HUMAN RIGHTS IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND WELL-BEING IN GEORGIA: COUNTRY ASSESSMENT

PUBLIC DEFENDER'S OFFICE
OF GEORGIA

PUBLIC DEFENDER
(OMBUDSMAN) OF GEORGIA

The research was conducted with the support of United Nations Population Fund (UNFPA) Georgia Country office within the frameworks of the United Nations Joint Programme for Gender Equality, funded by the Government of Sweden.

The opinions expressed herein are those of the authors and do not necessarily reflect the views of UNFPA and the Swedish Government.

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GLOSSARY AND COMMON ACRONYMS

ARVs: Antiretrovirals, drugs that treat HIV.

Beijing Declaration and Platform for Action: consensus document adopted by states participating in the 1995 U.N. Fourth World conference on Women.

CEDAW Committee: U.N. body responsible for monitoring states' compliance with the U.N. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Children's Rights Committee (CRC): U.N. body responsible for monitoring states' compliance with the Convention on the Rights of the Child.

Coitus interruptus/withdrawal: The practice of withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation in order to prevent pregnancy.

Committee on the Rights of Persons with Disabilities (CRPD): U.N. Committee on the Rights of Persons with Disabilities. U.N. body responsible for monitoring states' compliance with the Convention on the Rights of Persons with Disabilities.

Concluding observations: following submission of a State report and a constructive dialogue with the State party to a particular convention, treaty monitoring bodies issue concluding observations to the reporting State, which include recommendations. They are compiled in an annual report and submitted to the United Nations General Assembly.

Council of Europe: regional intergovernmental body consisting of 47 European Member States dedicated to promoting the human rights and fundamental freedoms of European citizens and residents.

Emergency contraceptives: drugs that act to prevent ovulation and/or fertilization within the rest few days after an intercourse in order to prevent pregnancy.

Committee on Economic, Social and Cultural Rights (CESCR): U.N. body responsible for monitoring states' compliance with the International Covenant on Economic, Social and Cultural Rights.

Family planning (FP): the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births; it is achieved through use of contraceptive methods and the treatment of involuntary infertility.

General Comments/Recommendations: a treaty monitoring body's interpretation of the content of human rights provisions on thematic issues or its methods of work. General comments seek to clarify the reporting duties of State parties with respect to certain provisions and suggest approaches to implementing treaty provisions.

Hormonal contraceptives: oral pills, injectables, hormone- releasing implants, skin patches, vaginal rings, and some IUDs.

Human Rights Committee (HRC): U.N. body responsible for monitoring States' compliance with the International Covenant on Civil and Political Rights (ICCPR).

Human rights standards: the meaning and scope of human rights as interpreted and applied by the human rights bodies tasked with this work, e.g. international, regional and national courts, and human rights committees.

International Conference on Population and Development (ICPD): U.N. conference held in Cairo in 1994, where world leaders, high-ranking officials, representatives of NGOs, and U.N. agencies gathered to agree on a program of action to address issues related to population and development.

International human rights treaty: also sometimes referred to as Covenant or Convention, is adopted by the international community of States, normally at the United Nations General Assembly. Each treaty sets out a range of human rights, and corresponding obligations which are legally binding on States that have ratified the treaty.

IDU: intravenous drug user

IUD: intrauterine device. A small device that is inserted into a woman's uterine cavity to prevent pregnancy and is effective for up to 12 years depending on the type used.

KAPs: key affected populations

Legal gender recognition (LGR): an official procedure to change a trans person's name and gender identifier in official registries and documents such as their birth certificate, ID card, passport, driving license etc.

LEPL - legal entity of public law

LGBTI: Lesbian, Gay, Bisexual, Transgender, Intersex

Maternal death/mortality: maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Modern contraceptives: clinic and supply methods of contraception, including female and male sterilization; IUDs; hormonal methods, such as oral pills, injectables, hormone-releasing implants, skin patches, and vaginal rings; condoms; and vaginal barrier methods, such as the diaphragm, cervical cap, spermicidal foams, jellies, creams, and sponges.

MoLHSA: Ministry of Labour, Health and Social Affairs of Georgia

MoES: Ministry of Education and Science of Georgia

MIA: Ministry of Internal Affairs of Georgia

MoSYA: Ministry of Sport and Youth Affairs of Georgia

MoC: Ministry of Corrections of Georgia

NGO: non-governmental organization.

PDO: Public Defenders Office (the Public Defender of Georgia is the National Human Rights Institution in Georgia

PHC: primary health care

Pills or contraceptive pills: oral hormonal contraceptives that contain either estrogen and progestin, or only progestin.

Program of Action of the International Conference on Population and Development: consensus document adopted by the States participating in the International Conference on Population and Development.

PO: Prosecutor's Office of Georgia

RHS: Reproductive Health Survey

Reproductive health: within the framework of the World Health Organization's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

SC: Supreme Court of Georgia

Sexually transmitted infection (STI): an infection that can be transferred from one person to another through sexual contact.

SOGI: sexual orientation and gender identity

SRHR: sexual and reproductive health and rights

Sexual health: as defined by the World Health Organization, is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to human sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Traditional methods of family planning: non-supply methods of contraception, including rhythm, withdrawal, abstinence, and lactational amenorrhea (a method based on the natural postpartum infertility that occurs when a woman is fully breastfeeding and not menstruating; women must be continuously and exclusively breastfeeding and less than six months postpartum).

Treaty monitoring body: each of the U.N. human rights treaties is monitored by a designated treaty monitoring body. The treaty monitoring bodies are committees composed of independent experts. Their main function is to monitor the States' compliance with the treaty in question, including through the examination of State reports, issuing general guidance to all states on how to comply with treaty provisions, called General Comments or General Recommendations; and, in some cases, consider individual complaints against governments.

U.N.: United Nations

Unmet need for contraception/family planning: women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behaviour.

Unsafe abortion: a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.

UNFPA: United Nations Population Fund, the lead U.N. agency aiming to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

VCT: voluntary counselling and testing

WHO: World Health Organization. Lead U.N. agency devoted to researching and promoting public health worldwide.

PDO'S FOREWORD

The Public Defender's Office is the main national human rights institution in Georgia. According to the UN Paris principles, the Public defender of Georgia is an A-status national human rights institution, authorized to receive and review applications and complaints about human rights violations, conduct thematic monitoring, raise awareness in the field of human rights and freedoms amongst various target groups.[1] The Public Defender of Georgia pays special attention to gender equality and women's rights situation in the country.

The cases studied and analysed by the Gender Equality Department of the Public Defender's Office reveal that protection of sexual and reproductive health and rights remain a systemic problem in Georgia. Unfortunately, Georgia remains a society where gender stereotypes are deeply rooted. The information, obtained from the case analysis demonstrates that the awareness on sexual and reproductive health and rights is critically low, especially among ethnic minority groups, LGBTI community, as well as victims and survivors of domestic violence and violence against women.

After her visit in Georgia, Ms. Dubravka šimonović, U.N. Special Rapporteur on violence against women, its causes and consequences recommended[2] the Government to introduce education on gender equality, violence against women and age-appropriate sexual and reproductive health and rights into the curriculum at all levels of education, however, this recommendation has not yet been implemented. Other U.N. human rights bodies have also made recommendations to Georgia on rights related to sexual and reproductive health and well-being issues. These issues and recommendations are addressed in this Assessment.

The Country Assessment that was primarily based on a desk review was undertaken within the framework of partnership between the UNFPA country office in Georgia and Public Defender's Office that aiming to strengthen the latter's capacity in the field of monitoring human rights in the context of sexual and reproductive health and well-being.

The Country Assessment offers an evaluation of the current situation, complete with existing gaps and challenges within and beyond the health sector, with a special focus on human rights issues in the context of sexual and reproductive health and well-being connected to the marginalized groups, legal and policy frameworks, budgeting and financing, delivery and accessibility of health services, and the provision of remedies and redress.

The report was drafted by Christina Zampas, international human rights lawyer and consultant, with national consultants who conducted national level research and supported the drafting process: Tamar Dekanosidze, Lika Jalagania, and Lela Sheneglia. Also supporting some of the drafting process was Federica Merenda.
Hereby, we present the Country Assessment results, and hope that our recommendations will be taken into consideration during the development and implementation of laws and policies in the field of SRH&RR.

1 Paris Principles, as a set of international standards which frame and guide the work of National Human Rights Institutions (NHRIs), adopted by the United Nations General Assembly in 1993.

2 UN, Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, A/HRC/32/42/Add.3, 22 July 2016, 6, available on-line at: http://www.ohchr.org/Documents/Issues/Women/SR/A.HRC.32.42.Add.3.pdf

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Human rights in the context of sexual and reproductive health and well-being are essential to the dignity, survival, good health and the enjoyment of a range of other fundamental human rights. They are protected by international and regional human rights treaties which Georgia has ratified and which it is bound by, sexual and reproductive health and well-being, in the context of the human rights are also safeguarded by the laws and Constitution of Georgia.

The assessment of human rights in the context of sexual and reproductive health and well-being in Georgia

This Country Assessment is the first of its kind in Georgia. The objectives are to assess the degree to which human rights, in context of sexual and reproductive health and well-being, are enshrined in the laws of Georgia how they are realized in practice, through Georgia's laws and policies and in their implementation; to identify key areas of progress as well as barriers; and make recommendations to the Government of Georgia and other responsible authorities.

The assessment focuses on the following issues: access to contraceptive information and services; access to safe abortion services and post-abortion care; maternal health care; prevention and treatment of HIV/AIDS; life skills/comprehensive sexuality education; violence against women and girls; reproductive technologies: surrogacy; and select reproductive cancers and breast cancer. It also focused on marginalized groups with a particular focus on subgroups of women and girls, LGBTI, female sex workers; women who use drugs; internally displaced and conflict affected women; ethnic minorities; people with disabilities, and youth and adolescents.

Key human rights considerations such as non-discrimination and equality, participation, budgeting and allocation of resources, data collection, monitoring, accountability, and privacy and confidentiality were also a focus of the Assessment, as was the broader health system relevant for understanding human rights in this context, together with areas of progress and obstacles.

In order to assess progress and obstacles, the assessment identified a series of questions and indicators on these sexual and reproductive health and well-being issues. The obtained Information, based almost exclusively on existing data and studies, was analysed with three overarching questions in mind: what is the status of sexual and reproductive health and related rights of the population of Georgia, including marginalized groups? Which key laws, policies and initiatives have been adopted by the Government, and what is their implementation status? What are the main consistencies and discrepancies between legal protections of such health and rights, including domestic and international human rights and the reality? The report includes recommendations based on findings to these questions.

The report could serve as a strong basis for a future national inquiry. This Executive Summary and Recommendations provided immediately below should be read in conjunction with the details provided in the relevant sections of the report.

Key Areas of Progress and Remaining Problems

Georgia has made a laudable progress in the area of human rights, including in the area of sexual and reproductive health and well-being. It has a constitutional framework for the protection of human rights in this context as well as an extensive number of relevant laws in this area. While not legally binding, it also has an extensive number of policies addressing this issue. It has also ratified relevant international and regional human rights treaties, most recently the Council of Europe Convention on preventing and combating violence against women and domestic violence. In addition, the country has shown some advancement in developing a health system that is sustainable. In relation to particular sexual and reproductive health issues, important progress has been made in terms of improving maternal health, including reducing high levels of maternal mortality, for example. As shown in this assessment, the State has taken significant commitments in many other areas, some of which have been implemented, while others remain unattended.

Progress has not been even, with a wide range of challenges obstructing an adequate realization of human rights in this context in Georgia. Some of these concern the broader health system, including limitations on: financing of health care; implementing laws and policies; health information systems, including data collection; integrating sexual and reproductive health services into the primary health care system and referral systems; and training of health care providers on sexual and reproductive health and well-being, and related human rights. There is also a need to strengthen accountability, including with respect to laws, policies, regulations and standards, and their implementation.

In addition to these broad, cross-cutting challenges that each affect all or a range of human rights in the context of sexual and reproductive health and well-being , each key issue assessed in this report also faces its particular problems.

Georgia is a state party to all major international and regional human rights treaties, and is thus subject to review of its compliance with its commitments under these treaties. Human rights bodies have repeatedly found that Georgia falls short in its compliance with international human rights norms related to the sexual and reproductive health and well-being issues addressed in this Assessment. These human rights bodies have time and again issued recommendations to the Government of Georgia to ensure that the rights to sexual and reproductive health of persons in the country are not illusory, but a reality. This is particularly true for marginalized populations. Of particular concern are the persistent harmful gender stereotypes, which pervade the society and which impact the realization of human rights in Georgia. In addition, while Georgia is a State Party to human rights treaties, it has not ratified the Optional Protocols which allow for individual complaints and inquiry procedures namely, protocols to the Convention on the Rights of Persons with Disabilities and the Convention on Economic, Social and Cultural Rights.

The recommendations presented in this Assessment have been developed in light of Georgia's international human rights commitments. The PDO urges Georgia to implement these recommendations, alongside with the recommendations issued by international and regional human rights bodies.

The Public Defenders recommendations are provided immediately below, the same recommendations follow each relevant section of this Assessment.

Access to Contraceptive Information and Services

While many policies recognize the need to address challenges associated with the limited access to contraceptive services and information, by and large, they lack detailed account as to how this should be done. The Government overall, is so far failing to provide an adequate supportive environment for effective family planning services, largely due to the lack of integration of family planning services into the primary health care system. Other challenges include the low level of public awareness, including inadequate knowledge of the use of the range of contraceptive methods and affordability, as contraceptives are not funded by the State's health programs. In Georgia, there is no official essential medicines list for contraceptives to be included in. A core human rights requirement under the right to health is to ensure that contraceptives, including emergency contraception, are included in the country's essential medicines list which ensures availability and accessibility, including affordability, of these medicines for all persons. There is a shortage of information on the full range of the types of modern contraceptives available on the market. In addition, while emergency contraception should be available without a prescription, there appears to be an inconsistent practice whereby at times emergency contraception is provided without a prescription, while at other times a prescription is required, effectively hindering the access to this time-sensitive contraception. The low use of contraceptives and high unmet need is also attributed to misconceptions among the population about the side effects of these drugs (e.g. that contraceptives are harmful to health, hormonal contraceptives cause cancer, and that the pills may result in infertility). Lack of affordability, together with the lack of overall accurate information on effectiveness of modern contraceptive methods also contributes to their low use and high unmet need. Full access to accurate contraceptive information is essential for informed consent, including for adolescents and youth, but there are a lack of comprehensive youth friendly services.

Access to Safe Abortion Services and Post-Abortion Care

Numerous aspects of the legal and regulatory framework governing abortion are problematic and not aligned with Georgia's human rights obligations and WHO guidance. While the government is rightfully concerned about the high rates of abortion in Georgia, some aspects of the law and regulations appear -to address this by undermining women's self-determination rather than empowering women in their reproductive decision-making. While a MoHLSA's order provides a strong basis for respecting the dignity and decision of the women, the mandatory five-day waiting period and the language prioritizing the foetus in the Law on Health Care contradicts international health and human rights recommendations and impacts particularly marginalized populations access to the service. In addition, the consent form for abortion providing information on the moral and ethical issues concerning abortion and the harm it may bring about, appears to require biased counselling and misinformation focusing on the harms of abortion, contrary to international health and human rights recommendations.

The WHO recognizes that 'when performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.' Other barriers include the unregulated practice of conscientious objection: there appears to be no data gathered by the State on the number of providers refusing to perform terminations based on conscience and an alleged impact of abortions on women's health. An NGO report indicates that many clinics do not even provide for referral procedures because of conscience. This contravenes international human rights obligations of the state to ensure that conscientious objection is regulated so that it does not hinder women's access to lawful services. In addition, the MoLHSA order requiring a court confirmation in order to undergo an abortion on the grounds of rape past 12 weeks, could hinder victims' access to abortion, even further stigmatizing them and the practice, and is contrary to human rights obligations. An NGO reports that there are discriminatory restrictions imposed by some clinics in respect of certain groups of women and girls seeking abortions, particularly persons under 16, 16-18 year olds, women with sexually transmitted infections, and sex workers. Finally, in relation to the recently imposed abortion ban in Abkhazia, Georgia, there are no studies done on the extent to which women travel from Abkhazia, Georgia to nearby regions, to undergo abortions and the extent to which they can actually access abortion when they do travel.

Maternal Health

The Government has taken numerous commendable steps in improving maternal health and reducing maternal mortality, including addressing the three main delays: universal health coverage, antenatal care program, and improvement of information systems that often result in preventable maternal mortality and morbidity. Yet, Georgia still has one of the highest rates of maternal mortality in the region. The main reasons of high maternal mortality in Georgia are low quality antenatal and perinatal care, a weak transportation system, weak regulatory and monitoring systems, and lack of trained professionals at maternity houses and consultation centres, especially in the regions. The population's low awareness about reproductive health, particularly about pregnancy and pregnancy related complications also negatively influence pregnancy outcomes.

While there are welcome commitments made towards improving the quality of antenatal care, to date, there is still a need for improved mechanisms for timely detection of high-risk pregnant women and new-borns (antenatal care visit records do not require classifying pregnancy risks), proper referrals to the appropriate levels of care, and improved information sharing and feedback between the levels of care (village ambulatory, women's consultation centres, maternity hospital and emergency obstetric care facility (EmOC)). Ensuring the continuum of care is essential. The active epidemiological surveillance of maternal mortality revealed in recent years the transportation of pregnant women with complications was problematic. According to the available disaggregated data, however limited, ethnic minorities, women in rural areas, and those who have not completed secondary schooling use antenatal services less frequently. This is partly due to the lack of accessible information about the importance of health seeking behaviour and their lower economic status which drives them to avoid direct and indirect costs of seeking health care services.

