THIRD UNIVERSAL PERIODIC REVIEW of GEORGIA

37th Session

January-February 2021

JOINT STAKEHOLDER SUBMISSION

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Association “HERA-XXI” as a member Association of IPPF European Network in Georgia has actively worked on sexual and reproductive health and rights (SRHR) issues since 1998. Research, monitoring, local and international advocacy, and awareness-raising activities are used as main instruments to subsist the implementation of programs. The organization promotes the development of volunteers, youth activists, and formal and informal education on SRHR. It provides access to high quality sexual and reproductive health services and modern technologies through supporting development of organization systems model for primary healthcare with integrated SRHR services.

The Sexual Rights Initiative is a coalition of national and regional organizations based in Canada, Poland, India, Argentina, and South Africa that work together to advance human rights related to sexuality and gender at the United Nations.

The report is based on the research and program data of HERA-XXI, websites and statistics provided by State institutions, national policy documents and other secondary sources.

Key Words: Sexual and reproductive health and rights (SRHR), discrimination against women with disabilities, comprehensive sexuality education (CSE), access to sexual and reproductive health (SRH) services, youth-friendly services, access to family planning services, safe abortion

Executive Summary

1. This is an analysis of the status of implementation of Georgia's second cycle UPR-review recommendations concerning sexual and reproductive health and rights. It also considers the implementation of the matrix that was developed by the Government of Georgia in 2019.[1] In 2015, Georgia accepted 191 of 203 recommendations issued by other Member States; however, this report provides information on six specific recommendations related to women's access to SRH services and sexual and reproductive rights (117.11. Mexico; 117.104. Algeria; 117.105. Rwanda; 118.42. Denmark; 118.43. Brazil; and 118.41. Belarus).

2. The presenting report prepared by Association HERA-XXI in partnership with SRI addresses three SRHR themes: **Access to Safe Abortion; Family Planning Services;** and **SRHR of Women and Girls with Disabilities.**

3. Despite existing national and international protection mechanisms (including CEDAW, Istanbul Convention, Beijing Platform for Action, SDGs, CRPD) access to sexual and reproductive health services and information, remains very limited in Georgia. Women and girls still face daily experiences of stigma, discrimination and exclusion, denial of SRH services, lack of access to SRH information and violations of their fundamental rights to bodily autonomy, bodily integrity and to the attainment of the highest standard of health.

4. Since the second UPR reporting cycle, the Government of Georgia took some essential steps to develop relevant policies on sexual and reproductive health, including the Strategy of the Health Protection System (2014-2020), National Human Rights Action Plan (2018-2020), and the National Maternal & Newborn Health Strategy (2017-2030) and its corresponding 3-year Action Plan (2017-2019). However, the failure to allocate sufficient financial resources, lack of capacity of health systems, especially primary healthcare systems, significantly hinder the implementation of those policies (**Recommendation 118.41 Belarus**).

5. COVID-19 and subsequentlockdown has left women and girls without access to essential medical services such as abortion care**.** The huge reduction in these services is putting lives, health and wellbeing at risk, particularly those of vulnerable groups.

[1] United Nations Universal Periodic Review Mid Term Report Georgia (2019),available at: https://lib.ohchr.org/HRBodies/UPR/Documents/session23/GE/UPR2ndCycle_midterm.pdf

Access to safe abortion

6. Availability and accessibility to high-quality services are still critical problems in Georgia. Safe abortion services are not easily available and financially affordable for all women (**Recommendation 118.42. Denmark**).

7. Violations of standards of medical ethics, the right to privacy, the right to choose, and the right to dignity, bodily autonomy and decision making about sexual and reproductive matters are highly prevalent and pose significant barriers to accessing high-quality services, especially in densely populated regions of Georgia.

8. According to HERA-XXI research findings, doctors in many clinics refuse to provide abortion services on the grounds of conscientious objection and will not even provide referrals for procedures. They try to influence women's decision-making in relation to abortion. In some cases, they refer women seeking abortion services to religious leaders, which can lead to intense feelings of grief for women.

Geographical and financial barriers and access to quality services

9. According to HERA-XXI research findings, reproductive services are not readily available in rural areas and women have to travel long distances to have access to safe abortion. (**Recommendation 118.43, Brazil**).

   "I lived in the village of Otobaia and the only transport there is a horse-drawn cart. I had to travel in the cart to a place where I could get a taxi and then I had to get to the health-care facility by a taxi."[2]

10. Women and girls, especially in rural areas, face additional financial barriers in accessing abortion services incurringhightransportation costs. Often, they need to take loans to cover these costs. Lack of affordability of abortions leads to the use of unsafe methods to terminate pregnancies,which cancarry significant health risks[3](**Recommendation 117.104, Algeria**).

