risks of maternal mortality or morbidity, gestational age limits have negative implications for rights. Where such self-management of abortion is unsafe, gestational age limits have negative implications for rights.

Disqualification from unlawful abortion

- Gestational age limits may result in disqualification from lawful abortion and lead to unlawful abortion and/or self-management of abortion. Where such abortion is unsafe, gestational age limits have negative implications for rights.
- Provider-imposed gestational age limits may result in delay and subsequent disqualification from lawful abortion and undermine or hinder access to abortion with negative implications for rights as well as implications for safety and accessibility and, thus, negative implications for rights.
- Gestational age limits may result in disqualification from lawful abortion and resultant continuation of pregnancy and unwanted birth. Gestational age limits that have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy have negative implications for rights.

Disproportionate impact

- Gestational age limits impact disproportionately on adolescents, women with cognitive disabilities, women living remote from abortion clinics, those who have lower levels of educational attainment, and those with less income. This disproportionate impact has negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.

Referral to another provider

- Failure to regulate gestational age limits so that their application does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services) has negative implications for rights.
- Failure to regulate gestational age limits so that their application does not undermine or hinder access to abortion has negative implications for rights.

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- No studies identified

System costs

- Gestational age limits are associated with poor health outcomes and substantial opportunity costs, with sometimes disproportionate negative implications for rights. This exposes abortion seekers to substantial costs and risks, with negative implications for rights.
- Gestational age limits are associated with increased rates of maternal mortality and poor health, with negative implications for rights.

- Where deaths are associated with gestational age limits, such limits may violate the right to life.

Perceived impact on relationship with patient

- No studies identified

Stigmatization

- No studies identified

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes, we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy and disqualification of lawful abortion, and affordable care with as few logistical burdens as possible. We can also assume that health-care providers, regardless if they participate in abortion care or not, value reasonable workloads and avoidance of stigmatization.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *gestational age limits*.

Resources:

The studies did not speak to the issue of resources.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability or feasibility.

Equity:

The outcome *disproportionate impact* speaks to the issue of equity.

Gestational age limits: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Gestational Age Limits
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	Right to life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland, Mellet v Ireland, LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2017, 2018 Working Group on Discrimination against Women Report, 2016	<ul style="list-style-type: none">• Gestational age limits may lead people to access abortion outside of the formal system.• Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality.• Gestational age limits may lead to delays in accessing abortion as people seek a provider or jurisdiction where gestational age limits do not apply or do not result in their disqualification.• Such delays may expose women to risks of maternal mortality or morbidity.• In such cases, gestational age limits expose abortion seekers to violations of the right to life and the right to health.

<p>Where it is lawful, abortion must be safe and accessible.</p>	<p>The right to health The right to be free from torture, and cruel, inhuman and degrading treatment</p>	<p>CCPR: GC 36, <i>LMR v Argentina, LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • The application of gestational age limits can make lawful abortion inaccessible. • In such cases, gestational age limits would be inconsistent with the right to life and right to health. • Such cases may result in unwanted continued pregnancy, abortion travel, criminalization or other costs. • Such costs may be so substantial as to constitute torture, cruel, inhuman and degrading treatment. • Additional/secondary costs may include premature termination of education, forced and/or child marriage, and harm to physical and mental health and associated human rights deprivations and violations.
<p>States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.</p>	<p>Right to health Right to equality and non-discrimination Right of persons with disabilities to retain fertility on an equal basis with others</p>	<p>CCPR GC 36 CRC GC 4; GC 15 CRPD GC 3, GC 6 Special Rapporteur on Health Report, 2016</p>	<ul style="list-style-type: none"> • Gestational age limits can result in delayed or impeded access to abortion care. • Delays relating to gestational age limits may particularly affect teenagers, women with cognitive impairments, women living in areas that are poorly served by abortion services, and women who are more susceptible to later detection of pregnancy. • Where this is the case gestational age limits may result in discrimination and inequality in the provision of sexual and reproductive health care.
<p>States must protect people from the physical and mental health risks associated with unsafe abortions.</p>	<p>Right to health</p>	<p>CCPR: GC 28, GC 36, GR 34 CESCR: GC 22 CRC: GC 4 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Executions/Killings Report, 2017</p>	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits may lead people to seek abortion outside of the formal medical system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • In such cases, gestational age limits would be inconsistent with the right to life and right to

			health.
States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest.	Right to health	CCPR: GC 36 CESCR: GC 22	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits in cases of sexual violence including rape or incest can hinder or impede access to abortion. • In such cases, gestational age limits would be inconsistent with the right to health. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • In such cases, gestational age limits would be inconsistent with the right to life and right to health.
States should ensure provider refusal does not result in unavailability of abortion.	Right to health	CEDAW: GR 24 CESCR: GC 22	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of non-legally-mandated gestational age limits (including those regulated by providers or at the clinic level) may result in the unavailability of abortion. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to health.
States should protect people seeking abortion.	Right to health	CCPR: GC 36 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits can expose abortion seekers to stigmatization and indignity, significant opportunity costs at the time and in the future, impediments to their access to safe abortion, and lack of access to accurate pre- and post-abortion information and care. • In such cases gestational age limits may violate the right to health.

<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	<p>Right to health Right to security of person</p>	<p>CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018</p>	<ul style="list-style-type: none"> • The application of arbitrary gestational age limits undermines a pregnant person's ability safely to access abortion with disproportionate negative effects on her health, physical and mental integrity, and right to access abortion in cases of sexual violence and therapeutic indication.
<p>Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, government or health authorities.</p>	<p>Right to decide on the number and spacing of children Right to equality and non-discrimination Right to privacy</p>	<p>CESCR: GC 22 CCPR: GC 36, <i>LMR v Argentina</i> CEDAW: GR 21, GC 24, GR 34 CRPD: GC 3 Special Rapporteur on Torture Report, 2008</p>	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits can result in unwanted continuation of pregnancy. • In such cases gestational age limits constitute a limitation on the pregnant person's decision making about whether or not to have children. • This limitation may violate the right to decide on the number and spacing of children, right to equality and non-discrimination, and right to privacy.
<p>Criminalization of abortion may constitute a human rights violation.</p>	<p>Right to equality and non-discrimination Right to security of person Right to be free from torture, and cruel, inhuman and degrading treatment</p>	<p>CEDAW: GR 33, GR 35 CCPR, GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> Special Rapporteur on Torture Report, 2016 Working Group on Discrimination against Women Report 2016</p>	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits can result in criminal liability where a pregnant person seeks abortion outside the formal system including availing of unlawful self-management of abortion. • In such cases gestational age limits may operation as <i>de facto</i> criminalization provisions. • Criminalization of abortion may result in a violation of the right to equality and non-discrimination, right to security of person, or right to be free from torture, and cruel, inhuman and degrading treatment.

Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	Right to privacy	CCPR: <i>KNLG v Peru</i>	<ul style="list-style-type: none"> • In cases where therapeutic abortion is sought, disqualification from lawful abortion as a result of the application of gestational may violate the right to privacy.
Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.	Right to life	CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017	<ul style="list-style-type: none"> • Disqualification from lawful abortion as a result of the application of gestational age limits can lead people to seek abortion outside of the formal medical system. • In such cases abortion may be unsafe. • Where such unsafe abortion results in death of the abortion seeker this <i>prima facie</i> violates the right to life.

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4. EtD framework for Mandatory waiting periods

Recommendation 6: Recommend against mandatory waiting periods for abortion.

PICO 4: What is the impact of mandatory waiting periods on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of MWP on abortion related outcomes, 33 studies were identified addressing the following outcomes; delayed abortion (n=7), continuation of pregnancy (n=11), opportunity costs (n=20), disproportionate impact (n=5), workload implications (n=1), system costs (n=9). No studies were identified that encompassed information related to the outcomes self-managed abortion, unlawful abortion, disqualification from lawful abortion, referral to another provider, impact on provider–patient relationship or stigmatization. All studies were conducted in the USA. Study designs in this EtD framework include cross-sectional studies, times-series design, retrospective and prospective cohort studies, mixed-methods studies and qualitative interviews.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion

Outcome: DELAYED ABORTION

Findings table 1: Impact of mandatory waiting periods (MWP) on abortion delay

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Ehrenreich 2019a ¹	▲	Abortion seekers perceive that MWPs restrict access to care. For some women MWPs cause delays that limit the available abortion management options.	Overall, evidence from 7 studies suggests that MWPs contribute to abortion delays by increasing the time from counselling to the abortion appointment, and by contributing to logistical difficulties in obtaining care. This effect is magnified when two visits are required.
Ehrenreich 2019b ¹	▲	MWPs add to the waiting time for an appointment and cause delays in accessing care	
Jones 2016	▲	MWPs are associated with an increased time to abortion appointment of 1.5–2 days longer time to an abortion appointment: <ul style="list-style-type: none"> • without a 2-visit requirement, mean days = 8.2 • with a 2-visit requirement, mean days = 8.9 • no MWP mean days 6.7. MWPs are associated with increased odds of making an abortion appointment > 14 days following the initial visit compared with no MWPs: <ul style="list-style-type: none"> • without a 2-visit requirement: OR 1.45; 95% CI 1.07–1.98 • with 2-visit requirement: OR 1.88; 95% CI 1.39–2.54. 	
Mercier 2015 ¹	▲	When MWP are combined with mandated scripted counselling by a health-care professional, logistical difficulties in providing the care may further increase abortion delays.	

Morse 2018 ²	▲	A 72-hour MWP compared with a 24-hour MWP may increase time from first clinic visit to the abortion procedure.	
White 2016 ¹	▲	MWPs contribute to abortion delays among women who need to travel far for an abortion.	
White 2017	▲	Where MWPs with a 2-visit requirement is implemented, women with fewer resources and women who need to travel farther (50–100 miles) for an abortion (OR 1.25; CI 95% 1.01–1.56) are more likely to have longer intervals between the two visits than women who travel less than 25 miles.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Study was not powered to look at this outcome.

Additional considerations

Study design and setting of included studies:

Ehrenreich 2019a; Qualitative individual interviews (n=18); Utah, USA

Ehrenreich 2019b; Qualitative individual interviews (n=20); Utah, USA

Jones 2016; Cross-sectional study (n=8330); USA

Mercier 2015; Qualitative individual interviews (n=31); North Carolina, USA

Morse 2018; Cross-sectional study (n=48); North Carolina, USA

White 2016; Qualitative individual interviews (n=25); Alabama, USA

White 2017; Cross-sectional study (n=2730); Alabama, USA

Findings table 2: Impact of mandatory waiting periods on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY			
Human rights standards engaged: right to health, right to security of person, right to equality and non-discrimination, right to decide on the number and spacing of children, right to privacy			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Coles 2010	▲	Among minors with live births, MWP are associated with increased risk of reporting an unwanted birth (RR 2.51; 1.11–5.57).	Overall, evidence from 4 studies suggests that MWP may contribute to continuation of pregnancy, especially among adolescents and among Black and Hispanic women. Evidence from 7 studies suggests that MWP do not contribute to any changes to abortion rates, unintended pregnancy or birth rates in general, but MWP may decrease births among unmarried women.
Colman 2010	○	MWP that do not require an in-person visit, but a self-attestation to having viewed mandatory online materials, are not associated with changes in abortion rates < 16 weeks' gestation after the policy change or when compared with states without MWP (mean 14.71/1000, SE 0.6, 4.11% change).	
Medoff 2010a	▼	MWP are associated with a 17% decrease in nonmarital birth rates among women 15–44 years.	
Medoff 2010b	○	Targeted Regulation of Abortion Provider (TRAP) laws (state laws that impose licensing fees, physical/personnel regulations and other regulations on abortion providers governing procedures and protocols) that include MWP are not associated with significant changes in abortion rates.	
Medoff 2012	○	MWP with a 2-visit requirement are not associated with significant changes in unintended pregnancy rates.	
Medoff 2014a	○	MWP with a 2-visit requirement are associated with a significant decrease in abortion rates among White women, and no change among Latina or Black women. Regression coefficient: White abortion rate: $\beta = -0.035 (2.08), P < 0.05$ Black abortion rate: $\beta = 1.1068 (0.5), P > 0.10$ Hispanic abortion rate: $\beta = 0.3751 (0.77), P > 0.10$	
Medoff 2014c	○	MWP are not associated with significant changes in unintended pregnancy rates.	

Medoff 2016	○	MWPs are not associated with changes in unintended birth rates.
Sanders 2016	▲	Fewer women return for the abortion procedures after implementation of a 72h MWP (77% after implementation vs 80% before $P < 0.5$) and may instead continue their pregnancies.
Tosh 2015*	▲	Abortion regulations, including MWPs, are negatively associated with teen abortion rates ($\beta = -0.437$, $P = 0.013$) and positively associated with Black teen birth rates ($\beta = 0.525$, $P = 0.008$), but do not significantly affect White teen birth rates ($\beta = 0.219$, $P = 0.230$) or Hispanic teen birth rates ($\beta = 0.367$, $P = 0.068$).
White 2017	▲	Where MWPs with a 2-visit requiring are implemented, women with fewer resources (OR 1.47; 95% CI 1.20–1.80) and those travelling 50–100 miles one way (OR 1.25; 95% CI 1.01–1.56) are more likely to have longer durations between the first and second visit. Adolescents (OR 2.97; 95% CI 1.40–6.27) and women with fewer resources (OR 1.51; 95% CI 1.19–1.92) are more likely to not return for an abortion and may instead continue their pregnancies.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

* Used an alpha of 0.10 to determine significance ($P < 0.10$).

Additional considerations

Study design and setting of included studies:

Coles 2010; retrospective cohort study (n=8245); USA

Colman 2010; Time-series design (n=16 029); Texas, USA

Medoff 2010a; Time-series design (n=not reported); USA

Medoff 2010b; Time-series design (n=not reported); USA

Medoff 2012; Time-series design (n=not reported); USA

Medoff 2014a; Time-series design (n=not reported); USA

Medoff 2014c; Time-series design (n=not reported); USA

Medoff 2016; Time-series design (n=not reported); USA

Sanders 2016; Cross-sectional study (n=3618 from database/307 completed questionnaire); Utah, USA

Tosh 2015; Cross-sectional study (n=not reported); USA
White 2017; Cross-sectional study (n=2730); Alabama, USA

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Findings table 3: Impact of mandatory waiting periods on opportunity cost

OUTCOME: OPPORTUNITY COSTS			
Human rights standards engaged: right to health, right to security of person, right to equality and non-discrimination, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Ehrenreich 2019a ¹	▲	Abortion seekers perceive that MWP restrict access to care and contribute to emotional and logistical burdens. For some women MWP causes delays that limit the options available for abortion management.	Overall, evidence from 18 studies suggests that MWP contribute to opportunity costs including financial and emotional opportunity costs such as: logistical burdens, emotional stress, financial costs, increased price for an abortion, travel time and out of state travel. Online or phone-based counselling may mitigate some opportunity costs related with 2-visits. The negative impacts of MWP are exacerbated for women who need to travel far for an abortion. Evidence from 2 studies suggests that MWP are not associated with incidence of postpartum depression and for most women, MWP do not impact women’s certainty in the abortion decision.
Ehrenreich 2019b ¹	▲	MWP are associated with opportunity costs; including an additional clinic visit, delays, increased travel time and financial costs, some of which may be mitigated through the use of telemedicine.	
Coles 2010	▲	Among minors with live births, MWP are associated with reporting an unwanted birth (RR 2.51; 1.11–5.57).	
Cooney 2017	▲	Genetic counsellors perceive that MWP restrict women’s access to abortion and places additional stress on abortion seekers.	
Denis 2014 ¹	▲	Women report that MWP increase the emotional difficulty of the abortion decisions and impacts them negatively.	
Ely 2018	▲	Where MWP are implemented, geographical distance (to an abortion clinic) ($\beta = -0.003$, $P = 0.151$; 95% CI -0.007 to 0.001) or rural residence (OR = 1.013 95% CI 0.565 to 1.81) does not impact the likelihood of returning for the abortion. The travel, however, may be associated with opportunity costs including travel time and financial costs.	
Fuentes 2019	▲	Abortion seekers residing in settings with MWP compared with no MWP, may have higher odds of travelling further for an abortion (OR 1.7; 95% CI 1.0–2.8, $P = 0.043$).	

Jerman 2017 ¹	▲	In an effort to avoid MWP, abortion seekers may travel out of state, as the waiting periods are perceived as a barrier to accessing care.
Jones 2013	▲	Women living in settings with MWPs compared with settings with no MWPs, have higher odds of travelling further for abortion (OR 2.6; 95% CI 1.7–3.9).
Jones 2017	▲	MWPs with a 2-visit requirement compared to no MWPs, decrease the likelihood of obtaining an abortion < 6 weeks (OR 0.51; 95% CI 0.39–1.66). MWPs do not increase the likelihood of a second trimester abortion.
Karasek 2016	▲	Among women with economic hardships, MWPs are associated with increased odds of the perception an abortion would not then be attainable (OR 1.88, 95% CI 1.18–2.99).
Medoff 2014a	▲	MWPs with a 2-visit requirement are associated with a significant decrease in abortion rates among White women, and no change among Latina or Black women. Regression coefficient: White abortion rate: $\beta = -0.035$ (2.08), $P < 0.05$ Black abortion rate: $\beta = 1.1068$ (0.5), $P > 0.10$ Hispanic abortion rate: $\beta = 0.3751$ (0.77), $P > 0.10$
Medoff 2014b	○	MWPs are not associated with changes in the incidence of postpartum depression.
Medoff 2015	▲	MWPs and a 2-visit requirement are associated with an increase in the inflation-adjusted price for an abortion by US\$ 107 (19%) and a decrease in the number of abortions performed (between 13–15%).
Roberts 2016	▲	A MWP with a 2-visit requirement increases financial costs for women, with the first visit representing 11% of the abortion costs. For some women, the MWP and 2-visit requirement, cause frustration and emotional stress and anxiety.
Roberts 2017	▲	A majority of women (455/500) report that the MWP does not impact certainty of their decision but results in a minimum of a 72-hour delay.

Ruhr 2016	▲	A 72-hour MWP, compared with 24-hour MWP, is associated with a significantly larger number of days waiting for an abortion after signing the consent form (mean 7.6 vs. mean 6.1 days). 55/132 of the abortion seekers do not support the 72h MWP and perceive it as having a negative impact on them. Some women perceive the MWP as being an emotional, mental and physical burden for them and report increased financial costs due lost wages and travel costs.
Sanders 2016	▲	Out of 307 women, 62% report that the 72h MWP impacts them negatively, including lost wages or needing to take extra time off work (47%), excess childcare costs (18%) increased transportation costs (30%), lost wages by family or friends (27%), and unwanted disclosure of pregnancy (33%).
White 2016 ¹	▲	For women who need to travel far for an abortion, the MWPs with a 2-visit requirement are especially burdensome as they are linked to increased travel costs, time off work, and abortion delays.
White 2017	▲	Where MWPs with a 2-visit requirement are implemented, women with fewer resources and women who need to travel farther for an abortion (OR 1.25; CI 95% 1.01–1.56) are more likely to have longer intervals between the two visits.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Ehrenreich 2019a; Qualitative individual interviews (n=18); Utah, USA
 Ehrenreich 2019b; Qualitative individual interviews (n=20); Utah, USA
 Coles 2010; Retrospective cohort study (n=8245); USA
 Cooney 2017; Cross-sectional study (n=286); USA
 Denis 2014; Qualitative individual interviews (n=30); Oklahoma, USA

Ely 2018; Cross-sectional study (n=422); Tennessee, USA
Fuentes 2019; Cross-sectional study (n=889 142); USA
Jerman 2017; Qualitative individual interviews (n=29); Michigan, New Mexico, USA
Jones 2013; Cross-sectional study (n=8338); USA
Jones 2017; Cross-sectional study (n=8330); USA
Karasek 2016; Cross-sectional study (n=379); Arizona, USA
Medoff 2014a; Time-series design (n=not reported); USA
Medoff 2014b; Time-series design (n=not reported); USA
Medoff 2015; Time-series design (n=not reported); USA
Roberts 2016; Prospective cohort study (n=500); Utah, USA
Roberts 2017; Prospective cohort study (n=500); Utah, USA
Ruhr 2016; Mixed-methods study (n=139/52 completed follow up survey); Missouri, USA
Sanders 2016; Cross-sectional study (n=3618 from database/307 completed questionnaire); Utah, USA
White 2016; Qualitative individual interviews (n=25); Alabama, USA
White 2017; Cross-sectional study (n=2730); Alabama, USA

Outcome: UNLAWFUL ABORTION

No studies identified

Outcome: SELF-MANAGED ABORTION

No studies identified

Outcome: DISQUALIFICATION FROM LAWFUL ABORTION

No studies identified

Findings table 4: Impact of mandatory waiting periods on disproportionate impact

OUTCOME: DISPROPORTIONATE IMPACT			
Human rights standards engaged: right to health, right to equality and non-discrimination, right of persons with disabilities to retain fertility on an equal basis with others			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Coles 2010	▲	Hispanic and Black minors may be disproportionately impacted by MWP. MWPs are associated with increased risk of mistimed birth among Hispanic minors (RR 2.86; $P < 0.1$), and increased risk of unwanted birth among Black minors (RR 3.9; $P < 0.1$).	Overall, evidence from 5 studies suggests that MWPs have a disproportionate negative impact on women who need to travel farther for an abortion, women of colour, and women with fewer resources.
Karasek 2016	▲	Women who experienced more economic difficulties as a result of the abortion procedure (aOR 1.88; 95% CI 1.18–2.99) and those who experienced delays in obtaining an abortion (aOR 4.39 95% CI 1.11–17.42) are more likely to report that a MWP with a 2-visit requirement would prevent them from accessing abortion care. Women who experience more economic difficulties (aOR 1.50; 95% CI 1.11–1.93) and women who travel > 1 hour (aOR 2.6; 95% CI 1.26–5.52) are also more likely to report that a MWP would further delay access to care.	
Tosh 2015*	▲	Abortion restrictions, including MWPs, are negatively associated with teen abortion rates ($\beta = -0.437$, $P = 0.013$) and positively associated with Black teen birth rates ($\beta = 0.525$, $P = 0.008$), but do not significantly affect White teen birth rates ($\beta = 0.219$, $P = 0.230$) or Hispanic teen birth rates ($\beta = 0.367$, $P = 0.068$).	
White 2016 ¹	▲	For women who need to travel far for an abortion, the MWP with a 2-visit requirement is especially burdensome, as it is linked to increased travel costs and time off work, and abortion delays.	

White 2017	▲	<p>Where MWP with a 2-visit requirement are implemented, women with fewer resources (OR 1.47; 95% CI 1.20–1.80) and those travelling 50–100 miles one way (OR 1.25; 95% CI 1.01–1.56) are more likely to have longer durations between the first and second visit.</p> <p>Adolescents (OR 2.97; 95% CI 1.40–6.27) and women with fewer resources (OR 1.51; 95% CI 1.19–1.92) are more likely to not return for an abortion, which may lead to continuation of pregnancy.</p>
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

* Used an alpha of 0.10 to determine significance ($P < 0.10$).

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Coles 2010; Retrospective cohort study (n=8245); USA
 Karasek 2016; Cross-sectional study (n=379); Arizona, USA
 Tosh 2015; Cross-sectional study (n=not reported); USA
 White 2016; Qualitative individual interviews (n=25); Alabama, USA
 White 2017; Cross-sectional study (n=2730); Alabama, USA

Outcome: REFERRAL TO ANOTHER PROVIDER

No studies identified

POPULATION: Medical professionals providing abortion services

Outcome: *WORKLOAD IMPLICATIONS*

Findings table 5: Impact of mandatory waiting periods on workload implications

OUTCOME: WORKLOAD IMPLICATIONS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Mercier 2015 ¹	▲	Implementing MWPs, in combination with mandated scripted counselling by a health-care professional, are burdensome for health-care providers and organizations, as they increase staffing costs and require extensive changes to appointment schedules when two visits need to be organized. Even when consent and counselling can be provided over the phone, this requires staffing and bureaucratic changes.	Overall, evidence from 1 study suggests that MWPs, including when the first visit can be done through over phone, contribute to workload implications increasing staffing costs and logistical difficulties.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Mercier 2015, qualitative individual interviews (n=31), North Carolina, USA

Findings table 6: Impact of mandatory waiting periods on system costs

OUTCOME: SYSTEM COST			
Human rights standards engaged: right to health, right to security of person, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Coles 2010	▲	MWPs are associated with increased odds of reporting an unwanted birth among minors with live births (RR 2.51; 95% CI 1.11–5.57).	Overall, evidence from 4 studies suggests that MWP contribute to system costs by: increasing child homicides and unwanted births among minors, Black minors in particular; and by decreasing the proportion of abortions performed <14 weeks and medication abortions. Evidence from 2 studies suggests that when women cannot return for an abortion procedure due to MWPs, the impact on system costs is unclear. Evidence from 2 studies suggests that MWPs do not contribute to system costs due to preterm birth, low birth weight or postpartum depression, and evidence from 1 study indicates that MWPs reduce system costs by lowering non-marital birth rates.
Medoff 2014b	○	MWPs are not associated with changes in the incidence of postpartum depression.	
Medoff 2010a	▼	MWPs are associated with a 17% decrease in nonmarital birth rates among women 15–44 years.	
Sen 2012	▲	MWPs are associated with an increase in child homicides compared with settings without MWPs (OR 1.13; 95% CI 1.03–1.25).	
Sanders 2016	○	Fewer women return for the abortion procedures after implementation of a 72h MWP (77% after implementation vs 80% before $P < 0.5$) and may instead continue their pregnancies.	
Tosh 2015*	▲	Abortion regulations, including MWPs, are negatively associated with teen abortion rates ($\beta = -0.437$, $P = 0.013$) and positively associated with Black teen birth rates ($\beta = 0.525$, $P = 0.008$), but do not significantly affect White teen birth rates ($\beta = 0.219$, $P = 0.230$) or Hispanic teen birth rates ($\beta = 0.367$, $P = 0.068$).	
Wallace 2017	○	MWPs are not associated with preterm birth (OR 1.06; 95% CI 0.96–1.18) or low birth weight (OR 1.01; 95% CI 0.93–1.09).	
White 2017	○	Where MWPs with a 2-visit requiring are implemented, adolescents (OR 2.97; 95% CI 1.40–6.27) and women with fewer resources (OR 1.51; 95% CI 1.19–1.92) are more likely to not return for an abortion and may instead continue their pregnancies.	

Williams 2018	▲	When MWP's are implemented in combination with other regulatory policies, the proportion of medication abortions decrease by 17.8% (95% CI 16.9–18.8) and the proportion of abortions performed < 14 weeks decrease by 3.3% (95% CI 2.8–3.8).
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect

Additional considerations

Study design and setting of included studies:

Coles 2010; Retrospective cohort study (n=8245); USA
 Sen 2012; Time-series design (n=5100); USA
 Sanders 2016; Cross-sectional study (n=3618 from database/307 completed questionnaire); Utah, USA
 Tosh 2015; Cross-sectional study (n=not reported); USA
 Wallace 2017; Cross-sectional study (n=3 948 761)
 White 2017; Cross-sectional study (n=2730); Alabama, USA
 Williams 2018; Time-series design (n=43 692); Arizona, USA

Outcome: IMPACT ON PROVIDER–PATIENT RELATIONSHIP

No studies identified

Outcome: STIGMATIZATION

No studies identified

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Overall, evidence from 7 studies suggests that MWP contribute to abortion delays by increasing the time from counselling to the abortion appointment, and by contributing to logistical difficulties in obtaining care. This effect is magnified when two visits are required.

Continuation of pregnancy

- Overall, evidence from 4 studies suggests that MWPs may contribute to continuation of pregnancy, especially among adolescents and among Black and Hispanic women.
- Evidence from 7 studies suggests that MWPs do not contribute to any changes to abortion rates, unintended pregnancy or birth rates in general, but MWPs may decrease births among unmarried women.

