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Women's SRHR in Georgia

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Key Words: Sexual and Reproductive Health and Rights, discrimination against women with disabilities, comprehensive sexuality education, access to sexual and reproductive health services, youth friendly services, access to family planning services, safe abortion, domestic violence, violence against women

ABOUT THE COALITION

By the initiative of Association HERA XXI, Coalition of Reproductive Health and Rights has been working to improve social, economic, legislative and political environment regarding the SRHR in Georgia since 2015.

The following report was prepared by the members of Georgian NGO Coalition for Reproductive Health and Rights – Association HERA XXI, Anti Violence Network of Georgia (AVNG) and Cultural-humanitarian Fund Sokhumi.

Association "HERA-XXI" as a member Association of IPPF European Network in Georgia actively works on SRHR issues since 1998. The Association actively works on research, advocacy, and provides access to high quality sexual and reproductive health services through supporting the development of organization system model for primary healthcare.

Anti-Violence Network of Georgia (AVNG) founded in 2003. The organization runs shelters for women who have been victims of domestic violence. It provides free legal consultations and representation in court, as well as psychosocial services for domestic violence victims. The Network actively works on raising awareness of domestic violence and engages in different information campaigns.

Cultural-Humanitarian Fund 'Sukhumi' works to empower women to take on an active role in building a democratic society in Georgia and in the peaceful resolution of conflicts through educational, economic, social and cultural activities. It is an IDP women's non-governmental organization which was founded in 1997.

Executive Summary

1. The report is an analysis of the status of implementation of Georgia's second cycle review UPR-recommendations on Sexual and Reproductive Health and Rights and Women Rights issues and also considers the implementation of the matrix. [i] In 2015, Georgia accepted 191 of 203 recommendations issued by other member states; however, we will provide information on six specific recommendations related to Women's Rights and access to SRHR services (117.11. Mexico; 117. 104.Algeria; 117. 105.Rwanda; 118.42. Denmark; 118.43. Brazil; 118.41. Belarus; 117.58. Algeria; 117.60. Slovenia; 117.70 Slovakia; 117.71. Chile)

METHODOLOGY

2. The report is based on the reports, evidences, researches and program data of the organizations, websites and statistics provided by state institutions, national policy documents and other secondary sources.

Problem identification for specific issues

3. During the past ten years, noteworthy legal and institutional reforms were made to improve policy framework on Gender Equality, Sexual and Reproductive Health and Rights, Domestic Violence, and Violence against Women, and discrimination. Georgia is a contracting party to the most major human rights instruments.

4. Georgia has strengthened national institutional and policy framework on gender equality and women's rights. However, the lack of allocation of sufficient financial resources, weakness and no readiness of health system especially primary healthcare system hinders the possibilities to implement those policies into the practice. (Recommendation 118.41 Belarus)

5. Different groups of the population face some important problems related to their human rights, including sexual and reproductive rights.

6. Among the existing issues on SRHR are: implementation of laws and policies; integration of sexual and reproductive health services into the primary health care system and referral systems; knowledge and awareness of health care providers on sexual and reproductive health and rights; Awareness of the population and access to information on SRHR, Lack of fund allocation on SRHR services, lack of unified statistic information on DV and VAW, post shelter services, etc.

Availability, Accessibility, Acceptability and Quality of SRH services

7. Availability and accessibility to high-quality services are still critical problems in Georgia.
8. SRHR services are not readily available in rural areas, and women have to travel long distances to have access to the SHR services. It presents a geographical and financial obstacle for women, which requires additional transportation costs and time. (Recommendation 118.43, Brazil)
9. Nowadays, the State recognizes the need to address challenges associated with availability and accessibility of SRHR services including contraception and safe abortion, however, they fail in terms of implementation.
10. Violation of the standards of medical ethics, the dignity of women, the right to choose and violation patient confidentiality are a significant barrier to accessing high-quality services, especially in densely populated regions of Georgia.
11. There are no training or continuing education requirements for family, rural doctors, midwives and nurses on the modern medical achievements on SRHR, that significantly reduces the quality of maternal health services.[ii]
12. Government of Georgia is failing to comply with the Recommendation 118.42 provided by Denmark on the ensuring the accessibility information and services on SRHR.
13. Special issues have women and girls with disabilities who often avoid visiting medical facilities for SRH services until it becomes a health emergency unless it concerns their serious health issues. This is mainly caused by the existing stereotypes, non-confidential environment and unadopted gynecological services for the person with special needs. [iii] (Recommendation 118.42. Denmark)
14. The main obstacles on family planning/contraception services for women with disabilities are that they lack information on SRH services and medical persons lack knowledge on the specificity of the services delivery for the women with disability. This creates a strong barrier in receiving necessary and adequate services.[iv]
15. In Georgia, medical facilities are not accessible to women with physical disabilities. Gynecological chairs and examination rooms are not wheelchair accessible. In most cases, even entrance or inside infrastructure facilities are not adapted for wheelchair users. [v]