The extent of the problem, however, is unclear since comprehensive data disaggregated by ethnicity, age, geographical location and other characteristics are not available. In relation to the increased number of C-sections, a study showed that the increase is partially due to women opting to reduce pain during delivery and the lack of information regarding the benefits of natural delivery and the complications involved in caesarean sections. Another study indicated that the influence of doctors 'guided by their own interest of making more money and saving time may also impact women's decisions to opt for C-sections.' These challenges raise serious concerns about the extent to which informed consent is followed. In addition, Georgia has a low percentage of women receiving postpartum care, in fact, the lowest in the region. These challenges may be due to the lack of programs and low awareness of the need for postnatal care. Article 37 of the Law on Patients' Rights provides for overriding a woman's decision related to childbirth, even in situations presenting minimal risks. However, there is no detailed guidance on this, which raises concerns regarding the quality of care and women's autonomous decision-making. The right to maternal health is a well-recognized human right under the rights to health, life, and the right to non-discrimination, amongst other rights, obligating the State to address these deficiencies.

Prevention and Treatment of HIV/AIDS

The HIV law adopted in 2009 has improved the overall legal environment for national response and the national strategy is laudable in setting forth goals addressing some of the barriers to HIV prevention, testing, treatment and care. However, formidable barriers still exist both in regulations and in practice, especially for key populations. These stem from various problems, including the overly broad criminalization of HIV transmission,, as well as requirement to show an ID to be tested, and stigma attached to key populations, for example, against men having sex with men (MSM) and sex workers. The overly broad criminalization of HIV transmission in Georgia, can hinder people from actually undergoing testing and to obtaining appropriate treatment if tested positive. UNAIDS recognizes that the overly broad criminalization of HIV non-disclosure, exposure and transmission can undermine public health efforts and lead to a miscarriage of justice. In addition, a strict drug law environment represents a severe obstacle for effective implementation of the National Strategic Plan on HIV/AIDS. WHO notes that persons living with HIV in Georgia do not wish to disclose their status to primary care doctors and dentists for instance, and it is commonly more accepted to say that one has hepatitis C rather than HIV.

This seems to be a particular problem in the regions outside Tbilisi, as examples were given of patients being transferred to Tbilisi because doctors refused to treat them for other conditions because of their HIV status. In addition, according to WHO, low testing coverage of people at risk is the core of the problem in Georgia. This may be, in part, due to the widespread stigma towards people living with HIV and key populations among the public, as well as among relevant professionals including health care workers, and non-observance of anonymity in testing. It is reported that in 2011 the state began requesting identification from all people being tested, but that since 2015 anonymous testing was reintroduced for at-risk populations. Such risk groups are generally hard to reach under usual circumstances, and given the levels of social inequality and stigma which seem to be present, gathering data on these sub- populations, in order to understand the extent and characteristics of the epidemic, remains very challenging. Of concern is also the increased numbers of young people with HIV.

Life Skills Education/Comprehensive Sexuality Education

Life skills education/comprehensive sexuality education provides people with essential knowledge and skills to be healthy. It limits vulnerability to sexual ill-health, through reducing exposure to unwanted pregnancies, unsafe abortions, STIs and HIV. According to human rights standards and UNFPA and UNSECO guidance, in order to make informed and sound decisions about sexuality and reproduction individuals, particularly adolescents, need accessible, comprehensive and quality information provided throughout schooling in an age-appropriate manner. This information should also aim to promote gender equality, and address such issues as gender-based violence and harmful stereotypes and practices. Despite the laudable initiatives undertaken by the State, to date, there is no comprehensive and compulsory program of age-appropriate life skills/sexuality education in Georgia.

The existing information provided in some courses are primarily focused on biological aspects of reproduction and do not fully address critical issues in Georgia, such as harmful gender stereotyping and gender-based violence. Inadequate counselling services, limited or inexistent life skills/sexuality education in and beyond schools, together with little or no information, or even misleading information, hinder the ability of adolescents and youth in Georgia to have responsible, satisfying and safe sex lives. In addition, there is a lack of comprehensive teacher training on the subject matter throughout the country, and lack of teaching methodologies and materials, both for students and teachers. Not all school doctors are trained on the subject matter and there is no mechanism to make such training mandatory. Public information campaigns to reach all youth, including those out of school, are also lacking.

Violence against Women

Despite the positive efforts made by the Government of Georgia, including the recently adopted legislation on violence against women and gender equality, numerous deficiencies still exist, both in legislation and in practice. (This Assessment deals with select issues on violence against women in particular, and not all gender-based violence.). Violence against women and particularly domestic violence is a widespread problem in Georgia. In addition, the number of cases is likely to be underestimated. For example, the UN Special Rapporteur on violence against women, expressed concern that in Georgia, some cases are registered by the police under 'family conflict', which may leave cases of domestic violence invisible. The lack of public awareness, the fear of retaliation and stigmatization, the lack of trust in law enforcement agencies and the lack of effectiveness of protection mechanisms for victims, including rehabilitation services can also be contributing factors to underreporting the cases of both domestic violence and sexual violence. In addition, numerous gaps exist in the legislation, despite international human rights requirements. For example, there is no definition of femicide (gender-related killing of a woman) included in criminal legislation. The definitions of rape and other forms of sexual violence in the Criminal Code, amended in 2017, are still not in line with the requirements of CEDAW and the Istanbul Convention. In practice, in the overwhelming majority of instances, criminal prosecution of an alleged rape will be launched only if physical injuries are present, which contravenes the well-established international and regional human rights standards. Even though the Law on Gender Equality contains the definition of sexual harassment in labour relations, it does not include an explicit penalty nor any civil law remedy for such an act. Regarding public awareness campaigns, although many of the State institutions have taken measures to raise public awareness on violence against women and domestic violence, and more people are aware of the problem, patriarchal attitudes on violence and gender equality are still deeply entrenched within society, influencing the investigation and reporting of these crimes. In addition, systemic and individual gaps in responding to violence against women by the courts still persist. Law enforcement bodies appear to be failing in assessing duly the threats and risks posed to victims and do not apply adequate or any preventive measures. Finally, full access to effective remedies, particularly compensation, are not available to survivors to date.

Reproductive System and Breast Cancers

Breast and cervical cancer are the main killers for women of reproductive age in Georgia. Availability and accessibility, including affordability for the rural population, particularly of screening programs, are the main barriers to reproductive cancer screenings and treatment in Georgia. While, since 2013, the State is financing, to some extent, cancer treatment through the Universal Health Care (UHC) program, including chemotherapy, hormonotherapy, radial therapy and all related diagnostic testing, the screening programs have not been integrated into primary health care services, and that is why there are geographical and financial barriers for utilization of screening programs. The utilization of the cancer screening programs (breast, cervical, prostate and colorectal) is significantly low. While earlier public information campaigns related to cancer screenings seemed to have been effective, they were discontinued and currently there are no public awareness programs funded by the State or by municipal programs.

Artificial Reproductive Technology (ART): the situation concerning surrogacy

Georgia's current legislation does not adequately address issues concerning surrogacy, and as a result much of the practice goes unregulated. A consultation meeting in 2014 organized by the MoLHSA, the Ministry of Justice, the Healthcare and Social Affairs Committee of the Parliament, and the Maternal and Child Health

Coordination Council with the technical support of the UNFPA Country Office in Georgia, resulted in a consensus on the need to develop a regulatory system of control. It was agreed that such a regulatory system should be designed not to encourage surrogacy arrangements but rather to restrain their harmful effects on individuals and wider society, which may stem from- uncontrolled surrogate motherhood arrangements and incentives, while at the same time not prohibiting the practice. The framework developed as a result of this meeting, however, has not been implemented, and to date, the practice of surrogacy remains essentially unregulated.

Particularly Marginalized and Disadvantaged Groups

Whereas discrimination affects access to health and to other social services and the enjoyment of the human rights of persons marginalized on many different grounds, in this report we have selected marginalized groups which are particularly vulnerable in terms of their access to sexual and reproductive health services. Since our focus is on human rights related to sexual and reproductive health and wellbeing, which impacts women in particular, due to the prevalence of violence and biological and social factors, special emphasis has been placed on groups of marginalized women experiencing intersectional discrimination because of multiple characteristics and or identities, such as being a woman with a disability. The groups covered in this report are LGBTI; female sex workers; women who use drugs; internally displaced and conflict affected women; people with disabilities; ethnic minorities; youth and adolescents.

Persons belonging to these groups are exposed to discrimination either due to inadequate laws or faulty practices, both in and outside health care settings. Stigma because of who they are or what they do, and criminalization in some cases, leads to poor treatment in health facilities and pushes persons belonging to marginalized groups to refrain from getting care. The lack of disaggregated data results in the State failing to adequately address the needs of its most vulnerable and marginalized populations through laws, policies and programming, and leads, in part, to a reduced accountability on the part of the State. Further information on marginalized groups can be found in other chapters of this Assessment.

RECOMMENDATIONS

Access to Contraceptive Information and Services:

- Develop an Essential Medicines List which includes modern contraceptive methods, including emergency contraception.
- Include family planning counselling and free provision of contraceptive supplies in the basic benefit package of the Georgia's Universal Healthcare Program, and ensure that youth and those with low economic status are covered, and that all women, adolescents and youth are able to access the full range of the latest modern contraceptives, and that they are affordable for all.
- Ensure effective integration of FP services at the PHC level and ensure that family/village doctors are adequately equipped with competencies and knowledge to provide high quality FP services, including youth-friendly services.
- Provide training to family planning and village doctors in order to strengthen their knowledge on contraceptive methods and counselling principles, including on confidentiality and non-discrimination, and the provision of youth-friendly services.
- Ensure that, in practice, there is an access to emergency contraception without prescription, as per the regulatory framework.
- Develop minimum data collection tools for each level of care for gathering and analysing monitoring data on FP service quality and utilization.
- Conduct research aiming at improvement in service delivery and identifying social barriers and administration and policy constraints. Ex., MICS-RHS.
- Elaborate and consistently implement public awareness campaigns and educational programs concerning the importance of family planning, including modern contraception, paying particular attention to the regions and rural areas. Priority topics for health promotion should be identified using epidemiological information and data on the coverage with key services, generated through the routine health information system and periodic population-based surveys.
- Build partnerships with other stakeholders and civil society organizations for the promotion of FP to ensure youth friendly sexual and reproductive health care, including family planning information and services.
- Ensure that the provision of all family planning information and services is not-contingent upon third party authorization, including parents and spouses, and is based on free and informed consent.

Access to Safe Abortion Services and Post Abortion Care Recommendations:

- Eliminate mandatory waiting periods and ensure that any counselling provided to women is evidence-based and non-directive.
  Ensure that information provided to women on abortion, both in and outside of counselling, is accurate, evidence-based and in line with WHO standards, including by revising the consent form to abortion to reflect WHO recognition of abortion as a very safe procedure when conducted by a trained provider in a legal setting. Ensure oversight mechanism for pre-abortion counselling.
- Revise the Law on Health Care to guarantee that women's rights take precedent over the interest of the foetus.
- Abolish the legal provision requiring court authorization to obtain an abortion in cases of a rape.
- Monitor the practice of conscientious objection so that it does not hinder women's access to abortion and ensure that services are provided in a non-judgmental and respectful manner.
- Address the underlying causes of gender-biased sex-selective abortion.
- Guarantee the provision of post abortion contraceptive counselling and commodities and ensure it is covered as a part of primary healthcare package.
- Ensure that a broad range of health care facilities are authorized to provide abortions, so as to make the service geographically accessible for women in rural areas.
- Ensure the effective participation of women undergoing abortions at all decision-making levels, including beyond 12 weeks gestation.
- Ensure that internal regulations and practices of medical facilities provide for non-discriminatory access to abortion services.

- Ensure that abortion providers are adequately trained, including on human rights in patient care and non-discrimination.
- Ensure that abortion is affordable for women, including for survivors of violence and women with lower socio-economic status.
- Conduct a study regarding the extent of travels from Abkhazia, Georgia with the purpose of accessing abortion services in nearby regions. Ensure that women who travel to nearby regions are not hindered from obtaining an abortion.

Maternal Health Care Recommendations:

- Improve early identification and adequate management of pregnancy related complications, which are the two main ways to avoid preventable maternal deaths.
- Improve postpartum care so as to address the low percentage of women receiving such care.
- Organize training of primary health care providers on a range of maternal health services, including antenatal care, and implement mandatory CME programs and recertification.
- The Ministry of Health should promote the routine use of the Robson Classification to guide decisions about recourse to caesarean sections and monitor whether clinics are using these criteria in practice. The Ministry of Health should support the provision of information for the public on the appropriate use of caesarean sections.
- Improve availability of maternal health care services at the primary and village health care level, particularly in rural areas.
- Evaluate, and if appropriate, expand the Near Miss Case Reviews program throughout the country.
- The Ministry of Health should develop and implement programs and guidance for timely detection of high-risk pregnant women and ensure proper referrals to the appropriate levels of care and information sharing and feedback between the various levels of care (village ambulatory, women's consultation centres, maternity hospital and emergency obstetric care facility (EmOC)).
- Ensure that perinatal healthcare centres, particularly in rural areas, are adequately equipped to provide emergency care or make timely referrals to higher level facilities; implement and monitor the perinatal regionalization programme across the country.
- Ensure quality information flow and continuum of care in perinatal care and across all maternal health care.
- Ensure that the budget adequately supports reaching targets set forth in the Maternal and Newborn Health Strategy (2017-2030).
- Provide greater subsidies towards antenatal visits and other maternal health services so that women do not need to pay for services out of pocket, and increase the number of antenatal visits from 4 to 8, as per new WHO recommendations on antenatal care.
- Put systems in place to collect comprehensive data disaggregated by ethnicity, age, geographical location and other characteristics and develop targeted programs to address challenges facing vulnerable groups.
- Raise awareness about available maternal health services amongst the general public and implement specific campaigns targeting marginalized populations, such as ethnic minorities and women living in rural areas.
- Ensure that respecting women's decision-making is at the centre of quality of care programming.

Prevention and Treatment of HIV/AIDS Recommendations:

- Gather disaggregated data, including on key affected populations.
- Ensure that strategies in the National Strategic Plan are fully funded and implemented, including but not limited to, strengthening preventative services with a focus on key affected populations.
- Community-based testing should be prioritized as it is crucial to reach at-risk populations. Encourage and support collaborative efforts among community-based organizations and the health care system so as to ensure access to testing for the most at-risk populations and guarantee appropriate linkages made to care in case of a positive test result.
- Guarantee anonymous testing, as per the law on HIV.
- Revise the relevant provisions of the Criminal code to eliminate the overly broad criminalization of HIV.
- Consider decriminalizing drug use, particularly the possession and use of injecting drugs, as it is hampering access of IDUs to HIV testing.

- Cease police monitoring of opioid substitution therapy centers for the purposes of identifying drug users.
- Information and de-stigmatization education for health care providers is needed to ensure the proper care of persons living with HIV and other key affected populations.
- Scale up and implement harm reduction and OST programs supporting voluntary testing and counselling within the programs.
- Implement HIV testing at the primary level, including ensuring accessibility for key populations.
- Make information on HIV available to the public, especially targeting young people both in and beyond schools, focusing on such issues as transmission methods and ways of preventing HIV and eliminating stigma and discrimination against key populations. This information should integrated into the compulsory school curriculum on life skills education/comprehensive sexuality education.
- Ensure effective remedies for cases when persons living with HIV and other key affected populations have been discriminated against.

Life Skills/Sexuality Education Recommendations:

- The Ministry of Education and Science should ensure that a strategy and action plan for age- appropriate comprehensive life skills/sexuality education, both in and beyond schools, is developed and implemented as a matter of priority.
- The Ministry of Education and Science must ensure that age-appropriate comprehensive life skills/ sexuality education is compulsory to all children in schools of Georgia. This should be an explicit commitment in the curriculum framework for different levels of education and reflected in relevant strategies.
- Life skills/comprehensive sexuality education should be in line with international standards and UNESCO guidelines (see below). Age-appropriate learning materials for comprehensive life skills/ sexuality education should be developed for pupils.
- Ministry of Education and Science must ensure that all teachers who will be delivering comprehensive life skills/sexuality education receive training on the provision of age-appropriate and comprehensive life skills/sexuality education. Human rights-based training materials shall be developed for teachers.
- Mandatory training programs for teachers and school doctors should be developed and implemented as per commitments made in 2017 (see below).
- Life skills/comprehensive sexuality education for out of school adolescents and youth should build on the existing infrastructure; engaging with civil society organizations working in this area. National standards for peer education on comprehensive life skills/sexuality should be developed/adapted according to the international standards.
- Adolescents and young people should participate in the design of life skills/comprehensive sexuality education in school and non-school settings and delivery of this education through peer-to-peer initiatives.
- Implement relevant recommendations issued by the international human rights bodies, including recent recommendations by the Committee on the Rights of the Child.

Violence against Women Recommendations:

- Adopt provisions/legislation which prohibit and sanction sexual harassment in the public sphere, including within educational institutions and at workplace. Make the protection mechanisms for victims/ survivors more effective and flexible to all forms of violence against women, including stalking and sexual harassment.
- Amend the definition of rape in the Criminal Code to bring it in compliance with the CEDAW and Istanbul conventions, including by stressing the element of the absence of consent by victims.
- Ensure delivery of support services for victims of violence in the languages of all ethnic minorities and make the services easily accessible to women living in areas inhabited by ethnic minorities.
- Intensify mandatory training across the country and enhance the already existing training programs for public servants, including law enforcement officers and members of the judiciary.
- Intensify training of social workers, teachers and doctors on the identification of cases of domestic violence.

- Intensify awareness-raising campaigns and programs, including in co-operation with civil society to raise awareness and understanding among the general public and professionals of different manifestations of violence against women their causes, consequences and available remedies, with the aim of their prevention.
- Organise awareness-raising activities and campaigns to combat discriminatory gender stereotypes pervading society, including in the media.
- Collect disaggregated data on all forms of violence against women, including sexual harassment, and gather and analyse data on suicides among women victims of violence.
- Collect disaggregated data by sex and age on all de facto child marriages.
- Enforce the criminal law provision on the ban of forced marriages and collect data on relevant prosecution rates.
- Ensure that the sanctions imposed for crimes related to child marriages (sexual intercourse with minor, deprivation of liberty, etc.) are commensurate to the gravity of the crime.
- Implement relevant recommendations issued by international human rights bodies, including recommendations by the UN Special Rapporteur on Violence against Women.