Opportunity costs

- Overall, evidence from 18 studies suggests that MWPs contribute to opportunity costs including financial and emotional opportunity costs such as: logistical burdens, emotional stress, financial costs, increased price for an abortion, travel time and out of state travel. Online or phone-based counselling may mitigate some opportunity costs related with 2-visits. The negative impacts of MWPs are exacerbated for women who need to travel far for an abortion.
- Evidence from 2 studies suggests that MWPs are not associated with incidence of postpartum depression and for most women, MWPs do not impact women's certainty in the abortion decision.

Unlawful abortion

- No studies identified

Self-managed abortion

- No studies identified

Disqualification of lawful abortion

- No studies identified

Disproportionate impact

- Overall, evidence from 5 studies suggests that MWPs have a disproportionate negative impact on women who need to travel farther for an abortion, women of colour, and women with fewer resources.

Referral to another provider

- No studies identified

Workload implications

- Overall, evidence from 1 study suggests that MWP, including when the first visit can be done through over phone, contribute to workload implications increasing staffing costs and logistical difficulties.

System costs

- Overall, evidence from 4 studies suggests that MWP contribute to system costs by: increasing child homicides and unwanted births among minors, Black minors in particular; and by decreasing the proportion of abortions performed < 14 weeks and medication abortions.
- Evidence from 2 studies suggests that when women cannot return for an abortion procedure due to MWP, the impact on system costs is unclear.
- Evidence from 2 studies suggests that MWP do not contribute to system costs due to preterm birth, low birth weight or postpartum depression, and evidence from 1 study indicates that MWP reduce system costs by lowering non-marital birth rates.

Impact on provider–patient relationship

- No studies identified

Stigmatization

- No studies identified

DRAFT

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Mandatory waiting periods

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Overall, evidence from 7 studies suggests that MWP's contribute to abortion delays by increasing the time from counselling to the abortion appointment, and by contributing to logistical difficulties in obtaining care. This effect is magnified when two visits are required.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	MWP's can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.
		States should protect people seeking abortion.	▲	MWP's can result in delayed access to abortion care. Such delays may expose women to risks of maternal mortality or morbidity with negative implications for the right to health.
Continuation of Pregnancy	Overall, evidence from 4 studies suggests that MWP's may contribute to continuation of pregnancy, especially among adolescents and among Black and Hispanic women. Evidence from 7 studies suggests that MWP's do not contribute to any changes to abortion rates, unintended pregnancy or birth rates in general, but MWP's may decrease births among unmarried women.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Where MWP's are associated with undesired continuation of pregnancy they may interfere disproportionately with the rights of abortion seekers.
			○	Where MWP's are not associated with undesired continuation of pregnancy their impact on abortion seekers' rights in respect of continuation of pregnancy are unclear.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Where MWP's are associated with undesired continuation of pregnancy, adolescents, Black, and Hispanic women are disproportionately affected, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.

		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State, or health authorities.	▲	Where MWP are associated with undesired continuation of pregnancy, they may limit a woman's ability to give effect to her decision about whether or not to have children, and thus have negative implications for rights.
			○	Where MWP are not associated with undesired continuation of pregnancy, their impact on abortion seekers' rights in respect of continuation of pregnancy are unclear.
Opportunity Costs	Overall, evidence from 18 studies suggests that MWP contribute to opportunity costs including financial and emotional opportunity costs such as: logistical burdens, emotional stress, financial costs, increased price for an abortion, travel time and out of state travel. Online or phone-based counselling may mitigate some opportunity costs related with 2-visits. The negative impacts of MWP are exacerbated for women who need to travel far for an abortion. Evidence from 2 studies suggests that MWP are not associated with incidence of postpartum depression and for most women, MWP do not impact women's certainty in the abortion decision.	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	MWP are associated with opportunity costs. In the absence of clinical justification for such MWP, these costs may constitute a disproportionate interference with the rights of abortion seekers.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.	▲	Where MWP are linked with opportunity costs, these costs (including travel costs, unnecessary multiple visits etc) are exacerbated for women who need to travel for abortion, with implications for their right to equality and non-discrimination in the provision of sexual and reproductive health care.
		Where it is lawful, abortion must be safe and accessible.	▲	Where MWP are associated with opportunity costs, these costs (including travel costs, unnecessary multiple visits etc.) make abortion less accessible in practice.
Unlawful Abortion	No studies included			
Self-managed Abortion	No studies included			

Disqualification from Lawful Abortion	No studies included			
Disproportionate Impact	Overall, evidence from 5 studies suggests that MWP's have a disproportionate negative impact on women who need to travel farther for an abortion, women of colour, and women with fewer resources.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	MWP's have a disproportionate impact on women of colour, women with fewer resources, and women who need to travel for an abortion, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.
Referral to Another Provider	No studies included			

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE: Mandatory waiting periods

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
<p>Workload Implications</p>	<p>Overall, evidence from 1 study suggests that MWP, including when the first visit can be done through over phone, contribute to workload implications increasing staffing costs and logistical difficulties.</p>	<p>States should protect health-care professionals providing abortion care.</p>	<p>▲</p>	<p>Workload implications arising from MWPs place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.</p>
		<p>States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.</p>	<p>▲</p>	<p>Workload implications arising from MWPs may result in reduced or hindered access to abortion. Where this is the case, MWPs interfere disproportionately with rights to health and to physical and mental integrity.</p>
<p>System Costs</p>	<p>Overall, evidence from 4 studies suggests that MWP contribute to system costs by: increasing child homicides and unwanted births among minors, Black minors in particular; and by decreasing the proportion of abortions performed < 14 weeks and medication abortions.</p> <p>Evidence from 2 studies suggests when women cannot return for an abortion procedure due to MWPs, the impact on system costs is unclear.</p>	<p>States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.</p>	<p>▲</p>	<p>MWPs are associated with system costs. In the absence of clinical justification for such MWPs, these costs may constitute a disproportionate interference with the rights of abortion seekers.</p>

	Evidence from 2 studies suggests that MWP's do not contribute to system costs due to preterm birth, low birth weight or postpartum depression, and evidence from 1 study indicates that MWP's reduce system costs by lowering non-marital birth rates.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Where MWP's are associated with system costs, adolescents and Black minors are disproportionately affected, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.
Impact on Provider–Patient Relationship	No studies included			
Stigmatization	No studies included			

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON MANDATORY WAITING PERIODS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: MANDATORY WAITING PERIODS: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	Overall, evidence from 7 studies suggests that MWP's contribute to abortion delays by increasing the time from counselling to the abortion appointment, and by contributing to logistical difficulties in obtaining care. This effect is magnified when two visits are required.	MWP's can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights.	We recommend against MWP's for access to abortion care.
Continuation of pregnancy	Overall, evidence from 4 studies suggests that MWP's may contribute to continuation of pregnancy, especially among adolescents and among Black and Hispanic women. Evidence from 7 studies suggests that MWP's do not contribute to any changes to abortion rates, unintended pregnancy or birth rates in general, but MWP's may decrease births among unmarried women.	Where MWP's are associated with undesired continuation of pregnancy they may interfere disproportionately with the rights of abortion seekers. This may disproportionately be the case for adolescents, and Black and Hispanic women.	We recommend against MWP's for access to abortion care.
Opportunity Costs	Overall, evidence from 18 studies suggests that MWP's contribute to opportunity costs including financial and emotional opportunity costs such as: logistical burdens, emotional stress, financial costs, increased price for an abortion, travel time and out of state travel. Online or phone-based counselling may mitigate some opportunity costs related with 2-visits. The negative impacts of MWP's are exacerbated for women who need to travel far for an abortion. Evidence from 2 studies suggests that MWP's are not associated with incidence of postpartum depression and for most women, MWP's do not impact women's certainty in the abortion decision.	MWP's are associated with opportunity costs. These costs (including travel costs, unnecessary multiple visits etc) make abortion less accessible in practice, and are exacerbated for women who need to travel for abortion.	We recommend against MWP's for access to abortion care.

<p>Unlawful Abortion</p>	<p>No studies included</p>	<p>The operation of MWP's may lead persons to avail of abortion outside of the formal medical system, including unlawful abortion. Such abortion may be unsafe. States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.</p> <p>Disqualification from lawful abortion as a result of the application of a MWP (often in conjunction with gestational age limits) can result in criminal liability where a pregnant person seeks abortion outside the formal system including availing of unlawful self-management of abortion. Criminalization of abortion may constitute a human rights violation.</p>	<p>We recommend against MWP's for access to abortion care.</p>
<p>Self-managed Abortion</p>	<p>No studies included</p>	<p>The operation of MWP's may lead persons to avail of abortion outside of the formal medical system, including self-management of abortion. Such abortion may be unsafe. States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.</p> <p>Disqualification from lawful abortion as a result of the application of a MWP (often in conjunction with gestational age limits) can result in criminal liability where a pregnant person seeks abortion outside the formal system including availing of unlawful self-management of abortion. Criminalization of abortion may constitute a human rights violation.</p>	<p>We recommend against MWP's for access to abortion care.</p>

Disqualification from Lawful Abortion	No studies included	<p>Mandatory waiting limits may result in exceeding gestational age limits, which may result in disqualification from lawful abortion including in cases of sexual violence or therapeutic abortion, with implications for the rights to health, life, security of person, and privacy.</p> <p>Disqualification from lawful abortion as a result of the application of a MWP (often in conjunction with gestational age limits) can result in criminal liability where a person avails of abortion without satisfaction of the MWP. Criminalization of abortion may result in a violation of the right to equality and non-discrimination, right to security of person, or right to be free from torture, and cruel, inhuman and degrading treatment.</p>	We recommend against MWPs for access to abortion care.
Disproportionate Impact	Overall, evidence from 5 studies suggests that MWPs have a disproportionate negative impact on women who need to travel farther for an abortion, women of colour, and women with fewer resources.	MWPs have a disproportionate impact on women of colour, women with fewer resources, and women who need to travel for an abortion, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.	We recommend against MWPs for access to abortion care.
Referral to Another Provider	No studies included	MWPs may operate to delay referral and thus to delay access to abortion care.	We recommend against MWPs for access to abortion care.
Workload Implications	Overall, evidence from 1 study suggests that MWPs, including when the first visit can be done through over phone, contribute to workload implications increasing staffing costs and logistical difficulties.	Workload implications arising from MWPs place significant burdens on health-care professionals providing abortion care and may result in reduced or hindered access to abortion with negative implications for both their rights and the rights of persons seeking to access abortion.	We recommend against MWPs for access to abortion care.

<p>System Costs</p>	<p>Overall, evidence from 4 studies suggests that MWP contribute to system costs by: increasing child homicides and unwanted births among minors, Black minors in particular; and by decreasing the proportion of abortions performed < 14 weeks and medication abortions.</p> <p>Evidence from 2 studies suggests when women cannot return for an abortion procedure due to MWPs, the impact on system costs is unclear.</p> <p>Evidence from 2 studies suggests that MWPs do not contribute to system costs due to preterm birth, low birth weight or postpartum depression, and evidence from 1 study indicates that MWPs reduce system costs by lowering non-marital birth rates.</p>	<p>MWPs are associated with system costs. In the absence of clinical justification for such MWPs these costs may constitute a disproportionate interference with the rights of abortion seekers. This may disproportionately be the case for adolescents and Black minors.</p>	<p>We recommend against MWPs for access to abortion care.</p>
<p>Impact on Provider–Patient Relationship</p>			
<p>Stigmatization</p>			

DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- MWP can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have negative implications for rights. Such delays may expose women to risks of maternal mortality or morbidity with negative implications for the right to health.

Continuation of pregnancy

- Where MWPs are associated with undesired continuation of pregnancy, they may interfere disproportionately with the rights of abortion seekers
- Where MWPs are not associated with undesired continuation of pregnancy, their impact on abortion seekers' rights in respect of continuation of pregnancy are unclear.
- Where MWPs are associated with undesired continuation of pregnancy, adolescents and Black and Hispanic women are disproportionately affected, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.
- Where MWPs are associated with undesired continuation of pregnancy, they may limit a woman's ability to give effect to her decision about whether or not to have children, and thus have negative implications for rights.

Opportunity costs

- MWPs are associated with opportunity costs. In the absence of clinical justification for such MWPs, these costs may constitute a disproportionate interference with the rights of abortion seekers.
- Where MWPs are linked with opportunity costs, these costs (including travel costs, unnecessary multiple visits, etc.) are exacerbated for women who need to travel for abortion, with implications for their right to equality and non-discrimination in the provision of sexual and reproductive health care. These opportunity costs also make abortion less accessible in practice.

Unlawful abortion

- No studies included

Self-managed abortion

- No studies included

Disqualification of lawful abortion

- No studies included

Mandatory waiting periods

Disproportionate impact

- No studies included

Referral to another provider

- No studies included

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- Workload implications arising from MWP place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.
- Workload implications arising from MWP may result in reduced or hindered access to abortion. Where this is the case, MWP interfere disproportionately with rights to health and to physical and mental integrity.

System costs

- MWP are associated with system costs. In the absence of clinical justification for such MWP, these costs may constitute a disproportionate interference with the rights of abortion seekers.
- Where MWP are associated with system costs, adolescents and Black minors are disproportionately affected, with negative implications for the right to equality and non-discrimination in the provision of sexual and reproductive health care.

Impact on provider–patient relationship

- No studies included

Stigmatization

- No studies included

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes, we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy and disqualification of lawful abortion, and affordable care with as few logistical burdens as possible. We can also assume that health-care providers, regardless if they participate in abortion care or not, value reasonable workloads and avoidance of stigmatization.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *mandatory waiting periods*.

Resources:

The studies did not speak to the issue of resources.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability or feasibility.

Equity:

The outcome disproportionate impact speaks to the issue of equity.

Mandatory waiting periods: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Mandatory Waiting Periods
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	Right to Life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland, Mellet v Ireland, LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report,	<ul style="list-style-type: none">• MWP's lead to delays in accessing abortion for at least as long as the MWP and, where it operates as a requirement of multiple in-person visits, possibly longer.• Such delays may expose women to risks of maternal mortality or morbidity.• In such cases, MWP's expose abortion seekers to violations of the right to life and the right to health.

		<p>2017, 2018 Working Group on Discrimination against Women Report, 2016</p>	<ul style="list-style-type: none"> • MWP may dissuade people from engaging with the formal health system and instead lead people to access abortion outside the formal health system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality, exposing abortion seekers to possible violations of the rights to life and health. • Mandatory waiting limits may result in exceeding gestational age limits, which may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality, exposing abortion seekers to possible violations of the rights to life and health.
<p>Where it is lawful, abortion must be safe and accessible.</p>	<p>The right to health The right to be free from torture, and cruel, inhuman and degrading treatment</p>	<p>CCPR: GC 36, <i>LMR v Argentina, LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • MWP can make lawful abortion inaccessible in practice either because of their operation in conjunction with gestational age limits, or their operation as multi-visit requirements with particular associated opportunity costs for marginalized, rural, or young women and for persons in respect of whom late detection of pregnancy is more likely. • Such inaccessibility may lead to abortion seeking outside of the formal health care system or in another jurisdiction with associated opportunity costs and exposure to

			<p>unsafe abortion.</p> <ul style="list-style-type: none"> • MWP can thus make lawful abortion inaccessible in practice, exposing abortion seekers to possible violations of the rights to health, and the right to be free from torture, and cruel, inhuman and degrading treatment.
States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.	<p>Right to health</p> <p>Right to equality and non-discrimination</p> <p>Right of persons with disabilities to retain fertility on an equal basis with others</p>	<p>CCPR GC 36</p> <p>CRC GC 4; GC 15</p> <p>CRPD GC 3, GC 6</p> <p>Special Rapporteur on Health Report, 2016</p>	<ul style="list-style-type: none"> • MWPs (alone, or in combination with gestational age limits or multiple in-person visit requirements) have a disproportionate impact on persons likely to detect pregnancy later, or those for whom access to locations where abortion is provided is difficult (e.g. people in remote areas, adolescents, persons with limited resources). • MWPs expose abortion seekers to violations of the right to equality and non-discrimination.
States must protect people from the physical and mental health risks associated with unsafe abortions.	Right to health	<p>CCPR: GC 28, GC 36, GR 34</p> <p>CESCR: GC 22</p> <p>CRC: GC 4</p> <p>CEDAW: GR 34</p> <p>Working Group on Discrimination against Women Report 2016</p> <p>Special Rapporteur on Executions/Killings Report, 2017</p>	<ul style="list-style-type: none"> • MWPs may dissuade people from engaging with the formal health system and instead lead people to access abortion outside the formal health system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality, exposing abortion seekers to possible violations of the right to health. • Mandatory waiting limits may result in exceeding gestational age limits, which may lead people to access abortion outside of the formal system. • Such abortion may be unsafe abortion, with implications for

			maternal morbidity and mortality, exposing abortion seekers to possible violations of the right to health.
States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest.	Right to health	CCPR: GC 36 CESCR: GC 22	<ul style="list-style-type: none"> • MWPs may result in exceeding gestational age limits, which may result in disqualification from lawful abortion including in cases of sexual violence. • Where this occurs, MWPs expose abortion seekers to violations of the right to health.
States should protect health-care professionals providing abortion care.	Right to health	Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • MWPs may have workload implications and impose other burdens on health-care professionals.
States should protect people seeking abortion.	Right to health	CCPR: GC 36 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • MWPs lead to delays in accessing abortion for at least as long as the MWP and, where it operates as a requirement of multiple in-person visits, possibly longer. • Such delays may expose women to risks of maternal mortality or morbidity. • In such cases, MWPs expose abortion seekers to violations of the right to health. • MWPs may dissuade people from engaging with the formal health system and instead lead people to access abortion outside the formal health system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality, exposing abortion seekers to possible

			<ul style="list-style-type: none"> violations of the right to health. Mandatory waiting limits may result in exceeding gestational age limits, which may lead people to access abortion outside of the formal system. Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality, exposing abortion seekers to possible violations of the right to health.
States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	Right to health Right to security of person	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	<ul style="list-style-type: none"> The application of MWP undermines a pregnant person's ability safely to access abortion with disproportionate negative effects on her health, physical and mental integrity, and right to access abortion in cases of sexual violence and therapeutic indication. In such cases MWPs expose abortion seekers to possible violations of the right to health and right to security of person.
Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, Government, or health authorities.	Right to decide on the number and spacing of children Right to equality and non-discrimination Right to privacy	CESCR: GC 22 CCPR: GC 36, <i>LMR v Argentina</i> CEDAW: GR 21, GC 24, GR 34 CRPD: GC 3 Special Rapporteur on Torture Report, 2008	<ul style="list-style-type: none"> The application of MWPs combined with other restrictions (such as grounds for access and/or gestational age limits) may operate to limit the pregnant person's ability to decide whether or not to have children.
Criminalization of abortion may constitute a human rights violation.	Right to equality and non-discrimination Right to security of person Right to be free from	CEDAW: GR 33, GR 35 CCPR, GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> Special Rapporteur on Torture Report, 2016 Working Group on Discrimination against	<ul style="list-style-type: none"> Disqualification from lawful abortion as a result of the application of a MWP (often in conjunction with gestational age limits) can result in criminal liability where a pregnant person seeks abortion outside the formal

	torture, and cruel, inhuman and degrading treatment	Women Report 2016	<p>system including availing of unlawful self-managed abortion.</p> <ul style="list-style-type: none"> • MWP's can result in criminal liability where a pregnant person avails of abortion, or a health-care provider provides abortion, within the formal health system but without expiration of the MWP. • In such cases MWP's may operate as <i>de facto</i> criminalization provisions. • Criminalization of abortion may result in a violation of the right to equality and non-discrimination, right to security of person, or right to be free from torture, and cruel, inhuman and degrading treatment.
Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	Right to privacy	CCPR: <i>KNLG v Peru</i>	<ul style="list-style-type: none"> • MWP's may result in exceeding gestational age limits, which may result in disqualification from lawful abortion including in cases of therapeutic indication. • Where this occurs, MWP's expose abortion seekers to violations of the right to privacy.
Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.	Right to life	CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017	<ul style="list-style-type: none"> • The operation of MWP's may lead persons to avail of abortion outside of the formal medical system. • In such cases, abortion may be unsafe. • Where such unsafe abortion results in death of the abortion seeker this <i>prima facie</i> violates the right to life.

5. EtD framework for Third-party authorization

Recommendation 7: Recommend that abortion be available at the request of the woman, girl or other pregnant person without the authorization of any other individual, body or institution.

PICO 5: What is the impact of judicial bypass for abortion on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND (judicial bypass)

Setting: Global

Perspective: Minors using judicial bypass to access abortion in settings where parental consent is required

Literature review: For the analysis of impact of judicial bypass on abortion related outcomes, a total of 3 studies were identified. These studies related to the outcomes of delayed abortion (n=1), opportunity costs (n=2), anticipated family disharmony (n=2), anticipated exposure to interpersonal violence or exploitation (n=2), and anticipated reproductive coercion (n=2). No studies were identified that encompassed information related to the remaining outcomes. All included studies were conducted in the USA. Study designs include a cohort study (comparative) and qualitative study designs using in-depth interviews.

FINDINGS TABLES (judicial bypass)

Outcome: *DELAYED ABORTION*

Findings table 1: Impact of judicial bypass on abortion delay

OUTCOME: DELAYED ABORTION				
Human rights standards engaged: right to health, right to life, right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
-	Coleman-Minahan 2019 ^{1,2}	▲	Minors using judicial bypass experience delays in accessing abortion (Median 17 days; Range: 2 days – 8 weeks).	Evidence from one study suggests that judicial bypass may be associated with delayed abortion.

▲ = the intervention (judicial bypass) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Coleman-Minahan 2019: Qualitative, in-depth interviews (n=20); Texas, USA

Outcome: *CONTINUATION OF PREGNANCY*

No studies identified

Findings table 2: Impact of judicial bypass on opportunity cost

OUTCOME: OPPORTUNITY COST				
Human rights standards engaged: right to health, the right to security of person, and the right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
-	Coleman-Minahan 2019 ^{1,2}	▲	Minors using judicial bypass when independent consent is not permitted experience logistical burdens (e.g. travel coordination and costs; mandatory appointments with missed time at school, work and home; care coordination with clinics) when having to travel to and from the courthouse.	Evidence from two studies supports that judicial bypass may be associated with opportunity costs. Some minors need a confidential pathway to obtain abortion care. These minors report meaningful logistical burdens and opportunity costs in obtaining an abortion by judicial bypass.
	Kavanaugh ^{1,2}	▲	Minors report that the need for judicial bypass would complicate the process significantly (e.g. difficulties finding free or affordable legal services, making an appointment with a judge, transportation, missed time from school).	

▲ = the intervention (judicial bypass) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Coleman-Minahan 2019: Qualitative, in-depth interviews (n=20); Texas, USA

Kavanaugh 2012: Qualitative, in-depth interviews (n=30); USA

Outcome: SYSTEM COSTS

No studies identified

Outcome: UNLAWFUL ABORTION

No studies identified

Outcome: SELF-MANAGED ABORTION

No studies identified

DRAFT

Outcome: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION

Findings table 3: Impact of parental judicial bypass on anticipated exposure to interpersonal violence or exploitation

OUTCOME: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION				
Human rights standards engaged: right to health and the right to privacy				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
-	Colman-Minahan 2019 ^{1,2}	▼	Minors use judicial bypass when independent consent is not available in order to avoid anticipated violence.	Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions.
	Friedman 2015	▼	Minors use judicial bypass when independent consent is not available in order to avoid anticipated violence.	Minors request judicial bypass when they anticipate violence if a pregnancy is disclosed. Judicial bypass may decrease anticipated violence by creating a pathway where minors can obtain confidential abortions.

▲ = the intervention (judicial bypass) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Coleman-Minahan 2019: Qualitative, in-depth interviews (n=20); Texas, USA

Friedman 2015; Cohort study – non-comparative (n=55); Ohio, USA

Outcome: ANTICIPATED REPRODUCTIVE COERCION

Findings table 4: Impact of judicial bypass on anticipated of reproductive coercion

OUTCOME: ANTICIPATED REPRODUCTIVE COERCION				
Human rights standards engaged: right to health, right to security of person, right of persons with disabilities to retain fertility on an equal basis with others, right to be free from torture, and cruel, inhuman or degrading treatment, right to exercise legal capacity, women’s right to legal capacity on an equal basis with men, right to decide on the number and spacing of children, right to non-discrimination and equality, and right to privacy				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
--	Colman-Minahan 2019 ^{1,2}	▼	Minors use judicial bypass when independent consent is not available to avoid anticipated reproductive coercion (e.g. forced continuation of pregnancy) by parents.	Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions. Minors request judicial bypass when they anticipate reproductive coercion if a pregnancy is disclosed.
	Friedman 2015	▼	Minors use judicial bypass when independent consent is not available in order to avoid anticipated reproductive coercion	Judicial bypass may decrease the risk of reproductive coercion by creating a path where minors can have confidential abortions.

▲ = the intervention (judicial bypass) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Coleman-Minahan 2019: Qualitative, in-depth interviews (n=20); Texas, USA

Friedman 2015; Cohort study – non-comparative (n=55); Ohio, USA

Findings table 5: Impact of judicial bypass on anticipation of family disharmony

OUTCOME: ANTICIPATED FAMILY DISHARMONY				
Human rights standards engaged: right to health, right to privacy				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
-	Colman-Minahan 2019 ^{1,2}	▼	Minors use judicial bypass when independent consent is not available in order to avoid family disharmony (e.g. being kicked out of house, increased family substance abuse, conflicting family religious values).	Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions. Minors request judicial bypass when they anticipate family disharmony if a pregnancy is disclosed.
	Friedman 2015	▼	Minors use judicial bypass when independent consent is not available in order to avoid family disharmony (e.g. being kicked out of home, poor relationship with parents family religious values).	Judicial bypass may decrease family disharmony by creating a path where minors can have confidential abortions.

▲ = the intervention (judicial bypass) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Coleman-Minahan 2019: Qualitative, in-depth interviews (n=20); Texas, USA

Friedman 2015; Cohort study – non-comparative (n=55); Ohio, USA

DETAILED JUDGEMENT

Desirable effects:

Anticipated exposure to interpersonal violence or exploitation

- Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions.
- Minors request judicial bypass when they anticipate violence if a pregnancy is disclosed.
- Judicial bypass may decrease anticipated violence by creating a pathway where minors can obtain confidential abortions.

Anticipated reproductive coercion

- Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions.
- Minors request judicial bypass when they anticipate reproductive coercion if a pregnancy is disclosed.
- Judicial bypass may decrease the risk of reproductive coercion by creating a path where minors can have confidential abortions.

Anticipated family disharmony

- Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions.
- Minors request judicial bypass when they anticipate family disharmony if a pregnancy is disclosed.
- Judicial bypass may decrease family disharmony by creating a path where minors can have confidential abortions.

Undesirable effects:

Delayed abortion

- Evidence from one study suggests that judicial bypass may be associated with delayed abortion.

Opportunity costs

- Evidence from two studies supports that judicial bypass may be associated with opportunity costs
- Some minors need a confidential pathway to obtain abortion care. These minors report meaningful logistical burdens and opportunity costs in obtaining an abortion by judicial bypass.

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES (judicial bypass)

HUMAN RIGHTS STANDARD TO EVIDENCE: Judicial bypass

Outcome	Overall from Evidence	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Evidence from one study suggests that judicial bypass may be associated with delayed abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Judicial bypass may not effectively mitigate the impact of parental consent laws because: <ul style="list-style-type: none"> • Parental consent laws are associated with delay. • Judicial bypass may be associated with delayed abortion compared with minors’ ability to consent to care. • Delay is associated with increased maternal mortality and morbidity. • States are required to take steps to reduce maternal mortality and morbidity.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination	▲	Judicial bypass may not effectively mitigate the impact of parental consent laws because: <ul style="list-style-type: none"> • These laws apply only to minors • Judicial bypass mechanisms also apply only to minors. • Any associated delays apply only to minors as a class without regard to whether an individual has capacity to consent. • States are required to ensure

				equality and non-discrimination in the provision of sexual and reproductive health care.
Opportunity Cost	<p>Evidence from two studies supports that judicial bypass may be associated with opportunity costs.</p> <p>Some minors need a confidential pathway to obtain abortion care. These minors report meaningful logistical burdens and opportunity costs in obtaining an abortion by judicial bypass.</p>	<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	▲	<p>Judicial bypass may not effectively mitigate the impact of parental consent laws because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they mitigate the opportunity costs associated with parental consent laws. • In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective). • States should ensure laws regulating abortion are evidence-based and proportionate.