RECOMMENDATIONS FOR ACTION

16. Ensure that sexual and reproductive health services, including abortion and contraception services and information, are available, accessible and affordable to all women and girls
17. Provide training to medical facilities management on the principles of gender-sensitive, human rights-based, patient-centered services; Ensure continuous education for family and rural doctors to provide quality and human rights based sexual and reproductive health counselling techniques.
18. Ensure the implementation of quality control mechanisms provided under the guidelines and protocols and implement internal and external audits to ensure the Availability, Accessibility, Acceptability and Quality of SRH services.
19. 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 and ensure that their rights are respected, protected and fulfilled.

20. Ensure adaptation of healthcare facilities based on the needs of women with disabilities.

Access to safe abortion

21. According to the assessment conducted by HERA-XXI It has been revealed that women use abortion as the primary method of family planning.[vi]
22. Safe abortion service is not easily available and financially affordable for all women. (Recommendation 118.42. Denmark)
23. Given the social and economic problems, especially in rural areas, abortion service present financial obstacle for women, which requires additional transportation costs and time for many women. They need to take loans or to apply for termination of pregnancy.[vii] (Recommendation 117.104, Algeria)
24. The Ministry of Labor Health and social affairs of Georgia identified 655 service medical facilities that have a license for provision gynecological services in the country. However, only 17 % facilities provide abortion services and 95% of medical facilities are secondary health care 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.[viii]
25. According to the Analytical Report findings, doctors in many clinics refuse to provide abortion services because of their conscience and do not even provide for referral procedures. They try to influence women's decision-making to have an abortion. In some cases, they are referring to the religious leaders, that cause intense feelings of grief and self-stigma for women. These conditions can be one of the reasons for the post-abortion syndrome (PAS).[ix]
26. In 2014, the abortion law was revised to include a new provision on mandatory counseling and a five-day waiting period requirement before obtaining an abortion during the first 12 weeks of pregnancy. Under an order of the Minister of Health, the period can be reduced to three days, if a woman applies for abortion in the 12th week of pregnancy and the term of 12 weeks is expiring. The amendment contradicts to the WHO recommendation on the removal of the obstacles for accessing the safe abortion.[x]
27. The report of HERA XXI shows that the five-days waiting period required for making decisions related to abortions, does not work in practice and considerably adds to the costs as it requires additional visits to a medical facility. *"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"*[xi]
28. In practice women did not return to the medical facility after the five-days waiting period and instead received an abortion at another facility or chose an arbitrary method for termination of the pregnancy and then, with a deteriorating health condition, returned to the original medical facility.[xii]
29. Despite officially abortion rate is decreased significantly throughout previous years and in 2019 rate is 21086, usage of contraception has not increased. The number of artificial terminations of abortion is 12992 (2019), and nearly half of the abortions performed in Georgia are registered

as spontaneous abortion, such as miscarriages. There has not been any official national-level study on the reasons for the high level of "miscarriages". This data reported on by the state is contradicted by monitoring data that shows that cases associated with "miscarriage" are often outcomes such as bleeding from self-inducing abortion efforts with uneven usage of Cytotec (misoprostol only).[xiii]

30. The Law of Georgia on Health Care prohibits advertising abortion. The law does not specify what abortion advertising includes. As a result, many women and girls face challenges in accessing rights based, scientific information and education on modern methods of contraception.
31. 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, the Association "HERA-XXI" reported a program 'Abortion as Judgment' produced by Maestro TV to the Council of the Georgian Charter of Journalistic Ethics. The program was about abortion, featured inaccurate information and stigmatizing content . The council ruled that the program violated a number of articles in the Charter of Ethics considered a violation of journalistic ethics and highlighted the positive obligation of media in reducing discriminatory attitudes in society.[xiv]
32. All of these create barriers for women to have access to safe abortion and quality reproductive health services.