Reproductive System Cancers and Breast Cancer Recommendations:

- Integrate screening programs into the primary health care services across the country.
- Develop and implement public awareness-raising programs on reproductive system and breast cancers that also inform people about the available screening and treatment programs.
- Introduce HPV vaccination programs on a country-wide basis, guaranteeing that vaccinations are based on informed consent and without coercion or discrimination.

Surrogacy Recommendations:

- Establish a regulatory agency within or accountable to an appropriate ministry endowed both with a monitoring role with respect to surrogacy agreements and a proactive function in drafting the template for surrogate motherhood arrangements.
- Entrust the regulatory agency with a monitoring function with respect to payment arrangements, in order to ensure that they are equitable, sufficient to cover the costs related to the pregnancy and not exploitive of the vulnerability of potential surrogate mothers but not as generous as to amount to an undue inducement to surrogacy services.
- Entrust the regulatory agency with a counselling function consisting of: advising prospective participants in surrogate motherhood arrangements, inter alia, on the risks related to pregnancy and natural or surgical childbirth and of the implications of surrendering a child at birth, particularly one's own genetic child in traditional surrogacy; disclosing to potential parents information, inter alia, on the chances of spontaneous or medically induced miscarriage and the emotional and financial burdens of such misfortune and of receiving and being responsible for a severely disabled child due to a genetic inheritance, or to congenital causes.
- Establish criteria of infertility in order to ensure that recourse to surrogate motherhood is a last resort in seeking parenthood.
- Ensure non-discrimination in access to surrogacy arrangement, including on the grounds of marital status and sexual orientation.
- Include the established residence in Georgia as a necessary requirement in order to enter a surrogate motherhood arrangement, in order to prevent a possible emergence of "reproductive-tourism" practices.
- Establish the minimum age threshold for the gestational carrier above the age of adult status corresponding to 18 years of age under the Convention on the Rights of the Child (CRC), in order to ensure surrogate mothers are sufficiently mature to perceive possible implications of their decisions upon own future health and childbearing; possibly, establish age criteria also for client parents, while respecting the human rights standards which prohibit discrimination on the grounds of age.
- Establish a system for the collection of data and their periodic submission to the regulatory agency or another appropriate national institution as a necessary condition for receiving and maintaining a license for the provision of medically assisted human reproduction services.

Marginalized Groups Recommendations:

- Collect disaggregated data on access to sexual and reproductive health services by all the marginalized groups.
- Effectively investigate, prevent and record cases of violence on the grounds of sexual orientation and gender identity and ensure effective remedies to victims.
- Provide appropriate (mandatory) training to all healthcare professionals to ensure that lack of awareness and existing negative stereotypes do not undermine access to health care for LGBTI individuals.
- Adapt and introduce international clinical guideline focused on the needs of transgender, transsexual, and gender non-conforming persons for securing transgender persons' access to quality healthcare for such individuals.
- Grant legal recognition for the preferred gender of transgender persons based on self-identification, without need of any medical, including surgical, or psychological interventions.
- Study and assess the social needs of LGBT people and reflect their needs in the state plans and healthcare strategies.
- Train police officers in order to combat and prevent inappropriate conduct towards women sex workers and ensure proper investigation in cases of alleged abuse.
- Ensure effective and impartial investigation of all cases of abuse of power by police officers in relation to sex workers and create relevant statistics.
- Organize campaigns in order to combat the social stigma faced by sex workers, which results in them becoming victims of violence.
- Organize information activities addressed to sex workers on treatment methods for STIs.
- Organize awareness-raising activities with a view to combating social stigma and gender stereotypes which negatively affect the life and prevent access to services including healthcare services for women who use drugs, and for all women.
- Equip shelters for victims of domestic violence with the necessary infrastructure and furnishings to receive women who use drugs, and provide them with an access to relevant services, such as methadone substitution treatment.
- Elaborate national guidelines on reproductive health services specifically for women who use drugs.
- Ensure effective and impartial investigation of all cases of abuse of power by police officers in relation to women drug users and gather relevant statistics.
- Consider decriminalizing drug use, particularly the possession and use of injecting drugs.
- Conduct information campaigns to raise awareness on sexual and reproductive health services among internally displaced women.
- Guarantee non-discrimination in law and practice in respect of persons with disabilities, and all marginalized groups.
- Ensure that hospitals operating in local areas inhabited by ethnic minorities do not lack the equipment necessary to provide basic and sexual and reproductive health services.
- Ensure that Georgia's family planning and other sexual and reproductive health programs, including on HIV, include specific programs for disadvantaged groups.
- Adapt gynaecological wards as to ensure de physical access to wheelchair users.
- Adapt all shelters for victims of domestic violence to be accessible for women with various disabilities, including women with psycho-social needs.
- Train healthcare professionals and conduct awareness-raising campaigns in order to combat discrimination against people with disabilities and all other marginalized groups.
- Conduct research on the barriers to services faced by women with all types of disabilities with the aim of developing effective policies and programs.
- Cease practices which hinder the exercise of reproductive rights by women and young people with disabilities, including control over voluntary sexual activity.
- Ensure that youth-friendly, confidential services, are included in SRH programs, especially for disadvantaged groups.
- Ensure effective mechanisms exist that guarantee access to justice for marginalized groups when their rights have been violated.
- Ratify the Optional Protocols on individual complaints procedures and inquiry procedures to the Convention on the Rights of Persons with Disabilities and the Covenant on Economic, Social and Cultural Rights.

INTRODUCTION

This national assessment of human rights in the context of sexual and reproductive health and well-being is the first of its kind in Georgia. The UNFPA Country Office in Georgia supported the Public Defender's Office of Georgia (PDO) to conduct a country assessment, following UNFPA's "Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well- being" (UNFPA Guide).

This Country Assessment is one of growing number of such assessments carried out worldwide by national human rights institutions aimed at identifying areas of progress, obstacles and ways of improving sexual and reproductive health. The UNFPA Guide, together with the results of this first Country Assessment, provides an ongoing platform to conduct periodic and consistent analysis and monitor progress of the situation of human rights in the context of sexual and reproductive health and well-being in the country.

The objectives of the National Assessment of Sexual and Reproductive Health and Rights in Georgia are in line with the commitment made by The Public Defender's Office of Georgia and many other National Human Rights Institutions across the globe which participated to the Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights (Amman, Jordan, November 2012) where they committed to "protect and promote reproductive rights without any discrimination" and to "aid the compilation of an evidence base (e.g. data, inquiries, research) concerning the exercise of reproductive rights and the right to reproductive health."

It is important to keep in mind that a national assessment is not a national inquiry,[3] but can serve as a solid basis for a national inquiry on human rights in the context of sexual and reproductive health and well-being.

The Public Defender's Office of Georgia

The Country Assessment was undertaken by the Public Defender's Office of Georgia (PDO).

The PDO is an independent constitutional institution whose mandate is to oversee the protection of the human rights and freedoms within its jurisdiction in the territory of Georgia. It identifies the violations of human rights by supervising the state agencies, local self-government agencies, public institutions and public officials and facilitates the restoration of violated rights and freedoms.

The PDO studies the cases of human rights violations both on the basis of received applications and on its own initiative. The cases it considers relate to:

- Decisions of public institutions;
- Violation of human rights and freedoms during the review of cases in the courts;
- Violations of the rights of detainees, prisoners or individuals whose liberty has been otherwise restricted;
- Compliance of normative acts with Chapter Two of the Constitution of Georgia;
- Constitutionality of the norms regulating referendums and elections, as well as the referendums and elections held or to be held on the basis of these norms.

3 **A national inquiry** is a transparent, public investigation into a systematic human rights problem in which the general public and expert stakeholders (including experts from government and civil society) are invited to participate, a **national assessment** like the one presented here serves a different function and it can be done before or during a national inquiry. A national assessment is a systematic review of information and data compiled through secondary sources to identify and understand the country's main human rights problems related to sexual and reproductive health and well-being and the efforts (or lack of thereof) undertaken by the State as the main duty-bearer, and other non-state actors, to address these problems. See UNFPA's *"Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-being"* (UNFPA Guide)

The PDO is authorized to consider applications concerning violations of human rights and freedoms enshrined in the laws of Georgia, as well as in the international treaties and agreements Georgia is a party to.

Among other activities, in order to ensure the protection of human rights and freedoms, the PDO of Georgia:

- Submits proposals, remarks and recommendations concerning Georgian legislation and draft laws to the Parliament or other relevant bodies;
- Addresses state agencies, local self-government bodies, public institutions and public officials with proposals and recommendations concerning the restoration of violated human rights and freedoms;
- Issues parliamentary reports, activity reports and special reports on selected human rights themes, such as the "Women's Rights and Gender Equality Report" issued in 2016, referred to throughout this Country Assessment
- Addresses the relevant investigative authorities with proposals to initiate an investigation and/or criminal prosecution;
- Addresses the relevant agencies whose actions caused violations of human rights and freedoms;
- Performs the function of a friend of the court (amicus curiae) in the Common Courts and Constitutional Court;
- Submits constitutional cases to the Constitutional Court;
- In special cases, appeals to the Parliament of Georgia to set up a temporary investigative commission to consider a specific issue.

Human Rights related to Sexual and Reproductive Health

Human rights in the context of sexual and reproductive health and well-being are derived from established human rights recognized by Georgia's Constitution and laws, international and regional human rights treaties ratified by Georgia, international human rights documents and outcome documents of international conferences. They include the rights to:

- life;
- the highest attainable standard of health, including sexual and reproductive health;
- decide freely and responsibly on the number, spacing and timing of children and have access to the information, education and means to do so;
- education and information;
- equality;
- non-discrimination;
- privacy;
- consent to marriage and equality in marriage;
- be free from torture and other cruel, inhumane and degrading treatment and punishment;
- An effective remedy.

Human rights in the context of sexual and reproductive health and well-being are essential to good health, survival, dignity, poverty reduction, equality- including on the grounds of gender, and the enjoyment of a wide range of other human rights. Reproductive rights were explicitly recognized as human rights at U.N. international conferences such as the International Conference on Population and Development (1994) and the Fourth World Conference on Women (1995). Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and

provide couples with the best chance of having a healthy infant.[4] In addition, sexual health as defined by the World Health Organization is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Legal and Conceptual Framework of the Country Assessment

The rights and freedoms in the Constitution and laws of Georgia, as well as the international human rights treaties addressing human rights in the context of sexual and reproductive health and well-being ratified by Georgia provide an overarching legal framework for this Country Assessment.

Though there have been several initiatives which have positively influenced access to sexual and reproductive health (SRH) services for women in the country, to date there is no unified document regarding this in Georgia. In 2006, the draft Law on Reproductive Health and Rights was elaborated with the help of international experts, but this law has never been adopted by the Georgian Government; also, there is no explicit definition of sexual and reproductive health and rights in Georgian legislation and thus are regulated fragmentally under different legislative provisions and policy documents.[5]

The present assessment explores the degree to which rights related to sexual and reproductive health and well-being are realized and whether the State's human rights obligations are met under these standards.

Relevant international and regional human rights treaties ratified by Georgia are set forth in Chapter 1, below.

Research Questions

The basic key questions asked during the research, and answered in this Assessment are:

1) How far have the laws, policies, regulations and other initiatives by the Government of Georgia and other authorities helped fulfil the country's international human rights treaty obligations and political commitments on these issues?

2) How far have the laws, policies, regulations and other initiatives by the Government of Georgia and other authorities helped fulfil the human rights obligations under the national legislation?

3) What actions are required in order to meet these obligations?

Based on the answers to these questions, this Assessment makes recommendations to duty bearers, more specifically, to the Government, the Parliament, and to the judiciary, offering a framework for action to improve the human rights in the area of sexual and reproductive health in the country and thereby secure better outcomes in the field of sexual and reproductive health. The recommendations can and should be used as a basis to monitor progress in the coming years.

Due to social, cultural, political, economic and legal disadvantages, women and girls often face particular challenges to their enjoyment of rights related to sexual and reproductive health and well-being. This assessment includes a focus on some women-specific issues. However, such health and rights issues are also central to the human rights of men and boys. Hence, the analysis – including that of family planning, comprehensive sexuality education, and HIV, – are relevant to the fulfilment of sexual and reproductive health and related rights of all people.

4 World Health Organization, Reproductive Health. http://www.who.int/topics/reproductive_health/en/

5 In Georgia, sexual and reproductive health and rights is often referred to in terms that excludes sexuality and the full understanding of sexual health; in Georgia it is only generally understood in reference to biological sex characteristics. This understanding is not consonant with the WHO definition of sexual health. http://www.who.int/topics/sexual_health/en/

While giving particular attention to gender, in line with international and domestic human rights standards, equality and non-discrimination are cross-cutting principles, and therefore the Assessment gives particular attention to other groups which have been marginalized or are vulnerable, including ethnic and religious minorities, internally displaced people, people living in poverty, drug users, rural populations, adolescents and youth, women, Roma, sex workers, lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, and persons with disabilities (physical, psychosocial or intellectual).

Methodology

A country assessment of human rights in the context of sexual and reproductive health and well-being is a "systematic review of information and data compiled through secondary sources to identify and understand the country's main human rights problems related to sexual and reproductive health and well-being and the efforts (or lack of thereof) undertaken by the State as the main duty-bearer, and other non-state actors, to address these problems."[6]

The following paragraphs describe the key steps and methods of the assessment:

Identification of issues for research and analysis

The country assessment focused on the following key sexual and reproductive health and related rights issues:

- Access to contraceptive information and services
- Access to safe abortion services and post-abortion care
- Maternal health care
- Prevention and treatment of HIV/AIDS
- Comprehensive sexuality education
- Violence against women and girls
- Reproductive Technologies: the case of Surrogacy
- Select reproductive cancers and breast cancer
- Marginalized and disadvantaged groups

Particular attention has also been given to a set of cross-cutting human rights concerns, namely:

- Non-discrimination and equality
- Participation
- Budgeting and allocation of resources
- Data collection and monitoring
- Accountability, including access to justice and redress for victims, as well as non-judicial forms of accountability, such as political mechanisms, administrative mechanisms such as maternal death or near-miss reviews; and impact assessments
- Privacy and confidentiality

The selection of issues and cross-cutting themes was based on a model included in UNFPA's Guide, and adapted to the Georgian context, where appropriate. For each of the key issues and the cross-cutting human rights concerns, the UNFPA Guide provides a set of questions and corresponding indicators to assess compliance with related human rights standards.

6 See *UNFPA's "Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well- being"* (UNFPA Guide)

Research

The main methods employed in the review of information and data are:

1. A desk review of primary data and information, such as statistics, national laws, regulations and policies, national strategies (such as the Maternal and Newborn Health Strategy) national surveys (e.g. the Reproductive Health Survey);

2. A desk review of secondary literature, including qualitative and quantitative information, namely reports on SRHR issued by international organizations and bodies (such as UN agencies), UN and regional human rights bodies (including specific recommendations by UN treaty monitoring bodies, the Universal Periodic Review to Georgia, and Special Rapporteurs' country visits), civil society and academics, as well as by the government.

3. Introductory meetings were held with some relevant government ministries, the Parliament, and civil society organizations, for example. The meetings were primarily held to inform relevant stakeholders of the upcoming assessment, to confirm the main issues identified, and to garner overall support for the assessment.

4. The PDO made requests for information to relevant governmental authorities. Responses, where relevant, were used to inform this report.

Analysis and report writing

After analysing the data, the report on the assessment was drafted. This Assessment is not intended to be an exhaustive analysis of sexual and reproductive health and related rights in Georgia but covers the main concerns regarding the identified issues and cross-cutting themes noted above.

CHAPTER 1: GEORGIA'S LEGAL OBLIGATIONS ON SEXUAL AND REPRODUCTIVE HEALTH

1. The domestic legal and policy framework

The national legal and policy framework of Georgia has undergone significant changes in supporting sexual and reproductive health and in combating discrimination and inequality on the grounds of sex, gender, and SOGI, including the adoption of new normative acts and incorporation of additional norms and amendments into the existing legislation.

Nonetheless, the state's understanding of sexual and reproductive health and human rights framework lacks realization of the need to act with systemic-level responsibility, which is manifested in a number of ways, such as: lack of effective financing and shortfalls in the collection of disaggregated data; inaccessibility to high standards of health as reflected in high maternal mortality rates; fragmentary character of family planning services and neglecting life skills/comprehensive sexuality education as a human right. These and others factors detailed in this Assessment make it difficult for the State to achieve gender equality and implement large-scale, comprehensive, and coordinated policy in an effective manner.

This report contains a detailed account of the domestic laws and policies pertaining to or recognizing human rights in the context of sexual and reproductive health and well-being and the respective obligations, alongside with the Constitution of Georgia. Below follows a list of the main relevant laws and policies accompanied by short descriptions. Relevant details can be found under the topics covered later in this Assessment.

The Constitution of Georgia

The Constitution of Georgia (adopted in 1995, last amended in 2017) directly mentions universally recognized human rights and freedoms in its Preamble and contains a number of provisions expressly devoted to them.

Article 7 of the Constitution specifies that the State shall recognize and protect universally recognized human rights and freedoms as "eternal and supreme human values" and that these rights and freedoms are directly applicable. Article 4 complements this provision by clarifying that "[t]he Constitution of Georgia shall not deny other universally recognized rights, freedoms and guarantees of an individual and a citizen, which are not referred to herein but stem inherently from the principles of the Constitution".

More specifically, the Constitution of Georgia enshrines the principle of non-discrimination (Article 14) and protects, *inter alia*, the right to life (Article 15), the prohibition of torture and inhuman or cruel treatment (Article 17), the right to privacy (Article 20), the rights of the mother and the child (Article 36) and the right to enjoy health insurance as a means of affordable medical aid (Article 37). All of which are rights central to the realization of rights related to sexual and reproductive health.