		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	o	While judicial bypass may provide an alternative to mandated disclosure to parents required by parental consent laws, they do not mitigate the opportunity costs of these laws because: <ul style="list-style-type: none"> • Some minors report meaningful logistical burdens and opportunity costs to judicial bypass. • These laws apply only to minors. • Judicial bypass mechanisms also apply only to minors. • Any associated opportunity costs apply only to minors as a class without regard to whether an individual has capacity to consent. • Within minors as a class, judicial bypass may have disproportionate impact on some groups. • States are required to ensure equality and non-discrimination in the provision of sexual and reproductive health care.
Anticipated exposure to interpersonal violence or exploitation	Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions. Minors request judicial bypass when they anticipate violence if a pregnancy is disclosed. Judicial bypass may decrease	SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	o	Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because: <ul style="list-style-type: none"> • Disclosure of abortion seeking to parents is not compelled. • Although, disclosure of abortion seeking to judicial authority is compelled.

	<p>anticipated violence by creating a pathway where minors can obtain confidential abortions.</p>	<p>States should protect people seeking abortion.</p>	▼	<p>Judicial bypass may protect people seeking abortion where parental consent laws apply because:</p> <ul style="list-style-type: none"> • Minors may anticipate interpersonal violence from parents on disclosure of abortion seeking. • Judicial bypass relieves the compulsion to disclose abortion seeking to parents.
<p>Anticipated reproductive coercion</p>	<p>Evidence from two studies indicates that minors value and need a pathway to obtain confidential abortions.</p> <p>Minors request judicial bypass when they anticipate reproductive coercion if a pregnancy is disclosed.</p> <p>Judicial bypass may decrease the risk of reproductive coercion by creating a path where minors can have confidential abortions.</p>	<p>States may not undertake, and must take steps to prevent, forced or coerced abortion including for marginalized people, people with disabilities, children, and people in conflict settings.</p>	▼	<p>Judicial bypass may protect people seeking abortion from forced or coerced abortion because:</p> <ul style="list-style-type: none"> • Parental consent requirements may expose minors to forced or coerced abortion. • Judicial bypass allows bypass of parental consent requirements. • States must take steps to prevent forced or coerced abortion including for children.
		<p>SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantees confidentiality.</p>	○	<p>Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because:</p> <ul style="list-style-type: none"> • Disclosure of abortion seeking to parents is not compelled. • Although, disclosure of abortion seeking to judicial authority is compelled.

		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State or health authorities.	▲	Parental consent laws with judicial bypass mechanisms should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws empower another entity (parent or bypass mechanism) to limit decisions about whether or not to have children. • Decisions about whether or not to have children must not be limited by spouse, parent, partner, the State, or health authorities.
Anticipated family disharmony	Evidence from two studies indicates that minors value and some minors need a pathway to obtain confidential abortions.	SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	○	Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because: <ul style="list-style-type: none"> • Disclosure of abortion seeking to parents is not compelled. • Although, disclosure of abortion seeking to judicial authority is compelled.
	Minors request judicial bypass when they anticipate family disharmony if a pregnancy is disclosed. Judicial bypass may decrease family disharmony by creating a path where minors can have confidential abortions.	States should protect people seeking abortion.	▼	Judicial bypass may protect people seeking abortion where parental consent laws apply because: <ul style="list-style-type: none"> • Minors may anticipate family disharmony resulting from disclosure of abortion seeking to parents. • Judicial bypass relieves the compulsion to disclose abortion seeking to parents.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS) (judicial bypass)

Desirable effects	Unable to determine	- Varies		Trivial	- Small	✓ Moderate	Large
Undesirable effects	Unable to determine	- Varies		Large	✓ Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	Does not favour the intervention	✓ Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON PARENTAL INVOLVEMENT LAWS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: JUDICIAL BYPASS—EVIDENCE AND HUMAN RIGHTS STANDARDS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed Abortion	Evidence from one study suggests that judicial bypass may be associated with delayed abortion.	Delay is associated with increased maternal mortality and morbidity. As these delays apply only to minors without regard to their individual capacity to consent to medical treatment, judicial bypass is associated with reduced enjoyment of the right to health, the right to life, and the right to equality and non-discrimination.	We recommend laws requiring parental consent to abortion should be repealed and should not be introduced, including those that provide for judicial bypass to the parental consent requirement.
Opportunity Cost	Evidence from two studies supports that judicial bypass may be associated with opportunity costs. Some minors need a confidential pathway to obtain abortion care. These minors report meaningful logistical burdens and opportunity costs in obtaining an abortion by judicial bypass.	As judicial bypass is associated with increased opportunity costs compared to a minor’s own ability to consent, these mechanisms may be associated with reduced enjoyment of the right to health, the right to security of person, and the right to equality and non-discrimination.	We recommend laws requiring parental consent to abortion should be repealed and should not be introduced, including those that provide for judicial bypass to the parental consent requirement.
Anticipated exposure to interpersonal violence or exploitation	Evidence from two studies indicates that minors’ value and need a pathway to obtain confidential abortions. Minors request judicial bypass when they anticipate violence if a pregnancy is disclosed. Judicial bypass may decrease anticipated violence by creating a pathway where minors can obtain confidential abortions.	Where parental consent laws exist, judicial bypass can provide an alternative route to accessing abortion that reduces anticipated exposure to interpersonal violence or exploitation. Thus, judicial bypass may enhance enjoyment of the right to health and the right to privacy <i>relative to</i> parental consent requirements. However, the requirement for judicial authorization impacts negatively on the right to privacy when compared to the ability to consent to medical treatment according to capacity.	We recommend that where parental consent laws exist, they should allow for a bypass mechanism such as a judicial bypass. However, as that still entails limitations on rights enjoyment, we recommend that parental consent to abortion should be repealed and should not be introduced as a general matter.

<p>Anticipated reproductive coercion</p>	<p>Evidence from two studies indicates that minors' value and need a pathway to obtain confidential abortions.</p> <p>Minors request judicial bypass when they anticipate reproductive coercion if a pregnancy is disclosed.</p> <p>Judicial bypass may decrease the risk of reproductive coercion by creating a path where minors can have confidential abortions.</p>	<p>Where parental consent laws exist, judicial bypass can provide an alternative route to accessing abortion that reduces anticipated reproductive coercion. Thus, judicial bypass may enhance enjoyment of the right to health, right to security of person, right of persons with disabilities to retain fertility on an equal basis with others, right to be free from torture, and cruel, inhuman or degrading treatment, right to exercise legal capacity, women's right to legal capacity on an equal basis with men <i>relative to</i> parental consent requirements. However, the requirement for judicial authorization impacts negatively on the right to decide on the number and spacing of children, right to equality and non-discrimination, and right to privacy.</p>	<p>We recommend that where parental consent laws exist, they should allow for a bypass mechanism such as a judicial bypass. However, as that still entails limitations on rights enjoyment, we recommend that parental consent to abortion should be repealed and should not be introduced as a general matter.</p>
<p>Anticipated family disharmony</p>	<p>Evidence from two studies indicates that minors' value and some minors need a pathway to obtain confidential abortions.</p> <p>Minors request judicial bypass when they anticipate family disharmony if a pregnancy is disclosed.</p> <p>Judicial bypass may decrease family disharmony by creating a path where minors can have confidential abortions.</p>	<p>Where parental consent laws exist, judicial bypass can provide an alternative route to accessing abortion that reduces anticipated family disharmony. Thus, judicial bypass may enhance enjoyment of the right to health <i>relative to</i> parental consent. However, the requirement for judicial authorization impacts negatively on the right to privacy.</p>	<p>We recommend where parental consent laws exist, they should allow for a bypass mechanism such as a judicial bypass. However, as that still entails limitations on rights enjoyment, we recommend that parental consent to abortion should be repealed and should not be introduced as a general matter.</p>

DETAILED JUSTIFICATION FOR THE JUDGEMENT (judicial bypass)

Application of Rights to Evidence per outcome

Delayed abortion

Judicial bypass may not effectively mitigate the impact of parental consent laws because:

- Parental consent laws are associated with delay.
- Judicial bypass may be associated with delayed abortion compared with minors' ability to consent to care.
- Delay is associated with increased maternal mortality and morbidity.
- States are required to take steps to reduce maternal mortality and morbidity.

Judicial bypass may not effectively mitigate the impact of parental consent laws because:

- These laws apply only to minors.
- Judicial bypass mechanisms also apply only to minors.
- Any associated delays apply only to minors as a class without regard to whether an individual has capacity to consent.
- States are required to ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Opportunity cost

Judicial bypass may not effectively mitigate the impact of parental consent laws because:

- There is no clear evidence-base that they mitigate the opportunity costs associated with parental consent laws.
- In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
- States should ensure laws regulating abortion are evidence-based and proportionate.

While judicial bypass may provide an alternative to mandated disclosure to parents required by parental consent laws, they do not mitigate the opportunity costs of these laws because:

- Some minors report meaningful logistical burdens and opportunity costs to judicial bypass.
- These laws apply only to minors.
- Judicial bypass mechanisms also apply only to minors.
- Any associated opportunity costs apply only to minors as a class without regard to whether an individual has capacity to consent.
- Within minors as a class, judicial bypass may have disproportionate impact on some groups.
- States are required to ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Anticipated exposure to interpersonal violence or exploitation

Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because:

Mandatory waiting periods

- Disclosure of abortion seeking to parents is not compelled.
- Although, disclosure of abortion seeking to judicial authority is compelled.

Judicial bypass may protect people seeking abortion where parental consent laws apply because:

- Minors may anticipate interpersonal violence from parents on disclosure of abortion seeking.
- Judicial bypass relieves the compulsion to disclose abortion seeking to parents.

Anticipated reproductive coercion

Judicial bypass may protect people seeking abortion from forced or coerced abortion because:

- Parental consent requirements may expose minors to forced or coerced abortion.
- Judicial bypass allows bypass of parental consent requirements.
- States must take steps to prevent forced or coerced abortion including for children.

Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because:

- Disclosure of abortion seeking to parents is not compelled.
- Although, disclosure of abortion seeking to judicial authority is compelled.

Parental consent laws with judicial bypass mechanisms should be repealed and should not be introduced because:

- These laws empower another entity (parent or bypass mechanism) to limit decisions about whether or not to have children.
- Decisions about whether or not to have children must not be limited by spouse, parent, partner, the State or health authorities.

Anticipated family disharmony

Judicial bypass may ensure the provision of abortion in a way that better respects women and girls' privacy and confidentiality because:

- Disclosure of abortion seeking to parents is not compelled.
- Although, disclosure of abortion seeking to judicial authority is compelled.

Judicial bypass may protect people seeking abortion where parental consent laws apply because:

- Minors may anticipate family disharmony resulting from disclosure of abortion seeking to parents.
- Judicial bypass relieves the compulsion to disclose abortion seeking to parents.

Application of Rights to Evidence across all outcomes

Mandatory waiting periods

Desirable effects

As noted above: Moderate

Undesirable effects

As noted above: Moderate

Certainty of the evidence:

As noted above: Unable to determine

Values:

Minors do not value abortion delays and logistical burdens associated with judicial bypass. At the same time, minors value judicial bypass as it circumvents exposure to violence, reproductive coercion and family disharmony, associated with involuntary disclosure of pregnancy.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *judicial bypass*.

Resources:

The studies did not speak to the issue of resources, however, it can be assumed that there are significant systems costs associated with judicially bypass.

Acceptability and feasibility:

Acceptability is addressed indirectly where minors anticipate anticipated reproductive coercion and family disharmony. The studies did not speak to the issue of feasibility.

Equity:

Equity was considered in terms of disproportionate impact, however, the included studies did not speak to the issue of equity.

DRAFT

PICO 6: What is the impact of judicial bypass versus parental consent on abortion-related outcomes (for pregnant people seeking abortion)?
(for PICO details, see Annex 8 in the main guideline)

BACKGROUND (judicial bypass versus parental consent)

Setting: Global

Perspective: Minors seeking abortion where parental consent or judicial bypass is required

Literature review: For the analysis of impact of judicial bypass versus parental consent on abortion related outcomes, 3 studies were identified relating to the outcome delayed abortion. No studies were identified that relate to the remaining outcomes. All studies were conducted in the USA. Study designs include time-series and cohort study designs.

FINDINGS TABLES (judicial bypass versus parental consent)

Outcome: DELAYED ABORTION

Findings table 1: Impact of judicial bypass versus parental consent on delayed abortion

OUTCOME: DELAYED ABORTION				
Human rights standards engaged right to health, right to life, right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
---	Altindag 20171	▼	Minors using judicial bypass compared with parental consent experience shorter delays in obtaining abortion.	<p>Evidence from four studies examining the difference between judicial bypass and parental consent on delayed abortion is unclear.</p> <p>Differences in estimates may be due to significant variation in the bypass process across settings.</p> <p>When judicial bypass is associated with greater delays compared with parental</p>

	Janiak 2019 ¹	▲	Minors using judicial bypass compared with parental consent experience greater delays in obtaining abortion.	consent, minors using judicial bypass are more likely to pass gestational thresholds for medical abortion per local guidance. Specific populations of minors are more likely to use judicial bypass than parental consent to obtain an abortion, and thus may be disproportionately impacted by the effects of judicial bypass.
	Joyce 2010 ¹	▼	Minors using judicial bypass compared with parental consent undergo abortions at earlier gestational ages, and are less likely to have a second trimester abortion.	
Passing gestational thresholds	Janiak 2019	▲	Minors using judicial bypass compared with parental consent, are more likely to pass gestational thresholds that render them ineligible for medical abortion (per local guidance).	
Disproportionate impact	Janiak 2019	▲	Minors requesting abortion by judicial bypass compared with parental consent vary significantly. Minors obtaining abortion under judicial bypass as compared with parental consent are significantly more likely to be racial or ethnic minorities and of low socioeconomic status.	
	Joyce 2010	▲	Minors seeking an abortion by judicial bypass as compared with parental consent, are more likely to be Hispanic, be under 15 years of age, and be an out-of-state resident.	

▲ = the intervention (judicial bypass) leads to an increase in the sub-outcome; ○ = the intervention leads to no change in the sub-outcome; ▼ = the intervention leads to a decrease in the sub-outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Symbol indicates the directionality of the outcome *delayed abortion*, as there are no sub-outcomes.

Additional considerations

Study design and setting of included studies:

Altindag 2017; Time-series design (n=2624); USA

Janiak 2019; Cohort study (n=2026); Massachusetts, USA
Joyce 2010; Time-series design (n=not reported); Arkansas, USA

Outcome: CONTINUATION OF PREGNANCY

No studies identified

Outcome: OPPORTUNITY COST

No studies identified

Outcome: SYSTEM COSTS

No studies identified

Outcome: UNLAWFUL ABORTION

No studies identified

Outcome: SELF-MANAGED ABORTION

No studies identified

Outcome: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION

No studies identified

Outcome: ANTICIPATED REPRODUCTIVE COERCION

No studies identified

Outcome: ANTICIPATED FAMILY DISHARMONY

No studies identified

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Evidence from four studies examining the difference between judicial bypass and parental consent on delayed abortion is unclear. Differences in estimates reported on time delay may be due to significant variation in the bypass process across settings.
- When judicial bypass is associated with greater delays compared with parental consent, minors using judicial bypass are more likely to pass gestational thresholds for medical abortion per local guidance.
- Specific populations of minors are more likely to use judicial bypass than parental consent to obtain an abortion, and thus be disproportionately impacted by the effects of judicial bypass.

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE (judicial bypass versus parental consent)

HUMAN RIGHTS STANDARDS TO EVIDENCE: JUDICIAL BYPASS vs PARENTAL CONSENT

Outcome	Overall Conclusion from Comparison	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Evidence from four studies examining the difference between judicial bypass and parental consent on delayed abortion is unclear.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	○	Judicial bypass mechanisms to avoid parental consent requirements do not <i>by themselves</i> have a clear impact on human rights because: <ul style="list-style-type: none"> • Judicial bypass is not necessarily associated with delay and associated risks of maternal mortality and morbidity. • Judicial bypass does not necessarily ameliorate delays associated with parental consent laws, where they arise.
	When judicial bypass is associated with greater delays compared with parental consent, minors using judicial bypass are more likely to pass gestational thresholds per local guidelines.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Judicial bypass mechanisms should be carefully designed to minimize delay and the associated risk of a minor passing gestational thresholds for certain medical procedures because: <ul style="list-style-type: none"> • Minors who avail of judicial bypass and experience associated delay may have reduced options on abortion methods compared to those who secure parental consent. • Increased gestational age is associated with increased risks of maternal mortality and morbidity.

		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination	▲	Judicial bypass mechanisms should be carefully designed to minimize risk of a minor passing gestational thresholds for certain medical procedures because: <ul style="list-style-type: none"> • Minors who avail of judicial bypass may have reduced options on abortion methods compared to those who secure parental consent. • States must ensure equality in the provision of sexual and reproductive health care.
	Specific populations of minors are more likely to use judicial bypass than parental consent to obtain an abortion, and thus may be disproportionately impacted by the effects of judicial bypass.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination	▲	Judicial bypass mechanisms should be carefully designed to minimize risk of disproportionate impact because: <ul style="list-style-type: none"> • Delay associated with judicial bypass is disproportionately experienced by people of colour and those travelling to access abortion.
		States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Judicial bypass mechanisms should be carefully designed to minimize risk of disproportionate impact because: <ul style="list-style-type: none"> • Delay is associated with increased maternal mortality and morbidity. • States are required to take steps to reduce maternal mortality and morbidity.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS) (judicial bypass versus parental consent)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	Does not favour the intervention	✓ Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON PARENTAL INVOLVEMENT LAWS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: JUDICIAL BYPASS VS PARENTAL CONSENT—EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	<p>Evidence from four studies examining the difference between judicial bypass and parental consent on delayed abortion is unclear. Differences in estimates reported on time delay may be due to significant variation in the bypass process across settings.</p> <p>When judicial bypass is associated with greater delays compared with parental consent, minors using judicial bypass are more likely to pass gestational thresholds.</p> <p>Specific populations of minors are more likely to use judicial bypass than parental consent to obtain an abortion, and thus be disproportionately impacted by the effects of judicial bypass.</p>	<p>Delays are associated with increased maternal mortality and morbidity. As judicial bypass may be used more by specific populations and may be associated with increased delay, judicial bypass is associated with reduced enjoyment of the right to health, the right to life, and the right to equality and non-discrimination.</p>	<p>We recommend that laws requiring parental consent to abortion should be repealed and should not be introduced.</p> <p>We recommend that where such laws exist, States should ensure appropriate mechanisms of avoiding parental involvement laws and introduce appropriate services to protect minors and their children exposed to resultant violence.</p>

DETAILED JUSTIFICATION FOR THE JUDGEMENT (judicial bypass versus parental consent)

Application of Rights to Evidence per outcome

Delayed abortion

Judicial bypass mechanisms to avoid parental consent requirements do not *by themselves* have a clear impact on human rights because:

- Judicial bypass is not necessarily associated with delay and associated risks of maternal mortality and morbidity.
- Judicial bypass does not necessarily ameliorate delays associated with parental consent laws, where they arise.

Judicial bypass mechanisms should be carefully designed to minimize delay and the associated risk of a minor passing gestational thresholds for certain medical procedures because:

- Minors who avail of judicial bypass and experience associated delay may have reduced options on abortion methods compared to those who secure parental consent.
- Increased gestational age is associated with increased risks of maternal mortality and morbidity.

Judicial bypass mechanisms should be carefully designed to minimize risk of a minor passing gestational thresholds for certain medical procedures because:

- Minors who avail of judicial bypass may have reduced options on abortion methods compared to those who secure parental consent.
- States must ensure equality in the provision of sexual and reproductive health care.

Judicial bypass mechanisms should be carefully designed to minimize risk of disproportionate impact because:

• Delay associated with judicial bypass is disproportionately experienced by people of colour and those travelling to access abortion

Judicial bypass mechanisms should be carefully designed to minimize risk of disproportionate impact because:

- Delay is associated with increased maternal mortality and morbidity.
- States are required to take steps to reduce maternal mortality and morbidity.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Mandatory waiting periods

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcome *delayed abortion*, we can assume that minors value timely abortion care, avoidance of continuation of pregnancy where undesired, and affordable care with as few logistical burdens as possible.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *parental consent laws* or the comparison *judicial bypass*.

Resources:

The studies did not speak to the issues of resources, however, it can be assumed that the intervention *judicial bypass* is associated with significant system costs. *Parental involvement laws* are associated with significant systems costs (see EtD for *parental involvement*).

Acceptability and Feasibility:

The studies did not speak to the issues of acceptability and/or feasibility.

Equity:

Equity was considered in terms of disproportionate impact.

PICO 7: What is the impact of parental consent versus parental notification laws/requirements for abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND (parental consent versus parental notification laws/requirements)

Setting: Global

Perspective: Minors seeking abortion where parental consent or notification is required

Literature review: For the analysis of impact of parental consent versus parental notification laws on abortion related outcomes, 2 studies were identified relating to the outcomes *delayed abortion* (n=1) and *continuation of pregnancy* (n=1). No studies were identified that encompassed information related to the remaining outcomes. The included studies were conducted in the USA and were time-series designs.

FINDINGS TABLES (parental consent versus parental notification laws/requirements)

Outcome: DELAYED ABORTION

Findings table 1: Impact of parental consent versus notification laws/requirements on delayed abortion

OUTCOME: DELAYED ABORTION				
Human rights standards engaged: right to health, right to life, right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
--	Joyce 2010	○	Minors using parental consent statutes vs parental notification to obtain abortion do not have different rates of second trimester abortion.	Evidence from one study examining the difference between parental consent statute vs notification requirement suggests there is no difference on delayed abortion.

▲ = the intervention (parental consent compared with notification requirements) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

Additional considerations

Study design and setting of included studies:

Joyce 2010; Time-series design (n=7463); Arkansas, USA

Mandatory waiting periods

Outcome: CONTINUATION OF PREGNANCY

Findings table 2: Impact of parental consent versus notification laws/requirements on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY				
Human rights standards engaged: right to health, right to life, right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
Abortion rate	Chevrette 2015	▼	Settings with mandatory parental consent laws as compared with parental notification or minor’s own ability to consent, may have lower abortion rates.	Evidence from one study suggests that parental consent laws in comparison with parental notification, decrease minors’ abortion rates to a greater extent and contribute to continuation of pregnancy.
Adolescent birth rate	Chevrette 2015 ¹	○	States with mandatory parental consent laws as compared with parental notification or minor’s own ability to consent, have no difference in adolescent birth rates.	

▲ = the intervention (parental consent compared with notification requirements) leads to an increase in the sub-outcome; ○ = the intervention leads to no change in the sub-outcome; ▼ = the intervention leads to a decrease in the sub-outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Study was not powered to look at this sub-outcome (P=007) and model did not adjust for all known confounders.

Additional considerations

Study design and setting of included studies:

Chevrette 2015: Time-series design (n=434 503); USA

Outcome: OPPORTUNITY COST

No studies identified

Outcome: SYSTEM COSTS

No studies identified

Outcome: UNLAWFUL ABORTION

No studies identified

Outcome: SELF-MANAGED ABORTION

No studies identified

Outcome: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION

No studies identified

Outcome: ANTICIPATED REPRODUCTIVE COERCION

No studies identified

Outcome: ANTICIPATED FAMILY DISHARMONY

No studies identified

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

Evidence from one study examining the difference between parental consent laws vs notification requirement suggests there is no difference on delayed abortion.

Continuation of pregnancy

Evidence from one study suggests that parental consent laws in comparison with parental notification, decrease minors' abortion rates to a greater extent and contribute to continuation of pregnancy.

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE (parental consent versus parental notification laws/requirements)

HUMAN RIGHTS STANDARDS TO EVIDENCE: PARENTAL CONSENT VERSUS NOTIFICATION

Sub-Outcome	Overall Conclusion from Comparison	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Evidence from one study examining the difference between parental consent vs notification requirement suggests there is no difference on delayed abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	○	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • Parental notification laws are not associated with lesser or greater delay than parental consent laws. • However, parental consent laws are associated with delay. • Delay is associated with increased maternal mortality and morbidity. • States are required to take steps to reduce maternal mortality and morbidity.
Continuation of pregnancy	Evidence from one study suggests that parental consent laws in comparison with parental notification, decrease minors' abortion rates to a greater extent and contribute to continuation of pregnancy.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	<p>Parental consent and parental consent laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • Where parental involvement laws are associated with changes to abortion rates and birth rates, this change impacts exclusively on minors. • These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care. • States must ensure equality and non-discrimination in the provision of

				sexual and reproductive health care.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	○	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • They may be associated with lower abortion rates and increased birth rates compared to notification requirements or lack of a consent requirement. • In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective). • States should ensure laws regulating abortion are evidence-based and proportionate.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS) (parental consent versus parental notification laws/requirements)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		Large	✓ Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	- Does not favour the intervention	✓ Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON PARENTAL INVOLVEMENT LAWS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: PARENTAL CONSENT VERSUS PARENTAL NOTIFICATION—EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	<p>Evidence from one study examining the difference between parental consent statute vs notification requirement suggests there is no difference on delayed abortion.</p> <p>The results suggest that it is the requirement of any parental involvement, and not whether the policy is a notification or consent statute, that may alter minors' reproductive outcomes.</p>	<p>As delay is associated with increased maternal mortality and morbidity, and as delay associated with parental consent laws has disproportionate impact on specific populations, and as a parental notification requirement rather than parental consent requirement does not change associated abortion delay, these laws are associated with reduced enjoyment of the right to health, the right to life, and the right to equality and non-discrimination.</p>	<p>We recommend that laws requiring parental consent or notification to abortion should be repealed and should not be introduced.</p>
Continuation of pregnancy	<p>Evidence from one study suggests that parental consent laws in comparison with parental notification, decrease minors' abortion rates to a greater extent and contribute to continuation of pregnancy.</p>	<p>As delay is associated with increased maternal mortality and morbidity, and as delay associated with parental consent laws has disproportionate impact on specific populations, and as a parental notification requirement rather than parental consent requirement does not change associated abortion delay, and as written parental consent requirements may be associated with lower abortion rate and higher birth rates, these laws are associated with reduced enjoyment of the right to health, the right to life, and the right to equality and non-discrimination.</p>	<p>We recommend that laws requiring parental consent or notification to abortion should be repealed and should not be introduced.</p>

DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome

Delayed abortion

Parental involvement laws should be repealed and not introduced because:

- Parental notification laws are not associated with lesser or greater delay than parental consent laws.
- However, parental consent laws are associated with delay.
- Delay is associated with increased maternal mortality and morbidity.
- States are required to take steps to reduce maternal mortality and morbidity.

Continuation of pregnancy

Parental consent and parental consent laws should be repealed and not introduced because:

- Where parental involvement laws are associated with changes to abortion rates and birth rates, this change impacts exclusively on minors.
- These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care.
- States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Parental involvement laws should be repealed and not introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- They may be associated with lower abortion rates and increased birth rates compared to notification requirements or lack of a consent requirement.
- In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
- States should ensure laws regulating abortion are evidence-based and proportionate.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Moderate

Mandatory waiting periods

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes *Delayed abortion* and *Continuation of pregnancy*, we can assume that minors value timely abortion care, avoidance of continuation of pregnancy and affordable care with as few logistical burdens as possible.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention, *parental consent laws* or the comparison *parental notification laws*.

Resources:

The studies did not speak to the issue of resources.

Acceptability and Feasibility:

The studies did not speak to the issues of acceptability and/or feasibility.

Equity:

Equity was considered in terms of disproportionate impact, however, the included studies did not speak to the issue of equity.