RECOMMENDATIONS FOR ACTION

33. Revise article 139 of the law on Health Care to remove mandatory waiting periods for women who decide to have abortion and review the law on prohibition of abortion advertisements.
34. Integrate safe abortion services in the primary healthcare system, Revise and update existing national guidelines in line with most recent WHO recommendations (2019) considering the needs and challenges faced by women to ensure managing abortion care at early stage of pregnancy with safe affordable options; Develop differentiated package for socially vulnerable women in the state's Universal Health Care Program to cover costs of safe abortion at early stage of gestation.
35. Ensure the implementation of quality control mechanisms provided under the guidelines and protocols and implement internal and external audits to ensure the Availability, Accessibility, Acceptability and Quality of SRH services.
36. Revise existing curiculums for media bachelor programs and ensure continuous education for mass media representatives on sensitive reporting;

Access to family planning services and information

37. In 2015, all 192 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.

38. Key obstacles about family planning usage in Georgia are the following: low level of Sexual and Reproductive health information and education; fears, myths and misconceptions about modern methods of contraception; unavailability, low readiness and inaccessibility of quality family planning services. (Recommendation 117.105, Rwanda)
39. Family planning services are not fully integrated into primary health care services and are unsystematically undertaken as part of the duties of different specialists. The absence of relevant indicators on SRHR in primary healthcare level for all groups of the population during whole life-cycle, approaches focused on the dissemination of information on family planning and contraceptives by the State creates significant barriers to accessing services. [xv]
40. Despite National Strategy of Maternal and Newborn Health for 2017-2030 and its action plan for 2017-2019 includes integration of contraception and youth friendly SRH services in universal health coverage, the state has no budget allocated to ensure implementation of the plan, and the service packages of State programs or private insurance companies do not cover such services. The State also does not include contraceptives on the list of medications that are part of State health care programs. [xvi]
41. Lack of comprehensive source of information and state communication strategy on family planning as lifesaving option for women create barriers in terms of the availability and undermines women's right to have informed choice.
42. Widespread myths and misconceptions on modern methods of contraception often promoted by medical personal cause lack of knowledge of family planning methods, which create an additional barrier to protecting women against unwanted pregnancy. [xvii]
43. Adolescent girls have limited access to contraceptive services and information. Most frequently, young girls from the regions are trying to avoid pharmacies and medical institutions when they need SRH services. [xviii]
44. Adolescents primarily learn information about contraceptives and family planning from their peers and the internet. This information may not be accurate and cannot guarantee their protection from risky behavior.
45. According to the Law on the Rights of the Patient, 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 a health facility to ask for services and concerns about judgmental staff or their privacy. Often, they are even confronted with denial by health facilities to provide certain services because of their age.
46. Youth-friendly Sexual and Reproductive service delivery, youth involvement component are integrated in the Maternal and New-born Health (MNH) Strategy for 2017-2030 and in its Action Plan. However, currently there are no specific public youth friendly SRH services available in Georgia.

RECOMMENDATIONS FOR ACTION

47. Integrate the life-cycle approach in the primary healthcare system and in the provision of SRH services for all groups of the population; Include provision of contraceptives in the Basic Package of the Universal Health Care Program of Georgia particularly for socially vulnerable groups of women, internally displaced persons, youth, students, women living in hard to reach areas.
48. Provide continuous education for gynecologists and reproductive health specialists on family planning, contraceptive methods and counselling principles, including patient confidentiality, prohibition of discrimination, and the provision of services favorable to young people.

49. Develop a national communication strategy and action plan on SRHR. Ensure implementation of the campaigns and programs to raise public awareness on the importance of family planning, including on modern contraception and the importance of its usage; (especially focus on the regions and rural areas of Georgia).
50. Develop standard of youth friendly services and ensure relevant capacity building for service providers.