Other related laws

A range of other laws set out sexual and reproductive health and related rights and obligations. Among these, is the ***Law on Health Care*** (1997, amended several times) which lays out the conditions for safe motherhood and child health care (Chapter 22) and family planning (Chapter 23), clarifying in its Article 136 that Georgian citizens have the right to independently determine the number of children they have and the timing of their birth and setting out the framework for abortion (Article 139) and in vitro fertilization (Article 143), amongst other provisions.

The ***Law on Patient Rights*** (2000) further protects the right to receive healthcare, prohibiting discrimination (Article 6), and protecting the right to confidentiality and privacy (Chapter 5) and the rights of pregnant women and nursing mothers (Chapter 7).

In 2010, Georgia adopted the ***Law on Gender Equality,*** which guarantees equal rights, freedoms and opportunities for men and women as also enshrined in the Georgian Constitution, and defines legal mechanisms and conditions for their implementation in relevant spheres (Article 1). The stated purpose of this law is to ensure inadmissibility of discrimination in all spheres of public life, creation of proper conditions for the enjoyment of equal rights, freedoms and opportunities by men and women, and support eradication and mitigation of all forms of gender discrimination (Article 2). The Law also provides equal access to healthcare without discrimination and special measures for the protection of maternal and child's health and reproductive rights. It also importantly contains an article on ensuring gender equality in family relations (Article 10).

Other relevant pieces of legislation are the ***Criminal and Civil Codes,*** and the ***Law on the Elimination of All Forms of Discrimination*** of 2014, which is the first legislative mechanism in Georgia that explicitly prohibited all forms of discrimination, including on the grounds of sexual orientation and gender identity, both in public and private sectors.

Relevant Policies

There have been significant developments in terms of strategies and policies related to human rights in the context of sexual and reproductive health and well-being in Georgia. The most notable one is the ***National Maternal and Newborn Health Strategy*** (2017-2030) and a 3-year Action Plan (2017-2019), the strategy is aimed at giving direction and providing guidance for the improvement of maternal and newborn health and related reproductive health fields in Georgia. The main goal is to ensure that by 2030, there are no preventable deaths of mothers or newborns, or stillbirths and that every child is wanted and every unwanted pregnancy is prevented through appropriate education and full access to all high quality integrated services.[7] The 3-year Action Plan (2017-2019) serves as a general framework for maternal and newborn health, reproductive health and family planning, and as a guide for interventions for the next three years.

National Youth Policy was adopted in 2014, to make youth a development priority for the country. The policy recognizes – and commits to meeting – young people's needs for education, sexual and reproductive health services, employment, and participation in decision-making, alongside with the provision of age-appropriate information about gender equality, sexual and reproductive health and rights, HIV prevention, and family planning. The policy sets forth an objective to make this information available also through informal channels, such as through peer education programmes.

The Georgian Parliament recently adopted **The Demographic Security Policy** for the years 2017-2030. One of the objectives of the policy is to ensure "Universal access to reproductive health care services, information and education". The **National Strategy for the Protection of Human rights in Georgia 2014-2020** and the State Policy implemented by Georgia's Health Care System in 2010, are also relevant.

National Action Plans on Gender Equality and on **Violence against Women/Domestic Violence** are also relevant to as they address matters of non-discrimination, equality and violence, intersecting with numerous issues raised in this report.

Reproductive Health Survey (RHS) was issued by the National Centre for Disease Control (NCDC), the Ministry of Labour, Health, and Social Affairs, and the National Statistics Office in 2012 and includes data from 2010. The Reproductive Health Survey has helped inform development of laws and policies on some reproductive health issues.

7 The World Health Organization recognizes that not while most unwanted pregnancies can be prevented, not every unwanted pregnancy can be prevented. Contraceptive failure and sexual violence are two factors which influence this recognition. World Health Organization. 2012. "Safe Abortion: Technical and Policy Guidance for Health Systems". Second Edition. Geneva. p. 23

It is important to note that while policies are important tool to realize human rights and to properly implement laws, they are not legally binding and should not be used to replace laws and regulations.

2. International Human Rights Obligations

Georgia is a party to the major international and regional human rights treaties which encompass rights related to sexual and reproductive health. Below are the treaties which Georgia has ratified with reference to some rights relevant to SHRH found in the treaties.

International Covenant on Civil and Political Rights (ICCPR): right to an effective remedy and to access to justice for human rights violations (art.2), equal rights of men and women (art. 3), right to life (art.6), prohibition of torture or cruel, inhuman or degrading treatment or punishment (art.7), prohibition of interference with privacy, family, home or correspondence (art.17), freedom of expression, including the right to seek, receive and impart information (art. 19), prohibition of forced marriages (art.23.3), and the right to non-discrimination (art.26).

International Covenant for Economic, Social and Cultural Rights (ICESCR): equal rights of men and women (art.3), prohibition of forced marriages (art.10.1), special protections to mothers (art.10.2), right to an adequate standard of living (art.11), right to the highest attainable standard of health (art.12), right to education which shall strengthen the respect for human rights and fundamental freedoms (art.13).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): obligation to take all appropriate measure to ensure the full development and advancement of women (art.3), adoption of temporary special measures aimed at accelerating de facto equality between men and women and at protecting maternity not to be regarded as discriminatory (art.4), modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women and ensure that family education includes a proper understanding of maternity as a social function (art.5), obligation to take all appropriate measures to eliminate discrimination against women in health care in order to ensure access to health care services, including family planning (art.12.1), to ensure access to information on health and family planning, and eliminate stereotyped roles of men and women at all levels and forms of education. Including through the revision of text books and programs and adaptation of teaching methods (art. 10), obligation to ensure that women get all appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services, when necessary, as well as an adequate nutrition during pregnancy and lactation (art.12.2), obligation to address concerns of rural women (art. 14), ensure equality with men before the law (art. 15), obligation to take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations, including prohibition of forced marriages and the same rights with men to decide on the number and spacing of children (art.16).

Convention on the Elimination of All Forms of Racial Discrimination (CERD): obligation to prohibit and eliminate racial discrimination in all its forms and to guarantee [to] everyone the right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution, the right to marriage and choice of spouse, the right to public health, medical care, social security and social services, the right to education and training (art. 5).

Convention on the Rights of the Child (CRC): right to the highest attainable standard of health including appropriate pre-natal and post-natal health care for mothers (art.24), right to education directed to the development of respect for human rights and fundamental freedoms (art.29), protection of the child from all forms of sexual exploitation and abuse (art.34), promotion of physical and psychological recovery and social reintegration of a child victim of abuse or torture or other cruel, inhuman or degrading treatment (art.39).

Convention on the Rights of Persons with Disabilities (CRPD): to take measures to ensure the full and equal enjoyment of all human rights and fundamental freedoms by women and girls with disabilities (art.6), freedom from exploitation, violence and abuse of persons with disabilities including gender-based aspects, respect for privacy, including protection of the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others (art.22), respect for home and family life including prohibition of forced marriages, right to decide on the number and spacing of children and right of persons with disabilities to retain their fertility on equal basis with others (art.23), right to the enjoyment of the highest attainable standard of health without discrimination, right to an adequate standard of living (art.28).

European Convention of Human Rights (ECHR) with its Protocols: right to life (art.2), prohibition of torture and inhuman or degrading treatment or punishment (art.3), right to respect for private and family life (art.8), right to an effective remedy (art.13), prohibition of discrimination (art.14).

Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention): equality and non-discrimination (art.4), training of professionals dealing with victims or perpetrators of all acts of violence covered by the Convention (art.15), preventive intervention and treatment programmes for victims and perpetrators, access to health care for the victims (art.20), setting up sexual violence referral centres (art.25), ensuring that forced marriages may be voidable, annulled or dissolved (art.32), criminalizing sexual violence (art.36), forced marriages (art.37), female genital mutilation (art.38), forced abortion and forced sterilization (art.39), legal sanctioning of sexual harassment (art.40), and recognizing honour as an unacceptable justification for crimes.

Box 1: Key human rights concepts

International human rights treaties spell out the types of obligations they give rise to on States, including in the context of rights related to sexual and reproductive health. They are the following:

- **Respect, protect, fulfill:** Respect means that the State must not interfere with the enjoyment of a right; protect means that the State must protect against harm by third parties, which has relevance in the context of private sector provision of healthcare as well as in domestic violence; and fulfill means that the State must take positive steps such as developing and implementing laws, policies and budgets for the enjoyment of human rights, including the right to sexual and reproductive health.
- **Immediate obligations, progressive obligations and use of available resources:** Some freedoms (e.g. from torture, of expression and non-discrimination) must be given full effect immediately. Minimum essential levels of the right to health must also be given effect immediately such as access to health services on a nondiscriminatory basis, essential drugs and the equitable distribution of health facilities, goods and services. Other aspects of the right to health are subject to an obligation of progressive realization which means that they should take steps that are deliberate, concrete and targeted towards the full realization of the right. States must use the maximum resources available to them, including from domestic sources and from the international community.
- **Non-discrimination and equality:** Human rights must be guaranteed without discrimination, including on grounds of age, sex, race, ethnicity, religion, nationality, birth, political or other opinion or other status such as disability, health status, age, Lesbian, gay, bisexual, transgender and intersex (LGBTI) status. Special measures are often required to ensure the enjoyment of human rights without discrimination on these grounds, as well as for other marginalized groups such as adolescents, sex workers, and injection drug users (IDU). Certain individuals and population groups experience multiple and intersecting forms of discrimination that exacerbate exclusion in both law and practice, such as LGBTI persons, poor women, rural women, migrants, indigenous or other ethnic minorities, adolescents, people living with HIV/AIDS and persons with disabilities, whose full enjoyment of the right to sexual and reproductive health is further restricted.

- **Participation:** Rights-holders should be meaningfully and actively involved in the design and development, implementation and monitoring and review of sexual and reproductive health-related laws, policies and programmes that affect them. Participation on a non-discriminatory basis requires attention to the involvement of marginalized groups.
- **Accountability:** States must ensure that there are monitoring, review and remedies/redress procedures that support the enjoyment of human rights. National accountability mechanisms include judicial (e.g. courts), quasi-judicial (e.g. the PDO), political (e.g. parliamentary scrutiny) and administrative (e.g. impact assessment, maternal death reviews) mechanisms. These mechanisms should operate transparently, be accessible to rights holders and be effective. The right to a remedy is an important human right that is an integral element of accountability.

- **Availability, Accessibility, Acceptability, and Quality (AAAQ)**

Although the CESCR has previously addressed sexual and reproductive health in its General Comment 14,[1] the Committee issued a new comment in 2016 (General Comment 22) in light of constant and severe violations of the right to sexual and reproductive health care. CESCR's General Comment 22 explains States' duties and providing guidance to ensure the right to sexual and reproductive health, as an integral part of the right to health protected by Article 12 of the International Covenant on Economic, Social and Cultural Rights. CESCR General Comments 14 and 22 identify four central components of the right to health, including sexual and reproductive health: availability, accessibility, acceptability, and quality.

- Accessibility requires the state to ensure access to health services in a nondiscriminatory basis and in ways that are physically accessible, economically accessible, and in which information is accessible.
- Availability of health services requires that States must ensure that there are an adequate number of functioning health care facilities, services, good and programs to serve the population including essential drugs as defined by the WHO Model List of Essential Medicines which includes, contraception and emergency contraception, for example.
- Acceptability requires that health facilities, services and goods must be respectful of the culture of individuals, including the needs of minorities, and different genders and age-groups, and designed to respect medical ethics, including confidentiality and informed consent.
- Quality requires that sexual and reproductive healthcare must be of good quality, meaning that it is scientifically and medically appropriate, which requires skilled (trained) medical personnel, scientifically approved and unexpired drugs and equipment.

UN Human Rights Treaty Bodies' Recommendations to Georgia and UPR Commitments

As a party to U.N. treaties on human rights, Georgia, like other countries which have ratified treaties, is subject to review by expert U.N. treaty monitoring bodies which assess Georgia's compliance with provisions of the treaties. Georgia has received a number of recommendations to better ensure compliance with treaty obligations related to SRHR. Below is a summary of recent recommendations by treaty monitoring bodies related to the issues raised in this assessment. It is followed by information on the persistent problem of gender stereotyping in Georgia and the recommendations made by the *U.N. Special Rapporteur on Violence against Women, Its Causes and Consequences* (UN Special Rapporteur on Violence against Women) after her important mission to Georgia in 2016.

In 2014, *the Committee on the Elimination of All Forms of Discriminations Against Women* called upon Georgia to strengthen its Gender Equality Council, establish a comprehensive mechanism to implement and monitor gender equality policies, take actions to fight gender stereotyping, study and take measures to prevent child marriage and domestic violence, give effective protection to victims of violence, and prohibit and sanction the practice of virginity tests. Also, it recommended the national authorities should take steps to promote a culture of school attendance by girls among ethnic minorities and introduce education on SRHRs, to improve

access to quality healthcare for women, particularly for ethnic minority women and women with disabilities, and to address the issue of violence against LGBTI persons.[8] The UN Special Rapporteur on Violence against Women, its causes and consequences issued a lengthy report on Georgia after having conducted a country visit and set forth many concerns and recommendations on VAW, (see section on Violence against Women for details).

In 2014, the *Human Rights Committee,* which monitors compliance with the International Covenant on Civil and Political Rights (ICCPR), called upon Georgia to develop strategies for combating patriarchal attitudes, gender stereotyping, early marriage, sex-selective abortions and stigmatization of LGBTI persons, as well as prohibiting sexual harassment and preventing and combating domestic violence. The Committee also urged the country to adopt a human rights based approach in addressing the problem of drug use.[9]

In 2016, the *Committee on the Elimination of Racial Discrimination* recommended Georgia to adopt measures to raise awareness on its new anti-discrimination legislation and to continue to engage with the PDO for its implementation. Placing a particular focus on Roma individuals, it asked the national authorities to intensify efforts to provide all members of the Roma Community with documents, and to ensure the practical implementation of the prohibition of child and forced marriages.[10]

More recently, in 2017, the *Committee on the Rights of the Child* recommended Georgia to combat the practice of sex-selective abortion and place particular emphasis on adolescent health in its strategy for reproductive health; with regard to HIV/AIDS, the CRC Committee further urged Georgia to improve follow-up treatment for HIV-infected mothers and infants and to improve the access to quality and age-appropriate HIV/AIDS and sexual and reproductive health services.[11]

Also, in 2015, as Georgia was examined in the course of the *2nd cycle of the Universal Periodic Review (UPR)* of the Human Rights Council, it accepted around 70 recommendations on SRHR.[12] These mainly focused on the commitments to strengthen efforts with a view to combating domestic violence and gender stereotyping, harmonizing domestic legislation with ratified international treaties on human rights, including SRHR, and further implement National Action Plans on Gender Equality and other strategies related to SRHR and the anti-discrimination legislation protecting vulnerable groups – particularly persons with disabilities, LGBTI and members of ethnic minority groups. Georgia agreed to take steps to ensure that sexual and reproductive health services including abortion and contraception are available, accessible and affordable to all women and girls, especially in rural areas and among vulnerable groups; it also agreed to ensure universal access to quality reproductive and sexual health and services, including contraception, especially for rural women and those living with HIV/AIDS.

Gender Stereotypes in Georgia: a particular concern

The realization of the right to sexual and reproductive health in Georgia is negatively impacted by the existence of deeply-rooted gender stereotypes regarding existing social roles of women in society and the construction

8 Committee on the Elimination of Discrimination against Women, Concluding observations on the combined fourth and fifth periodic reports of Georgia, 24 July 2014, CEDAW/C/GEO/CO/4-5, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GEO/CO/4-5&Lang=En

9 Human Rights Committee, Concluding observations on the fourth periodic report of Georgia, 19 August 2014, CCPR/C/GEO/CO/4, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/GEO/CO/4&Lang=En

10 Committee on the Elimination of Racial Discrimination, Concluding observations on the sixth to eighth periodic reports of Georgia, 13 May 2016, CERD/C/GEO/CO/6-8, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD/C/GEO/CO/6-8&Lang=En

11 Committee on the Rights of the Child, Concluding observations on the fourth periodic report of Georgia, 9 March 2017, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GEO/CO/4&Lang=En

12 Human Rights Council, Thirty-first session, Agenda item 6. Universal periodic review, Report of the Working Group on the Universal Periodic Review on Georgia, 13 January 2016, A/HRC/31/15 and A/HRC/31/15/Corr.1, available at: http://www.ohchr.org/EN/HRBodies/UPR/Pages/GEIndex.aspx

of their sexuality. The CEDAW Convention explicitly spells out that one of the human rights obligations of the State is to address gender stereotyping in society. In fact, human rights bodies have consistently criticized Georgia for failing to take sufficient measures to address this problem.[13]

In a patriarchal society, women bear a double reproductive function: biological and symbolic[14] and women's bodies are often instrumentalized in violation of their human dignity, resulting in barriers to autonomous, effective and affordable access to health care. Instrumentalization is defined as the subjection of women's natural biological functions to a politicized patriarchal agenda, which aims at maintaining and perpetrating certain ideas of femininity versus masculinity or of women's subordinate role in society. Women's bodies are instrumentalized for cultural, political and economic purposes rooted in patriarchal traditions. Instrumentalization occurs within and beyond the health sector and it is deeply embedded in multiple forms of social and political control over women. It aims at perpetuating taboos and stigmas concerning women's bodies and their traditional roles in society, especially in relation to their sexuality, reproduction and motherhood. As a result, women face continuous challenges in accessing health care and maintaining autonomous control in decision-making about their own bodies. Understanding and eliminating the instrumentalization of women's bodies, which is based on harmful cultural norms and stereotypes, and its detrimental impact on women's health, is critical for change to occur.[15]

Analysis conducted by United Nations Development Program (UNDP) in 2013 shows that in Georgian culture, woman's sexuality is still limited by a reproductive function and by the roles of housewives and mothers.[16] Also, a study conducted in 2012 demonstrated that "sex is primarily associated with pleasure for men (51.8%), more than for women (19.3%). Women are more likely to perceive it as a spousal obligation (10.9%), than men (2.1%)."[17]

Sexual orientation also plays a role in such stereotyping. A study conducted by the Women's Initiative Supporting Group (WISG) in 2016, showed that there is a high degree of aggression towards lesbian women, and provides analyses of this aggression in relation to the construction of woman's sexuality. According to the study, "being a lesbian, in the first place, violates the widespread myth in the Georgian culture about woman's asexuality. Besides, her sexuality cannot be narrowed down to her reproductive role and is not limited by the confines of the traditional family, which in turn, excludes men's and therefore society's control over her sexuality and desire."[18]

Findings of the CEDAW Committee in its 2014 assessment (concluding observations) of Georgia[19] confirm that notwithstanding the efforts by Georgia to implement the recommendations contained in its previous assessments, patriarchal attitudes and stereotypes regarding the roles and responsibilities of women and men in the family and in society remain deeply rooted and are exacerbated by the increased sexualization of women in the media, which undermines the social status, participation in public life and professional careers of women. The Committee recommended Georgia to further strengthen its efforts to overcome stereotypical attitudes regarding the roles and responsibilities of women and men in the family and in society and continue to implement measures to eliminate gender stereotypes by promoting the substantive equality of women.