PICO 8: What is the impact of authorization by parent through consent or notification on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND (authorization by parent through consent or notification or “parental involvement”)

Setting: Global

Perspective: Minors seeking abortion where parental consent or notification is required

Literature review: For the analysis of impact of parental involvement laws on abortion related outcomes, 25 studies were identified addressing the following outcomes; delayed abortion (n=2), continuation of pregnancy (n=13), opportunity costs (n=4), system costs (n=6), unlawful (n=1), anticipated family disharmony (n=2), anticipated exposure to interpersonal violence or exploitation (n=2), anticipated reproductive coercion (n=2). No studies were identified that encompassed information related to the remaining outcomes. All studies were conducted in the USA apart from one that was conducted in Hong Kong Special Administrative Region (China). Study designs in this EtD framework include cohort studies (comparative and non-comparative), cross-sectional studies, time-series design and qualitative studies using in-depth interviews.

Note: The intervention includes studies that look at parental consent laws, parental notification laws or both, e.g. parental involvement laws.

FINDINGS TABLES (authorization by parent through consent or notification)

Outcome: DELAYED ABORTION

Findings table 1: Impact of parental involvement laws on delayed abortion

OUTCOME: DELAYED ABORTION				
Human rights standards engaged: right to health, the right to life, and the right to equality and non-discrimination				
Sub-outcomes	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
--	Ralph 2018 ¹	○	Overall, parental notification laws are not associated with increasing gestational age among minors seeking abortions.	Evidence from two studies reporting on the association between parental notification requirement and delayed abortion are unclear. Variation in findings may be due to the study setting or inadequate sample size. Requirements for parental notification are not observed to be associated with delayed abortion for all minors.
		▲	Subpopulation: Among minors who must travel outside their community to obtain abortion care, parental notification laws are associated with a higher proportion of second trimester abortions compared with young adults (ages 18–21).	
	MacAfee 2015 ²	○	Parental notification requirement was not observed to be associated with an increase in gestational age among abortion seekers or in the number of second trimester abortions.	However, minors who must travel outside their community to obtain abortion care experience significant delays in receiving care.

▲ = the intervention (parental consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Data are from a single institution, which affects generalizability.

² Study was not powered to look at this outcome. Study population was restricted to pregnancies < 16 weeks, meaning that study results were biased towards showing no difference in gestational age or number of second trimester abortions.

Additional considerations

Study design and setting of included studies:

MacAfee 2015; Cohort study – non-comparative (n=373); New England, USA

Ralph 2018; Cohort study – comparative (n=1577); Illinois, USA

Outcome: CONTINUATION OF PREGNANCY

Findings table 2: Impact of parental involvement laws on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY				
Human rights standards engaged: right to health, right to security of person, right to equality and non-discrimination				
Sub-outcome	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
Unintended pregnancy rates	Medoff 2014c ¹	o	Parental involvement laws are not associated with reductions in overall unintended pregnancy rates among minors and adults.	<p>Overall, 14 studies across four sub-outcomes suggest that parental involvement laws for minors decrease abortion access and contribute to continuation of pregnancy.</p> <p>The relationship between parental involvement laws and unintended pregnancy and birth rates suggests that overall, parental involvement laws increase adolescent birth rates but do not reduce unintended pregnancy or births.</p> <p>When parental consent is associated with increased birth rates, there is a disproportionate impact on adolescents within specific populations (black teens) and those engaged in cross-border travel. However, minors' ability to travel to avoid parental consent laws is limited; the distance to a state without parental consent laws is irrelevant.</p>
Abortion rates	Medoff 2010b	▼	Parental involvement laws are associated with reduced overall abortion rates (minors and adults).	
	Medoff 2010c	▼	Parental involvement laws are associated with reductions in overall abortion rates (minors and adults).	
	Medoff 2012b	▼	Parental involvement laws are associated with reductions in overall abortion rate (minors and adults).	
	Ralph 2018	▼	Parental notification requirement is associated with a decrease in the number of abortions among minors (relative to numbers of abortion among young adults 18–21).	
	MacAfee, 2015	▼	Parental notification requirement is associated with a decrease in the numbers of abortions among minors (attributed to a decrease in minors crossing into the state where the law applies).	
	Ramesh 2016 ²	o	The impact of a parental notification requirement on the number of abortions among minors is unclear.	

	Joyce, 2019	o	Parental involvement laws adopted after 1995 were not observed to be associated with any decrease in adolescent abortion rates. The effect of parental involvement laws on abortion rates is not impacted by distance to a setting without a parental consent law.
	Tosh 2015	o	Parental involvement laws are not associated with reduced adolescent abortion rates.
Unintended birth rates	Medoff 2016 ³	o	Parental involvement laws are not associated with increasing unintended birth rates.
Birth rate	Medoff 2010a	▲	Parental involvement laws are associated with an increase in birth rates among unmarried adolescents.
	Myers 2017	▲	Parental involvement laws after year 1992 are associated with an increase in birth rates among minors. Births rates increase with increasing distance to another setting (state) where parental involvement is not required.
	Tosh, 2015	▲	Parental involvement laws are associated with increased adolescents birth rates.
Disproportionate impact	Myers 2017	▲	Increased birth rates associated with parental consent laws are disproportionately experienced by Black teens. Increased birth rates associated with parental consent laws are disproportionately experienced by individuals who must travel over 100 miles to avoid the parental consent law (travel to another region).
	Medoff 2014a	o	Parental consent laws do not have a different effect on rates of abortion between White, Black or Hispanic women (15–44).

▲ = the intervention (parental consent) leads to an increase in the sub-outcome; o = the intervention leads to no change in the sub-outcome; ▼ = the intervention leads to a decrease in the sub-outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Unintended pregnancy rates are from Kost et al. *Unintended pregnancy rates at the state level: estimates for 2002, 2004, 2006 and 2008*. New York (NY): Guttmacher Institute; 2013.

2 Study was not powered to look at this outcome; no sample size calculation performed.

3 Unintended birth rates are from Sonfield A, Kost K, Gold RB, Finer LB. The public costs of births resulting from unintended pregnancies: national and state-level estimates. *Perspectives on Sexual and Reproductive Health*. 2011;43:84–102.

Additional considerations

Study design and setting of included studies:

Joyce 2010; Time-series design (n=7463); Arkansas, USA

Joyce 2019; Cohort – non-comparative (n=43594); USA

MacAfee 2015; Cohort study – non-comparative (n=373); New England, USA

Medoff 2010a; Time-series design (n=not reported); USA

Medoff 2010b; Time-series design (n=not reported); USA

Medoff 2010c; Time-series design (n=not reported); USA

Medoff 2012b; Time-series design (n=not reported); USA

Medoff 2014a; Time-series design (n=not reported); USA

Medoff 2014c; Time-series design (n=not reported); USA

Medoff 2016; Time-series design (n=not reported); USA

Myers 2017; Cross-sectional (n=3142); USA

Ralph 2018; Cohort study – comparative (n=1577); Illinois, USA

Ramesh 2016; Cohort study – comparative (n=5505); Illinois, USA

Tosh 2015; Cohort study – comparative (n=not reported); USA

Turn Away Study <https://www.ansirh.org/publications/turnaway>

Findings table 3: Impact of parental involvement laws on opportunity costs

OUTCOME: OPPORTUNITY COST				
Human rights standards engaged: right to health, right to security of person				
Sub-outcome	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
Travel for abortion	Ralph, 2018	○	Implementation of parental notification requirements do not impact on the number of minors and adult women engaged in cross-state travel to obtain abortion care.*	Evidence from four studies suggests that parental involvement laws are associated with increased opportunity costs for minors. ³ Parental involvement laws may lead to opportunity costs due to travel for abortion to states where parental consent or notification is not required, but do not prevent abortions from occurring. Variation in findings may be due to specific differences in study settings.
	MacAfee 2015	○	Implementation of parental notification laws is associated with decreased travel into the state by abortion seekers living outside the state, but not associated with an increase in travel out of the state by those abortion seekers living within the state.	
	Fuentes 2019 ³	▲	Where parental involvement laws apply, minors are more likely to travel long distances (> 100 miles) to access abortion.	
	Hung 2010 ^{1,2}	▲	Some minors will travel far to obtain unlawful abortion to avoid parental consent laws.	

▲ = the intervention (parental consent) leads to an increase in the sub-outcome; ○ = the intervention leads to no change in the sub-outcome; ▼ = the intervention leads to a decrease in the sub-outcome. Symbol does *not* indicate magnitude or certainty of effect.

*While the number of minors engaged in cross-border travel is not impacted by parental notification requirement, those that do travel are more likely to be in their second trimester when undergoing abortion – Captured under *Delay Outcome*

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

³ In framing this conclusion, greater weight was placed on the findings from the nationally representative study than the three smaller studies.

Additional considerations

Study design and setting of included studies:

Fuentes 2019; Cross-sectional (n=889); USA

Hung 2010; Qualitative, in-depth interviews (n=29); Hong Kong SAR (China)

MacAfee 2015; Cohort study – non-comparative (n=373); New England, USA

Ralph 2018; Cohort study – comparative (n=1577); Illinois, USA

DRAFT

Findings table 4: Impact of parental involvement laws on system costs

OUTCOME: SYSTEMS COSTS				
Human rights standards engaged: right to health, right to security of person				
Sub-outcome	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
Sexually transmitted infections	Colman 2013	○	Parental involvement laws are not associated with increased rates of sexually transmitted infections, a proxy for sexual risk-taking behaviour.	Overall evidence from six studies across six sub-outcomes suggest that parental involvement laws increase system costs. Parental involvement laws have no impact on STI cases or pregnancy rates. Parental involvement laws may increase system costs related to pre-term birth and low birth weight, unwanted pregnancy rates and child homicide deaths.
Pregnancy rates	Medoff 2010d	○	Parental involvement laws are not associated with increased rates of adolescent pregnancies.	
Unintended pregnancy rates	Medoff 2012a ¹	▼	Parental involvement laws are associated with an overall reduction in unintended pregnancy rates among minors and adults (ages 15–44).	
Preterm birth and low birth weight	Wallace 2017	▲	Parental involvement laws are associated with increased odds of preterm birth and low birth weight infants.	
Postpartum depression	Medoff 2014b	○	Parental involvement laws are not associated with an increased occurrence of postpartum depression.	
Homicide deaths among children < 5 year	Sen 2012	▲	Parental involvement laws are associated with an increased number of homicide deaths among children under age 5.	

▲ = the intervention (parental consent) leads to an increase in the sub-outcome; ○ = the intervention leads to no change in the sub-outcome; ▼ = the intervention leads to a decrease in the sub-outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ It is not clear how pregnancy intention is measured.

Additional considerations

Study design and setting of included studies:

Colman 2013: Time-series design (n=not reported), USA

Medoff 2010d: Time-series design (n=not reported); USA

Medoff 2012a: Time-series design (n=not reported); USA

Wallace 2017: Cross-sectional (n= 398 4761 = all births during 2012 in the USA); USA

Sen 2012: Cross-sectional (n=5100); USA

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Outcome: UNLAWFUL ABORTION

Findings table 5: Impact of parental involvement laws on unlawful abortion

OUTCOME: UNLAWFUL ABORTION				
Human rights standards engaged: right to life, right to health				
Sub-outcome	Studies	Directionality of the evidence	What does this mean?	Overall conclusion
-	Hung 2010 1, 2	▲	Some minors resort to unlawful abortion to avoid parental consent laws.	Evidence from one study suggests that parental consent laws may lead to unlawful abortion among minors.

▲ = the intervention (parental consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Hung 2010; Qualitative, in-depth interviews (n=29); Hong Kong SAR (China)

Outcome: SELF-MANAGED ABORTION

No studies identified

Outcome: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION

Findings table 6: Impact of parental involvement laws on anticipated exposure to interpersonal violence or exploitation

OUTCOME: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION				
Human rights standards engaged: right to health, right to privacy				
Sub-outcome	Studies	Directionality of Evidence	What does this mean?	Overall conclusion
--	Kavanaugh 2012 ^{1,2}	▲	<p>Minors are concerned that parental notification laws will expose them to physical and psychological violence during or after their pregnancy.</p> <p>Minors are concerned that, if they continue their pregnancy, parental notification laws will expose their future children to violence.</p>	Evidence from one study demonstrates that minors anticipate that involuntary disclosure of a pregnancy due to a requirement for parental notification may increase the risk for physical and psychological violence directed at them or their future children.

▲ = the intervention (parental consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Kavanaugh 2012; Qualitative, in-depth interviews (n=30); USA

Outcome: ANTICIPATED REPRODUCTIVE COERCION

Findings table 7: Impact of parental involvement laws on anticipated reproductive coercion

OUTCOME: ANTICIPATED REPRODUCTIVE COERCION				
Human rights standards engaged: right to health, right of persons with disabilities to retain fertility on an equal basis with others, right to be free from torture, and cruel, inhuman or degrading treatment, right to exercise legal capacity, right to decide on the number and spacing of children, right to non-discrimination and equality, right to privacy, and women’s right to legal capacity on an equal basis with men				
Sub-outcome	Studies	Directionality of Evidence	What does this mean?	Overall conclusion
-	Kavanaugh 2012 ^{1,2}	▲	Minors expressed concern that parental notification laws will diminish their reproductive autonomy and lead to either a forced abortion or forced continuation of pregnancy.	Evidence from two studies indicate that minors anticipate that involuntary disclosure of a pregnancy due to a requirement of parental notification or consent, may increase the risk for reproductive coercion.
	Hasselbacher 2014 ^{1,2}	▲	Minors reasons for not wanting to disclose a pregnancy to a parent include a wish to preserve reproductive autonomy and avoid forced continuation of pregnancy	

▲ = the intervention (parental consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich – data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Kavanaugh 2012; Qualitative, in-depth interviews (n=30); USA

Hasselbacher 2014; Qualitative, in-depth interviews (n=30); Illinois, USA

Outcome: ANTICIPATED FAMILY DISHARMONY

Findings table 8: Impact of parental involvement laws on anticipated family disharmony

OUTCOME: ANTICIPATED FAMILY DISHARMONY				
Human rights standards engaged: right to health, right to privacy				
Sub-outcome	Studies	Directionality of Evidence	What does this mean?	Overall conclusion
--	Kavanaugh 2012 ^{1,2}	▲	Some minors anticipate that involuntarily disclosing their pregnancy due to parental notification requirements would result in a profound change in their relationship with their parent.	Evidence from two studies indicate that minors anticipate that involuntary disclosure of a pregnancy due to requirements for parental notification or consent may increase risk of family disharmony.
--	Hasselbacher 2014 ^{1,2}	▲	Some minors anticipate that involuntarily disclosing their pregnancy due to parental involvement laws would result in a profound change in their relationship with their parent. Reasons for not disclosing a pregnancy to a parent include a wish avoid anticipated family disharmony.	

▲ = the intervention (parental consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Kavanaugh 2012; Qualitative, in-depth interviews (n=30); USA

Hasselbacher 2014; Qualitative, in-depth interviews (n=30); Illinois, USA

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Evidence from two studies reporting on the association between parental notification requirement and delayed abortion are unclear. Variation in findings may be due to the study setting or inadequate sample size.
- Requirements for parental notification are not observed to be associated with delayed abortion for all minors. However, minors who must travel outside their community to obtain abortion care experience significant delays in receiving care.

Continuation of pregnancy

- Overall, 14 studies across four sub-outcomes suggest that parental involvement laws for minors decrease abortion access and contribute to continuation of pregnancy.
- The relationship between parental involvement laws and unintended pregnancy and birth rates suggests that overall, parental involvement laws increase adolescent birth rates but do not reduce unintended pregnancy or births.
- When parental consent is associated with increased birth rates, there is a disproportionate impact on adolescents within specific populations (Black teens) and those engaged in cross-border travel. However, minors' ability to travel to avoid parental consent laws is limited; the distance to a state without parental consent laws is irrelevant.

Opportunity cost

- Evidence from four studies suggests that parental involvement laws are associated with increased opportunity costs for minors.
- Parental involvement laws may lead to opportunity costs due to travel for abortion to states where parental consent or notification is not required, but do not prevent abortions from occurring.
- Variation in findings may be due to specific differences in study settings.

System costs

- Overall evidence from six studies across six sub-outcomes suggest that parental involvement laws increase system costs.
- Parental involvement laws have no impact on STI cases or pregnancy rates. Parental involvement laws may increase system costs related to pre-term birth and low birth weight, unwanted pregnancy rates and child homicide deaths.

Unlawful abortion

- Evidence from one study suggests that parental consent laws may lead to unlawful abortion among minors.

Anticipated exposure to interpersonal violence or exploitation

- Evidence from one study demonstrates that minors anticipate that involuntary disclosure of a pregnancy due to a requirement for parental notification may increase the risk for physical and psychological violence directed at them or their future children.

Anticipated reproductive coercion

- Evidence from two studies indicate that minors anticipate that involuntary disclosure of a pregnancy due to a requirement of parental notification or consent, may increase the risk for reproductive coercion.

Anticipated family disharmony

- Evidence from two studies indicate that minors anticipate that involuntary disclosure of a pregnancy due to requirements for parental notification or consent may increase risk of family disharmony.

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HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES (authorization by parent through consent or notification)

HUMAN RIGHTS STANDARD-TO-EVIDENCE: Parental involvement

Outcome	Overall from Evidence	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed abortion	<p>Evidence from two studies reporting on the association between parental notification requirement and delayed abortion are unclear. Variation in findings may be due to the study setting or inadequate sample size.</p> <p>Requirements for parental notification are not observed to be associated with delayed abortion for all minors. However, minors who must travel outside their community to obtain abortion care experience significant delays in receiving care.</p>	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	○	<p>Laws requiring parental involvement for all minors should be repealed and should not be introduced because:</p> <ul style="list-style-type: none"> • The association between parental notification requirements and delayed abortion are unclear. • Delay is associated with increased maternal mortality and morbidity • States are required to take steps to reduce maternal mortality and morbidity
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	<p>Laws requiring parental involvement for all minors should be repealed and should not be introduced because:</p> <ul style="list-style-type: none"> • Parental notification laws are associated with disproportionate impact on specific populations. • These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care. • States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Continuation of pregnancy	<p>Overall, 14 studies across four sub-outcomes suggest that parental involvement laws for minors decrease abortion access and contribute to continuation of pregnancy.</p> <p>The relationship between parental involvement laws and unintended pregnancy and birth rates suggests that overall, parental involvement laws increase adolescent birth rates but do not reduce unintended pregnancy or births.</p> <p>When parental consent is associated with increased birth rates, there is a disproportionate impact on adolescents within specific populations (Black teens) and those engaged in cross-border travel. However, minors' ability to travel to avoid parental consent laws is limited; the distance to a state without parental consent laws is irrelevant.</p>	<p>States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.</p>	▲	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • Where parental involvement requirements are associated with changes to abortion rates and birth rates, they are associated with disproportionate impact on specific populations. • These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care. • States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.
		<p>States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	○	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective). • States should ensure laws regulating abortion are evidence-based and proportionate.

<p>Opportunity cost</p>	<p>Evidence from four studies suggests that parental involvement laws are associated with increased opportunity costs for minors.</p> <p>Parental involvement laws may lead to opportunity costs due to travel for abortion where parental consent or notification is not required, but do not prevent abortions from occurring.</p> <p>Variation in findings may be due to specific differences in study settings.</p>	<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	<p>▲</p>	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective). • States should ensure laws regulating abortion are evidence-based and proportionate.
<p>Systems costs</p>	<p>Overall evidence from six studies across six sub-outcomes suggest that parental involvement laws increase system costs.</p> <p>Parental involvement laws have no impact on STI cases or pregnancy rates. Parental involvement laws may increase system costs related to pre-term birth and low birth weight, unwanted pregnancy rates and child homicide deaths</p>	<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	<p>▲</p>	<p>Parental involvement laws should be repealed and not introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • They may increase and do not reduce system costs. • In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective). • States should ensure laws regulating abortion are evidence based and proportionate.

Unlawful abortion	Evidence from one study suggests that parental consent laws may lead to unlawful abortion among minors.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • They may lead to unlawful abortion. • Unlawful abortion may be unsafe. • Unsafe abortion is associated with increased maternal mortality and morbidity. • States must take steps to reduce maternal mortality and morbidity.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Parental consent laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • They may lead to unlawful abortion. • Unlawful abortion may be unsafe. • Unsafe abortion is associated with physical and mental health risks. • States must protect people from the physical and mental health risks of unsafe abortion.
		Where it is lawful, abortion must be safe and accessible.	▲	Parental consent laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • Where abortion is lawful it must be safe and accessible. • Parental consent laws may lead to unlawful abortion. • When States legalize abortion, they must ensure the arrangement of law, policy, and health care provision to ensure safe and legal abortion is accessible in practice.

Anticipated exposure to interpersonal violence or exploitation	Evidence from one study demonstrates that minors anticipate that involuntary disclosure of a pregnancy due to a requirement for parental notification may increase the risk for physical and psychological violence directed at them or their future children	States should protect people seeking abortion.	▲	States should repeal and not introduce parental involvement laws; they should ensure appropriate mechanisms of avoiding parental involvement laws where they exist; and should introduce appropriate services to protect minors and their future children exposed to resultant violence because: <ul style="list-style-type: none"> • These laws compel exposure of abortion seeking to parents. • This exposure may expose minors to violence directed at themselves or their future children. • States should protect people seeking abortion.
		SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent. • This disclosure may expose minors or their future children to violence. • Abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment. • Torture or cruel, inhuman or degrading treatment are absolutely prohibited in international law.

				<ul style="list-style-type: none"> • States should take steps to protect people seeking abortion. • States must take steps to protect people from torture, inhuman and degrading treatment. • SRH services must be provided in a way that respects women and girls' privacy and guarantees confidentiality. • In the absence of evidence that these laws achieve policy goals, and given their association with exposure to interpersonal violence, it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
Anticipated reproductive coercion	Evidence from two studies indicate that minors anticipate involuntary disclosure of a pregnancy due to requirement of parental notification or consent, may increase risk for reproductive coercion	States may not undertake, and must take steps to prevent, forced or coerced abortion including for marginalized people, people with disabilities, children and people in conflict settings.	▲	Parental involvement laws should be repealed, or not introduced, or reformed to include appropriate bypass mechanisms because: <ul style="list-style-type: none"> • These laws may expose minors to forced or coerced abortion. • States must take steps to prevent forced or coerced abortion including for children.
		Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State or health authorities.	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws empower another entity (parent or bypass mechanism) to limit decisions about whether or not to have children. • Decisions about whether or not to have children must not be limited by spouse, parent, partner, the State or health authorities.

		SRH services including abortion and post-abortion care must be provided in a way that respects women and girls' privacy and guarantees confidentiality.	▲	<p>Parental involvement laws should be repealed and should not be introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent. • These laws may expose minors to forced or coerced abortion or to coerced continuation of pregnancy. • States must take steps to prevent forced or coerced abortion. • In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
Anticipated family disharmony	Evidence from two studies indicate that minors anticipate that involuntary disclosure of a pregnancy due to requirements for parental notification or consent may increase risk for family disharmony.	SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantee confidentiality.	▲	<p>Parental involvement laws should be repealed and should not be introduced because:</p> <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • These laws compel exposure of abortion seeking by minors to parents and/or to a

				<ul style="list-style-type: none"> mechanism of bypassing parental consent. • These laws may expose minors to family disharmony and associated risks of violence or reproductive coercion. • Abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment. • Torture or cruel, inhuman or degrading treatment are absolutely prohibited in international law. • States should take steps to protect people seeking abortion. • States must take steps to protect people from torture, inhuman and degrading treatment. • States must take steps to protect people from forced or coerced abortion. • In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
		States should protect people seeking abortion.	○	<p>States should ensure appropriate mechanisms of avoiding parental involvement laws where they exist because:</p> <ul style="list-style-type: none"> • These laws compel exposure of abortion seeking to parents. • This exposure may expose minors to violence directed at themselves or their future children. • States should protect people seeking abortion

Across all outcomes	Parental consent laws apply only to minors seeking abortion care.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws apply to minors only and regardless of capacity. • These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care. • States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.
Across all outcomes	Parental consent laws compel the exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent.	SRH services, including abortion and post-abortion care, must be provided in a way that respects women and girls' privacy and guarantees confidentiality. States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers • These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent. • In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective) SRH services must be provided in a way that respects women and girls' privacy and guarantees confidentiality.
Across all outcomes	Parental consent laws enable the limitation by a parent of a person's decision about whether or not to have children.	Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State or health authorities.	▲	Parental involvement laws should be repealed and should not be introduced because: <ul style="list-style-type: none"> • There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers. • These laws expose minors to the limitation by their parent(s) of the decision whether or not to have children.

		States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.		<ul style="list-style-type: none"> In the absence of such clear evidence it cannot be established that their negative impact on the right to decide on the number and spacing of children is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
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▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS) (authorization by parent through consent or notification)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON PARENTAL INVOLVEMENT LAWS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: PARENTAL INVOLVEMENT: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	<p>Evidence from two studies reporting on the association between parental notification requirement and delayed abortion are unclear. Variation in findings may be due to the study setting or inadequate sample size.</p> <p>Requirements for parental notification are not observed to be associated with delayed abortion for some minors. Minors who must travel outside their community to obtain abortion care experience significant delays in receiving care.</p>	<p>Delay is associated with increased maternal mortality and morbidity. As any delays associated with parental involvement laws have disproportionate impact on specific populations, these laws are associated with reduced enjoyment of the right to health, the right to life, and the right to equality and non-discrimination.</p>	<p>We recommend laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.</p>
Continued pregnancy	<p>Overall, 14 studies across four sub-outcomes suggest that parental involvement laws for minors decrease abortion access and contribute to continuation of pregnancy.</p> <p>The relationship between parental involvement laws and unintended pregnancy and birth rates suggests that overall, parental involvement laws increase adolescent birth rates but do not reduce unintended pregnancy or births.</p> <p>When parental consent is associated with increased birth rates, there is a disproportionate impact on adolescents on specific populations (Black teens) and those engaged in cross-border travel. However, minors ability to travel to avoid parental consent laws is limited; the distance to a state without parental consent requirements is irrelevant.</p>	<p>As parental involvement laws may be associated with a reduction in overall abortion rates and may decrease the number of abortions for minors, and as those impacts can disproportionately affect certain populations, these laws can impact negatively on the right to equality and non-discrimination, and may undermine the rights to health and to security of person.</p>	<p>We recommend laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.</p>

<p>Opportunity costs</p>	<p>Evidence from four studies suggests that parental involvement laws are associated with increased opportunity costs for minors.</p> <p>Parental involvement laws may lead to opportunity costs due to travel for abortion to states where parental consent or notification is not required, but do not prevent abortions from occurring.</p> <p>Variation in findings may be due to specific differences in study settings.</p>	<p>As parental consent laws may lead to opportunity costs these laws have negative impacts on the rights to health and to security of person.</p>	<p>We recommend laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.</p>
<p>System costs</p>	<p>Overall evidence from six studies across six sub-outcomes suggest that parental involvement laws increase system costs.</p> <p>Parental involvement laws have no impact on STI cases or pregnancy rates. Parental involvement laws may increase system costs related to pre-term birth and low birth weight, unwanted pregnancy rates and child homicide deaths.</p>	<p>As parental involvement laws may increase and not reduce system costs, these laws have negative impacts on the rights to health and to security of person.</p>	<p>We recommend laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.</p>
<p>Unlawful abortion</p>	<p>Evidence from one study suggests that parental consent requirements may lead to unlawful abortion among minors.</p>	<p>As parental involvement laws may increase unlawful abortion and as unlawful abortion is associated with maternal mortality and morbidity and with physical and mental health risks, parental involvement laws impact negatively on the right to life and the right to health.</p>	<p>We recommend laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.</p>
<p>Exposure to interpersonal violence or exploitation</p>	<p>Evidence from one study demonstrates that minors anticipate that involuntary disclosure of a pregnancy due to a requirement for parental notification, may increase the risk for physical and psychological violence directed at minors or their future children.</p>	<p>As compelled disclosure of abortion seeking can expose minors to violence, parental involvement laws impact negatively on rights to health and privacy, and engage States' positive obligations to protect abortion seekers from harm.</p>	<p>We recommend that laws requiring parental involvement relating to minor access should be repealed and should not be introduced.</p> <p>We recommend that where such laws exist, States should ensure appropriate mechanisms of avoiding parental involvement laws and introduce appropriate services to protects minors</p>

			and their children exposed to resultant violence.
Reproductive coercion	Evidence from two studies indicate that minors anticipate involuntary disclosure of a pregnancy due to requirement of parental notification or consent, may increase risk for reproductive coercion.	As compelled disclosure of abortion seeking can expose minors to reproductive coercion, these laws may impact negatively on the right to health, right to security of person, right of persons with disabilities to retain fertility on an equal basis with others, right to be free from torture, and cruel, inhuman or degrading treatment, right to exercise legal capacity, the right to decide on the number and spacing of children, right to equality and non-discrimination right to privacy, and women's right to legal capacity on an equal basis with men; engaging States positive obligation to protect abortion seekers from harm and from forced or coerced abortion.	We recommend that laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced. We recommend that where such laws exist, States should ensure appropriate mechanisms of avoiding parental involvement laws.
Family disharmony	Evidence from two studies indicate that minors anticipate involuntary disclosure of a pregnancy due to requirements for parental notification or consent may increase risk for family disharmony.	As compelled disclosure of abortion seeking may expose minors to family disharmony, this may have negative impacts on the right to health and the right to privacy.	We recommend parental involvement laws should be repealed and should not be introduced.
Across all outcomes	Parental involvement laws may have implications for system and opportunity costs, delay and associated risks, and apply to all minors without regard to their individual and evolving capacities to consent to medical treatment.	As parental involvement laws apply only to minors, apply to all minors as a class, and do not take account of differing and evolving capacity to consent to medical treatment, these laws are associated with reduced enjoyment of the right to equality and non-discrimination.	We recommend that laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.
Across all outcomes	Parental involvement laws compel disclosure of abortion seeking on the part of minors without regard to their individual and evolving capacities to consent to medical treatment.	As parental involvement laws apply only to minors and compel disclosure of their abortion seeking without regard to their individual and evolving capacities to consent to medical treatment, these laws are associated with reduced enjoyment of the right to privacy, right to health and right to	We recommend that laws requiring parental involvement relating to minor access to abortion should be repealed and should not be introduced.

		security if the person.	
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DETAILED JUSTIFICATION FOR THE JUDGEMENT (authorization by parent through consent or notification)

Application of Rights to Evidence per outcome

Delayed abortion

Laws requiring parental involvement for all minors should be repealed and should not be introduced because:

- The association between parental notification requirements and delayed abortion are unclear.
- Delay is associated with increased maternal mortality and morbidity.
- States are required to take steps to reduce maternal mortality and morbidity.