11. The lockdown from the COVID-19 pandemic and thesubsequent transportation restrictions left rural women and girls isolated, and aggravatedexisting affordability and accessibility barriers. Online digital alternatives of services were also inaccessible due to lack of knowledge of innovative technologies and technical barriers.

12. The Ministry of Labor, Health and Social Affairs of Georgia identified 655 medical facilities that have a license for provision of gynecological services in the country. However, only 17% of facilities provide abortion services and 95% of medical facilities are secondary health care

[2] Barriers to access to safe abortion services in women of reproductive age, 2019, available at : http://hera-youth.ge/wp-content/uploads/2019/05/Barriers-to-accessing-safe-abortion.pdf
[3] Ibid

facilities. Generally, secondary health care facilities are multi-profile clinics and functioning in cities. Only 5% of primary health care facilities provide abortion and family planning services.[4]

13. Medical facilities are privatized in Georgia: it is up to the management of facilities to choose whether they want to offer specific services and then go through the respective accreditation process. This is a systemic problem. There are no State regulations defining which services should be provided by medical facilities, or by primary health care facilities. The decisions of medical facilities management are based on cost-effectiveness and potential profits from services, and therefore create a huge gap in provisions of abortion and other SRH services.

5-days mandatory waiting period

14. In 2014, the abortion law was revised to include a new provision on mandatory counselling and **a five-days waiting period requirement before obtaining an abortion** during the first 12 weeks of the pregnancy.[5] Under an order of the Minister of Health, the period can be reduced to three days if a woman applies for abortion in the 12thweek of pregnancy and the term of 12 weeks is expiring. The amendment directly contradicts the WHO recommendation on the removal of obstacles for accessing safe abortion.[6]

15. This violates women's right to bodily autonomy and the right to a safe abortion. In many cases, women are not sufficiently informed about the five-day period and are denied services point-blank:

    "I received a pre-abortion counselling service, but I was not informed about the five-day waiting period. The fact was that my doctor refused to perform that abortion the day I visited the clinic; she might have been busy or might not feel like performing that procedure."[7]

16. In practice, women did not return to the medical facility after the five-days waiting period. Instead they received an abortion at another facility or turned to unsafe methods for termination of the pregnancy.[8]

17. Officially, abortion rate has decreased significantly since the introduction of the five-day waiting period. However, the usage of contraception has not increased. In 2019, the abortion rate was 21,086, including 12,992inducedabortions. Nearly half of the abortions in Georgia were registered as spontaneous abortions, such as miscarriages. There has not been any official national-level study on the reasons for the high level of "miscarriages." This data reported by the State is contradicted by monitoring data that shows that cases associated with "miscarriages" are from self-induced abortion efforts from Cytotec (misoprostol

[4] Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2016
[5] Law of Georgia on Health Care, Article 139, 2 b. available at: https://matsne.gov.ge/en/document/view/29980?publication=37
[6] WHO, 2012 Safe Abortion Guidance at 96-97
[7] Barriers to access to safe abortion services in women of reproductive age, 2019, available at : http://hera-youth.ge/wp-content/uploads/2019/05/Barriers-to-accessing-safe-abortion.pdf
[8] Sexual and Reproductive Health and Human Rights: National Assessment, Public Defender's Office Georgia, 2019

only).[9]HERA-XXI's research shows that the five-days waiting period has not resulted in a decrease in the number of abortions: it has only created an additional barrier for women seeking safe abortions.

Lack of information on safe abortion

18. The Law of Georgia on Health Care[10] prohibits advertising of abortion. However, the Law does not specify what is included in abortion advertising. As a result, many women and girls face challenges in accessing rights-based scientific information and education on modern methods of contraception.

19. The media has a crucial role in increasing public awareness of safe abortion. Unfortunately, in most cases, media coverage on abortion and SRH lacks sensitivity and is not rights-based or scientifically accurate. In 2019, HERA-XXI reported a program called 'Abortion as Judgment' produced by Maestro TV to the Council of the Georgian Charter of Journalistic Ethics. This program was about abortion, and featured inaccurate information and stigmatizing content. The Council ruled that the program violated a number of Articles in the Charter of Journalistic Ethics and highlighted the positive obligation of the media in reducing discriminatory attitudes in society.[11]

Family planning

20. In 2015, all 193 members of the United Nations, including Georgia committed to Sustainable Development Goal 3.7: "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" by 2030.

21. Key obstacles preventing use of family planning methods in Georgia are the following: insufficient SRH information and education; fears, myths and misconceptions about modern methods of contraception; and unavailability, low readiness and inaccessibility of quality family planning services (**Recommendation 117.105, Rwanda**).