13 UN Special Rapporteur on Violence against Women report on her mission to Georgia (2016); CEDAW Committee Concluding Observations to Georgia (2014).

14 E. Aghdgomelashvili, "From Prejudice to Equality", WISG, 2016, p. 236 (ENG)

15 UN Office of the High Commissioner for Human Rights (OHCHR), Report of the U.N. Working Group on the issue of discrimination against women in law and in practice, 8 April 2016.

16 UNDP Georgia, "Public Attitudes towards Gender Equality in Politics and Business", 2013

17 T. Kekelia et al "Sexuality in Contemporary Georgia: Discourse and Behavior", Tbilisi, 2012, p. 134 (As cited in E. Aghdgomelashvili, From Prejudice to Equality, WISG, 2016).

18 E. Aghdgomelashvili, "From Prejudice to Equality", WISG, 2016, pp. 236-237 (ENG)

19 Concluding observations on the combined fourth and fifth periodic reports of Georgia, 24 July 2014

The *UN Special Rapporteur on Violence against Women* further noted in her recent report following her mission to Georgia[20] that among the factors that most likely increase the risk of intimate-partner violence are discriminatory gender stereotypes and patriarchal attitudes. The Special Rapporteur also expressed her concern that sexual crimes are underreported by victims, due among others to social stigma – including the importance placed on women's virginity and family honour – fear of the perpetrator, the non-confidence on law enforcement authorities and the lack of specialized services.

ICPD, SDGs, FWCW objectives

It is an obligation on States under international law to ensure that laws, regulations and policies are consistent with human right obligations. But the reason for integrating human rights into those laws, regulations and policies on sexual and reproductive health is about more than a legal obligation. There is an intrinsic rationale to do so not just because of the inherent value of human rights, there is also an instrumental rationale because human rights can support better sexual and reproductive health outcomes.

Sexual and reproductive health and related rights were thus identified as key elements of international consensus documents on development.

The **2030 Agenda for Sustainable Development,** containing the Sustainable Development Goals (SDGs), which are the new lynchpin of the global development agenda, is grounded in human rights principles and includes important commitments related to sexual and reproductive health that are also in line with States' human rights obligations. In the SDGs, States agreed to, for example:

- Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences. (Target 5.6).
- By 2030, to 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 (Target 3.7).
- Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation (Target 5.2).
- Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (Target 5.3)
- By 2030, to reduce the global maternal mortality ratio to less than 70 per 100,000 live births (Target 3.1)
- By 2030, to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases Target 3.3)

20 Report of the U.N. Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 2016

The **International Conference on Population and Development (ICPD)** in 1994 and of the occasion of its review process, ICPD+5 in 1999, clearly defined reproductive rights to include entitlements to:

- Family planning;
- Antenatal, safe delivery and post-natal care;
- Prevention and appropriate treatment of infertility;
- Abortion, where legal, and management of the consequences of abortion in all cases;
- Diagnosis and treatment of reproductive tract infections, breast cancer and cancer of the reproductive system;
- Prevention, care and treatment of sexually transmitted infections (STIs) and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS);
- Information, education and counselling, as appropriate, on human sexuality and reproductive health.

In the outcome document, the **ICPD Program of Action, participating** State, including Georgia, committed to take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. They accepted that reproductive health-care programmes should provide the widest range of services without any form of coercion and that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so (ICPD Program of Action, Principle 8).

The **Beijing Declaration and Platform for Action** constituting the outcome of the Fourth World Conference on Women (FWCW) held in Beijing in 1995, includes women's rights to health care and sexual and reproductive health among its strategic objectives that states, including Georgia, agreed to. The Beijing Declaration declared that women have the right "to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." The participating States agreed to review their punitive laws on abortion.

CHAPTER 2: THE ORGANIZATION OF AND KEY CHALLENGES IN GEORGIA'S HEALTH SYSTEM

Each of the key sexual and reproductive health and rights topics that are at the heart of this Assessment is significantly affected by the broader context of the health system, which delivers health goods, services and information to the population. Smooth functioning of a health system depends on an effective financing mechanism, reliable data for policy-making, well trained and adequately paid workforce, well-maintained facilities and logistics for delivering medicines and technologies, and strong laws. This chapter begins with a brief description of the organization and key institutions of Georgia's health system, and then focuses on several critical healthcare system issues in Georgia that affect most or all of the topics analysed in the following chapter and that have recurrently raised in the findings of the research as challenges. Additional information on these key challenges can be found in relevant sections of this report along with recommendations.

The Organization and Key Institutions of Georgia's Health System

The Georgian healthcare system covers both Primary Healthcare and Hospital Sectors. Its geographical availability for the basic care is satisfactory: medical facilities providing outpatient services (e.g. policlinics, Family Medicine Centres) function in the same manner both in large cities, as regional centres. The institution of rural doctors is responsible for the provision of healthcare in villages.[21] However, many medical facilities, especially specialized ones, are located in Tbilisi, which causes geographical and financial barriers for households as it increases direct and indirect costs such as fees for services, transportation and accommodation costs.[22]

State healthcare programs are implemented by the Ministry of Labor, Health and Social Affairs (MoLHSA) that also comprising the following entities: LEPL Social Service Agency, LEPL L. Sakvarelidze National Centre of Disease Control and Public Health and LEPL Emergency Coordination and Urgent Assistance Centre.[23] Given that almost 95% of medical facilities are privately owned, MoLHSA is left with little regulation capacity in hand.[24] The Oxfam Research Report on Health-Care Reform in Georgia (2009) states, that the other ministries (such as the Ministry of Finance or Economy) and individuals are having great impact on the overall direction of health policy, thus, limiting MoLHSA's mandate with regard to direct service provision, purchasing, and some other aspects of regulation.[25]

During past three decades, the Georgian healthcare system went through many systemic changes. In early 1990's, upon gaining independence, Georgia inherited a centralized healthcare model from the Soviet Union.[26] It was thus challenging to develop a health system as a part of market economy. The first actual changes were effected in 1995, when a Georgian healthcare reform package was introduced.[27] It included reorganization of the healthcare system, creating and implementing state medical programs, development of the pharmaceutical sector, the first stage of the privatization of healthcare facilities and the launching of social health insurance.[28]

21 T. Rukhadze «An overview of the health care system in Georgia: expert recommendations in the context of predictive, preventive and personalised medicine»,Tbilisi, 2013, p. 4

22 Welfare Foundation "Civil Monitoring of Universal Healthcare Program Assessment of budget spending efficiency", 2016, p. 8-9

23 Government of Georgia decree of December 30 2016 #638 on Approval of state health programs for 2017 available at: http://ssa.gov.ge/files/01_GEO/KANONMDEBLOBA/Kanon%20Qvemdebare/206.pdf accessed on 03 October 2017

24 K. Chkhatarashvili «Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries Georgia Country Report», CIF, 2015, p. 13

25 «Health-Care Reform in Georgia. A Civil-Society Perspective: Country Case Study», Oxfam International, 2009, p.30

26 K. Chkhatarashvili «Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries" Georgia Country Report»,CIF, 2015, p. 12

27 T. Rukhadze «An overview of the health care system in Georgia: expert recommendations in the context of predictive, preventive and personalised medicine», Tbilisi, 2013, p. 1

28 T. Chanturidze et al «Health Systems in Transition», WHO, 2009, p. 15-16

Following this, a centralized model was transformed into a decentralized health system, which developed in several stages: the first wave occurred in 1995 by creating 12 regional health authorities governed by regional agencies. In parallel, privatization took place by switching all pharmacies and dental facilities to the private sector.[28] The second wave took place in 2007, after the Government's initiative regarding public services privatization, when hospitals were purchased by private entities.[30] These entities were mostly private insurance companies that were endowed with greater functions and responsibilities, including through involving them in state-funded service delivery to socially vulnerable populations.[31] The so-called "state health insurance program" covered vulnerable populations, including people below the national poverty line and internally displaced persons, orphans, teachers, national actors, painters and laureates of the Rustaveli prize.[32]

The next wave of reforms in the healthcare system included enactment of the Universal Healthcare Program in 2013.[33] This program aimed to benefit the population not covered by other state healthcare programs and/or private insurance. This caused an increase in healthcare services utilization resulting in an increase in costs.[34] The national health system was financed from the State budget through revenues, but it wasn't capable to keep pace with the growing financial needs created by the Universal Healthcare Program.[35] Government spending on healthcare through the Universal Healthcare Program increased from 69 million GEL in 2013, to 575 million GEL in 2015.[36] This increase in costs required a change in the state's approach, resulting amending of the Universal Healthcare Program in 2017.[37] Changes included categorization of beneficiaries based on their income and thus, providing different packages of services based on this categorization.[38]

Key Challenges:

Financing

Despite the fact that State expenses have significantly increased since 2013 when the Universal Healthcare Program came into effect, their share in relation to the population's healthcare expenditure is still low (6.9% for 2015).[39] As a result, out-pocket payments remain high, representing almost 58.6% of total healthcare expenditures in Georgia in 2014.[40] According to the Curatio Study on Health System, the most burdensome expenditures for the population are those associated with medicines, which represented 2/3 of out-pocket payments and amounted to 57,3% of total healthcare expenditures in 2015.[41]

In parallel to the health-care system reforms, private health insurance went through dramatic changes as well. The State Universal Healthcare Program that entered into force in 2013 caused an 8% decrease in attracted health accounts premiums and 31% increase of reimbursements for private insurance companies.[42]

29 T. Chanturidze et al «Health Systems in Transition», WHO, 2009, p. 18-19
30 S. Gabritchidze «An analysis of recent health system reforms in Georgia: future implications of mass privatization and increasing the role of the private health market", 2007, p. 2.-
31 K. Chkhatarashvili «Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries Georgia Country Report», CIF, 2015, p. 12
32 L. Shengelia «Impact of Healthcare Reform on Universal Coverage in Georgia: A Systematic Review», 2016
33 L. Avalishvili et al. "Challenges of Universal Healthcare Program and the ways of overcoming them", IDFI, 2016
34 Welfare Foundation "Civil Monitoring of Universal Healthcare Program Assessment of Budget Spending Efficiency", 2016
35 K. Chkhatarashvili «Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries Georgia Country Report», CIF, 2015, p. 13
36 Welfare Foundation "Civil Monitoring of Universal Healthcare Program Assessment of Budget Spending Efficiency", 2016, p. 16
37 Government of Georgia decree of December 30 2016 #638 on Approval of state health programs for 2017.
38 Curatio International Foundation "Health System Barometer IX Wave", 2017
39 T. Verulava "Health expenses according to WHO recommendations and healthcare financing in Georgia", 2015 available at: https://idfi.ge/ge/health-care-expenditure-who-recommendations-georgia accessed on 04 October 2017
40 Out-of-pocket health expenditure (% of total expenditure on health) https://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS (last seen on 05 October 2017)
41 Curatio International Foundation "Health System Barometer IX wave", 2017
42 T. Iobashvili "Overview of Georgian insurance companies in 2013" available at: http://aaf.ge/index.php?menu=1&jurn=0&rubr=5&mas=2045 accessed on 05 October 2017

The Ministry of Labour, Health and Social Affairs receives state budget lines programmatically, including sexual and reproductive health-specific lines.[43] In spite of specifically designated budget lines, the resources allocated are insufficient. For example, since the late 1990's, women have been entitled to four free antenatal care visits, in accordance with WHO recommendations. Since that period, the antenatal package has remained the same and the government pays the same amount (55 GEL), which is insufficient and results in pregnant women paying for additional tests and consultancies out-of-pocket (see section below on maternal health regarding forthcoming changes to antenatal care visits.)[44]

According to the World Bank, the main challenge associated with healthcare system financing is non-efficient management of public funds. This is further compounded by the complex financing mechanisms due to different tariffs and co-payment schemes, coupled with a fragmented primary healthcare system and lack of motivation on the part of healthcare providers to stimulate proper PHC service delivery.[45]

Implementation of Laws and Policies

The Georgian health system is regulated by local and international laws. They mostly cover the main issues in healthcare, but suffer from certain inconsistencies, which are not just solely connected with the issues covered in this Assessment, but rather with all health care issues.[46] They include the following:

- Technical inaccuracies and inconsistencies in terms that don't require systemic changes. For example, discrepancies in definitions of terms such as "informed consent", "patient", "patient's relative", "healthcare service", "healthcare service provider", "medical records", etc. There is a need to ensure these terms are consistent throughout all laws and policies, including bylaws.
- issues which need to be solved on a law and/or policy level because they are either not addressed, ot not addressed fulling including addressing confidentiality of information, continuous professional development, informing patients regarding their rights, safety of medical devices and disability assessment and determining status, patient safety; issues facing marginalized populations such as guidelines on hormonal therapy and medical transition of transgender persons; surrogacy,.

The main laws regulating healthcare issues include:[47]

- The Law of Georgia on Patient Rights;
- The Law of Georgia on Health Care;
- The Law of Georgia on Medical Practice;
- The Law of Georgia on Public Health;
- The Law of Georgia on Donation of Blood and Its Components;
- The Law of Georgia on Human Organs Transplantation;

43 Government resolution #638 on approving State Healthcare Programs 2017
available at: https://www.matsne.gov.ge/ka/document/view/3530020 accessed on 05 October 2017

44 Mothers' and Children's State program
available at: http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=812 accessed on 05 October 2017; L. Shengelia et al Stakeholders' views on the strengths and weaknesses of maternal care financing and its reform in Georgia available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5549305/ accessed on 10 October 2017

45 Curatio International Foundation "Health System Barometer IX wave", 2017 as per WB "Overview of State Costs", 2017
available at: http://curatiofoundation.org/wp-content/uploads/2017/09/HSB-9-Results_September-18-2017.pdf accessed on 04 October 2017

46 A. Talakvadze et al. «Review and analysis of Georgian Health Legislation», GYLA, 2011
available at: http://www.nplg.gov.ge/gsdl/cgi-bin/library.exe?e=d-01000-00---off-0samartal--00-1----0-10-0---0---0prompt-10---4-------0-1l--11-ka-50---20-about---00-3-1-00-0-0-11-1-0utfZz-8 -00&cl=CL4.1&d=HASH4e35112dccb841ea499b55.5&gt=1 (last seen on 03 October 2017)

47 The main laws regulating healthcare issues, available at: http://rama.moh.gov.ge/geo/static/5/kanonebi and http://www.healthrights.ge/legislation/; A. Talakvadze et al. «Review and Analysis of Georgian Health Legislation», GYLA, 2011
available at: http://www.nplg.gov.ge/gsdl/cgi-bin/library.exe?e=d-01000-00---off-0samartal--00-1----0-10-0---0---0prompt-10---4-------0-1l--11-ka-50---20-about---00-3-1-00-0-0-11-1-0utfZz-8 -00&cl=CL4.1&d=HASH4e35112dccb841ea499b55.5&gt=1 (not all of the laws listed are relevant or addressed in this report).

- The Law of Georgia on Medical and Social Expertise;
- The Law of Georgia on Medicines and Pharmaceutical Activities;
- The Law of Georgia on Narcotic Drugs, Psychotropic Substances and Precursors and Narcological Assistance;
- The Law of Georgia on Licenses and Permits;
- The Law of Georgia on Protection and Promotion of Infants' Natural Feeding and Artificial Feeding Controlled Use;
- The Law of Georgia on the HIV/AIDS Prevention and Control;
- Criminal Code of Georgia;
- Civil Code of Georgia;
- Administrative Code of Georgia;
- International conventions and protocols ratified by Georgia.