Laws requiring parental involvement for all minors should be repealed and should not be introduced because:

- Parental notification laws are associated with disproportionate impact on specific populations.
- These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care.
- States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Continuation of pregnancy

Parental involvement laws should be repealed and not introduced because:

- Where parental involvement requirements are associated with changes to abortion rates and birth rates, they are associated with disproportionate impact on specific populations.
- These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care.
- States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Parental involvement laws should be repealed and not introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
- States should ensure laws regulating abortion are evidence-based and proportionate.

Opportunity cost

Parental involvement laws should be repealed and not introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
- States should ensure laws regulating abortion are evidence-based and proportionate.

Mandatory waiting periods

System costs

Parental involvement laws should be repealed and not introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- They may increase and do not reduce system costs.
- In the absence of such clear evidence it cannot be established that their negative impact on rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).
- States should ensure laws regulating abortion are evidence-based and proportionate.

Unlawful abortion

Parental involvement laws should be repealed and should not be introduced because:

- They may lead to unlawful abortion.
- Unlawful abortion may be unsafe.
- Unsafe abortion is associated with increased maternal mortality and morbidity.
- States must take steps to reduce maternal mortality and morbidity.

Parental consent laws should be repealed and should not be introduced because:

- They may lead to unlawful abortion.
- Unlawful abortion may be unsafe.
- Unsafe abortion is associated with physical and mental health risks.
- States must protect people from the physical and mental health risks of unsafe abortion.

Parental consent laws should be repealed and should not be introduced because:

- Where abortion is lawful it must be safe and accessible.
- Parental consent laws may lead to unlawful abortion.
- When States legalize abortion, they must ensure the arrangement of law, policy, and health care provision to ensure safe and legal abortion is accessible in practice.

Anticipated exposure to interpersonal violence or exploitation

States should repeal and not introduce parental involvement laws; they should ensure appropriate mechanisms of avoiding parental involvement laws where they exist; and should introduce appropriate services to protect minors and their future children exposed to resultant violence because:

- These laws compel exposure of abortion seeking to parents.
- This exposure may expose minors to violence directed at themselves or their future children.
- States should protect people seeking abortion.

Parental involvement laws should be repealed and should not be introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent.
- This disclosure may expose minors or their future children to violence.
- Abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.
- Torture or cruel, inhuman or degrading treatment are absolutely prohibited in international law.
- States should take steps to protect people seeking abortion.
- States must take steps to protect people from torture, inhuman and degrading treatment.
- SRH services must be provided in a way that respects women and girls' privacy and guarantees confidentiality.
- In the absence of evidence that these laws achieve policy goals, and given their association with exposure to interpersonal violence, it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).

Anticipated reproductive coercion

Parental involvement laws should be repealed, or not introduced, or reformed to include appropriate bypass mechanisms because:

- These laws may expose minors to forced or coerced abortion.
- States must take steps to prevent forced or coerced abortion including for children.

Parental involvement laws should be repealed and should not be introduced because:

- These laws empower another entity (parent or bypass mechanism) to limit decisions about whether or not to have children.
- Decisions about whether or not to have children must not be limited by spouse, parent, partner, the State or health authorities.

Parental involvement laws should be repealed and should not be introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent.
- These laws may expose minors to forced or coerced abortion or to coerced continuation of pregnancy.
- States must take steps to prevent forced or coerced abortion.
- In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).

Anticipated family disharmony

Parental involvement laws should be repealed and should not be introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent.

- These laws may expose minors to family disharmony and associated risks of violence or reproductive coercion.
- Abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.
- Torture or cruel, inhuman or degrading treatment are absolutely prohibited in international law.
- States should take steps to protect people seeking abortion.
- States must take steps to protect people from torture, inhuman and degrading treatment.
- States must take steps to protect people from forced or coerced abortion.
- In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective).

States should ensure appropriate mechanisms of avoiding parental involvement laws where they exist because:

- These laws compel exposure of abortion seeking to parents.
- This exposure may expose minors to violence directed at themselves or their future children.
- States should protect people seeking abortion.

Application of Rights to Evidence across all outcomes

Parental involvement laws should be repealed and should not be introduced because:

- These laws apply to minors only and regardless of capacity.
- These laws may instantiate inequality and discrimination in the provision of sexual and reproductive health care
- States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Parental involvement laws should be repealed and should not be introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- These laws compel exposure of abortion seeking by minors to parents and/or to a mechanism of bypassing parental consent.
- In the absence of such clear evidence it cannot be established that their negative impact on privacy rights is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a legitimate State objective) SRH services must be provided in a way that respects women and girls' privacy and guarantees confidentiality.

Parental involvement laws should be repealed and should not be introduced because:

- There is no clear evidence-base that they achieve public policy goals of improving outcomes for minor abortion seekers.
- These laws expose minors to the limitation by their parent(s) of the decision whether or not to have children.
- In the absence of such clear evidence it cannot be established that their negative impact on the right to decide on the number and spacing of children is proportionate (i.e. can be said to be rationally connected to, necessary for, and proportionate to achieve a

legitimate State objective).

Desirable effects

As noted above: Trivial

Undesirable effects

As noted
above:
Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Minors value being free from violence and reproductive coercion, and avoiding family disharmony. Although we did not identify any direct evidence pertaining to values in relation to the outcomes *delayed abortion, continuation of pregnancy* and *opportunity costs*, we can assume that minors value timely abortion care, avoidance of continuation of pregnancy, and affordable care with as few logistical burdens as possible.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *parental involvement*.

Resources:

The studies did not speak to the issue of resources.

Acceptability and Feasibility:

The studies did not speak to the issues of acceptability and/or feasibility.

Equity:

Equity was considered in terms of disproportionate impact.

Mandatory waiting periods

DRAFT

PICO 9: What is the impact of authorization by spousal consent on abortion-related outcomes? (for PICO details, see [Annex 8](#) in the main guideline)

BACKGROUND (authorization by spousal consent)

Setting: Global

Perspective: Pregnant people seeking abortion where spousal consent is required

Literature review: For the analysis of impact of spousal consent on abortion related outcomes, one study was identified relating to the outcome unlawful abortion. No studies were identified that encompassed information relating to the remaining outcomes. The included study was conducted in Turkey and was a qualitative study using in-depth interviews.

FINDINGS TABLES (authorization by spousal consent)

Outcome: DELAYED ABORTION

No studies identified

Outcome: CONTINUATION OF PREGNANCY

No studies identified

Outcome: OPPORTUNITY COST

No studies identified

Outcome: SYSTEM COSTS

No studies identified

Outcome: UNLAWFUL ABORTION

Findings table 1: Impact of spousal consent on unlawful abortion

SPOUSAL CONSENT – OUTCOME: UNLAWFUL ABORTION

OUTCOME: UNLAWFUL ABORTION				
Human rights standards engaged: right to life, the right to health, the right to non-discrimination and equality, and the right to be free from cruel inhuman and degrading treatment				
Sub-outcome	Studies	Direction of the Evidence	What does this mean?	Overall conclusion
--	Macfarlane 2016 ^{1,2}	▲	When spousal consent laws are present, women experience reproductive coercion, and some will resort to unlawful abortion.	Evidence from one study suggest that some women will resort to unlawful abortion in order to avoid spousal consent.

▲ = the intervention (spousal consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

1 Qualitative study design: tests of statistical significance not applicable.

2 Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Macfarlane 2016; Qualitative – in-depth interviews (n=14); Turkey

Outcome: SELF-MANAGED ABORTION

No studies identified

Outcome: ANTICIPATED EXPOSURE TO INTERPERSONAL VIOLENCE OR EXPLOITATION

No studies identified

Outcome: ANTICIPATED REPRODUCTIVE COERCION

No studies identified

Outcome: ANTICIPATED FAMILY DISHARMONY

No studies identified

Mandatory waiting periods

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

Evidence from one study suggests that some women will resort to unlawful abortion in order to avoid parental consent.

DRAFT

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLE (authorization by spousal consent)

HUMAN RIGHTS STANDARDS-TO-EVIDENCE: SPOUSAL CONSENT

Sub-Outcome	Overall Conclusion from Comparison	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Unlawful abortion	Evidence from one study suggest that some women will resort to unlawful abortion in order to avoid parental consent.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Laws requiring spousal consent to abortion should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws may lead to unlawful abortion. • Risks of maternal morbidity and mortality are increased in cases of unlawful abortion. • States must take steps to reduce maternal mortality and morbidity including addressing unsafe abortion.
		States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination.	▲	Laws requiring spousal consent to abortion should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws only apply to married women. • These laws are associated with the possibility of seeking unlawful abortion and with associated increased risks of maternal morbidity and mortality. • These laws reduce the availability and accessibility of safe abortion care to married women. • States must ensure equality and non-discrimination in the provision of sexual and reproductive health

				care.
		Where it is lawful, abortion must be safe and accessible.	▲	Laws requiring spousal consent to abortion should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws may mean that safe abortion is not accessible even though it is lawful. • Where abortion is lawful, States must ensure the arrangement of law, policy and health care so that abortion is accessible in practice.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Laws requiring spousal consent to abortion should be repealed and should not be introduced because: <ul style="list-style-type: none"> • These laws may lead to unlawful abortion. • Increased physical and mental health risks are associated with unlawful abortion. • States must protect people from the physical and mental health risks of unlawful abortion.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS) (authorization by spousal consent)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON SPOUSAL CONSENT WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: SPOUSAL CONSENT – EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Unlawful abortion	Evidence from one study suggest that some women will resort to unlawful abortion in order to avoid parental consent.	As spousal consent requirements apply only to married women and may lead to unlawful abortion, and as unlawful abortion is associated with increased maternal mortality and morbidity, making abortion less safe and accessible, giving rise to physical and mental health risks, these requirements are associated with reduced enjoyment of the right to life, the right to health, the right to equality and non-discrimination, and the right to be free from cruel inhuman and degrading treatment.	We recommend that laws requiring spousal consent to abortion should be repealed and should not be introduced.

DRAFT

DETAILED JUSTIFICATION FOR THE JUDGEMENT (authorization by spousal consent)

Application of Rights to Evidence per outcome

Unlawful abortion

Laws requiring spousal consent to abortion should be repealed and should not be introduced because:

- These laws may lead to unlawful abortion.
- Risks of maternal morbidity and mortality are increased in cases of unlawful abortion.
- States must take steps to reduce maternal mortality and morbidity including addressing unsafe abortion.

Laws requiring spousal consent to abortion should be repealed and should not be introduced because:

- These laws only apply to married women.
- These laws are associated with the possibility of seeking unlawful abortion and with associated increased risks of maternal morbidity and mortality.
- These laws reduce the availability and accessibility of safe abortion care to married women.
- States must ensure equality and non-discrimination in the provision of sexual and reproductive health care.

Laws requiring spousal consent to abortion should be repealed and should not be introduced because:

- These laws may mean that safe abortion is not accessible even though it is lawful.
- Where abortion is lawful, States must ensure the arrangement of law, policy and health care so that abortion is accessible in practice.

Laws requiring spousal consent to abortion should be repealed and should not be introduced because:

- These laws may lead to unlawful abortion.
- Increased physical and mental health risks are associated with unlawful abortion.
- States must protect people from the physical and mental health risks of unlawful abortion.

Application of Rights to Evidence across all outcomes

Desirable effects

As noted above: Trivial

Mandatory waiting periods

Undesirable effects

Asa noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Women value being able to make autonomous decisions about their sexual and reproductive health, and they value access to safe and legal abortion services.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *spousal consent*.

Resources:

The study did not speak to the issue of resources

Feasibility:

The study did not speak to the issue of feasibility

Equity:

Equity was considered in terms of disproportionate impact, however, the included study did not speak to the issue of equity

Third-party authorization: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Third Party Authorization Requirements
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion	Right to Life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland, Mellet v Ireland, LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report: 2016 Special Rapporteur on Extrajudicial Killings Report, 2017, 2018 Working Group on Discrimination against Women Report, 2016	<ul style="list-style-type: none"> • Third-party authorization requirements can lead people to seek abortion outside of the formal medical system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • In such cases, third-party authorization requirements are inconsistent with the right to life and right to health.
Where it is lawful, abortion must be safe and accessible	The right to health The right to be free from torture, and cruel, inhuman and degrading treatment	CCPR: GC 36, <i>LMR v Argentina, LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Third-party authorization requirements can make abortion inaccessible even where it is lawful because of a third-party refusal to “allow” abortion. • In such cases, lawful abortion would be inaccessible. • In such cases, third-party authorization requirements are inconsistent with the right to life and right to health. • Such cases may result in unwanted continued pregnancy, abortion travel, criminalization or other costs. • Such costs may be so substantial as to constitute torture, cruel, inhuman and degrading treatment. • Additional/secondary costs may include premature termination of education, forced and/or child marriage, and harm

			to physical and mental health and associated human rights deprivations and violations.
States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care which must be accessible to all (including children) without discrimination	<p>Right to health</p> <p>Right to equality and non-discrimination</p> <p>Right of persons with disabilities to retain fertility on an equal basis with others</p>	<p>CCPR GC 36</p> <p>CRC GC 4; GC 15</p> <p>CRPD GC 3, GC 6</p> <p>Special Rapporteur on Health Report, 2016</p>	<ul style="list-style-type: none"> • Mandated parental involvement upon which a minor's access to abortion is contingent results in differential treatment of young people without regard to their capacity or general right to (refuse) consent to medical treatment. • As such, mandated parental involvement upon which a minor's access to abortion is contingent, is discriminatory and inconsistent with the right to equality and non-discrimination. • Third-party authorization requirements in respect of access to abortion apply exclusively to women, girls [and other pregnant people] without regard to their capacity or general right to (refuse) consent to medical treatment. • As such, third-party authorization requirements in respect of abortion are inconsistent with the right to equality and non-discrimination.
States must protect people from the physical and mental health risks associated with unsafe abortions	Right to health	<p>CCPR: GC 28, GC 36, GR 34</p> <p>CESCR: GC 22</p> <p>CRC: GC 4</p> <p>CEDAW: GR 34</p> <p>Working Group on Discrimination against Women Report, 2016</p> <p>Special Rapporteur on Executions/Killings Report, 2017</p>	<ul style="list-style-type: none"> • Third-party authorization requirements can lead people to seek abortion outside of the formal medical system. • Such abortion may be unsafe abortion, with implications for physical and mental health. • In such cases, third party authorization requirements are inconsistent with the right to health.

<p>Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction</p>	<p>Right to health Right to information</p>	<p>CCPR, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CRPD: GC 3 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2018 Special Rapporteur on Torture Report, 2013</p>	
<p>States may not undertake, and must take steps to prevent, forced or coerced abortion including for marginalized people, people with disabilities, children, and people in conflict settings</p>	<p>Right to health Right to security of person Right of persons with disabilities to retain fertility on an equal basis with others Right to be free from torture, and cruel, inhuman or degrading treatment Right to exercise legal capacity Women's right to legal capacity on an equal basis with men</p>	<p>CCPR: GC 28 CRPD: GC 3, GC 6 CEDAW: GR 30, GR 35 Special Rapporteur on Health Report, 2004, 2009, 2011 Special Rapporteur on Torture Report, 2008, 2013 Working Group on Discrimination against Women Report, 2016</p>	
<p>States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest</p>	<p>Right to health</p>	<p>CCPR: GC 36 CESCR: GC 22</p>	<ul style="list-style-type: none"> • Third-party authorization requirements may make abortion inaccessible in cases of rape or incest, including where the person empowered to authorize/refuse to authorize the abortion has perpetrated sexual violence against the abortion seeker (e.g. incest, spousal rape). • As such, third-party authorization requirements may make SRH care and services effectively inaccessible to women and girls in cases of sexual violence. • In such cases, third-party authorization requirements are inconsistent with

			the right to health
States must provide post-abortion care in all circumstances including where abortion is illegal	Right to health	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 14 CRC: GC 15 CEDAW: GC 34 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2004, 2011, 2016 Special Rapporteur on Torture Report, 2013, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	
States should ensure provider refusal does not rely in unavailability of abortion	Right to health	CEDAW: GR 24 CESCR: GC 22	
States should protect health-care professionals providing abortion care	Right to health	Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013	

<p>States should protect people seeking abortion</p>	<p>Right to health</p>	<p>CCPR: GC 36 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Third-party authorization requirements compel disclosure of abortion seeking to third parties including parents, guardians and spouses (depending on context) without regard to their wishes or their capacity to make decisions about medical treatment and to (refuse) consent to medical treatment under national law, • Revelation of pregnancy and abortion seeking can expose pregnant people to significant harms from these persons including interpersonal violence, forced marriage (including child marriage), forced abortion, forced continuation of pregnancy, • Third-party authorization requirements thus expose people seeking abortion to harms and are inconsistent with the right to health,
<p>States should ensure Laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity</p>	<p>Right to health Right to security of person</p>	<p>CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018</p>	<ul style="list-style-type: none"> • Third-party authorization requirements should be justified on the basis of clear public policy objectives. • Third-party authorization requirements should be rationally connected with these public policy objectives. • These public policy objectives should themselves be human rights compliant. • Maintenance of third-party authorization requirements should be dependent on evidence of their effectiveness in fulfilling these public policy objectives. • Where third-party authorization requirements are not based on rights-compliant public policy objectives, and

			where the evidence does not show their effectiveness in fulfilling these objectives, such requirements are not evidence-based or proportionate and are inconsistent with the right to health and the right to security of person.
Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, government, or health authorities	Right to decide on the number and spacing of children Right to equality and non-discrimination Right to privacy	CESCR: GC 22 CCPR: GC 36, <i>LMR v Argentina</i> CEDAW: GR 21, GC 24, GR 34 CRPD: GC 3 Special Rapporteur on Torture Report, 2008	<ul style="list-style-type: none"> • Third party authorization requirements limit the decision about whether or not to have children without regard to the capacity of the pregnant person to (refuse) consent to medical treatment. • As such, third-party authorization requirements are inconsistent with the right to decide on the number and spacing of children, the right to equality and non-discrimination, and the right to privacy.
Criminalization of abortion may constitute a human rights violation	Right to equality and non-discrimination Right to security of person Right to be free from torture, and cruel, inhuman and degrading treatment	CEDAW: GR 33, GR 35 CCPR, GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> Special Rapporteur on Torture Report, 2016 Working Group on Discrimination against Women Report 2016	
SRH services including abortion and post-abortion care must be provided in a way that respects women and girls' privacy and guarantee confidentiality	Right to privacy	CCPR GC 36 CCPR: GC 28, GC 36 Special Rapporteur on Health Report, 2011, 2016 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Third-party authorization requirements compel disclosure of abortion seeking to third parties including parents, guardians and spouses (depending on context) without regard to their wishes or their capacity to make decisions about medical treatment and to (refuse) consent to medical treatment under national law. • As such, third-party authorization requirements are inconsistent with

			the right to privacy.
Denial of therapeutic abortion may interfere arbitrarily with the right to privacy	Right to privacy	CCPR: <i>KNLG v Peru</i>	
Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life	Right to life	CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017	

Third-party authorization requirements (i.e. laws/policies that *require* third-party authorization before someone can access a desired abortion):

- apply to classes of abortion seeker without regard to individual capacity;
- constitute exceptions to the ordinarily law of consent to medical treatment;
- compel disclosure of confidential information;
- may expose people to harms such as unlawful abortion (including unsafe abortion), interpersonal violence, forced marriage (including child marriage), torture, cruel inhuman or degrading treatment, premature termination of education, inaccurate abortion information, maternal mortality and morbidity, and physical and mental health risks.

As such, third-party authorization requirements interfere negatively with the enjoyment of a range of human rights, some of which do not permit limitation or qualification (e.g. the right to be free from torture, and cruel, inhuman and degrading treatment).

- Where implicated human rights are qualified this interference is permissible only where it is justified and proportionate.
- Potential justifications for such requirements (avoiding family disharmony, protection of minors, support of minor decision-making, support for decision-making on the part of persons with limited or no capacity) do not require third-party authorization. They can instead be fulfilled through rights-based law and policy interventions such as education, assisted decision-making processes, rights-based general laws of consent in medical treatment, encouragement of appropriate parental and spousal involvement in reproductive decision-making, etc.

6. EtD framework for Provider restrictions

Recommendation 21: Recommend against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.

PICO 10: What is the impact of provider restrictions on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of provider restrictions on abortion related outcomes, 7 studies were identified addressing the following outcomes; delayed abortion (n=2), opportunity costs (n=5), self-managed abortion (n=1), workload implications (n=5), system costs (n=3), perceived imposition on conscience or ethics (n=1), perceived impact on relationship with patient (n=1). No studies were identified that encompassed information related to the outcome continuation of pregnancy, unlawful abortion, referral to another provider or stigmatization.

Studies were conducted in Australia, Ethiopia, Nepal and USA. Study designs in this EtD framework include qualitative studies using individual interviews, a case study, a legal commentary, a Delphi process study, and a descriptive program evaluation.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion

Outcome: DELAYED ABORTION

Findings table 1: Impact of provider restrictions on abortion delay

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Battistelli 2018 ¹	▲	Involving nurse-practitioners, certified nurse-midwives and physician assistants may improve abortion access and timely management of post abortion care for individuals obtaining first trimester surgical abortions.	Overall, evidence from two studies suggests that provider restrictions may result in delayed abortions. One study indirectly examines provider restrictions on delayed abortion by demonstrating how expansion of health worker roles (and thereby reducing provider restrictions) improve timely access to first trimester surgical and medical abortion.
Mercier 2015 ¹	▲	Government mandated scripted abortion counselling laws increase logistical and psychological burdens for abortion providers. Mandated counselling is provided in addition to, not as a replacement for, existing clinical standards and processes for informed consent. These laws may increase abortion delays for some women.	Evidence from one study suggests that government mandated abortion counselling increases the administrative and logistical burdens for providers and women, and may increase abortion delays.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Battistelli 2018; Qualitative individual semi-structured interviews (n=20); California, USA

Mercier 2015; Qualitative individual interviews (n=31); North Carolina, USA

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Outcome: CONTINUATION OF PREGNANCY

No studies identified

Outcome: OPPORTUNITY COST

Findings table 2: Impact of provider restrictions on opportunity cost

OUTCOME: OPPORTUNITY COSTS			
Human rights standards engaged: right to health, right to be free from torture, and cruel, inhuman and degrading treatment, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Afework 2015 ¹	▲	Involving health extension workers in abortion care may reduce costs and need to travel, as well as save time for abortion seekers.	Overall evidence from five studies suggests that provider restrictions increase opportunity costs for abortion seekers. Provider restrictions may be linked to opportunity costs such as increased financial costs, need for travel, waiting times, additional clinic contacts, and emotional distress.
Andersen 2016 ¹	▲	Training of auxiliary nurse-midwives increases access to abortion care in rural areas and at the primary health care level.	
Battistelli 2018 ¹	▲	Involving nurse-practitioners, certified nurse-midwives and physician assistants in abortion care means that a greater number of first trimester abortion procedures can be conducted and waiting times are reduced.	
Grossman 2015	▲	Expanding mifepristone prescription rights to pharmacists may increase access to medical abortion.	
Mercier 2015 ¹	▲	Government mandated scripted counselling prior to an abortion is perceived by providers to be an obstacle for women seeking an abortion, and a cause of emotional distress. Government mandated counselling leads to an additional appointment needed for abortion care.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Afework 2015; Qualitative individual semi-structured interviews (n=54); Ethiopia

Andersen 2016; Program evaluation (n=290); Nepal

Battistelli 2018; Qualitative individual semi-structured interviews (n=20); California, USA

Grossman 2015; Legal commentary; Australia and USA

Mercier 2015; Qualitative individual interviews (n=31); North Carolina, USA

Outcome: UNLAWFUL ABORTION

No studies identified

Outcome: SELF-MANAGED ABORTION

Findings table 3: Impact of provider restrictions on self-management of abortion

OUTCOME: SELF-MANAGED ABORTION			
Human rights standards engaged: right to health, right to life, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Afework 2015 ¹	▲	² Involving health extension workers in abortion care may prevent unsafe self-management of abortion.	Overall evidence from one study suggests that provider restrictions, when they limit access to care, may be linked to unsafe self-management of abortion.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Afework 2015; Qualitative individual semi-structured interviews (n=54); Ethiopia

Outcome: REFERRAL TO ANOTHER PROVIDER

No studies identified

POPULATION: Medical professionals (to include doctors [specialists and non-specialists], nurses, midwives) and other health-care professionals

Outcome: *WORKLOAD IMPLICATIONS*

Findings table 4: Impact of provider restrictions on workload implications

OUTCOME: WORKLOAD IMPLICATIONS			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Andersen 2016 ¹	▲	Involving auxiliary nurse-midwives in abortion care improves sustainability of services when auxiliary nurse-midwives are local to their communities. This leads to more consistent availability of abortion care at the primary health care level.	Overall evidence from five studies suggests that provider restrictions have workload implications. Four of the five studies examined this indirectly, by demonstrating the benefit in task sharing abortion care with health workers who are not physicians. One study directly examined workload implications from provider restrictions with mandated counselling. All studies reported that provider restrictions may be linked with a range of workload implications including issues surrounding sustainability of staffing, logistical and financial costs, organizational changes, increased workload and stress among providers.
Battistelli 2018 ¹	▲	Employing nurse-practitioners, certified nurse-midwives and physician assistants to provide surgical first trimester abortion care may require changes to staffing, logistical and financial costs to the organization in the short term.	
Bridgman-Packer 2018 ¹	▲	Expanding health worker roles in abortion care shifts components of care away from physicians and expands access to care.	
De Moel-Mandel 2019 ¹	▲	Expanding health worker roles in abortion care to midwives requires challenging the current traditional doctor nurse distribution of labour. Requiring physician involvement in prescriptions and for public finance reimbursement introduces inefficiencies even where nurses are permitted to provide abortion care.	