Family planning as part of primary health care services

22. Family planning services are not fully integrated into primary health care services and are undertakenunsystematicallyby different medical specialists. Both the absence of relevant data on SRHR in primary health care in accordance with the life-cycle approach, and the lack of dissemination of information on family planning and contraceptives by the State, create significant barriers to accessing services.[12] It is impossible to design and provide services and information if the State lacks the data on what is required by women and girls.

[9] NCDC official letter N06/4825/ 30.12.19

[10]Law of Georgia on Health Care, available at: https://matsne.gov.ge/en/document/view/29980?publication=37

[11]https://www.qartia.ge/ka/gadatsyvetilebebis-dzebna/article/76120-asociacia-hera-xxiq-magda-anikashvilis-thornike-kverenchkhiladzis-irakli-maisuradzis-da-theo-mtcedlidzis-tsinaaghmdeg

[12] Sexual and Reproductive Health and Human Rights: National Assessment, Public Defender's Office Georgia, 2019

23. The National Strategy of Maternal and Newborn Health (2017-2030) and its associated Action Plan (2017-2019), stressthe integration of contraception and youth-friendly SRH services underuniversal health coverage.The State has not allocated any budget to ensure implementation of this plan, and State programs and private insurance companies do not cover such services. Contraceptives are also not included in the list of medications underState healthcare programs.[13]

24. There are no trainings or continuing education requirements for family doctors, midwives or nurseson the modern medical advancementsof SRH, which significantly impacts the quality of maternal health services provided throughout the country, especially in rural areas.[14]

Lack of information on contraception

25. The Government of Georgia is failing to comply with the **Recommendation 118.42 provided by Denmark**on ensuringaccessibility of SRHR information and services.

26. The lack of comprehensive information and communication creates barriers to the availability of appropriate services and undermines women's rights to bodily autonomy and bodily integrity, and their right to health.

27. Pervasive myths and misconceptions about modern methods of contraception, often spread by medical personnel, create an additional barrier to women seeking to make informed decisions to prevent unwanted pregnancies.[15]

Youth-friendly services

28. Adolescent girls have limited access to rights-based contraceptive services and information. The components of youth participation and youth-friendly sexual and reproductive service delivery are integrated in the National Strategy of Maternal and Newborn Health (2017-2030) and its Action Plan (2017-2019). However, currently there are no specific public youth-friendly SRH services available in Georgia.

29. Adolescents primarily learn about contraceptives and family planning from their peers and the Internet. This information may not be accurate and can undermine their ability to make informed decisions in relation to their sexual and reproductive behavior.

30. According to the Law on the Rights of the Patient, Article 40, 2 (b)[16] 14-18 years old patients have a right to provide informed consent to counselling on the methods of non-surgical contraception without parental notification. However, adolescents do not feel comfortable visiting health facilities to ask for SRH services due to fears and concerns about judgmental

[13]https://matsne.gov.ge/ka/document/view/3825285?publication=0

[14] Sexual and Reproductive Health and Human Rights: National Assessment, Public Defender's Office Georgia, 2019

[15] Barriers to access to safe abortion services in women of reproductive age, 2019, available at : http://hera-youth.ge/wp-content/uploads/2019/05/Barriers-to-accessing-safe-abortion.pdf

[16] Available at: https://matsne.gov.ge/en/document/download/16978/7/en/pdf

staff and the potential violation of their right to privacy and confidentiality.Young girls try to avoid pharmacies and medical institutions when they need SRH services.[17]They are also often denied services on the basis of their age.

SRHR ofwomen with disabilities

31. In 2013 Georgia ratified the UN Convention on the Rights of Persons with Disabilities. However, harmonization of the Convention has not taken place onalegal or a policy level.The Government does not prioritize or consider the needs of women and girls with disabilities during the development of State programs, policies or the budget.

32. Women and girls with disabilities often avoid visiting medical facilities for SRH services unless they have serious health issues or an emergency. This is due to existing stereotypes about women with disabilities not requiring SRH services, gynecological services that are not accessible for people with disabilities, and potential violation of confidentiality[18](**Recommendation 118.42. Denmark**).

33. Medical personnel lack knowledge on the specificity of SRH services for women with disabilities; women with disabilities are not adequately provided with information about family planning and contraceptives. This creates a strong barrier in boththe provisionand receiving of appropriate services.[19]

34. In Georgia, medical facilities are not accessible to women with physical disabilities. In most cases, internal infrastructureand entrances are not adapted for wheelchair users, including gynecological chairs and examination rooms.[20]

35. Women with physical and intellectual disabilities are often accompanied by relatives for their medical consultations. This is in part due to SRH service providers not making their consultation accessible, including not offering interpreter service for women with hearing and speech impairments. Medical personnel often violate the right to privacy and confidentialitybyinterviewing patients in a non-confidential space. This creates an unsafe environment and negatively affects the quality of the services.[21]

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[17] Sexual and Reproductive Health and Human Rights: National Assessment, Public Defender's Office Georgia, 2019