Government Resolution #724 of 26 December 2014 sets priorities for the healthcare system (2014-2020) regarding "universal healthcare and quality management for patients' rights." Strategic objectives include decreasing improper access to healthcare services, improving quality of healthcare, upholding patients' rights, improving public health issues, setting up comprehensive healthcare management, and increasing efficacy of the healthcare sector.[48]

Health Information System (HIS)

The first E-Health management strategy was created in 2011 and aimed at developing a new program to serve information needs of the Ministry, insurance companies, medical facilities and patients, and facilitating the introduction of international standards in healthcare.[49] The MoLHSA has been using this Unified Healthcare Information System since 2011. It ensures confidentiality and safety of information, sets unified standards, provides for real-time information exchange, arranges financial and medical data and helps with gathering accurate statistics and analysing data. It consists of 14 main modules, each regulating a part of healthcare system, including: medical activities, immunization, supply management, pharmaceutical products, medical cases, etc.[50] Application of the healthcare information system by the MoLHSA is regulated by Paragraph 3^1 of Government Resolution #274 of 6 June 2017, which authorises the Ministry to process all data associated with healthcare.[51] In 2015, a new E-Health Surveillance System for Pregnant Women and Newborns was introduced, with the financial assistance of UNICEF and technical support of the Arctic University of Norway.[52]

In addition, the National Centre for Disease Control and Public Health of Georgia collects aggregated data from health facilities country wide.[53] The existing healthcare information system proved to have some shortcomings in practice, as the quality of information received through the system doesn't always correspond to standard.[54] This is due to lack of, or incomplete or non-disaggregated data, particularly regarding marginalized groups (such as sex-workers, men having sex with men, intravenous drug users, LGBTI, etc.), by geographic location,

48 TGovernment resolution #724 of 26 December 2014 on 2014-2020 State concept for healthcare system on "Universal healthcare and quality management for patients' rights"
available at: https://matsne.gov.ge/ka/document/view/2657250

49 MoLHSA "Strategy of Georgia on Health Informational Systems Management", 2011
available at: http://www.georgia-ccm.ge/wp-content/uploads/ABT_ka-GE.pdf

50 USAID "Unified Healthcare Information System
available at: http://www.healthquality.ge/sites/default/ffiles/23%20Turdzeladze%20Tatoshvili%20HMIS%20Presentation_GAMPHA_GEO.pdf

51 Government Resolution #274 of 6 June 2017 on "Approval of Ministry of Labor, Health and Social Affairs Statute"
available at: https://matsne.gov.ge/ka/document/view/3689920 accessed on 06 October 2017

52 UNICEF "Informational Bulletin #1 (#19)", 2016
available at: https://issuu.com/unicefgeorgia/docs/_____

53 Heath Care Statistics Yearbook, National Center for Disease Control and Public Health of Georgia

54 MoLHSA "Report on Assessment of Heath Systems Efficacy", 2013
available at: http://www.healthrights.ge/wp-content/uploads/2013/01/jandacvis-sistemis-efekturobis-angarishi.pdf

ethnicity, disability status, economic quintile, etc. This lack of comprehensive disaggregated data hinders the creation of evidence-based policies and practices and can lead to discrimination.

Integrating SRH into the Primary Health Care System and Referral Systems

For the purpose of promoting the integration of sexual and reproductive health services into the public healthcare system, the Government of Georgia established over 200 family planning centres to provide ante- and post-natal services. They are designed to provide consultations on contraception, sexually transmitted infections and HIV/AIDS. However, the number of such services in rural areas is still insufficient, as family planning centres do not operate in village ambulatories, except in pilot regions.[55] The integration of sexual and reproductive health care into Georgia's primary healthcare system is mainly donor-funded: for example, more than 1400 family doctors have been trained in prevention and early detection of breast and cervical cancer with the financial assistance of USAID/SUSTAIN and UNFPA.[56]

Training Healthcare Providers

The Georgian Law on Public Health defines continuous medical education as a professional development process which includes self-education and formal education and trainings, as well as the participation of health care professionals in various activities promoting knowledge acquisition and skills development. It also regulates baseline educational requirements for doctors.[57] However, no mandatory continuing medical education exists in Georgia: the lifelong medical activity license doesn't oblige doctors to develop their medical skills and knowledge throughout their career.[58]

Non-mandatory continuous medical education, together with the lack of fully integrated sexual and reproductive health services in the primary healthcare system in Georgia, present a major challenge. Insufficient training on sexual and reproductive health topics results in a lack of knowledge and experience regarding family planning methods by family doctors and nurses, especially in rural areas.[59] They are also not trained in some maternal care topics, including emergency obstetrics care. On the primary healthcare level, aside from the pilot regions, family doctors lack training on early detection of oncological diseases, for example.[60]

Accountability

Challenges related to accountability for such human rights violations, result both from weak monitoring mechanisms of the State for ensuring human rights compliance by health care institutions and professionals, and the lack of effective enforcement mechanisms in current laws governing healthcare.

Justiciability and Enforcement

The right to health is not fully justiciable in Georgian courts.[61] Patient rights provided for by key laws in

55 N. Tsuleiskiri et al. "Reproductive rights and their realization warranties according to the Georgian legislation", Association Hera-XXI, 2015

56 Government of Georgia "National Report on Millennium Development Goals in Georgia", 2014

57 Georgian Law on Public Health
availabel at: http://ssa.gov.ge/files/01_GEO/KANONMDEBLOBA/Sakanonmdeblo/30.pdf

58 K. Chkhatarashvili «Transition From Global Fund Support and Programmatic Sustainability Research in Four CEE/CIS Countries Georgia Country Report», CIF, 2015, p. 46

59 Interview with Magda Kostava, Association Hera XXI (Interview was conducted in May)

60 N. Tsuleiskiri et al. "Reproductive rights and their realization warranties according to the Georgian legislation", Association Hera-XXI, 2015

61 The provisions of the Constitution of Georgia in force provide that everyone has the right to health insurance and that the conditions of free healthcare is envisaged under the law (Art. 37.1 of the Constitution). The Constitution also states that the State exercises control over all healthcare institutions, as well as manufacturing and selling of medicine (Art. 37.2 of the Constitution).
Under the recent amendments of the Constitution (which is yet to be enacted), the right of a citizen to accessible and quality healthcare is envisaged by the law (draft Art. 28.1) and the State exercises control over all healthcare institutions and the quality of healthcare, pharmaceutic manufacturing and the circulation of pharmaceutical products (draft Art. 28.2).

the field of healthcare, such as the Law on Patient Rights and the Law on Health Care, lack enforcement mechanisms. Patient rights violations may lead to liability in the court only if it can be proven that the patient sustained a material or moral damage as a result of the violation.[62] Moral damage may only be claimed if the patient's health was affected as a result of the violation,[63] or if the patient suffered discrimination during the delivery of health services.[64] To substantiate a claim based on health damage, the applicant needs to obtain a medical expert's conclusion corroborating the alleged violations committed by the doctor/health professional and the damages suffered, which evidence is very hard to obtain.[65] In all the other instances, there is no remedy for patients that suffer human rights violations during the delivery of health (including sexual and reproductive health) services.

Criminal and Administrative Responsibility

Illegal medical activity entails criminal responsibility if the act in question results in the damage of a patient's health or deprivation of their life.[66] If in the course of the medical treatment a doctor negligently causes health damage or death of a patient, these acts are punishable usually under the general provisions of the Criminal Code and entail liability for committing such acts in any settings.[67]

The Administrative Offences Code of Georgia envisages administrative liability for illegal medical activities and medical activities without a license and imposes fines for such acts.[68] In contrast to the criminal liability for illegal medical activities, the act does not necessarily have to cause damage to the patient's health for it to amount to an administrative offence.

State Oversight Mechanisms for Violations in Healthcare Settings

The State Regulatory Agency for Medical Activities is responsible for controlling the quality of medical services provided (including the services rendered in the framework of State healthcare programs) and for examining the complaints of individuals regarding medical treatment. The Agency is also responsible to raise the liability of a medical professionals or institutions to the relevant body.[69] Overseeing human rights compliance in the delivery of healthcare is outside the mandate of the Agency, and no other agency has this mandate.

In 2014, in a decision by the European Court of Human Rights in the case of *Dzebniauri v.* Georgia,[70] the State acknowledged responsibility for the shortcomings in medical treatment provided to the patient in a private health care institution and the lack of inspection by the State of the institution's compliance with medical license requirements. To support the implementation of the Court's decision, the Georgian Young Lawyers' Association (GYLA) made submissions to the Ministry of Health, as well as to the Committee of Ministers of the Council of Europe, advocating for the establishment of a special mechanism by the State to oversee human rights compliance at private healthcare institutions. The decision has not been implemented to this date.

62 Law of Georgia on the Rights of Patient, Art. 10. Law of Georgia on Health Care, Art. 103 and 104.

63 Under Article 413.2 of the Civil Code of Georgia, moral damages can be claimed in case of bodily or health damage.

64 Law of Georgia on the Elimination of All Forms of Discrimination, Art. 10.

65 The court practice of GYLA in the damages proceedings has shown that, most of the times, medical expert conclusions tend not to be explicit about the violations committed by the doctor, which makes it hard to meet the burden of proof requirements at the court in civil litigation.

66 Art. 246 of the Criminal Code of Georgia, the act is punishable by fine or restriction of liberty for up to 3 years and/or deprivation of liberty for the same term. If the act resulted in the death of the patient, it shall be punished by restriction of liberty for up to five years or by imprisonment for a term of three to seven years, with or without deprivation of the right to hold an official position or to carry out a particular activity for up to three years.

67 Criminal Code of Georgia, Article 117 - Intentional infliction of grave injury; Article 118 – Intentional less grave bodily injury; Article 116 – Negligent manslaughter [translated from Georgian]

68 Administrative Offences Code of Georgia, Article 44^2 – Illegal medical activity

69 Order N01-64/ბ of the Minister of Labor, Health and Social Affairs on creation and affirming the regulations of the LEPL State Regulation Agency for Medical Activities, 28/12/2011 [translated from Georgian]

70 Dzebniauri v. Georgia, app. no. 67813/11, decision of the European Court of Human Rights, 09.09.2014.

CHAPTER 3: PRIORITY HUMAN RIGHTS ISSUES IN THE CONTEXT OF SEXUAL AND REPRODUCTIVE HEALTH AND WELL-BEING

Access to Contraceptive Information and Services

Health and human rights considerations

Access to contraceptive information and services enables individuals and couples to determine whether and when to have children, it also contributes to the achievement of their health and increases their autonomy and well-being, promoting a satisfying and safe sex life.[71] Contraceptive information and services are important in preventing pregnancies, including those resulting from sexual violence, and in preventing the spread of sexually transmitted infections and HIV. Human rights obligations require that contraceptive information and services should be available, accessible, acceptable and of good quality, and women should have access to a full range of contraceptive methods.[72] UN human rights bodies have framed the lack of access to modern contraception as implicating numerous rights, including the rights to non-discrimination and to health and to decide the number, spacing and timing of children. In cases of denial of access to emergency contraception in cases of sexual violence, it can also implicate the right to be free from inhuman and degrading treatment.[73]

States have an obligation under the right to the highest attainable standard of health to ensure access to medications on the WHO Essential Medicines List, which includes hormonal contraception, including emergency contraception.[74] This includes making them affordable to all. Human rights bodies have recommended that States should eliminate obstacles to accessing contraception, including those associated with high costs, marital status requirements and third-party authorization, such as spousal consent requirements, whether in law or in practice.[75]

Human rights emphasize the obligation of Sates to ensure that the use of contraceptives is voluntary and fully informed, without coercion or discrimination, and particular attention should be paid to groups who have historically been subject to coercive family planning practices, such as Roma people, persons with disabilities, or women living with HIV, for example.[76] Contraceptive information should include all available choices of contraception, as well as side effects and success rates. Effective remedies should be available when violations of informed consent and other irregularities around the use of contraceptives has occurred.[77]

States also have an obligation to gather disaggregated data on the use of contraceptive barriers to contraceptive access, and to formulate laws, policies and programs that reflect the needs of society, including vulnerable groups, such as adolescents, persons with disabilities and unmarried women.[78]

Sexually active young women face obstacles to accessing contraceptives and health services, increasing the risk of an unintended pregnancy and its consequences. Young men, too, need information and services so

71 Committee on Economic, Social and Cultural Rights, General Comment 22 on the right to sexual and reproductive health (2016) (hereinafter CESCR GENERAL COMMENT 22); ICPD PoA; Singh S and Darroch JE, *Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012,* New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012.

72 CESCR GENERAL COMMENT 22

73 UNFPA and Center for Reproductive Rights, "The Right to Contraceptive Information and Services for Women and Adolescents", 2010, available at: https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf; Center for Reproductive Rights Violations as Torture or Ill-treatment, available at: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Reproductive_Rights_Violations_As_Torture.pdf; CAT Committee, Concluding Observations: Peru, para. 15, U.N. Doc. CAT/C/PER/CO/5-6, 2013

74 Committee on Economic, Social and Cultural Rights, General Comment 14 on the right to the highest attainable standard of health (2000) (hereinafter CESCR General Comment 14); CESCR General Comment 22.

75 Committee on Economic, Social and Cultural Rights, General Comment 14 on the right to the highest attainable standard of health (2000); CESCR GENERAL COMMENT 22

76 CESCR GENERAL COMMENT 22

77 CESCR GENERAL COMMENT 22

78 CESCR GENERAL COMMENT 22

they can take responsibility and be partners in preventing unintended pregnancies.[79] Confidential and youth-friendly counselling services should also be implemented, and adolescents should have access to information and medical services without parental consent.[80]

UNFPA has recognized, in line with human rights standards, that "practical barriers to accessing contraceptive information and services often stem from socially or culturally ingrained discrimination, and States must take steps to eliminate these barriers to ensure women's and adolescents' access to contraception. Such access is central to achieving women's and adolescents' participation as full and equal members of society."[81]

Georgia has an obligation to implement all of the above human rights standards, and the CEDAW Committee in its recommendations to Georgia, for example, urges the State to improve women's and adolescent's access to high-quality healthcare and provide access to family planning services and ensure affordable contraceptive methods, including all modern forms of contraception, especially for women in rural areas.[82] Numerous UPR recommendations, which Georgia has accepted, also call for increasing access to contraceptive services and information and to make them affordable, especially among vulnerable populations.

Contraceptive Information and Services in Georgia

Contraceptives are available in Georgia mostly in pharmacies and, in most cases, on prescription issued by a doctor. They are not subsidized by the State's health program, including the Universal Health Care Program. Family planning services fall within the competencies of obstetricians and gynaecologists as well as family/village physicians, however, the latter have not been fully integrated at the PHC level.[83]

With regards to unintended pregnancies, according to the Reproductive Health Survey (RHS) 2010, only 41% of all pregnancies in Georgia were intended in 1999. This percentage increased to 48% in 2005 and to 63% by 2010, with 37% unintended – of which 26% were unwanted and 11% mistimed.[84] Thirty-nine per cent of all pregnancies among women aged 30-34 were unintended, and 54% among women aged 35-44 years.[85] Among young women aged 15-19, only 16% of pregnancies were unplanned and most of their unplanned pregnancies were reported mistimed rather than unwanted.[86] Vast majority of unwanted pregnancies did not result in a live birth (94.4% ended in induced or spontaneous abortion or stillbirth).[87] This indicates that access to family planning does not lower the birth rate, but it does decrease the number of abortions.

In relation to contraceptive use and unmet need, according to the RHS, in 2010, 12.3% of all married couples did not use any FP method, although they were at risk of unwanted pregnancy. In addition to this, 18.2% of married women at risk used unreliable methods of contraception. Together, this amounts to 30.5% of unmet need for *modern* contraception[88] for married women, and 18.5% for all women, which is very high for European standards. Unmet need is particularly high in rural areas, where it can reach 40%.[89]

79 UNFPA, State of the World Population Report 2013. Motherhood in Childhood.
80 CESCR GENERAL COMMENT 22; CRC General Comment 15 (2013); UN Special Rapporteur on the Right to Health report on the right to health of adolescents (2013).
81 UNFPA, Briefing Paper, "The Right to Contraceptive Information and Services For Women and Adolescents", 2010, p. 12, available at: https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf
82 CEDAW/C/GEO/CO/4-5, 2014, para. 31 (a)
83 Georgia Maternal and New-born strategy 2017-2030, p. 29
84 NCDC, Reproductive Health Survey, 2010, p. 46
85 Ibid., Figure 4.6.3
86 Ibid.
87 Ibid.
88 Modern contraception is defined as clinic and supply methods of contraception, including female and male sterilization; IUDs; hormonal methods, such as oral pills, injectables, hormone-releasing implants, skin patches, and vaginal rings; condoms; and vaginal barrier methods, such as the diaphragm, cervical cap, spermicidal foams, jellies, creams, and sponges.
89 NCDC, Reproductive Health Survey, 2010, p. 175, Table 9.1.2

Although overall contraceptive use increased since 1999 from 41% to 54% in 2010[90] Georgia still has almost the lowest level of use of modern contraceptives in Eastern Europe.[91] According to RHS 2010, the use of modern methods has increased regularly while that for traditional methods has declined. However, the use of full range of modern methods of contraception, especially female controlled, is still low. According to RHS, the most commonly used methods ever used were condoms (20%), calendar (rhythm) method (17%), IUDs (16%) and withdrawal (15%).[92] According to another study, while the use of hormonal contraception is low, it increased four times between 2000 and 2014.[93]

According to the RHS, of all married women in Georgia only 35%, and for all women only 20.9%, used a modern contraceptive method, these mostly being condoms or IUDs.[94] Use of oral contraception (pill (4%)) was still remarkably low among married women aged 15-44 compared to Europe as a whole (21.4%). The use of the pill is even lower for all women (2.4%). There was also a difference between urban and rural areas: among married women aged 15-44, the use of modern methods in urban areas was 42%, while in rural areas it was 28%.[95] There is very little difference according to ethnicity for any method. However, Georgian women tend to prefer modern methods to traditional methods more than Azeri or Armenian women. The use of modern contraceptive methods among married women was at least 50% higher among Georgians than among Azeri and Armenian women (37% vs. 23% and 20%, respectively).[96]

The RHS study also revealed that the main barrier to changing from traditional methods to more reliable modern contraceptive methods is the lack of information about methods of contraception, compounded by prevalent myths concerning side effects associated with them. Other concerns relate to the cost or limited availability of the methods, partner preferences, medical or other persons' advice against modern methods, and religious beliefs.[97]

The knowledge of women in reproductive age about all forms of modern contraception was still low in 2010.[98] Virtually all respondents in the RHS (97%) had heard of at least one modern method.[99] Condoms and the IUDs were quite well known, but 19% did not know about oral contraception and 50% did not know how to use the method.[100] Only 39% of women knew about female sterilisation, while male sterilisation was almost completely unknown (only 4% knew of it).[101]

The majority of women did not recognize any modern method as very effective. While 29% of women correctly stated that the IUD is very effective in preventing pregnancy, only 16% believed that contraceptive sterilization is very effective. The majority of women incorrectly thought that pills were not very effective.[102]

In addition, information on contraceptives was not obtained from credible sources, the main source of information about contraceptive methods was an acquaintance or a boyfriend (32%), followed by a doctor (17%), a relative other than a parent (15%), a partner/husband (12%), and TV, radio and internet (9%).[103]

90 It should be stated that according to 10 year period evidences induced abortion was replaced by contraceptive use without decreasing fertility. As the contraceptive prevalence rate increased and the total abortion rate declined, the total fertility rate rose from 1.7 to 2.0

91 World Contraceptive use 2011. UN Department of Economic and Social Affairs; Population Division. (Wallchart).

92 Regarding trends between 1999 and 2010, the percentage of women who reported that their partner had ever used a condom almost doubled (from 10%, to 13%, to 20%).