Mercier 2015 ¹	▲	When government mandated scripted counselling is required by a health-care professional, it requires changes to bureaucracy and staffing as well, as changes to modes of counselling. The process and legal obligation to ensure compliance, and coordinating necessary logistics increases the psychological workload of abortion providers.
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▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Andersen 2016; Program evaluation (n=290); Nepal

Battistelli 2018; Qualitative individual semi-structured interviews (n=20); California, USA

Bridgman-Packer 2018; Case study including a desk review and qualitative individual semi-structured interviews (n=8); Ethiopia

De Moel-Mandel 2019; Delphi process (n=24 whereof 17 completed three rounds); Victoria, Australia

Mercier 2015; Qualitative individual semi-structured interviews (n=31); North Carolina, USA

Findings table 5: Impact of provider restrictions on system costs

OUTCOME: SYSTEM COSTS			
Human rights standards engaged: right to life, right to security of person, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Battistelli 2018 ¹	▲	Involving nurse-practitioners, certified nurse-midwives and physician assistants in first-trimester abortion care may reduce system costs in several ways including by means of reduced staff expenses in settings of low reimbursement for abortion care, by averting costs from unwanted births, and related to delayed management of complications.	Overall, evidence from three papers suggests that provider restrictions contributes to increased system costs. Provider restrictions contributes to costs at the individual, provider and systems level. For individuals these costs are typically associated with increased time in obtaining care. At the provider and system level, provider restrictions may be associated with system inefficiencies that increase administrative burden, workload and staff time.
De Moel-Mandel 2019 ¹	▲	Health system reimbursement processes and requirements result in system costs and inefficiencies, even when medication abortion is nurse-led. For example, provider restrictions may involve funding models and regulatory structures that require physician involvement for billing, reimbursement and prescriptions.	
Mercier 2015 ¹	▲	Government mandated scripted counselling by a health-care professional prior to an abortion, incurs increased institutional costs due to staff time.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Battistelli 2018; Qualitative individual semi-structured interviews (n=20); California, USA

De Moel-Mandel 2019; Delphi process (n=24 whereof 17 completed three rounds); Victoria, Australia

Mercier 2015; Qualitative individual semi-structured interviews (n=31); North Carolina, USA

Staff costs are directly impacted by who is providing services; thus, where services can be provided by providers that are not physicians (e.g. nurse practitioners, physicians' assistants), staff costs can be kept low without sacrificing time with patients (*Afable-Munsuz, Gould et al., 2007*); there can be shorter waiting times among patients, and potentially lower costs associated with management of complications (*Sjostrom, Kopp Kallner et al., 2016*). For example, nurse-led services for termination of pregnancy can result in nearly 40% savings in costs annually compared to physician led clinics (*Harvey and Gaudoin, 2005*) and can free up physician providers for more complicated cases (*Benson, Okoh et al., 2012*). However, financial and logistical costs, including those related to reimbursement rates and moving providers from one service to another, may be incurred before achieving long term gains (*Battistelli, Magnusson et al., 2018*).

Outcome: PERCEIVED IMPOSITION ON PERSONAL CONSCIENCE OR ETHICS

Findings table 6: Impact of provider restrictions on perceived imposition on personal conscience or ethics

OUTCOME: PERCEIVED IMPOSITION ON PERSONAL ETHICS OR CONSCIENCE			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Mercier 2015 ¹	▲	² When government mandated scripted counselling is required by a health-care professional, some abortion providers perceive this as an unreasonable intrusion into the practice of medicine.	Overall, evidence from one study suggests that provider restrictions by means of mandated counselling may have a perceived imposition on providers' personal ethics or conscience.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Mercier 2015; Qualitative individual semi-structured interviews (n=31); North Carolina, USA

Outcome: PERCEIVED IMPACT ON RELATIONSHIP WITH PATIENT

Findings table 7: Impact of provider restrictions on perceived impact on relationship with patient

OUTCOME: PERCEIVED IMPACT ON RELATIONSHIP WITH PATIENT			
Human rights standards engaged: right to health, right to security of person			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Mercier 2015 ¹	▲	² When government mandated scripted counselling is required by a health-care professional, abortion providers consider it as having a negative impact on the provider–patient relationship.	Overall, evidence from one study suggests that provider restrictions by means of mandated counselling are perceived by some providers to have a negative impact on the provider–patient relationship.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Mercier 2015; Qualitative individual semi-structured interviews (n=31); North Carolina, USA

Outcome: STIGMATIZATION

No studies identified

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Overall, evidence from two studies suggests that provider restrictions may result in delayed abortions.
- One study indirectly examines provider restrictions on delayed abortion by demonstrating how expansion of health worker roles improve timely access to first trimester surgical and medical abortion.
- Evidence from one study suggests that government mandated abortion counselling increases the administrative and logistical burdens for providers and women, and may increase abortion delays.

Opportunity costs

- Overall evidence from five studies suggests that provider restrictions increase opportunity costs for abortion seekers.
- Provider restrictions may be linked to opportunity costs such as increased costs, need to travel, waiting times, additional clinic contacts and emotional distress.

Self-managed abortion

- Overall evidence from one country suggests that provider restrictions, when they limit access to care, may be linked to unsafe self-management of abortion.

Workload implications

- Overall evidence from five studies suggests that provider restrictions have workload implications.
- Four of the five studies examined this indirectly, by demonstrating the benefit in task sharing abortion care with health workers who are not physicians. One study directly examined workload implications from provider restrictions with mandated counselling.
- All studies reported that provider restrictions may be linked with a range of workload implications including issues surrounding sustainability of staffing, logistical and financial costs, organizational changes, increased workload and stress among providers.

System costs

- Overall, evidence from three papers suggests that provider restrictions contributes to increased system costs.
- Provider restrictions contributes to costs at the individual, provider and systems level. For individuals these costs are typically associated with increased time in obtaining care. At the provider and system level, provider restrictions may be associated with system inefficiencies that increase administrative burden, workload and staff time.

Perceived imposition on personal conscience or ethics

- Overall, evidence from one study in one country suggests that provider restrictions by means of mandated counselling may have a perceived imposition on providers' personal ethics or conscience.

Perceived impact on relationship with patient

- Overall, evidence from one study in one country suggests that provider restrictions by means of mandated counselling are perceived by some providers to have a negative impact on the provider-patient relationship.

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HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARD TO EVIDENCE: Provider restrictions

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Overall, evidence from two studies suggests that provider restrictions may result in delayed abortions.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Provider restrictions can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have a negative impact on rights.
	One study indirectly examines provider restrictions on delayed abortion by demonstrating how expansion of health worker roles (and thereby reducing provider restrictions) improve timely access to first trimester surgical and medical abortion. Evidence from one study suggests that government mandated abortion counselling increases the administrative and logistical burdens for providers and women, and may increase abortion delays.	States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health and protect persons’ physical and mental integrity.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to life, health and to physical and mental integrity.
Opportunity Costs	Overall evidence from five studies suggests that provider restrictions increase opportunity costs for abortion seekers.	Where it is lawful, abortion must be safe and accessible.	▲	Where provider restrictions are linked with opportunity costs, these costs (including travel costs, unnecessary multiple visits etc.) make abortion less accessible in practice.

	Provider restrictions may be linked to opportunity costs such as increased financial costs, need for travel, waiting times, additional clinic contacts, and emotional distress.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	Provider restriction can result in increased opportunity costs in accessing abortion that particularly affect women in rural areas with negative implications to their right to equality and non-discrimination in access to health care.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.
Unlawful abortion	No studies identified			
Self-managed Abortion	Overall evidence from one study suggests that provider restrictions, when they limit access to care, may be linked to unsafe self-management of abortion	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	Where provider restrictions lead abortion seekers to self-manage their abortions outside the formal health system, and where such self-management of abortion is unsafe, the provider restrictions have negative implications for rights.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.
		States should protect people seeking abortion.	▲	Where provider restrictions lead abortion seekers to self-manage their abortions outside the formal health system, and where such self-management of abortion is unsafe, the provider restrictions have negative implications for rights.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▲	Where provider restrictions lead abortion to self-manage their abortions outside the formal health system, and where such self-management of abortion is unsafe, the provider

				restrictions have negative implications for rights.
Referral to another provider	No studies identified			

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARD TO EVIDENCE: Provider restrictions

Outcome	Overall Conclusion	Rights Standards Engaged	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
<p>Workload implications</p>	<p>Overall evidence from five studies suggests that provider restrictions have workload implications.</p> <p>Four of the five studies examined this indirectly, by demonstrating the benefit in task sharing abortion care with health workers who are not physicians. One study directly examined workload implications from provider restrictions with mandated counselling.</p> <p>All studies reported that provider restrictions may be linked with a range of workload implications including issues surrounding sustainability of staffing, logistical and financial costs, organizational changes, increased workload and stress among providers.</p>	<p>States should protect health-care professionals providing abortion care.</p>	▲	<p>Workload implications arising from provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.</p>
		<p>States should ensure laws regulating abortion are evidence based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.</p>	▲	<p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may have workload implications for health-care professionals resulting in reduced or hindered access to abortion. Where this is the case they interfere disproportionately with rights to health and to physical and mental integrity.</p>
<p>System Costs</p>	<p>Overall, evidence from three papers suggests that provider restrictions contributes to increased system costs. Provider restrictions contributes to costs at the individual, provider and systems level. For individuals these costs are typically associated with</p>	<p>States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons’ physical and mental integrity.</p>	▲	<p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers’ rights to health and to physical and mental integrity.</p>

	increased time in obtaining care. At the provider and system level, provider restrictions may be associated with system inefficiencies that increase administrative burden, workload and staff time.	Where it is lawful, abortion must be safe and accessible	▲	Provider restrictions are linked with system costs. Where these restrictions are not justified by evidence (e.g. of competence, effectiveness, acceptability) they interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.
Perceived imposition on personal ethics or conscience	Overall, evidence from one study suggests that provider restrictions by means of mandated counselling may have a perceived imposition on providers' personal ethics or conscience.	States should protect health-care professionals providing abortion care.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may interfere with the right of health-care providers to thought, conscience or belief by prohibiting them conscientiously from providing abortion care.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.
Perceived impact on relationship with Patient	Overall, evidence from one study in one country suggests that provider restrictions by means of mandated counselling are perceived by some providers to have a negative impact on the provider-patient relationship.	States should protect people seeking abortion.	▲	Provider restrictions can impact negatively on the wider doctor-patient relationship. Where such restrictions are not justified by evidence (e.g. of competence, effectiveness, acceptability), they can negatively impact abortion seekers' right to health.
		States should ensure laws regulating abortion are evidence-based and proportionate to protect the right to health, and protect persons' physical and mental integrity.	▲	Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.
Stigmatization	No studies identified			

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON PROVIDER RESTRICTIONS WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: PROVIDER RESTRICTIONS: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	<p>Overall, evidence from two studies suggests that provider restrictions may result in delayed abortions.</p> <p>One study indirectly examines provider restrictions on delayed abortion by demonstrating how expansion of health worker roles (and thereby reducing provider restrictions) improve timely access to first trimester surgical and medical abortion.</p> <p>Evidence from one study suggests that government mandated abortion counselling increases the administrative and logistical burdens for providers and women, and may increase abortion delays.</p>	<p>Delayed access to abortion care can have negative impacts on the right to life, health, and to physical and mental integrity.</p> <p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Continuation of pregnancy	<p>No studies identified</p>	<p>If provider restrictions not based in evidence result in undesired continuation of pregnancy, this has negative impacts for rights to health, physical and mental integrity, privacy, and potentially the right to be free from torture, inhuman and degrading treatment or punishment.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Opportunity costs	<p>Overall evidence from five studies suggests that provider restrictions increase opportunity costs for abortion seekers.</p> <p>Provider restrictions may be linked to opportunity costs such as increased financial costs, need for travel, waiting times, additional clinic contacts, and emotional distress.</p>	<p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.</p> <p>Provider restrictions can particularly affect marginalized women and women in rural areas with negative implications to their right to equality and non-discrimination in access to health care.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Unlawful	<p>No studies identified</p>	<p>If provider restrictions not based in</p>	<p>We recommend against provider</p>

abortion		evidence result in inaccessibility of lawful abortion and recourse to unlawful abortion, which may be unsafe, this has negative impacts for rights to health, physical and mental integrity, and privacy.	restrictions that are not based in evidence of competence, effectiveness, and acceptability.
Self-managed Abortion	Overall evidence from one study suggests that provider restrictions, when they limit access to care, may be linked to unsafe self-management of abortion.	Where provider restrictions lead abortion seekers to self-manage their abortions outside the formal health system, and where such self-management of abortion is unsafe, the provider restrictions have negative implications for rights.	We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.
Referral to another provider	No studies identified	Where provider restrictions preclude a health-care provider from providing abortion care, immediate referral to a qualified and willing provider may ensure lawful abortion is safe and accessible for the abortion seeker.	We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability. Where evidence-based provider restrictions exist, we recommend requiring immediate referral to permitted abortion providers and organization of the health-care system to ensure sufficient abortion provision.
Workload implications	Overall evidence from five studies suggests that provider restrictions have workload implications. Four of the five studies examined this indirectly, by demonstrating the benefit in task sharing abortion care with health workers who are not physicians. One study directly examined workload implications from provider restrictions with mandated counselling. All studies reported that provider restrictions may be linked with a range of workload implications including issues surrounding sustainability of staffing, logistical and financial costs, organizational changes, increased workload and stress among providers.	Workload implications arising from provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.	We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.

System costs	<p>Overall, evidence from three papers suggests that provider restrictions contributes to increased system costs.</p> <p>Provider restrictions contributes to costs at the individual, provider and systems level. For individuals these costs are typically associated with increased time in obtaining care. At the provider and system level, provider restrictions may be associated with system inefficiencies that increase administrative burden, workload and staff time.</p>	<p>Provider restrictions are linked with system costs these costs. Where these restrictions are not justified by evidence (e.g. of competence, effectiveness, acceptability) they interfere disproportionately with rights to health and to physical and mental integrity.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Perceived imposition on personal ethics or conscience	<p>Overall, evidence from one study suggests that provider restrictions by means of mandated counselling may have a perceived imposition on providers' personal ethics or conscience.</p>	<p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may interfere with the right of health-care providers to thought, conscience or belief by prohibiting them conscientiously from providing abortion care and reducing or hindering access to lawful abortion.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Perceived impact on relationship with patient	<p>Overall, evidence from one study suggests that provider restrictions by means of mandated counselling are perceived by some providers to have a negative impact on the provider-patient relationship.</p>	<p>Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>
Stigmatization	<p>No studies identified</p>	<p>Provider restrictions may intensify or exacerbate abortion-related stigma for health-care providers permitted to provide abortion care. Stigma may result in decisions to opt out of or minimize abortion care provision, with consequences for the availability of lawful abortion.</p>	<p>We recommend against provider restrictions that are not based in evidence of competence, effectiveness, and acceptability.</p>

DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- Provider restrictions can result in delayed access to abortion care. Where such delays increase risks of maternal mortality or morbidity, they have a negative impact on rights.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to life, health and to physical and mental integrity.

Opportunity costs

- Where provider restrictions are linked with opportunity costs, these costs (including travel costs, unnecessary multiple visits) make abortion less accessible in practice.
- Provider restriction can result in increased opportunity costs in accessing abortion that particularly affect women in rural areas with negative implications to their right to equality and non-discrimination in access to health care.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.

Self-managed abortion

- Where provider restrictions lead abortion seekers to self-manage their abortions outside the formal health system, and where such self-management of abortion is unsafe, the provider restrictions have negative implications for rights.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with rights to health and to physical and mental integrity.

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- Workload implications arising from provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may have workload implications for health-care professionals resulting in reduced or hindered access to abortion. Where this is the case they interfere disproportionately with rights to health and to physical and mental integrity.

System costs

- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere

Provider restrictions

disproportionately with abortion seekers' rights to health and to physical and mental integrity.

- Provider restrictions are linked with system costs. Where these restrictions are not justified by evidence (e.g. of competence, effectiveness, acceptability) they interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.

Perceived imposition on personal conscience or ethics

- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) may interfere with the right of health-care providers to thought, conscience or belief by prohibiting them conscientiously from providing abortion care.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.

Perceived impact on relationship with patient

- Provider restrictions can impact negatively on the wider doctor-patient relationship. Where such restrictions are not justified by evidence (e.g. of competence, effectiveness, acceptability etc), they can negatively impact abortion seekers' right to health.
- Provider restrictions that are not justified by evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers' rights to health and to physical and mental integrity.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy, and affordable care with as few logistical burdens as possible. We can also assume that health-care providers, regardless if they participate in abortion care or not, value reasonable workloads, avoidance of imposition to personal ethics or conscience and stigmatization.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does not favour the intervention *provider restrictions* generally.

Resources:

The studies did not speak to the issue of resources.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability or feasibility.

Equity:

The studies did not speak to the issue of equity.

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Provider restrictions: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Implications for Provider Restrictions
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	Right to life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland, Mellet v Ireland, LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2017, 2018 Working Group on Discrimination against Women Report 2016	<ul style="list-style-type: none"> • Provider restrictions can result in delays in accessing abortion; such abortions may be unsafe abortion, with implications for maternal morbidity and mortality. • The imposition of provider restrictions without a basis in evidence would be inconsistent with abortion seekers' right to life and right to health.
Where it is lawful, abortion must be safe and accessible.	Right to health Right to be free from torture, and cruel, inhuman and degrading treatment	CCPR: GC 36, <i>LMR v Argentina, LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Provider restrictions can result in abortion being inaccessible, including where there are insufficient numbers of "permitted" providers and/or where immediate referral to a "permitted" provider is not assured. • In such cases, the imposition of provider restrictions without a basis in evidence, and failure to ensure effective referral processes, have negative implications for abortion seekers' right to health and the right to be free from torture, and cruel, inhuman and degrading treatment.
States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	Right to health Right to equality and non-discrimination Right of persons with disabilities to retain fertility on an equal basis with others	CCPR GC 36 CRC GC 4; GC 15 CRPD GC 3, GC 6 Special Rapporteur on Health Report, 2016	<ul style="list-style-type: none"> • Provider restrictions have disproportionate effects on marginalized women or women in places where there are insufficient providers. • In such cases, the imposition of provider restrictions without a basis in evidence has negative implications for abortion seekers' right to health, right to equality and non-discrimination, and right of persons with disabilities to retain fertility on an equal basis with others.

States must protect people from the physical and mental health risks associated with unsafe abortions.	Right to health	CCPR: GC 28, GC 36, GR 34 CESCR: GC 22 CRC: GC 4 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Executions/Killings Report, 2017	<ul style="list-style-type: none"> • Provider restrictions can result in women availing of unsafe abortion, with implications for maternal morbidity and mortality. • In such cases, the imposition of provider restrictions without a basis in evidence would be inconsistent with abortion seekers' right to health.
States should ensure appropriate SRH care and services to address sexual violence against women and girls including making abortion available in cases of rape or incest.	Right to health	CCPR: GC 36 CESCR: GC 22	<ul style="list-style-type: none"> • Provider restrictions can result in abortion being inaccessible in cases of sexual violence. • In such cases, the imposition of provider restrictions without a basis in evidence has negative implications for abortion seekers' right to health.
States should protect health-care professionals providing abortion care.	Right to health	Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Provider restrictions have workload implications for health-care providers. • These workload implications can, in turn, have negative impacts on the availability of abortion, including on the willingness to provide. • Where such restrictions are not based in evidence, they have negative implications for both their rights and the rights of persons seeking to access abortion.
States should protect people seeking abortion.	Right to health	CCPR: GC 36 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • Provider restrictions have implications for timely access to safe abortion. • Where such restrictions are not based in evidence, they have negative implications for abortion seekers' right to health.

States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.	Right to health Right to security of person	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	<ul style="list-style-type: none"> • Provider restrictions that are not based in evidence (e.g. of competence, effectiveness, acceptability) interfere disproportionately with abortion seekers' rights to health and security of person.
Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	Right to privacy	CCPR: <i>KNLG v Peru</i>	<ul style="list-style-type: none"> • Provider restrictions can result in therapeutic abortion being inaccessible. • In such cases, the imposition of provider restrictions without a basis in evidence has negative implications for abortion seekers' right to privacy.
Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life.	Right to life	CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017	<ul style="list-style-type: none"> • Provider restrictions can result in accessibility of safe abortion and recourse to unsafe abortion. • Where death results from such unsafe abortion there is a <i>prima facie</i> interference with abortion seekers' right to life.

7. EtD framework for Conscientious objection

Recommendation 22: Recommend that access to and continuity of comprehensive abortion care be protected against barriers created by conscientious objection.

PICO 11: What is the impact of conscientious objection on abortion-related outcomes? (for PICO details, see Annex 8 in the main guideline)

BACKGROUND

Setting: Global

Perspective: Population perspective

Literature review: For the analysis of impact of conscientious objection on abortion related outcomes, 26 studies were identified addressing the following outcomes; delayed abortion (n=12), continuation of pregnancy (n=3), opportunity costs (n=19), system costs (n=4), unlawful abortion (n=2), referral to another provider (n=12), workload implications (n=12), perceived imposition on conscience or ethics (n=5), perceived impact on relationship with patient (n=2), stigmatization of health-care providers (n=4). No studies were identified that encompassed information related to the outcome self-managed abortion. Studies were conducted in Australia, Brazil, Colombia, Ghana, Italy, Mexico, Nigeria, Norway, Portugal, South Africa, Slovakia, Switzerland, Tunisia, United Kingdom, USA and Zambia. Study designs in this EtD framework include cross-sectional studies, mixed-methods studies, case series design, panel data analysis, review studies, time-series design and qualitative interviews.

FINDINGS TABLES

POPULATION: Pregnant people seeking abortion

Outcome: DELAYED ABORTION

Findings table 1: Impact of conscientious objection (CO) on delayed abortion

OUTCOME: DELAYED ABORTION			
Human rights standards engaged: right to life, right to health, right to equality and non-discrimination			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Autorino 2018	▲	A higher proportion of objecting health-care providers is associated with longer waiting times for abortion seekers.	Overall, findings from 12 studies support that CO may delay timely access to abortion and post-abortion care. CO may delay access to abortion care by further decreasing limited resources such as health-care providers and facilities, and requiring abortion seekers to travel further to obtain care. CO may disproportionately affect vulnerable subgroups: women living in rural areas appear to experience the greatest delays in care due to CO. The effects of CO on delayed access to care are greatest where: CO is prevalent; where CO policies and referral practices are unclear; where CO policies are implemented inconsistently; and where CO regulations are not followed.
Awooner-Williams 2018 ¹	▲	A higher prevalence of CO among professional cadres that are already few in numbers, such as physicians, raises concern about access to timely care in such cases that require the skills of physicians.	
Bo 2015	▲	A higher proportion of objecting health-care providers is associated with longer waiting times for abortion seekers. Organizational models in individual regions to deliver abortion services impact on timely access to abortion which is also influenced by policy decisions that regulate CO.	
Chavkin 2017	▲	Women living in rural areas may experience abortion delays due to CO.	
Contreras 2011 ¹	▲	After abortion legalization occurred in one city, lack of clarity on who had the right to CO, and for what aspects of abortion care, there were delays in women obtaining	

		services.
Doran 2016 ¹	▲	Women living in rural areas may experience abortion delays due to CO among general practitioners.
Fink 2016 ¹	▲	Some objecting health-care providers intentionally use inaccurate legal and medical information to try to dissuade the abortion seeker, attempting to prevent her from accessing care she is legally entitled to. In some cases, this may result in abortion delay.
Freeman 2019 ¹	▲	Referrals by objecting health-care providers cause delays in abortion access as women are instructed to return on another day when an abortion provider is on duty.
Harries 2014 ¹	▲	Unregulated implementation of CO policies can cause service fragmentation with different cadres of providers and workers objecting to both direct and indirect aspects of abortion care. This may cause a delay in care due to worker shortages.
Homaifar 2017	▲	Some physicians who do not provide abortion care may contribute to delays in obtaining abortions by not providing a referral, or providing a misleading referral to clinicians or facilities who do not provide abortion care.
Lamina 2013 ¹	▲	Some health-care providers refuse to participate in any abortion related care, including post-abortion care, which can delay access to timely care.
Lema 2012	▲	CO leads to abortion delay and timely access to post-abortion care.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Autorino 2018; Panel data analysis (n=not reported); Italy
Awoonor-Williams 2018; Cross-sectional study (n=213); Ghana
Bo 2015; Time-series design (n=101 522); Italy
Chavkin 2017; Mixed-methods study (n=54); Portugal
Contreras 2011; Qualitative individual semi-structured interviews (n=64); Mexico
Doran 2016; Qualitative individual in-depth interviews (n=13); Australia
Fink 2016; Qualitative individual in-depth interviews (n=28); Colombia
Freeman 2019; Qualitative individual in-depth interviews (n=51); Zambia
Harries 2014; Qualitative individual in-depth interviews (n=48); South Africa
Homaifar 2017; Mixed-methods study (n=431); Nebraska, USA
Keogh 2019; Qualitative individual semi-structured interviews (n=19); Victoria, Australia
Lamina 2013; Qualitative individual in-depth interviews (n=36) and focus group discussions (n=1); Nigeria
Lema 2012; Case reports (n cases=5); Sub-Saharan Africa

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Findings table 2: Impact of conscientious objection on continuation of pregnancy

OUTCOME: CONTINUATION OF PREGNANCY			
Human rights standards engaged: right to health, right to security of person, right to decide on the number and spacing of children, right to equality and non-discrimination, right to privacy, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Keogh 2019 ¹	▲	Some objecting health-care providers (intentionally or inadvertently) provide inaccurate information delaying abortion access and leading to continuation of pregnancy.	Overall, findings from three studies suggest that objecting health-care providers may
Homaifar 2017	▲	15% of objecting health-care providers provide misleading referrals to women seeking abortion care to promote continuation of the pregnancy.	
Fink 2016 ¹		Some objecting health-care providers describe lengthy conversations with women seeking abortions with the goal of convincing them to continue the pregnancy. Some objecting health-care providers will use harsh, even abusive language if their initial attempts to promote pregnancy continuation are unsuccessful.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Homaifar 2017; Mixed-methods study (n=431); Nebraska, USA

Keogh 2019; Qualitative individual semi-structured interviews (n=19); Victoria, Australia

Findings table 3: Impact of conscientious objection (CO) on opportunity cost

OUTCOME: OPPORTUNITY COST			
Human rights standards engaged: right to health, right to security of person, right to privacy, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Amado 2016	▲	When it is unclear to women which providers offer abortion care, they may experience opportunity cost if they schedule with a provider who conscientiously objects, and need to seek another appointment.	<p>Overall, evidence from 19 studies describe the direct or indirect relationship that CO may have with diverse opportunity costs to abortion seekers.</p> <p>Opportunity costs include direct costs such as increased travel, financial burdens, and time. A pervasive indirect opportunity cost associated with CO is uncertainty of options. Significant variation in how and when CO is implemented creates uncertainty in the obstacles and options abortion seekers will have. This uncertainty has both psychological and physical consequences, and associated opportunity costs.</p> <p>Health-care providers who claim CO who attempt to prevent the abortion by providing misleading information may also stigmatize the abortion seeker in the process. Some providers will claim CO on a case by case basis, which leaves access to abortion care unpredictable and contributes to opportunity costs.</p>
Aniteye 2013 ¹	▲	<p>While most physicians and midwives will provide counselling on options available for unwanted pregnancy, few midwives will actually provide abortion specific information.</p> <p>In settings where senior physicians in management positions are against abortion, access to safe abortion services, including referrals to other health-care providers, may be blocked.</p> <p>When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.</p>	
Autorino 2018	▲	Higher proportions of objecting health-care providers are associated with larger proportions of women having to travel to another region of the country to have an abortion.	