[18] Thematic Inquiry on Accessibility of Healthcare Services for Women and Girls with Disabilities, available at: http://parliament.ge/ge/ajax/downloadFile/133083/%E1%83%97%E1%83%94%E1%83%9B%E1%83%90%E1%83%A2%E1%83%A3%E1%83%A0%E1%83%98_%E1%83%9B%E1%83%9D%E1%83%99%E1%83%95%E1%83%9A%E1%83%94%E1%83%95%E1%83%90_-_%E1%83%A8%E1%83%A8%E1%83%9B_%E1%83%A5%E1%83%90%E1%83%9A%E1%83%94%E1%83%91%E1%83%98%E1%83%A1%E1%83%90_%E1%83%93%E1%83%90_%E1%83%92%E1%83%9D%E1%83%92%E1%83%9D%E1%83%9C%E1%83%94%E1%83%91%E1%83%98%E1%83%A1_%E1%83%9B%E1%83%98%E1%83%A1%E1%83%90%E1%83%AC%E1%83%95%E1%83%93%E1%83%9D%E1%83%9B%E1%83%9D%E1%83%91%E1%83%90_%E1%83%AF%E1%83%90%E1%83%9C%E1%83%93%E1%83%90%E1%83%AA%E1%83%95%E1%83%98%E1%83%A1_%E1%83%A1%E1%83%94%E1%83%A0%E1%83%95%E1%83%98%E1%83%A1%E1%83%94%E1%83%91%E1%83%96%E1%83%94_-_WWD_VF_2

[19] "Research on sexual and reproductive health needs and barriers in young people and women with disabilities", Association HERA-XXI,2019

[20] Ibid

[21] "Research on sexual and reproductive health needs and barriers in young people and women with disabilities", Association HERA-XXI,2019

36. Disability is perceived as a "contagious disease," and women with disabilities are oftenencouraged or compelled to terminate pregnancies to not 'infect' the fetus with the disability.[22]

37. Insufficient funding for mental health services leads to a lack of qualified personnel, and appropriate treatment and care in facilities. Women with mental health disabilities lack information about safe SRHR services including the side effects of medication on libido, hormonal issues and bodily changes.

38. In psychiatric institutions, women are not provided with information and access to contraception, including emergency contraception and pregnancy tests. Consequently, pregnancieshave to be terminated late, which can have a detrimental impact on women's physical and mental health. Further, psychiatric facilities in Georgia do not offer free SRH-related screening programs,including for breast cancer or cervical cancer.[23]

39. Women and girls with disabilities also do not have access to information about State health programs, and therefore cannot participate or benefit in any way. This is especially noticeable among women and girls with disabilities residing in rural areas and regions settled by ethnic minorities.

RECOMMENDATIONS FOR ACTION

40. Ensure that SRH services, including abortion and contraception services and information are available, accessible and affordable to all women and girls. Remove legal barriers such as the five-day mandatory waiting period.

41. Revise and update existing national abortion care guidelines in line with the most recent WHO recommendations (2019), and integrate safe abortion services in the primary health care system. Ensure the State's Universal Health Care Program covers all costs of safe abortions and contraceptives for socially vulnerable women, internally displaced persons, youth, students, and women living in hard to reach areas.

42. Review and clarify the law on prohibition of abortion advertisements. Integrate SRHR themes in the editorial policy of the State funded Public Broadcaster to raise awareness and share information on SRHR, including safe abortions.

43. Provide mandatedtraining to medical facilities' management and all medical personnel on gender-sensitive, human rights-based and patient-centric services. Ensure continuous education for medical personnel on family planning, contraceptive methods, counselling techniques, and counselling principles such as patient confidentiality and prohibition of discrimination, for all patients including youth and women with disabilities.

[22] Ibid
[23] Ibid

44. Implement internal and external audits to ensure the availability, accessibility, acceptability and quality of SRH services; ensure the implementation of quality control mechanisms provided in national guidelines and protocols, especially for youth-friendly SRHR services.

45. Integrate the needs, experiences and meaningful participation of women and girls with disabilities in the development, implementation, and monitoring and evaluation of existing and forthcoming State policies and programs of the Ministry of Labour, Health and Social Affairs.

46. Adapt healthcare facilities' infrastructure and capacity to accommodate women with disabilities.This includes wheelchair friendly physical accommodations, availability of interpreters when needed, confidential and safe spaces, etc.

47. Integrate interventions focused on women and girls with disabilities in the National Communication Strategy of SRHR, and organize information campaigns on SRH issues for women and girls with disabilities, including contraception and family planning services.

48. Ensure access to SRH services, including consultation on family planning, contraception, pregnancy tests, and free menstrual hygiene products and SRH-related screening programs in psychiatric facilities.