93 Geostat, Analytical Report 'Women and Man in Georgia', 2015, p. 22, available at: http://geostat.ge/cms/site_images/_files/georgian/health/Qali%20da%20kaci_2015.pdf

94 NCDC, Reproductive Health Survey, 2010, p. 156, Table 8.2.2, Table 8.2.1.

95 Ibid. p. 156, Table 8.2.2

96 Ibid. p. 157, Table 8.2.3

97 NCDC, Reproductive Health Survey, 2010

98 Ibid, p. 125-138

99 NCDC, Reproductive Health Survey, 2010. Levels of awareness of any method were lowest in the Kvemo Kartli region and highest in Tbilisi and Imereti

100 NCDC, Reproductive Health Survey, 2010, p. 127

101 Ibid., p. 126

102 Ibid., p. 130

103 Ibid., p. 129

Government and Other Actions

The Georgian law on Protection of Health Care adopted in 1997, sets important principles concerning State obligations to ensure human rights in the sphere of reproduction and recognizes the right of every person to determine independently the number of children they wish to have and the timing of their birth.[104]

The State also recognizes the importance of guaranteeing reproductive health and rights in some of its policy documents.

Most recently, the Georgian Maternal and Newborn Health Strategy for 2017-2030 and its Action Plan for 2017-2019, laid down strategic interventions, directly or indirectly related to the contraceptive access, including addressing such issues as mother and child mortality, family planning, and identifying priority directions for adults' sexual and reproductive healthcare. In relation to modern contraceptive access, the MoLHSA has set out the following priority interventions:[105]

- Primary Health Care (PHC) will be the primary level for family planning (FP) counselling, service delivery, and coordination. Inclusion of FP counselling and prescription of contraceptive supplies (including the IUD and hormonal contraception) will be included in the basic benefit package of Georgia's Universal Healthcare Program, and relevant resource allocation within the state budget will be ensured.[106]
- PHC centres and rural PHC units will be licenced gradually to enable them to deliver all FP services (except a few that will be indicated), as soon as they meet defined quality criteria.[107]
- Modern methods of family planning (IUD and oral contraception) will be made available free of charge to beneficiaries of the Targeted Social Assistance (TSA) program and some other vulnerable population groups, like women under 21 years of age.[108]
- FP counselling, distribution or prescription of contraception, and contraceptive check-ups, if carried out by PHC staff, will be included in the basic benefits package of Universal Healthcare Program. Where medically indicated, referrals to and services provided by a higher level specialist will also be included.[109]

The Action Plan states that accessibility of family planning services will be improved substantially for target groups. Some of the relevant objectives in the Action Plan are:

Reduction of the unmet need for modern contraception from 31% in 2015 to 25% by 2020, and below 15% by 2030 and reduction of the Teenage Pregnancy Rate (TPR) from 48.6 per 1,000 women aged 15-19 in 2015 to < 40 by 2020, and to < 20 by 2030.

Georgia's Maternal & Newborn Health Action plan for 2017-2019 does not indicate budgeting of the relevant activities.[110]

The Strategy also envisages awareness-raising and educational interventions and prescribes relevant activities, including through use of mass media, aimed at fighting prevalent and newly emerging myths and misconceptions about methods of contraception and disseminating practical information on family planning service provision arrangements in the country.[111]

104 Article 136
105 Georgia Maternal and New-born strategy 2017-2030, p. 25
106 Ibid.
107 Ibid., p. 26
108 Ibid.
109 Ibid.
110 Georgia Maternal & New-born Health Action plan for 2017-2019.
111 Georgia Maternal and New-born Strategy 2017-2030.

In 2014, the Government of Georgia approved the State Concept on "Universal Health Care and Quality Management for the Protection of Patients' Rights."[112] The State Concept, which has a focus on maternal and child health, notes that "in order to ensure universal access to modern family planning services - recommendations are being considered to include contraceptive supplies and relevant consultative services in the state funding schemes".[113]

The Strategy of the Health Protection System 2014-2020 is also supportive of strengthening maternal and child health.[114] It seeks to ensure universal access to quality reproductive and sexual health services, including contraceptive services, for vulnerable populations, especially for women in rural areas and those living with HIV/AIDS.[115]

Human Rights Action Plans for 2014-2015 and 2016-2017 support raising awareness regarding the principles of reproductive health, human rights, and gender equality.[116] However, the plans include no interventions aimed at improving family planning services or enhancing access to contraceptives.

The National Recommendation on Clinical Practice of Family Planning (Guideline), covers post-abortion family planning and explicitly states the importance of raising patient awareness on various methods of contraception in order to prevent unwanted pregnancy and repeat abortions.[117]

Discrepancies

While many policies recognize the need to address challenges associated with contraceptive services and related information through ensuring broader access to contraceptives, by and large, they lacking in detail in terms of how this should be done. The State, overall, does not provide an adequate supportive environment for effective family planning services, which includes the lack of human resources on the supply side to provide these services. Challenges also include the low level of public awareness, including inadequate knowledge of the use of the range of contraceptive method, as well as affordability.[118]

Adoption of the Maternal Health Strategy is a welcome development; expressly stating the country's commitment to ensuring access to family planning. So far, family planning services are not fully integrated at the primary health care level and there are no contraceptive supplies through public sector health programs, despite the fact that family planning service delivery has been incorporated into the primary health care circle – and included into the competences of family/village physicians and nurses.[119] However, due to the absence of reinforcement mechanisms and any (financial) incentives for PHC doctors, family planning counselling is not yet fully integrated at the PHC level, and is still highly concentrated in the hands of obstetrics and gynaecology specialists who traditionally are not focused on the promotion of modern contraceptive methods.[120]

UNFPA and USAID have been the only providers of free modern contraception to those most in need. According to information received from the MoLSHA,[121] in 2015 USAID has provided a5-year supply of contraceptives

112 The Decree of the Government of Georgia N724, 26 December, 2014, Tbilisi, regarding approving 2014-2010 the state concept on health care system of Georgia 'Universal Health Care and quality management for the purpose of protecting patients' rights'. Available only in Georgian: https://matsne.gov.ge/ka/document/download/2657250/0/ge/pdf

113 Ibid, priority 7

114 A/HRC/31/15, Report of the Working Group on the Universal Periodic Review, 13 January 2015, Para. 118.41

115 Ibid., para. 118.43

116 Human Rights Action Plan for 2014-2015 years, para. 14.1.4.3; Human Rights Action Plan for 2016-2017 years, para. 12.1.3.2

117 MoLSHA, "National Recommendation on Clinical Practice of Family Planning (Guideline)", Ministerial decree N01-78 of MoLSHA, Aproved on April 21, 2017, p. 207, available only in Georgian: http://www.moh.gov.ge/uploads/guidelines/2017/04/26/0015f8eee1d4899f94a44386bb2e5ea1.pdf

118 UNFPA, Policy brief, 2014

119 The Decree of the Minister N01–9n, March 4, 2016 , Appendix N1, Article 3, para a). availableonly in Georgian: https://matsne.gov.ge/ka/document/view/3192567

120 Georgia Maternal and New-born strategy 2017-2030, p. 29

121 Letter from the MoLSHA No: 01/55418, August 29, 2017

for free to primary healthcare facilities, including the Combined Oral Contraceptive Pill (COC), some other contraceptive pills and condoms. In addition, women consultation services were provided with contraceptive implants (Implanon) and IUDs. The State, however, has budgeted no funds so far for family planning counselling, service delivery or contraceptive procurement. These services are not funded through any of the state's health programs, including the Universal Health Care Program introduced in 2013.[122] Neither are these services included in benefit packages of private insurance.[123] Contraceptives are available in pharmacies, which are mostly privately owned, and due to the recent regulatory changes fall under prescription practices; oral pills are sold at a relatively high price (starts from 10 Gel and goes up to 41 Gel)[124] and, thus are not affordable for many women in need, in particularin rural areas.[125]

In terms of family planning services there is little information on the specific service centres/clinics in Georgia that provide services. Information received from the MoLSHA[126] notes that the clinics that provide such services are available on a database[127] created by the Ministry itself, but detailed information on the specific FP clinics does not appear to be easily accessible.[128]

As contraceptive services are not funded by any of the state health programs, individuals and couples in need of contraception have to purchase it from pharmacies out of their own pocket.[129] However, because of the high price it is not affordable for most women, especially for adolescents, low income women, and women living in rural areas. Many international organizations and mechanisms call upon Georgia to allocate resources necessary to satisfy the unmet need for contraceptives.[130]

It is noted that few women receive consultation and corresponding services in relation to post-abortion family planning, despite the Ministerial decree requiring this. Unequal access to services is especially striking amongst rural residents who lack education and information."[131]

In addition, contraceptives are not included in an essential medicines list which is a core human rights requirement under the right to health. In fact, formally, such an essential medicines list does not exist in the country.[132] There is a general lack of information on the full range of the types of modern contraceptives available on the market. It appears that while emergency contraception should be available without a prescription, there appears to be an inconsistent practice which at times allows for access to emergency contraception without a prescription and at other times requires a prescription. The latter clearly hinders the access to this time-sensitive contraception.[133]

The low use of contraceptives and high unmet need is also attributed to the misconceptions rampant amongst the population about the side effects (e.g., that contraceptives are harmful to health, hormonal contraceptives cause cancer and that taking pills may result in infertility). The situation is further compounded by the low

122 Resolution N36 of the Georgian Government "on Some Measures to be taken for introducing Universal Health Care Program", February 21, 2013, available only in Georgian: http://ssa.gov.ge/files/2013/File/N36-2013.pdf

123 UNFPA, Invest in Family Planning, Policy Brief

124 Information on the contraceptives (pills, IUD, Vaginal Contraceptives) and prices was obtained here: http://pharmacy.moh.gov.ge/Pages/Products.aspx#

125 Georgia Maternal and New-born strategy 2017-2030, p. 30

126 Letter from the MoLSHA No. 01/55418, August 29, 2017

127 MoLSHA, available at: http://cloud.moh.gov.ge/Pages/SearchPage.aspx

128 The only information which is provided on the official web-page of the MoLSHA, is about the healthcare facilities which provides antenatal and perinatal services, even though, the information on family planning services is included under the above mentioned services.

129 Maternal and new-born strategy for 2017-2030 years, p. 24

130 For example, CEDAW/C/GEO/CO/4-5, para. 31

131 PDO, 'Women's Rights and Gender Equality', 2015, pp. 19-20

132 See generally, Letter from MoLSHA No: 01/55418, 29 August, 2017.

133 While a prescription is not required for emergency contraception, in practice, it is understood that some private pharmacies do require a prescription and have a doctor in-house that writes out a prescription for the customer.

affordability and lack of overall accurate information on the effectiveness of modern contraceptive methods, also contributing to the low use and high unmet need. This indicates a discrepancy in terms of the enjoyment of the right to access reliable, evidence-based information on sexual and reproductive health, including on contraception.

According to the Maternal and Newborn Health Strategy "women largely bypass medical specialists for obtaining oral contraception (the most widely used method in developed countries) and directly obtain this from pharmacies (in more than 60% of the cases). This indicates that consulting a specialist is felt to be too complicated, or just unnecessary."[134] It should be noted that some contraceptives are available only by prescription and others are available without.[135]

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.[136]

However, while full access to accurate contraceptive information is important for informed consent, including for adolescents, there is a distinctive lack of comprehensive youth friendly sexual and reproductive health services, including on family planning.

There seems to be an informal, and what appears to be illegal practice under the Georgian law, where a husband's consent is required before a woman can undergo sterilization.[137] The laws do not contain any provisions requiring spousal consent to sterilization.[138] Furthermore, clinical guidelines on Family Planning oblige medical personnel "to ensure that decision on sterilization is made by women independently and only according to her own will."[139] Hence, the above practice is a form of discrimination allowed against women in medical facilities, which deprives women of equality and violates their right to full legal capacity in relation to informed consent and confidentiality in healthcare.[140] Apparently, this contributes to stigma and prejudices regarding women's ability to make independent, autonomous decisions concerning their own body.

134 Maternal and Newborn Strategy for 2017-2030 years, p. 25

135 See the official site of MoLSHA: http://pharmacy.moh.gov.ge/Pages/Products.aspx#

136 Georgian Law on The Rights of The Patients, Art. 41.1

137 There is no official information on this practices, but these latter were revealed in individual cases and was covered by the national online media channels, available only in Georgian: http://www.tabula.ge/ge/story/116873-sterilizacia-qalis-ufleba-romelzec-qmris-tanxmobas-itxoven

138 The law of Georgia on "The Rights of the Patient", Art.22.1, 22.2

139 Family Planning, national recommendation on clinical practice (guideline), p. 149 (Geo), available at: http://www.moh.gov.ge/uploads/guidelines/2017/04/26/0015f8eee1d4899f94a44386bb2e5ea1.pdf

140 Carmel Shalev, Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination against Women, March 18, 1998, available at: http://www.un.org/womenwatch/daw/csw/shalev.htm

Recommendations:

- Develop an Essential Medicines List which includes modern contraceptive methods, including emergency contraception.
- Include family planning counselling and free provision of contraceptive supplies in the basic benefit package of Georgia's Universal Healthcare Program, ensuring that adolescents and youth and those with low economic status are covered, and that all women, adolescents and youth can access a full range of the latest modern contraceptives, and that they are affordable for all.
- Ensure effective integration of FP services at the PHC level and ensure that family/village doctors are adequately equipped with competencies and knowledge to provide high quality FP services, including youth-friendly services.
- Provide training to family planning and village doctors in order to strengthen their knowledge on contraceptive methods and counselling principles, including on confidentiality and non-discrimination, and the provision of youth-friendly services.
- Ensure that, in practice, there is access to emergency contraception without a prescription, as per the regulatory framework.
- Develop minimum data collection tools for each level of care for gathering and analysing monitoring data on FP service quality and utilization.
- Conduct research aiming at improving service delivery and identifying social barriers, and administration and policy constraints. Ex., MICS-RHS.
- Elaborate and consistently implement public awareness campaigns and educational programs concerning the importance of family planning, including modern contraception, paying particular attention to the regions and rural areas. Priority topics for health promotion should be identified using epidemiological information and data on the coverage with key services, generated through the routine health information system and periodic population-based surveys.
- Build partnership with other stakeholders and civil society organizations for the promotion of FP and establishment of youth-friendly sexual and reproductive health services, including family planning information and services.
- Ensure that the provision of all family planning information and services are free of third party authorization requirement, including parents and spouses, and are based on free and informed consent.

ACCESS TO SAFE ABORTION SERVICES AND POST-ABORTION CARE

Health and human rights considerations

Worldwide, a high proportion of unintended pregnancies end in abortion. Increasing contraceptive use reduces the number of unintended pregnancies and, subsequently, the need for induced abortion, but will never eliminate its need.[141] The UN General Assembly Review and Appraisal of the International Conference on Population and Development in 1999 stated that" in circumstances when abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that abortion is safe and accessible."[142] The World Health Organization has recognized that when performed by skilled health professionals in sanitary conditions, abortion is a safe procedure, yet where provided illegally, abortions are generally unsafe and lead to high rates of complications, including maternal deaths. Unsafe abortion is one of the leading causes of maternal mortality worldwide.[143] WHO has noted that safe abortion can be provided by a range of trained health care professionals, including nurses and midwives.[144]

The availability of reproductive health services, including abortion services, is critical for the implementation of women's human rights – International human rights treaty bodies and UN bodies have deemed that laws that generally criminalize abortion are discriminatory and constitute a barrier for women in terms of enjoyment of their right to health amongst other rights, and that States should decriminalize abortion in all circumstances.[145] They have specifically stated that denying or not ensuring women access to abortion in certain circumstances violates the rights to life, health, privacy, the right to be free from inhuman and degrading treatment, and the right to non-discrimination.[146] The CEDAW Committee has made clear that states must take measures to ensure that the life and health of the woman are prioritized over protection of the foetus.[147]

States also have an obligation to eliminate and refrain from adopting medically unnecessary barriers to abortion, including mandatory waiting periods,[148] biased counselling requirements,[149] and third party authorization requirements, and to regulate the practitioners' refusal of care based on grounds of conscience.[150] The Children's Rights Committee has also urged that "health care professionals provide medically accurate

141 WHO World Health Organization. 2012. "Safe Abortion: Technical and Policy Guidance for Health Systems". Second Edition. Geneva, 2012.

142 ICPD 1999

143 WHO World Health Organization. 2012. "Safe Abortion: Technical and Policy Guidance for Health Systems". Second Edition. Geneva, 2012.

144 World Health Organization. 2012. "Safe Abortion: Technical and Policy Guidance for Health Systems". Second Edition. Geneva: WHO; WHO guidelines on Health Worker Roles in Providing Safe Abortion Care and Post Abortion Contraception. Available at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/;

145 Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover,* para. 24, U.N. Doc. A/66/254 , Aug. 3, 2011; *Mellet v Ireland,* Human Rights Committee, Communication no. 2324/2013 (2016), para. 7.4; CEDAW General Recommendation 24 on women and health, (1999) para 31(c); CEDAW General Recommendation 35 on Violence against Women (2017), paras. 18 and 31 (a).
Committee on the Rights of the Child – Concluding Observations: Ireland, (2016), para. 58(a); Committee on the Rights of the Child Concluding Observations: Peru, (2016), para. 56(b); Committee on the Rights of the Child Concluding Observations: Kenya, (2016), para. 50(b); Committee on the Rights of the Child Concluding Observations: Haiti, (2016), para. 51(c); Committee on the Rights of the Child Concluding Observations: Senegal, para. 54(d).