Blaho 2017 ¹	▲	When it is unclear to women which providers offer abortion care, they may experience opportunity costs if they schedule with a provider who conscientiously objects, and need to seek another appointment.
Chavkin 2017	▲	CO is linked to increased need for travel for abortion.
Contreras 2011 ¹	▲	Some objectors employed in the public sector, provide abortion services in their private practices where they have a financial incentive. When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.
Doran 2016 ¹	▲	Some physicians will require abortion seekers to have multiple ultrasounds and have multiple appointments before they are willing to refer.
Diniz 2014	▲	Physicians who claim a religious affiliation frequently do not inform women of all of the options available to them and or refuse to refer women for abortion care. Some physicians claim conscientious objection in cases of rape (although abortion in cases of rape is legal) if he/she is not convinced the pregnancy was actually due to rape. When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.
Fink 2016 ¹	▲	Some objecting health-care providers provide misleading legal and medical information. One objecting provider regularly told his patients that their situation did not meet the legal criteria for abortion, regardless of their reasons for seeking one.

Freeman 2019 ¹	▲	<p>When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.</p> <p>Some objecting health-care providers try to deter women from having an abortion by delivering counselling that makes direct reference or allusion to religious teaching. Some health-care providers who will not personally perform an abortion, but may refer to someone else, will not reassure the abortion seeker of her legal rights related to abortion. This can cause confusion in claiming their legal rights and delay in obtaining abortion.</p> <p>Rather than reflect the existing legal framework, the majority of health-care providers reported making their abortion care decisions on a case-by-case basis, depending on the reasons the abortion was being requested.</p>	
Gerds 2016	▲	CO is linked to an increased need for travel for abortion for some women.	
Harries 2014 ¹	▲	<p>Some objecting health-care providers abandon their objections in exchange for financial remuneration.</p> <p>When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.</p>	

Harris 2016 ¹	▲	<p>Some objecting health-care providers impose unnecessary, additional administrative steps for abortion seekers.</p> <p>Some health-care providers expression of conscience is through biased counselling rather than provision: they provide abortions that they consider immoral if they are worried about the patient seeking unsafe abortion, but do their best to dissuade patients who they think are unsure about their decision.</p>	
Homaifar 2017	▲	Some clinicians (15%, n=63) provided misleading referrals to clinics or centres that do not provide abortions, resulting in unnecessary appointments and delay in care.	
Lamina 2013 ¹	▲	Some health-care providers note that when there is financial compensation, individuals who usually claim CO will provide abortion services. When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.	
Lema 2012	▲	Conscientious objection leads to delay in abortion and post-abortion care, even in emergent cases when care is needed to save a person's life.	
Nordberg 2014 ¹	▲	Some general practitioners will not refer directly for abortion services, but will give contact details to another general practitioner who will then refer to an abortion provider. This results in multiple, unnecessary visits.	
Keogh 2019 ¹	▲	<p>When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.</p> <p>Some health-care providers try to deter women from</p>	

		having an abortion, purposively delaying them and making access to abortion difficult.	
Raifman 2018 ¹	▲	Significant variation in CO affects the counselling and care provided. Where CO is permitted, some objecting health-care providers overtly or covertly attempt to persuade patients not to have an abortion, depending on the circumstances of the case. Some health-care providers will always provide abortion services to women in need; some providers will never provide abortion services; and other on a case-by-case basis. When CO is implemented unevenly, abortion seekers have uncertain options/paths and associated opportunity costs.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Amado 2016; Case series design (n=46); Colombia
 Aniteye 2013; Qualitative individual in-depth interviews (n=43); Ghana
 Autorino 2018; Panel data analysis (n=not reported); Italy
 Blaho 2017; Qualitative individual semi-structured interviews (n=11); Slovakia
 Chavkin 2017; Mixed-methods study (n=54); Portugal
 Contreras 2011; Qualitative individual semi-structured interviews (n=64); Mexico
 Diniz 2014; Mixed-methods study (n=1690); Brazil
 Doran 2016; Qualitative individual in-depth interviews (n=13); Australia
 Fink 2016; Qualitative individual in-depth interviews (n=28); Colombia
 Freeman 2019; Qualitative individual in-depth interviews (n=51); Zambia
 Gerdts 2016; Cross-sectional study (n=58); England, United Kingdom
 Harries 2014; Qualitative individual in-depth interviews (n=48); South Africa
 Harris 2016; Qualitative individual in-depth interviews (n=12); Colombia
 Homaifar 2017; Mixed-methods study (n=431); Nebraska, USA

Lamina 2013; Qualitative individual in-depth interviews (n=36) and focus group discussions (n=1); Nigeria
Lema 2012; Case reports (n cases=5); Sub-Saharan Africa
Nordberg 2014; Qualitative individual interviews (n=7); Norway
Keogh 2019; Qualitative individual semi-structured interviews (n=19); Victoria, Australia
Raifman 2018; Qualitative individual in-depth interviews (n=25); Tunisia

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Outcome: UNLAWFUL ABORTION

Findings table 4: Impact of conscientious objection on unlawful abortion

OUTCOME: UNLAWFUL ABORTION			
Human rights standards engaged: right to life, right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Freeman 2019 ¹	▼	² Even among objecting health-care providers, the desire to avoid illegal, unsafe abortion will prompt referrals for safe abortion care. Some objectors who refer patients for abortion find comfort in knowing that their patients receive safe care and may not have to resort to an illegal, unsafe option, such as self-induction or going to a clandestine clinic.	Overall, evidence from one study suggests that health-care providers who conscientiously object to abortion, may still provider referrals specifically to reduce unsafe, illegal abortion.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Freeman 2019; Qualitative individual in-depth interviews (n=51); Zambia

Outcome: SELF-MANAGED ABORTION

No studies identified

Findings table 5: Impact of conscientious objection on referral to another provider

OUTCOME: REFERRAL TO ANOTHER PROVIDER			
Human rights standards engaged: right to health, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Aniteye 2012 ¹	▼	Some objecting health-care providers will not refer abortion seekers contrary to local CO standards and protocols.	Overall, evidence from 12 papers suggests that objecting health-care providers implement the referral requirements for CO differently. This results in a net decrease of timely and appropriate referrals. Only one of 12 papers reported that “most” health-care providers were willing to refer. The vast majority of evidence speaks to an inconsistent and fragmented approach to abortion referrals, when CO is invoked.
Aniteye 2013 ¹	▼	Referrals under CO are made unevenly: some objecting health-care providers follow CO policy and make appropriate referrals. Others do not refer abortion seekers to clinics where they can receive care.	
Awoonor-Williams 2018	▼	Most health-care providers are willing to provide abortion-related referrals even if they will not provide abortion care themselves.	
Diniz 2014	▼	Many objecting health-care providers are unwilling to provide care or referrals even in cases of rape. In cases of rape, 43% (n=735) of objecting health-care providers would not refer or provide care, while 27% (n=460) would provide an appropriate referral. A minority of objecting health-care providers (21%, n= 353) would provide abortion in the case of rape.	
Doran 2016 ¹	▼	In settings where CO is allowed, some objectors will not provide referrals or will not provide accurate information about the option of self-referral, despite being obligated to do so according to national guidelines.	

Fink 2016 ¹	▼	Referrals under CO are made unevenly: some objecting health-care providers follow CO policy and make appropriate referrals. Others do not refer abortion seekers to clinics where they can receive care. Others will refer on a case-by-case basis.
Freeman 2019 ¹	▼	Referrals under CO are made unevenly: some objecting health-care providers follow CO policy and make appropriate referrals. Others do not refer abortion seekers to clinics where they can receive care. Others will refer on a case-by-case basis, with vague and inconsistent referral practices. In settings where senior physicians or management oppose abortion, some non-objectors may refer patients for abortions they would have otherwise provided themselves.
Harris 2016 ¹	▼	Some objecting health-care providers refuse to counsel and refer abortion seekers. For some providers this is a way of punishing the abortion seeker for socially unacceptable behaviour.
Homaifar 2017	▼	Referrals under CO are made unevenly. Only 18% (n=78) of objecting health-care providers facilitate referrals with direct assistance. An additional 39% (n=166) will passively refer by just providing the contact information for an abortion clinic. The remaining 44% (n=187) will not refer at all (29%, n=129) or will provide misleading referrals to clinics or centres that do not provide abortions (15%, n=63).
Keogh 2019 ¹	▼	While most objecting health-care providers will refer an abortion seeker to another provider, there were those who never refer. Refusal to refer is reported as a common practice in rural areas.

Nordberg 2014 ¹	▼	Referral patterns by objecting general practitioners varies significantly. Some will always refuse to refer, while others will refer depending on the reasons the abortion is sought. Among providers refusing to refer, some will indirectly refer by having a colleague contact the woman with referral information. Others will refer.
Stulberg 2016 ¹	▼	Institutional CO in health-care facilities makes it difficult for physicians to provide abortion and related services but also complicates referrals to other providers and transfers to the facility. Abortion seekers may be provided with informal referrals rather than formal referrals, or may not be referred at all.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Aniteye 2012; Qualitative individual in-depth interviews (n=76); Ghana
 Aniteye 2013; Qualitative individual in-depth interviews (n=43); Ghana
 Awooner-Williams 2018; Cross-sectional study (n=213); Ghana
 Diniz 2014; Mixed-methods study (n=1690); Brazil
 Doran 2016; Qualitative individual in-depth interviews (n=13); Australia
 Fink 2016; Qualitative individual in-depth interviews (n=28); Colombia
 Freeman 2019; Qualitative individual in-depth interviews (n=51); Zambia
 Harris 2016; Qualitative individual in-depth interviews (n=12); Colombia
 Homaifar 2017; Mixed-methods study (n=431); Nebraska, USA
 Keogh 2019; Qualitative individual semi-structured interviews (n=19); Victoria, Australia
 Nordberg 2014; Qualitative individual interviews (n=7); Norway
 Stulberg 2016; Qualitative individual semi-structured interviews (n=19); Victoria, Australia

POPULATION: Medical professionals who come into contact with women seeking abortion

Outcome: *WORKLOAD IMPLICATIONS*

Findings table 6: Impact of conscientious objection on workload implications

OUTCOME: WORKLOAD IMPLICATIONS			
Human rights standards engaged: right to health, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Autorino 2018	▲	In settings with a high proportion of objecting health-care providers, the workload of non-objecting providers is increased due to out of region travel for abortion and abortion delay.	Overall, evidence from 12 studies indicate that CO has workload implications. Workload implications may have physical, logistical, psychological or mixed components. The effects of CO on workload implications are increased when CO is implemented inconsistently or without clear, guiding rules. CO may contribute to workload implications such as difficulties in organizing staffing, increased workload for staff that provide abortion care, workplace conflicts and frustration. In some cases, objecting health-care providers feel pressure to participate in abortion care with resulting emotional workload implications. Unclear or inadequate regulation of CO may contribute to these negative workload implications.
Bo 2015	▲	A higher proportion of objecting health-care providers is associated with increased workload for abortion care providers. Lack of clear regulations and legal frameworks on CO undermine organizational models to deliver abortion services.	
Chavkin 2017	▲	Abortion providers experience increased workloads due to CO.	
Contreras 2011 ¹	▲	Shortages of non-objectors cause increased workloads for those willing and able to provide abortion care. Support from Ministry of Health and formation of teams of like-minded personnel willing to participate in abortion care help maintain the program and deliver abortion services.	

Czarnecki 2019 ¹	▲	<p>Shortages of non-objectors cause increased workloads for those willing and able to provide abortion care. Where formal opt in/opt out policies do not exist, and informal policies vary by department, ambiguous boundaries related to participation result in staffing shortages.</p> <p>Some nurses who opt out from abortion participation describe taking on more cases of caring for women experiencing miscarriage.</p>
Fleming 2019 ¹	▲	<p>CO may increase psychological workload; some objecting health-care providers feel pressured to participate in abortion care so as not to overload their colleagues with work.</p> <p>CO may increase psychological workload differentially by cadre of health-care providers. Midwives might not have the same flexibility to object or refer as physicians. This increases the psychological workload needed to navigate these challenges and increased pressure to participate in abortion related care.</p> <p>CO causes workplace conflicts in settings where objecting health-care providers are viewed as complicating service delivery.</p>
Freedman 2019 ¹	▲	<p>Opt-out options of abortion care may be compromised when workload is high and abortion services are understaffed, leading to some health-care providers feeling pressured to participate in some aspects of care. Thus, CO may increase psychological workload when physical workload is high.</p>

Harries 2014 ¹	▲	CO results in increased workloads for abortion care providers. CO can affect services more broadly as compared to direct abortion provision; some health-care providers may still claim CO in situations where CO does not apply (e.g. provision of analgesia, ultrasound). When this behaviour is overlooked by managers, it creates increased workloads for abortion providers.
Lamina 2013 ¹	▲	When CO policy is implemented without a clear regulatory structure, understanding is poor. CO policy is applied inconsistently and incorrectly. Professions who are not covered by the policy, such as administrative staff or cleaners, may claim exemptions, and increase the workload.
Nordberg 2014 ¹	▲	General practitioners who conscientiously object recognize they would not be able to practice in rural areas without other colleagues being able to handle their referrals.
Perrin 2012 ¹	▲	When public hospitals are required to ensure abortion access, how to manage the work flow when providers invoke CO may lead to conflict or logistical challenges. Some objecting health-care providers describe that this limits their ability to work in a public hospital.
Stulberg 2016 ¹	○	When institutional CO applies, some health-care providers develop practices to try to navigate ethics requirements, to be able to carry out a referral or participate in some aspect of abortion care, including contraceptive services while adhering to hospital policy on CO.

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Autorino 2018; Panel data analysis (n=not reported); Italy

Bo 2015; Time-series design (n=101 522); Italy

Chavkin 2017; Mixed-methods study (n=54); Portugal

Contreras 2011; Qualitative individual semi-structured interviews (n=64); Mexico

Czarnecki 2019; Qualitative individual semi-structured interviews (n=50); Michigan, USA

Fleming 2019; Qualitative individual interviews (n=8); Scotland, United Kingdom

Freedman 2019; Qualitative individual semi-structured interviews (n=30); USA

Harries 2014; Qualitative individual in-depth interviews (n=48); South Africa

Lamina 2013; Qualitative individual in-depth interviews (n=36) and focus group discussions (n=1); Nigeria

Nordberg 2014; Qualitative individual interviews (n=7); Norway

Perrin 2012; Qualitative individual in-depth interviews (n=77); Switzerland

Stulberg 2016; Qualitative individual semi-structured interviews (n=19); Victoria, Australia

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Findings table 7: Impact of conscientious objection on system costs

OUTCOME: SYSTEM COSTS			
Human rights standards engaged: right to health, right to security of person, right to be free from torture, and cruel, inhuman and degrading treatment			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Contreras 2011 ¹	▲	Financial incentives influence availability of abortion services in the private vs public sector. Some objecting health-care providers employed in the public sector, provide abortion services in their private practices, where they have a financial incentive to do so.	Overall, evidence from four papers suggests that CO contributes to broad health system and social costs. In some cases, it may contribute to direct out of pocket payments by the abortion seeker. CO appears to disproportionately affect women seeking care in public hospitals. CO contributes to costs at the individual, provider and systems level. In some cases, objecting health-care providers will offer abortion services in the private sector for informal or formal payment, but will object to providing uncompensated care in the public sector.
Harries 2014 ¹	▲	Some objecting health-care providers abandon their objections in exchange for financial remuneration.	
Lamina 2013 ¹	▲	Some health-care providers note that when there is financial compensation, individuals who usually refuse to participate in abortion care will assist.	
Lema 2012	▲	CO contributes increases abortion related morbidity and mortality.	Differentially restricting access to abortion among women with public insurance, may deter finances away from the public system and may also increase public costs through payment for unwanted births. It may also increase abortion related morbidity and mortality.

▲ = the intervention (spousal consent) leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Contreras 2011; Qualitative individual semi-structured interviews (n=64); Mexico

Harries 2014; Qualitative individual in-depth interviews (n=48); South Africa

Lamina 2013; Qualitative individual in-depth interviews (n=36) and focus group discussions (n=1); Nigeria

Lema 2012; Case reports (n cases=5); Sub-Saharan Africa

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Outcome: PERCEIVED IMPOSITION ON PERSONAL CONSCIENCE OR ETHICS

Findings table 8: Impact of conscientious objection on perceived imposition on personal conscience or ethics

OUTCOME: PERCEIVED IMPOSITION ON PERSONAL CONSCIENCE OR ETHICS			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Czarnecki 2019 ¹	▲	Participation in pre-and post-abortion procedures, such as treating post abortion haemorrhage, causes conflicting feelings among some objecting health-care providers who may partake in this type of care despite their perceived imposition on personal conscience	Overall, evidence from five studies reported on CO with a perceived imposition on providers personal conscience or ethics. Four studies described that CO, when implemented inconsistently; contribute to a perceived imposition on personal conscience or ethics among health-care providers. This perceived imposition may cause providers to refuse any kind of participation or to consider changing workplace.
Fleming 2019 ¹	▲	Busy ward settings may put midwives in situations where they participate more than they are comfortable with – sometimes this leads to people making career decisions e.g. what kind of hospitals to work in to avoid future such situations.	
Freedman 2010 ¹	▲	Opt-out options of abortion care may be compromised when workloads are high and abortion services are understaffed, leading to some health-care providers feeling pressured to participate in some aspects of care, which is perceived as an imposition on personal conscience or ethics.	
Nordberg 2014 ¹	▼	Several general practitioners considered the ability to refuse not to be about abortion per se, but to be about protecting themselves and their own integrity.	
Perrin 2012	▲	Where policies on CO exist in theory, but are implemented inconsistently in practice, objecting health-care providers may experience imposition on personal conscience and ethics.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Czarnecki 2019; Qualitative individual semi-structured interviews (n=50); Michigan, USA
Fleming 2019; Qualitative individual interviews (n=8); Scotland, United Kingdom
Freedman 2010; Qualitative individual semi-structured interviews (n=30); USA
Nordberg 2014; Nordberg 2014; Qualitative individual interviews (n=7); Norway
Perrin 2012; Qualitative individual in-depth interviews (n=77); Switzerland

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Findings table 9: Impact of conscientious objection (CO) on perceived impact on relationship with patient

OUTCOME: PERCEIVED IMPACT ON RELATIONSHIP WITH PATIENT			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Keogh ¹	▲	Objecting health-care providers, who express CO, appreciate that this may make women feel guilty or judged.	Overall, evidence from two studies reported on CO with a perceived impact on patient relationships with mixed findings. Evidence from 1 study described that objecting health-care providers thought this might make women feel guilty, thus impacting the relationship. Another study found no concern for negative impact on the provider–patient relationship.
Nordberg 2014 ¹	○	Some objecting health-care providers consider a refusal to refer may be perceived by patients as rejection and could damage the doctor-patient relationship, but most consider no damage in the majority of cases, as they consider themselves to have limited influence on patients.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

Additional considerations

Study design and setting of included studies:

Keogh 2019; Qualitative individual semi-structured interviews (n=19); Victoria, Australia
 Nordberg 2014; Qualitative individual interviews (n=7); Norway

Findings table 10: Impact of conscientious objection (CO) on stigmatization of health-care providers

OUTCOME: STIGMATIZATION			
Human rights standards engaged: right to health			
Studies	Direction of the Evidence	What does this mean?	Overall conclusion
Chavkin 2017	▲	In settings where CO is the norm, abortion providers experience stigmatization and discrimination, such as limited career trajectories.	Overall, evidence from four studies reports on the effect CO may have on stigmatization of health-care providers. Three papers report that when CO is prevalent, non-objecting health-care providers face stigmatization and limits career trajectory. One paper found no relationship between CO and stigmatization of abortion providers.
Contreras 2011 ¹	▲	Abortion care providers are stigmatized by objecting colleagues.	
Freeman 2019 ¹	▲	In settings where senior physicians or management oppose abortion, junior physicians may be prevented from providing abortion care directly, by not allowing the services in the health facility, or indirectly by stigmatization and discrimination.	
Nordberg 2014 ¹	○	² General practitioners, who are all conscientious objectors, experience respect and understanding for their views from colleagues.	

▲ = the intervention leads to an increase in the outcome; ○ = the intervention leads to no change in the outcome; ▼ = the intervention leads to a decrease in the outcome. Symbol does *not* indicate magnitude or certainty of effect.

¹ Qualitative study design: tests of statistical significance not applicable.

² Concerns about adequacy exist – data underlying the finding is not sufficiently rich, data come from a small number of studies and few participants.

Additional considerations

Study design and setting of included studies:

Chavkin 2017; Mixed-methods study (n=54); Portugal
 Contreras 2011; Qualitative individual semi-structured interviews (n=64); Mexico
 Freeman 2019; Qualitative individual in-depth interviews (n=51); Zambia
 Nordberg 2014; Qualitative individual interviews (n=7); Norway

DETAILED JUDGEMENT

Desirable effects:

-

Undesirable effects:

Delayed abortion

- Overall, findings from 13 studies support that CO may delay timely access to abortion and post-abortion care.
- CO may delay access to abortion care by further decreasing limited resources such as health-care providers and facilities, and requiring abortion seekers to travel further to obtain care. CO may disproportionately affect vulnerable subgroups: women living in rural areas appear to experience the greatest delays in care due to CO.
- The effects of CO on delayed access to care are greatest where: CO is prevalent; where CO policies and referral practices are unclear; where CO policies are implemented inconsistently; and where CO regulations are not followed.

Continuation of pregnancy

- Overall, findings from three studies suggest that objecting health-care providers may provide inaccurate information on referrals, intentionally or otherwise, that contribute to continuation of pregnancy.

Opportunity costs

- Overall, evidence from 19 studies describe the direct or indirect relationship that CO may have with diverse opportunity costs to abortion seekers.
- Opportunity costs include direct costs such as increased travel, financial burdens, and time. A pervasive indirect opportunity cost associated with CO is uncertainty of options. Significant variation in how and when CO is implemented creates uncertainty in the obstacles and options abortion seekers will have. This uncertainty has both psychological and physical consequences, and associated opportunity costs.
- Health-care providers who claim CO who attempt to prevent the abortion by providing misleading information may also stigmatize the abortion seeker in the process. Some providers will claim CO on a case-by-case basis, which leaves access to abortion care unpredictable and contributes to opportunity costs.

Unlawful abortion

- Overall, evidence from one study suggests that health-care providers who conscientiously object to abortion, may still provider referrals specifically to reduce unsafe, illegal abortion.

Referral to another provider

- Overall, evidence from 12 papers suggests that objecting health-care providers implement the referral requirements for CO differently. This results in a net decrease of timely and appropriate referrals. Only one of 12 papers reported that “most” health-care providers were willing to refer.
- The vast majority of evidence speaks to an inconsistent and fragmented approach to abortion referrals, when CO is invoked.

Workload implications

- Overall, evidence from 12 studies indicate that CO has workload implications. Workload implications may have physical, logistical, psychological or mixed components. The effects of CO on workload implications are increased when CO is implemented inconsistently or without clear, guiding rules.
- CO may contribute to workload implications such as difficulties in organizing staffing, increased workload for staff that provide abortion care, workplace conflicts and frustration. In some cases, objecting health-care providers feel pressure to participate in abortion care with resulting emotional workload implications. Unclear or inadequate regulation of CO may contribute to these negative workload implications.
- Organizational changes such as formation of teams of like-minded personnel who provide abortion care and increased clarity on who can object, to what and when, may reduce negative workload implications.

System costs

- Overall, evidence from four papers suggests that CO contributes to broad health system and social costs. In some cases, it may contribute to direct out of pocket payments by the abortion seeker. CO appears to disproportionately affect women seeking care with public insurance in public hospitals.
- CO contributes to costs at the individual, provider and systems level. In some cases, objecting health-care providers will offer abortion services in the private sector for informal or formal payment, but will object to providing uncompensated care in the public sector.
- Differentially restricting access to abortion among women with public insurance, may deter finances away from the public system and may also increase public costs through payment for unwanted births. It may also increase abortion related morbidity and mortality.

Perceived imposition on personal conscience or ethics

- Overall, evidence from five studies reported on CO and perceived imposition on providers personal conscience or ethics. Four studies described that CO, when implemented inconsistently; contribute to a perceived imposition on personal conscience or ethics among health-care providers. This perceived imposition may cause providers to refuse any kind of participation or to consider changing workplace.

Perceived impact on relationship with patient

- Overall, evidence from two studies reported on CO and the perceived impact on patient relationships with mixed findings. Evidence from 1 study described that objecting health-care providers thought this might make women feel guilty, thus impacting the relationship. Another study found no concern for negative impact on the provider–patient relationship.

Stigmatization of health-care providers

- Overall, evidence from four studies reports on the effect CO may have on stigmatization of health-care providers. Three papers report that when CO is prevalent, non-objecting health-care providers face stigmatization and limits to career trajectory. One paper found no relationship between CO and stigmatization of abortion providers.

HUMAN RIGHTS STANDARDS-TO-EVIDENCE TABLES

POPULATION: Pregnant people seeking abortion

HUMAN RIGHTS STANDARD TO EVIDENCE: CONSCIENTIOUS OBJECTION (CO)

Outcome	Overall Conclusion	Rights Standards Engaged ³	Direction – negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
Delayed Abortion	Overall, findings from 12 studies support that CO may delay timely access to abortion and post-abortion care.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▲	CO can result in delayed access to abortion care. Failure to regulate conscientious objection and arrange the system of abortion care provision, so that objection does not result in delays that increase risks of maternal mortality or morbidity, have negative implications for rights.
	CO may delay access to abortion care by further decreasing limited resources such as health-care providers and facilities, and requiring abortion seekers to travel further to obtain care. CO may disproportionately affect vulnerable subgroups: women living in rural areas appear to experience the greatest delays in care due to CO. The effects of CO on delayed access to care are greatest where: CO is prevalent; where CO policies and referral practices are unclear; where CO policies are implemented inconsistently; and where CO regulations are not followed.	States must ensure equality and non-discrimination in the provision of sexual and reproductive health care, including safe abortion care, which must be accessible to all (including children) without discrimination.	▲	CO can result in delayed access to abortion care. Delays relating to the regulation of CO may particularly affect women in rural areas with implications for their exposure to increased risks of maternal mortality or morbidity resulting in reduced rights enjoyment.

³ The relevant rights holder in this table is the person seeking abortion, i.e. the person in respect of whom the regulation of conscientious objection may result in or ease burdens in accessing safe abortion care.

<p>Continuation of Pregnancy</p>	<p>Overall, findings from three studies suggest that objecting health-care providers may provide inaccurate information on referrals, intentionally or otherwise, that contribute to continuation of pregnancy.</p>	<p>States should ensure laws regulating abortion are evidence based and proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	<p>▲</p>	<p>CO can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on health and physical and mental integrity, has negative implications for rights.</p>
		<p>Decisions about whether or not to have children are for a woman to make and must not be limited by spouse, parent, partner, the State or health authorities.</p>	<p>▲</p>	<p>Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy, has negative implications for rights.</p>
		<p>Where it is lawful, abortion must be safe and accessible.</p>	<p>▲</p>	<p>Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Where abortion is lawful, failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not hinder a pregnant person's ability safely to access abortion, has negative implications for rights.</p>

		States should ensure appropriate SRH care and services to address sexual violence against women and girls including making abortion available in cases of rape or incest.	▲	Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not prevent a woman from access abortion in cases of sexual violence including rape or incest, has negative implications for rights.
		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does undermine or hinder access to abortion, has negative implications for rights.
		Denial of therapeutic abortion may interfere arbitrarily with the right to privacy.	▲	Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does result in denial of therapeutic abortion, has negative implications for rights.
Opportunity Costs	Overall, evidence from 19 studies describe the direct or indirect relationship that CO may have with diverse opportunity costs to abortion seekers. Opportunity costs include direct costs such as increased travel, financial burdens, and time. A pervasive indirect opportunity cost associated	States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity	▲	Conscientious objection can be exercised in a way that imposes significant opportunity costs on people seeking abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on health and physical and mental integrity, has negative implications for rights.