Domestic Violence and Violence against Women

51. During the past ten years, Georgia significantly improved legislative framework on Gender Equality, Domestic Violence, and Violence against Women. Legislative amendments aimed to bring domestic legislation in compliance with international requirements set by pertinent international instruments Georgia is a party to. Georgia signed Convention on Preventing and Combating Violence against Women and Domestic Violence (hereinafter referred to as Istanbul Convention) in 2014 and ratified on 19 May 2017.
52. Despite positive changes with regards to the state actions on domestic violence and violence against women, the implementation of effective preventive measures remains a challenge.
53. According to the National Study on Violence against Women in Georgia 2017 conducted by UN Women and National Statistics Office of Georgia (Gesotat), 1 in 7 women (14 %) has experienced intimate partner violence, and 1 in 4 women in Georgia has experienced at least one form of Gender-based Violence. In January-February 2020 eight women were killed by family members.

54. The crisis caused by the pandemic, numerous restrictions imposed as a result of the state of emergency, deteriorating economic situation in the families have further increased the burden of responsibilities and obligations placed upon women. Against this background, constant stress and psychological problems have negatively affected women's daily life. Women have been subjected to constant psychological pressure and have often become victims of various explicit or implicit forms of domestic violence.

55. According to survey of Fund Sokhumi 34% of respondents noted that the situation created as a result of the pandemic had "increased the number of family conflicts and the prevalence of domestic violence".[xix] The mechanism for identifying cases of violence against women, domestic violence and cases of family conflicts, as well as for working with the victims and ensuring appropriate response to the problem has been revealed to be rather weak; there has been inadequate attention and response to the problem on the part of the State;

56. Being locked in the same space with abusers and restricted social contacts left women without support, alone to face their own problems and tragedy. The study has revealed that under the conditions created by the COVID-19 pandemic, victims are reluctant to disclose or report their own problems, because they feel ashamed to talk about their own problems given the current

situation as they consider it an issue that is not a priority for the public, the police and the State in general.

57. Under the conditions created by COVID-19 pandemic, women employed in the service sector in medical facilities, found themselves under serious psychological pressure and stigma from the side of both their family members and relatives, as well as from the side of the community.

58. One of the key issues related to the violence against women and domestic violence issues is that there are almost no supporting services for victims after they leave shelters. Given the specific nature of the problem, effective coordination among the state, institutions is crucial. The government of Georgia drafted the National Referral Mechanism on Violence against Women and Domestic Violence Issues, but the official document still is not approved. The State has neither a referral program/services for adults, nor appropriate financial obligation to provide actual assistance to victims/survivors of violence.

59. Psycho-social rehabilitation and educational programs in shelters for victims of domestic violence remain insufficient for supporting victims. It is imperative to have more time and recourses dedicated to planning and implementing rehabilitation programs and activities. Besides, these programs must be more inclusive. The shelters fail to properly ensure the self-realization of beneficiaries, their empowerment, and psycho-social rehabilitation.

60. The problems that persist include the provision of housing and financial support to victims after they have left shelters and collection of information about the health of beneficiaries upon their admittance to shelters.

RECOMMENDATIONS FOR ACTION

61. Approve Referral Procedures on Violence against Women and Domestic Violence Issues.
62. Develop supportive programs for victims of Domestic Violence and Violence against Women after leaving shelters. Introduction of flexible and transparent mechanisms for monitoring the survivors' social status after leaving the shelter.
63. Provide continuous education of social workers from State Social Service Agency in the issues of domestic violence and strengthening their role in supporting victims/survivors of such violence, especially in the direction of conducting preventive monitoring of high-risk families.
64. Increase number of crises centers to have geographical coverage of services for victims of Domestic Violence and Violence against Women.
65. Take steps to raise public awareness on Gender Equality issues by informational campaign of Ministry of Internal Affairs. Encourage population to increase their involvement and participation in the effort to reveal and identify cases of violence in the face of isolation and increased insecurity faces by victims;
66. Raise gender sensitivity and awareness of the increased risk of gender-based violence among police officers; and properly informing them of the necessity of ensuring confidentiality of the victims reporting cases of violence;
67. Support for the staff working in the field of provision of medical and other services in health care facilities of public stigma and psychological pressure and preventing their marginalization in society and in their families, due to the performance of their professional duties.

68. Ensure that the basic needs of the most vulnerable groups of population are met under the conditions created due to the pandemic and promoting cooperation between the opposing parties in humanitarian issues: focusing on serving the basic needs of the vulnerable groups of population: elderly, children, women, citizens with medical needs, persons with disabilities.

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[v] Ibid

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