<p>with CO is uncertainty of options.</p> <p>Significant variation in how and when CO is implemented creates uncertainty in the obstacles and options abortion seekers will have. This uncertainty has both psychological and physical consequences, and associated opportunity costs.</p> <p>Health-care providers who claim CO who attempt to prevent the abortion by providing misleading information may also stigmatize the abortion seeker in the process. Some providers will claim CO on a case-by-case basis, which leaves access to abortion care unpredictable and contributes to opportunity costs.</p>	States should protect people seeking abortion.	▲	Conscientious objection can be exercised in a way that imposes significant opportunity costs on people seeking abortion. Failure to regulate conscientious objection so that the exercise of rights to freedom of conscience and belief by health-care providers does not expose abortion seekers to harm has negative implications for rights.
	States must provide post-abortion care in all circumstances including where abortion is illegal,	▲	Conscientious objection can be exercised in a way that imposes significant opportunity costs on people seeking abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not result in non-provision of post-abortion care, has negative implications for rights.
	Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction,	▲	Conscientious objection can be exercised in a way that imposes significant opportunity costs on people seeking abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not result in non-provision of accurate abortion or provision of inaccurate or misleading information, has negative implications for rights.
	Where it is lawful, abortion must be safe and accessible	▲	Conscientious objection can be exercised in a way that imposes significant system costs. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.

Unlawful abortion	Overall, evidence from one study suggests that health-care providers who conscientiously object to abortion, may still provider referrals specifically to reduce unsafe, illegal abortion.	States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion.	▼	Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to unlawful abortion and thus, where unlawful abortion is unsafe, reduce maternal mortality and morbidity.
		States must protect people from the physical and mental health risks associated with unsafe abortions.	▼	Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to unlawful abortion and thus, where unlawful abortion is unsafe, reduce maternal mortality and morbidity.
Self-managed Abortion	No evidence identified			
Referral to Another Provider	Overall, evidence from 12 papers suggests that objecting health-care providers implement the referral requirements for CO differently. This results in a net decrease of timely and appropriate referrals. Only one of 12 papers reported that “most” health-care providers were willing to refer. The vast majority of evidence speaks to an inconsistent and fragmented approach to abortion referrals, when CO is invoked.	States should protect people seeking abortion.	▲	Even where referral is required, referral practice can be <i>ad hoc</i> , inconsistent, or non-compliant. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.
		States should ensure provider refusal does not undermine or hinder access to abortion.	▲	Even where referral is required, referral practice can be <i>ad hoc</i> , inconsistent, or non-compliant. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does undermine or hinder access to abortion, has negative implications for rights.

		Where it is lawful, abortion must be safe and accessible.	▲	Even where referral is required, referral practice can be <i>ad hoc</i> , inconsistent, or non-compliant. Where abortion is lawful, failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not hinder a pregnant person's ability safely to access abortion, has negative implications for rights.
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▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

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POPULATION: Medical professionals providing abortion services

HUMAN RIGHTS STANDARD TO EVIDENCE: CONSCIENTIOUS OBJECTION

Outcome	Overall Conclusion	Rights Standards Engaged	Direction— negative relationship with rights enjoyment	Overall: Application of Rights to Evidence
<p>Workload Implications (for health-care professionals)</p>	<p>CO may contribute to workload implications such as difficulties in organizing staffing, increased workload for staff that provide abortion care, workplace conflicts and frustration. In some cases, objectors feel pressure to participate in abortion care with resulting ethical and emotional workload implications. Unclear or inadequate regulation of CO may contribute to these negative workload implications.</p>	<p>States should ensure provider refusal does not undermine or hinder access to abortion.</p>	<p>▲</p>	<p>Workload implications arising from regulation of conscientious objection may reduce capacity for abortion care provision and thus hinder or undermine access to abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does undermine or hinder access to abortion, has negative implications for rights.</p>
	<p>Organizational changes such as formation of teams of like-minded personnel who provide abortion care and increased clarity on who can object, to what and when, may reduce negative workload implications.</p>	<p>States should protect health-care professionals providing abortion care.</p>	<p>▲</p>	<p>Workload implications arising from regulation of conscientious objection may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.</p>
<p>System costs</p>	<p>Overall, evidence from four papers suggests that CO contributes to broad health system and social costs. In some cases, it may contribute to direct out of pocket payments by the abortion seeker. CO appears to disproportionately affect women seeking care in public</p>	<p>States should ensure laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity.</p>	<p>▲</p>	<p>Conscientious objection can be exercised in a way that imposes significant system costs. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.</p>

	<p>hospitals.</p> <p>CO contributes to costs at the individual, provider and systems level. In some cases, objecting health-care providers will offer abortion services in the private sector for informal or formal payment, but will object to providing uncompensated care in the public sector.</p> <p>Differentially restricting access to abortion within public institutions, may deter finances away from the public system and may also increase public costs through payment for unwanted births. It may also increase abortion related morbidity and mortality.</p>	<p>Where it is lawful, abortion must be safe and accessible.</p>	<p>▲</p>	<p>Conscientious objection can be exercised in a way that imposes significant system costs. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.</p>
<p>Perceived imposition on personal conscience or ethics</p>	<p>Participation in clinical procedures that are related to the abortion may contribute to some perceived imposition on personal conscience or ethics for some health-care providers. In settings with high workloads and understaffed services, or where CO policies are not implemented in practice, some providers may find it difficult to object to participation, which contributes to the perceived imposition. This perceived imposition may cause providers to refuse any kind of participation or to consider changing workplace.</p>	<p>States should protect health-care professionals providing abortion care.</p>	<p>▲</p>	<p>Failure to regulate conscientious objection so that, e.g., workloads, staffing levels, or lack of regulatory clarity does not impede the exercise of conscientious objection in accordance with relevant regulations may impact negatively on the exercise of rights to freedom of conscience and belief by health-care providers who are either total or partial objectors. In the case of partial objectors this may necessitate changes in workplace or a full opt-out from abortion care provision in order to minimize imposition on personal conscience or ethics.</p>
		<p>States should ensure provider refusal does not undermine or hinder access to abortion.</p>	<p>▲</p>	<p>Regulation of conscientious objection or lack thereof, including around issues related to workload and staffing or where regulatory clarity does not exist, may lead partial objectors to fully opt out of service provision. This reduces the number of possible providers and</p>

				undermines or hinders access to abortion, thus having negative implications for rights.
Perceived impact on relationship with patient	Overall, evidence from two studies reported on CO and the perceived impact on patient relationships with mixed findings. Evidence from 1 study described that objecting health-care providers thought this might make women feel guilty, thus impacting the relationship. Another study found no concern for negative impact on the provider–patient relationship.	States should protect people seeking abortion.	▲	The exercise of conscientious objection can impact negatively on the wider doctor-patient relationship. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not expose abortion seekers to a negatively impacted relationship with their health-care provider, has negative implications for rights.
Stigma experienced by health-care providers	Overall, evidence from four studies reports on the effect CO may have on stigmatization of health-care providers. Three papers report that when CO is prevalent, non-objecting health-care providers face stigmatization and limits career trajectory. One paper found no relationship between CO and stigmatization of abortion providers	States should protect health-care professionals providing abortion care.	▲	Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where senior colleagues or managers are conscientious objectors, or where conscientious objection is norm. Failure to regulate conscientious objection in the order to avoid this may have negative effects on professional providing abortion care or result in those willing to provide acting as conscientious objectors in practice, with negative implications for both their rights and the rights of persons seeking to access abortion.

▲ = there is an increased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights decreases); ○ = the impact on rights enjoyment between the intervention and the outcome is unclear; ▼ = there is a decreased negative relationship with rights enjoyment between the intervention and the outcome (i.e. respect, protection, and fulfilment of relevant rights increases). Symbol does *not* indicate magnitude or certainty of effect.

SUMMARY OF JUDGEMENTS (EVIDENCE + HUMAN RIGHTS STANDARDS)

Desirable effects	Unable to determine	- Varies		✓ Trivial	- Small	- Moderate	- Large
Undesirable effects	Unable to determine	- Varies		✓ Large	Moderate	Small	- Trivial
Certainty of the evidence	✓ Unable to determine			Very low	- Low	- Moderate	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	Probably no important uncertainty or variability	✓ No important uncertainty or variability
Balance of effects	Unable to determine	- Varies	- Favours the comparison	✓ Does not favour the intervention	- Does not favour either the intervention or the comparison	- Probably favours the intervention	- Favours the intervention

OVERALL JUDGEMENT OF THE IMPACT ON CONSCIENTIOUS OBJECTION WHEN HUMAN RIGHTS STANDARDS ARE APPLIED

SUMMARY TABLE: CONSCIENTIOUS OBJECTION: EVIDENCE AND HUMAN RIGHTS TO RECOMMENDATION

Outcomes	Conclusion of evidence	Application to rights	Recommendation
Delayed abortion	<p>Overall, findings from 12 studies support that CO may delay timely access to abortion and post-abortion care.</p> <p>CO may delay access to abortion care by further decreasing limited resources such as health-care providers and facilities, and requiring abortion seekers to travel further to obtain care. CO may disproportionately affect vulnerable subgroups: women living in rural areas appear to experience the greatest delays in care due to CO.</p> <p>The effects of CO on delayed access to care are greatest where: CO is prevalent; where CO policies and referral practices are unclear; where CO policies are implemented inconsistently; and where CO regulations are not followed.</p>	<p>Failure to regulate conscientious objection and arrange the system of abortion care provision so that objection does not result in delays that increase risks of maternal mortality or morbidity, has negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes requiring objecting health-care providers immediately to refer abortion seekers to health-care providers who provide abortion.</p> <p>We recommend that failure to exercise conscientious objection in accordance with law and policy be subject to appropriate professional consequences.</p>
Continuation of pregnancy	<p>Overall, findings from three studies suggest that objecting health-care providers may provide inaccurate information on referrals, intentionally or otherwise, that contribute to continuation of pregnancy.</p>	<p>Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not undermine or hinder a pregnant person’s ability safely to access abortion, does not have a disproportionately negative effect on health and physical and mental integrity, does not prevent a woman from access abortion in cases of sexual violence including rape or incest, and does result in denial of therapeutic abortion has negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes requiring objecting health-care providers immediately to refer abortion seekers to health-care providers who provide abortion.</p> <p>We recommend that failure to exercise conscientious objection in accordance with law and policy be subject to appropriate professional consequences.</p>

<p>Opportunity costs</p>	<p>Overall, evidence from 19 studies describe the direct or indirect relationship that CO may have with diverse opportunity costs to abortion seekers.</p> <p>Opportunity costs include direct costs such as increased travel, financial burdens, and time. A pervasive indirect opportunity cost associated with CO is uncertainty of options. Significant variation in how and when CO is implemented creates uncertainty in the obstacles and options abortion seekers will have. This uncertainty has both psychological and physical consequences, and associated opportunity costs.</p> <p>Health-care providers who claim CO who attempt to prevent the abortion by providing misleading information may also stigmatize the abortion seeker in the process. Some providers will claim CO on a case-by-case basis, which leaves access to abortion care unpredictable and contributes to opportunity costs.</p>	<p>Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on health and physical and mental integrity, does not expose abortion seekers to harm, does not result in non-provision of post-abortion care, and does not result in non-provision of inaccurate or misleading information, has negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.</p>
<p>Unlawful abortion</p>	<p>Overall, evidence from one study suggests that health-care providers who conscientiously object to abortion, may still provider referrals specifically to reduce unsafe, illegal abortion.</p>	<p>Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to unlawful abortion and thus, where unlawful abortion is unsafe, reduce maternal mortality and morbidity.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes requiring objecting health-care providers immediately to refer abortion seekers to health-care providers who provide abortion.</p> <p>We recommend that failure to exercise conscientious objection in accordance with law and policy be subject to appropriate professional consequences.</p>
<p>Self-managed Abortion</p>	<p>No studies identified</p>	<p>Regulation of conscientious objection that ensures referral in situations of non-</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the</p>

		provision may prevent recourse to self-management of abortion and thus, where self-management of abortion is unsafe, reduce maternal mortality and morbidity.	rights of abortion seekers. This includes requiring objecting health-care providers immediately to refer abortion seekers to health-care providers who provide abortion. We recommend that failure to exercise conscientious objection in accordance with law and policy be subject to appropriate professional consequences.
Referral to another provider	Overall, evidence from 12 papers suggests that objecting health-care providers implement the referral requirements for CO differently. This results in a net decrease of timely and appropriate referrals. Only one of 12 papers reported that “most” health-care providers were willing to refer. The vast majority of evidence speaks to an inconsistent and fragmented approach to abortion referrals, when CO is invoked.	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), does not undermine or hinder access to abortion, and does not hinder a pregnant person’s ability safely to access abortion has negative implications for rights.	We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.
Workload implications	CO may contribute to workload implications such as difficulties in organizing staffing, increased workload for staff that provide abortion care, workplace conflicts and frustration. In some cases, objectors feel pressure to participate in abortion care with resulting ethical and emotional workload implications. Unclear or inadequate regulation of CO may contribute to these negative workload implications. Organizational changes such as formation of teams of like-minded personnel who provide abortion care and increased clarity on who can object, to what and when, may reduce negative workload implications.	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does undermine or hinder access to abortion, has negative implications for rights. Workload implications arising from regulation of conscientious objection may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.	We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.

<p>System costs</p>	<p>Overall, evidence from four papers suggests that CO contributes to broad health system and social costs. In some cases, it may contribute to direct out of pocket payments by the abortion seeker. CO appears to disproportionately affect women seeking care in public hospitals.</p> <p>CO contributes to costs at the individual, provider and systems level. In some cases, objecting health-care providers will offer abortion services in the private sector for informal or formal payment, but will object to providing uncompensated care in the public sector.</p> <p>Differentially restricting access to abortion within public institutions, may deter finances away from the public system and may also increase public costs through payment for unwanted births. It may also increase abortion related morbidity and mortality.</p>	<p>Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision abortion care (including through diversion to paid-for services), has negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.</p>
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<p>Perceived imposition on personal conscience or ethics</p>	<p>Participation in clinical procedures that are related to the abortion may contribute to some perceived imposition on personal conscience or ethics for some health-care providers. In settings with high workloads and understaffed services, or where CO policies are not implemented in practice, some providers may find it difficult to object to participation, which contributes to the perceived imposition. This perceived imposition may cause providers to refuse any kind of participation or to consider changing workplace.</p>	<p>Failure to regulate conscientious objection so that, e.g., workloads, staffing levels, or lack of regulatory clarity may impact negatively on the exercise of rights to freedom of conscience and belief by health-care providers who are either total or partial objectors. In the case of partial objectors this may necessitate changes in workplace or a full opt-out from abortion care provision in order to minimize imposition on personal conscience or ethics. Regulation of conscientious objection or lack thereof, including around issues related to workload and staffing or where regulatory clarity does not exist, may lead partial objectors to fully opt out of service provision. This reduces the number of possible providers and undermines or hinders access to abortion, thus having negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.</p>
<p>Perceived impact on relationship with patient</p>	<p>Overall, evidence from two studies reported on CO and the perceived impact on patient relationships with mixed findings. Evidence from 1 study described that objecting health-care providers thought this might make women feel guilty, thus impacting the relationship. Another study found no concern for negative impact on the provider–patient relationship.</p>	<p>Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not expose abortion seekers to a negatively impacted relationship with their health-care provider, has negative implications for rights.</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers. This includes clearly outlining when and by who conscientious objection is permitted, and addressing other recognized barriers to abortion access where conscientious objection is exercised.</p>
<p>Stigmatization</p>	<p>Overall, evidence from four studies reports on the effect CO may have on stigmatization of health-care providers. Three papers report that when CO is prevalent, non-objecting health-care providers face stigmatization and limits career trajectory. One paper found no relationship between CO and stigmatization of abortion providers.</p>	<p>Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where senior colleagues or managers are conscientious objectors, or where conscientious objection is the norm. Failure to regulate conscientious objection in order to avoid this may have negative effects on professionals providing abortion care or</p>	<p>We recommend regulating conscientious objection in a way that effectively protects the rights of abortion seekers and health-care providers.</p> <p>This includes protecting the right of health-care professionals conscientiously to provide abortion care, including through appropriate workplace and anti-discrimination protection.</p>

		result in those willing to provide acting as conscientious objectors in practice, with negative implications for both their rights and the rights of persons seeking to access abortion.	
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DETAILED JUSTIFICATION FOR THE JUDGEMENT

Application of Rights to Evidence per outcome: Pregnant people seeking abortion

Delayed abortion

- Conscientious objection can result in delayed access to abortion care. Failure to regulate conscientious objection and arrange the system of abortion care provision, so that objection does not result in delays that increase risks of maternal mortality or morbidity, have negative implications for rights.
- Conscientious objection can result in delayed access to abortion care. Delays relating to the regulation of conscientious objection may particularly affect women in rural areas with implications for their exposure to increased risks of maternal mortality or morbidity resulting in reduced rights enjoyment.

Continuation of pregnancy

- Conscientious objection can be exercised in a way that results in continuation of pregnancy and unwanted birth. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on a woman's ability to decide whether or not to continue with pregnancy, health, physical and mental integrity; or does not hinder a pregnant person's ability safely to access abortion, has negative implications for rights.
- Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not undermine or hinder access to abortion, does not prevent a woman from accessing an abortion in cases of sexual violence including rape or incest, or result in denial of therapeutic abortion, has negative implications for rights.

Opportunity costs

- Conscientious objection can be exercised in a way that imposes significant opportunity costs on people seeking abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on health and physical and mental integrity, has negative implications for rights.
- Failure to regulate conscientious objection so that the exercise of rights to freedom of conscience and belief by health-care providers does not expose abortion seekers to harm, does not result in non-provision of accurate abortion or provision of inaccurate or misleading information, or result in non-provision of post-abortion care, has negative implications for rights.

Unlawful abortion

- Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to unlawful abortion and thus, where unlawful abortion is unsafe, reduce maternal mortality and morbidity.

Self-managed abortion

- No studies identified

Referral to another provider

- Even where referral is required, referral practice can be *ad hoc*, inconsistent, or non-compliant. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.
- Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not undermine or hinder access to abortion, has negative implications for rights.
- Where abortion is lawful, failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not hinder a pregnant person's ability safely to access abortion, has negative implications for rights.

Application of Rights to Evidence per outcome: Medical professionals providing abortion services

Workload implications

- Workload implications arising from regulation of conscientious objection may reduce capacity for abortion care provision and thus hinder or undermine access to abortion. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not undermine or hinder access to abortion, has negative implications for rights.
- Workload implications arising from regulation of conscientious objection may place significant burdens on health-care professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.

System costs

- Conscientious objection can be exercised in a way that imposes significant system costs. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), has negative implications for rights.

Perceived imposition on personal conscience or ethics

- Failure to regulate conscientious objection so that, e.g. workloads, staffing levels, or lack of regulatory clarity does not impede the exercise of conscientious objection in accordance with relevant regulations may impact negatively on the exercise of rights to freedom of conscience and belief by health-care providers who are either total or partial objectors. In the case of partial objectors, this may necessitate changes in workplace or a full opt-out from abortion care provision in order to minimize imposition on personal conscience or ethics.
- Regulation of conscientious objection or lack thereof, including around issues related to workload and staffing or where regulatory clarity does not exist, may lead partial objectors to fully opt out of service provision. This reduces the number of

possible providers and undermines or hinders access to abortion, thus having negative implications for rights.

Perceived impact on relationship with patient

- The exercise of conscientious objection can impact negatively on the wider doctor-patient relationship. Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not expose abortion seekers to a negatively impacted relationship with their health-care provider, has negative implications for rights.

Stigmatization of health-care providers

- Decisions about whether to provide abortion care can have stigmatizing and career limiting effects where senior colleagues or managers are conscientious objectors, or where conscientious objection is the norm. Failure to regulate conscientious objection in order to avoid this may have negative effects on professional providing abortion care or result in those willing to provide acting as conscientious objectors in practice, with negative implications for both their rights and the rights of persons seeking to access abortion.

Desirable effects

As noted above: Trivial

Undesirable effects

As noted above: Large

Certainty of the evidence:

As noted above: Unable to determine

Values:

Although we did not identify any direct evidence pertaining to values in relation to the outcomes we can assume that abortion seekers value timely abortion care, avoidance of continuation of pregnancy, and affordable care with as few logistical burdens as possible. We can also assume that health-care providers, regardless if they participate in abortion care or not, value reasonable workloads, avoidance of imposition to personal ethics or conscience and stigmatization.

Balance of effects:

Considering the evidence and human rights standards applied, the balance of effects does the intervention *conscientious objection*. We also recognize that facilities can become de facto objectors where all providers refuse to provide care.

Resources:

The studies did not speak to the issue of resources.

Acceptability and feasibility:

The studies did not speak to the issue of acceptability or feasibility.

Equity:

The studies did not speak to the issue of equity.

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Conscientious objection: Overarching

Standard/Obligation	Relevant Rights	Express Sources	Application to Conscientious Objection
States must take steps to reduce maternal mortality and morbidity, including addressing unsafe abortion	Right to Life Right to health	CESCR: GC 22 CCPR: GC 28, GC 36, <i>Whelan v Ireland</i> , <i>Mellet v Ireland</i> , <i>LMR v Argentina</i> CRC: GC 4 CEDAW: GR 34 Special Rapporteur on the Right to Health Report, 2011 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2017, 2018 Working Group on Discrimination against Women Report, 2016	<ul style="list-style-type: none"> The exercise of conscientious objection without timely referral to lawful abortion services can lead people to seek abortion outside of the formal medical system. Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to life and right to health.
Where it is lawful, abortion must be safe and accessible	The right to health The right to be free from torture, and cruel, inhuman and degrading treatment	CCPR: GC 36, <i>LMR v Argentina</i> , <i>LC v Peru</i> CESCR: GC 22 Special Rapporteur on Health Report, 2004, 2011 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> The exercise of conscientious objection without timely referral to lawful abortion services can make lawful abortion inaccessible. In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to life and right to health. Such cases may result in unwanted continued pregnancy, abortion travel, criminalization or other costs. Such costs may be so substantial as to constitute torture, cruel, inhuman and degrading treatment. Additional/secondary costs may include premature termination of education, forced and/or child marriage, and harm to physical and mental health and associated human rights deprivations and violations.
States must ensure equality and non-discrimination in the provision of sexual and reproductive health care,	Right to health Right to equality and non-discrimination Right of persons with disabilities to retain	CCPR: GC 36 CRC: GC 4; GC 15 CRPD: GC 3, GC 6 Special Rapporteur on Health Report, 2016	<ul style="list-style-type: none"> Conscientious objection can result in delayed or impeded access to abortion care. Delays relating to the regulation of conscientious objection may particularly affect women in rural areas and immigrant women

including safe abortion care which must be accessible to all without discrimination	fertility on an equal basis with others		<p>with implications for their exposure to increased risks of maternal mortality or morbidity resulting in reduced rights enjoyment.</p> <ul style="list-style-type: none"> • Where this is the case the regulation and exercise of conscientious objection may result in discrimination and inequality in the provision of sexual and reproductive health care.
States must protect people from the physical and mental health risks associated with unsafe abortions	Right to health	<p>CCPR: GC 28, GC 36, GR 34 CESCR: GC 22 CRC: GC 4 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Executions/Killings Report, 2017</p>	<ul style="list-style-type: none"> • The exercise of conscientious objection without timely referral to lawful abortion services can lead people to seek abortion outside of the formal medical system. • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to life and right to health.
Accurate information about abortion must be provided, and safely accessible, without fear of criminal sanction	Right to health Right to information	<p>CCPR, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CRPD: GC 3 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2018 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • While exercising conscientious objection, health-care providers may attempt to dissuade abortion seekers from accessing abortion, provide biased, inaccurate or directive information, and mislead an abortion seeker about her legal entitlements to access abortion. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to information and right to health.
States should ensure appropriate SRH care and services to address sexual violence against women and girls incl. making abortion available in cases of rape or incest	Right to health	<p>CCPR: GC 36 CESCR: GC 22</p>	<ul style="list-style-type: none"> • The exercise of conscientious objection without timely referral to lawful abortion services in cases of sexual violence including rape or incest can hinder or impede access to abortion. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to health. • In such cases this may lead people to seek abortion outside of the formal medical system. • In such cases, the regulation and exercise of

			<p>conscientious objection would be inconsistent with the right to life and right to health.</p> <ul style="list-style-type: none"> • Such abortion may be unsafe abortion, with implications for maternal morbidity and mortality and the right to life and right to health.
States must provide post-abortion care in all circumstances including where abortion is illegal	Right to health	<p>CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 14 CRC: GC 15 CEDAW: GC 34 Working Group on Discrimination against Women Report, 2016 Special Rapporteur on Health Report, 2004, 2011, 2016 Special Rapporteur on Torture Report, 2013, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018</p>	<ul style="list-style-type: none"> • The exercise of conscientious objection without timely referral to lawful post-abortion services can result in denial of post-abortion care. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to health.
States should ensure provider refusal does not result in unavailability of abortion	Right to health	<p>CEDAW: GR 24 CESCR: GC 22</p>	<ul style="list-style-type: none"> • The exercise of conscientious objection without adherence to clear and enforceable regulations ensuring referral to safe and lawful abortion care hinders access to abortion. • In such cases, the regulation and exercise of conscientious objection would be inconsistent with the right to health.
States should protect health-care professionals providing abortion care	Right to health	<p>Special Rapporteur on Health Report, 2011 Special Rapporteur on Extrajudicial Killings Report, 2018 Special Rapporteur on Torture Report, 2013</p>	<ul style="list-style-type: none"> • Workload implications arising from regulation of conscientious objection may place significant burdens on health-care professionals providing abortion care. • In such cases this may have negative implications on health-care professionals' right to freedom of thought, conscience and belief. • Failure to regulate conscientious objection so that, e.g. workloads, staffing levels, or lack of regulatory clarity does not impede the exercise of conscientious objection in accordance with relevant regulations may impact negatively on

			<p>the exercise of rights to freedom of conscience and belief by health-care providers who are either total or partial objectors.</p> <ul style="list-style-type: none"> • In such cases this may result in changes in workplace or a full opt-out from abortion care provision in order to minimize imposition on personal conscience or ethics. • In such cases this may impede or hinder access to lawful abortion and thus violate the right to health.
States should protect people seeking abortion	Right to health	CCPR: GC 36 Special Rapporteur on Torture Report, 2013	<ul style="list-style-type: none"> • The exercise of conscientious objection can expose abortion seekers to stigmatization and indignity, impediments to their access to safe abortion, misinformation, and lack of access to accurate pre- and post-abortion information and care. • In such cases this may violate the right to health.
States should ensure Laws regulating abortion are evidence-based, proportionate to protect the right to health, and protect persons' physical and mental integrity	Right to health Right to security of person	CCPR: GC 36, <i>Whelan v Ireland, Mellet v Ireland</i> CESCR: GC 22 CEDAW: GR 34 Working Group on Discrimination against Women Report 2016 Special Rapporteur on Health Report, 2011, 2016, 2018 Special Rapporteur on Torture Report, 2016 Special Rapporteur on Extrajudicial Killings Report, 2018	<ul style="list-style-type: none"> • Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by health-care providers does not undermine or hinder a pregnant person's ability safely to access abortion, does not have a disproportionately negative effect on health and physical and mental integrity, does not prevent a woman from access abortion in cases of sexual violence including rape or incest, and does result in denial of therapeutic abortion has negative implications for rights.
Denial of therapeutic abortion may interfere arbitrarily with the right to privacy	Right to privacy	CCPR: <i>KNLG v Peru</i>	<ul style="list-style-type: none"> • In cases where therapeutic abortion is sought, the exercise of conscientious objection without timely referral to lawful abortion services may violate the right to privacy.

<p>Deaths related to regulatory approaches to abortion may <i>prima facie</i> constitute violations of the right to life</p>	<p>Right to life</p>	<p>CCPR: GC 28 Special Rapporteur on Executions/Killings, 2017</p>	<ul style="list-style-type: none"> • The exercise of conscientious objection without timely referral to lawful abortion services can lead people to seek abortion outside of the formal medical system. • In such cases abortion may be unsafe. • Where such unsafe abortion results in death of the abortion seeker this <i>prima facie</i> violates the right to life.
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