146 L.C. v. *Peru,* CEDAW Committee, Commc'n No. 22/2009 ; K.L. v Peru, CEDAW 2005; P and S v Poland (European Court of Human Rights 2012); RR v Poland (European Court of Human Rights, 2011); Tysiac v Poland (European Court of Human Rights, 2007)

147 L.C. v. *Peru,* CEDAW Committee, Commc'n No. 22/2009

148 A mandatory waiting period is a minimum amount of time that is legally required to elapse before a woman who requests an abortion can receive the service.

149 Biased information requirements require health professionals to provide information to women seeking to persuade women not to undergo abortion.

150 CESCR GENERAL COMMENT 22; CEDAW General Recommendation 24.

and non-stigmatizing information on abortion."[151] They have also called for removing requirements for court authorization and other law enforcement reporting, when pregnancy is a result of rape.[152]

The World Health Organization has called for the elimination of medically unnecessary barriers to abortion. For example, it recommends that States should not impose unnecessary administrative or judicial procedures such as requiring women to press charges or to identify the rapist.[153] WHO also recognizes the negative impact that mandatory waiting periods can have: "mandatory waiting periods can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services."[154] As a result of these concerns, the WHO indicates that mandatory waiting periods should not apply to abortion services.[155] It has underlined that "[o]nce the decision [to have an abortion] is made by the woman, abortion should be provided as soon as is possible"[156] and without delay.[157]

The WHO has also specified, in line with human rights standards, that information and counselling provided to women prior to abortion should always be evidence-based, non-directive, and voluntary.[158] Biased counselling and information requirements often seek to pressure women into deciding against abortion and can involve the provision of medically inaccurate, misleading, or stigmatizing information, which contravenes human rights obligations to ensure that health-related information and counselling be relevant, accurate, evidence-based, and non-directive and that medical decision-making be free from inducement, coercion, or discrimination.[159] It also can generate a sense of disapproval and shame and promoting a belief that women who terminate their pregnancies are doing something wrong. A UN Special Rapporteur on Health has noted that by generating and exacerbating stigma concerning abortion, biased and directive counselling and information can cause women trauma and suffering.[160]

151 CEDAW, *Concluding Observations: Slovakia,* para. 31(c), U.N. Doc. CEDAW/C/SVK/CO/5-6 (2015); CRC, *Concluding Observations: Slovakia,* para. 41(e), U.N. Doc. CRC/C/SVK/CO/3-5,2016

152 Children's Rights Committee Concluding Observations: Cameroon, para 35 (2017); Human Rights Concluding Observations: Bolivia, para 9 (2013); Human Rights Concluding Observations: Rwanda, paras 17 and 18 (2016), Human Rights Concluding Observations: Ireland (2014), para 9; CEDAW Concluding Observations: New Zealand, (2012), paras 33-34:
CEDAW CO on Timor-Leste (2015) paras. 30- 31; Commissioner for Human Rights of the Council of Europe, Report by Nils Muižnieks, Following His Visit to Ireland from 22 to 25 November 2016 (29 March 2017), para 77.

153 WHO, Safe Abortion: Technical and Policy Guidance for Health Systems 96 (2nd ed. 2012), page 69 [hereinafter WHO, 2012 Safe Abortion Guidance].

154 WHO, Safe Abortion: Technical and Policy Guidance for Health Systems 96 (2nd ed. 2012) [hereinafter WHO, 2012 Safe Abortion Guidance].

155 WHO, 2012 Safe Abortion Guidance, pp. 96-97

156 WHO, 2012 Safe Abortion Guidance, p. 36

157 WHO, 2012 Safe Abortion Guidance, p. 64

158 See WHO, 2012 Safe Abortion Guidance, at 36, 68, 97; see also World Health Organization, Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception 56, 2015

159 For example, the CESCR has highlighted that states must ensure women can access good quality health-related information that is scientifically and medically appropriate and refrain from "censoring, withholding or intentionally misrepresenting" such information, including on sexual and reproductive health. Committee on Economic, Social, and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health* (Art. 12), (22nd Sess., 2000), paras. 12(b) (iv), 12(d), 21, 34, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, Gen. Comment No. 14]. See also Center for Reproductive Rights, Mandatory waiting periods and biased counseling requirements in Central and Eastern Europe: restricting access to abortion, undermining human rights, and reinforcing harmful gender stereotypes (Sept. 2015) [hereinafter Mandatory waiting periods and biased counseling requirements in Central and Eastern Europe].

160 Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover,* para. 24, U.N. Doc. A/66/254 , Aug. 3, 2011; Anuradha Kumar et al., *Conceptualizing Abortion Stigma,* 11(6) Culture, Health & Sexuality 625, 2009; Alison Norris et al., *Abortion Stigma:* A Reconceptualization of Constituents, Causes, and Consequences, Women›s Health Issues 7, 2011 (authors ed.), available at http://www.guttmacher.org/pubs/journals/Abortion-Stigma.pdf; Rebecca J. Cook, Stigmatized Meanings of Abortion Law, in Abortion Law in Transnational Perspective: Cases and Controversies 347, 347 (Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens eds., 2014); Bruce G. Link & Jo C. Phelan, *Stigma and its Public Health Implications,* 367 The Lancet 528, 528-29, 2006; Bruce G. Link & Jo C. Phelan, *Conceptualizing Stigma,* 27 Ann. Rev. of Soc. 363, 367-76, 2001

In the context of refusals to provide care on basis of conscience, UN Treaty Monitoring Bodies have expressed concern about the impact of the practice of conscientious objection and have repeatedly urged States that permit the practice to adequately regulate it to ensure that it does not limit women's access to abortion services. They have explicitly specified that the relevant regulatory framework must put an obligation on healthcare providers to refer women to alternative health providers. In addition, institutional refusals of care must not be allowed, nor shall refusals be allowed in emergency situations, and states have an obligation to ensure that an "adequate number of health-care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach."[161]

Research indicates that adolescents may be deterred from seeking abortion services if they think they will be required to seek permission from a parent or guardian, which increases the likelihood that they will seek care from clandestine abortion providers. The Committee on the Rights of the Child has urged States to consider allowing children to seek and receive certain medical treatment without the consent of a parent or guardian, including sexual and reproductive health services such as contraception and safe abortion.[162] The most recent report of the UN Special Rapporteur on the Right to Health concerning adolescents, recognizes that mandatory consent laws fail to acknowledge adolescents' capacity to seek out necessary reproductive health needs and prevent the full realization of adolescents' sexual and reproductive health and rights. He has recommended that States introduce a legal presumption of capacity for adolescents seeking preventive and time-sensitive sexual and reproductive services.[163]

States should also take measures to address the underlying socio-cultural factors which lead to son preferences and sex-selective abortion.[164] Regardless of the legal status of abortion, human rights bodies have made clear that States must ensure that women receive confidential and adequate post-abortion care.[165]

As with other areas of sexual and reproductive health care, States must take measures to make services acceptable to women and to adolescents, for example, services must respect their right to dignity and confidentiality and be sensitive to their needs and perspectives.[166]

Georgia has an obligation to implement all of the above human rights standards, and has accepted UPR recommendations concerning taking steps to make sure sexual and reproductive health services, including abortion, are affordable and accessible to all women in girls, especially those living in rural areas and amongst vulnerable groups. The Human Rights Committee and other UN human rights treaty bodies have recommended that Georgia combat the practice of sex selective abortion, by monitoring its scale, addressing its root causes and improving access to family planning services.[167]

161 See, for example. CESCR GENERAL COMMENT 22, paras. 14, 43; Committee on the Elimination of All Forms of Discrimination against Women General Recommendation 24 on Women and Health (1999) (hereinafter CEDAW GR 24)

162 CRC Committee, General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health, (62nd Sess.), paras. 21 & 31, U.N. Doc. CRC/C/GENERAL COMMENT/15 (2013); See CRC Committee, Gen. Comment No. 3, para. 20; See, CRC Committee, General Comment No. 4, para. 36.,

163 Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Rep. of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, para. 60, U.N. Doc. A/HRC/32/32 (2016) (Mr. Dainius Puras) [hereinafter Rep. of the Special Rapporteur on the Right to Health].

164 UN Interagency Statement, Preventing Gender Biased Sex Selection (2011), https://www.unfpa.org/sites/default/files/resource-pdf/Preventing_gender-biased_sex_selection.pdf

165 CESCR GENERAL COMMENT 22

166 CEDAW GR 24

167 Human Rights Committee, Concluding observations on the fourth periodic report of Georgia, 19 August 2014, CCPR/C/GEO/CO/4, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/GEO/CO/4&Lang=En

Access to Safe Abortion Services and Post-Abortion Care in Georgia

According to the Reproductive Health Survey 2010, the total induced abortion rate steeply increased after 1990, when the USSR broke up, with a peak of 3.7 abortions per woman in 1997–1999. The abortion rate declined gradually to 3.1 abortions per woman in 2002–2005. Between 2005 and 2010, the abortion rate dropped significantly to 1.6 abortions per woman.[168] Before 2000 Georgia had the highest documented induced abortion rate in the world.[169]

The latest reported annual abortion rate in Georgia (56 abortions per 1,000 women, 15-44 years of age) was still more than double the rate in southern Europe (26) and three times the rate in north-western Europe (18).[170] But the reported abortion rate in Georgia should be handled with caution, because there are several reasons to assume that abortions were under-reported in the latest RHS. It is also very likely that induced abortions have been reported as "spontaneous" or as "stillbirth", because the latter rates are about twice as high as international averages.[171]

There are higher abortion rates amongst more marginalized women, such as rural women, less educated women, and women of Azeri descent.[172] The total induced abortion rate is also inversely correlated with the wealth quintile of the households, declining from around two abortions per woman in households in the lowest wealth quintiles to about one abortion per woman the highest quintile. Abortion rates were highest among women of the Azeri ethnic group (3.3 abortions per woman) and lowest among Georgian women, at 1.5 abortions per woman).[173] The adolescent abortion rate (abortions per 1,000 women) was 29 in 1999, 13 in 2005, and 10 in 2010.[174] According to the National Centre for Disease Control, the adolescent abortion rate in 2015 was 12.6 per 1,000 women.[175]

The 2015 report by UNFPA indicates the negative trend of sex-selection in Georgia when prospective parents give priority to boys over girls. According to the report, roots of gender-biased sex-selection are foundin the culture where, for examples, males are regarded as successors of the family name, and where females are considered inferior or as someone with no value. This practice has its roots in gender stereotypes and gender inequality, when it becomes systemic, also leads to more gender inequality, an increase in violence against women, an imbalance in the population, and violations of human rights.[176]

168 Reproductive Health Survey 2010, National Center for Disease Control and Public Health (NCDC) Ministry of Labor, Health, and Social Affairs (MoLHSA) National Statistics Office of Georgia, 2012, p. Ix, available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

169 Reproductive Health Survey 2010, National Centre for Disease Control and Public Health (NCDC) Ministry of Labor, Health, and Social Affairs (MoLHSA) National Statistics Office of Georgia, 2012, p. 62, available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

170 Gilda Sedgh, Jonathan Bearak, Susheela Singh et al. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. The Lancet, Published online May 11, 2016 available at: http://dx.doi.org/10.1016/S0140-6736(16)30380-4 referenced in Georgia Maternal & New-born Health Strategy 2017-2030

171 Georgia Maternal & New-born Health Strategy 2017-2030, Ministry of Labor, Health and Social Affairs of Georgia, p. 23

172 National Centre for Disease Control and Public Health (NCDC) Ministry of Labor, Health, and Social Affairs (MoLHSA) National Statistics Office of Georgia, 2012, Reproductive Health Survey 2010, p. 9,available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

173 National Centre for Disease Control and Public Health (NCDC) Ministry of Labor, Health, and Social Affairs (MoLHSA) National Statistics Office of Georgia, 2012, Reproductive Health Survey 2010, p. 67, available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

174 Reproductive Health Survey [RHS] (2010), p. 75
available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

175 NCDC Yearbook 2015, p. 141 (Table)
available at: http://www.ncdc.ge/AttachedFiles/yearbook%202016_53210b52-12da-4279-9f27-f7a361c84c96.pdf

176 UNFPA, Gender-based Sex Selection in Georgia, 2015, pp. 11-12, available at: http://en.calameo.com/read/000713529fba88352dbbb

Post-abortion care is regulated by the Protocol on Safe Termination of Pregnancy. The Protocol provides that in case of post-abortion complications, a woman should seek medical care. If the abortion did not lead to complications, additional services are still available and optional. The Order provides for an obligation to inform the patient on post-abortion contraception. Psychological assistance and referral to other sexual and reproductive or related health services shall also be available if needed upon patient's consent (e.g. STD testing, and assistance services for victims of violence).[177]

Government and Other Actions

The Law on Health Care and the Criminal Code sets out the legal basis for abortion in Georgia. The Law on Health Care provides that abortion can be carried out for any reason if the pregnancy does not exceed 12 weeks.[178] From 12 to 22 weeks, abortion is allowed only on the grounds of listed medical conditions (therapeutic abortion) and for social reasons, including if pregnancy is the result of rape or if the patient is under 15 or over 49 years of age.[179] Abortion is permitted after 22 weeks due to medical conditions only by the decision of a medical commission.[180] It is prohibited to terminate a pregnancy after 22 weeks for non-medical reasons.[181] (See below for details).

Illegal abortion is punishable by community service from 120 to 300 hours or imprisonment for the person performing the abortion.[182] Repeated violations will result in 2-4 years in prison and suspension of work license for 3 years, if done by a licensed medical professional.[183] The Criminal Code does not provide a definition of illegal abortion. According to the Commentary, however, abortion is illegal if it is performed against the requirements of the Law on Health Care, Article 139, outlined above.[184] The perpetrator of an illegal abortion can be any person performing the abortion, including medical personnel.[185] Women are not criminally liable for undergoing an illegal abortion.

Under the Law on Health Care, reducing the number of abortions is a priority objective of the State.[186] The same is stated in the Concept of Demographic Security of Georgia. The Concept provides that in order to ensure stability and sustainable development of the population, the right to reproductive health shall be ensured, which includes preventing induced abortions by increasing access to modern methods of family planning. The Concept also states that one of the State priorities is to significantly reduce the number of abortions 'as a method of family planning' and to avoid preventable abortions that are performed for medical reasons.[187]

177 Safe Termination of Pregnancy Protocol, Order of the Minsiter of Labor, Health and Social Affairs of Georgia 01-182/o, 20 May 2014. Annex N1, Chapter 8.6

178 Law on Health Care, Article 139.2.a

179 Law on Health Care, Art. 140.2; Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014,Tbilisi, On the Approval of the Rules of Artificial Termination of Pregnancy, Annex N1, Article N2.b. Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N5.

180 Order №01-74/ბ of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N4, Article N1.

181 Order №01-74/ბ of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N6.

182 Criminal Code of Georgia, Article 133.

183 Criminal Code of Georgia, Article 133.

184 M. Lekveishvili, N. Todua, G. Mamulashvili, Criminal Code of Georgia, Commentary, Book N1, 4th Edition, Publisher "Meridiani'', 2011, p. 153

185 153 M. Lekveishvili, N. Todua, G. Mamulashvili, Criminal Code of Georgia, Commentary, Book N1, 4th Edition, Publisher "Meridiani'', 2011, p. 153

186 Law on Health Care, Article 139.1

187 Concept of Demographic Safety of Georgia (Resolution of the Parliament of Georgia 24 June 2016, para. 1.3

The issue of induced abortion, though to a limited extent, is included in the Maternal & New-born Health Strategy 2017-2030, under the heading of Family Planning. It recognizes that primary healthcare workers do not usually have any (*financial*) interest in abortion, and therefore are more motivated to prevent an abortion than specialists who perform abortions, who do have a financial interest.[188] The Strategy also notes that unless family planning services can compete with the provision of abortion in terms of income for obstetrician/gynaecologists, there is little chance that providers will take the time, energy and resources required to counsel clients appropriately and offer them a family planning method of their choice.

Under the Order of the Minister of Health, one of the aims of pre-abortion counselling is to inform the patient about post-abortion contraception.[189]

As to priority interventions, the Strategy does not address providing access to safe abortion, but focuses on addressing preventing unwanted pregnancies, including through access to contraceptive information and services and through raising awareness among the public and youth on contraceptives.

Where and by whom abortions can be performed

The Law permits the voluntary termination of pregnancy at a medical institution holding the appropriate authorization and by a certified gynaecologist only. Surgical abortion (manual or electric vacuum aspiration) for pregnancy up to 7 weeks can be performed in outpatient or inpatient medical establishments, and for pregnancy over 7 weeks, abortions can only be performed in inpatient medical establishments. Any type of abortion for pregnancy over 12 weeks shall be performed only in inpatient medical establishments authorized to provide gynaecological services. Medication abortion (using a pill) up until 10 weeks of pregnancy can be performed in outpatient or inpatient medical establishments that provide gynaecological services.[190]

Mandatory counselling and waiting periods

In 2014, the abortion law was revised to include a new provision on mandatory counselling and a five-day waiting period requirement before obtaining an abortion during first 12 weeks of pregnancy.[191] 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.[192]

The law provides that during counselling, the physician shall give priority to the protection of the life of the foetus.[193] It also notes that deciding on an abortion is the prerogative of the woman, implying that she does not require any permission or consent from third parties.[194]

Under the Order of the Minister of Health,[195] counselling is an interactive process, which includes providing support and additional information to the patient with compassion and without coercion. Information shall be provided in a simple and clear manner, with the guarantee of confidentiality, and based on the woman's needs. According to the Order, during counselling, the doctor is mandated not to express personal views and

188 Georgia Maternal & New-born Health Strategy 2017-2030, Ministry of Labour, Health and Social Affairs of Georgia, p. 25

189 Order №01-74/n of the Minister of Labor, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N2, Art. 2.d.

190 Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy of the rules of artificial termination of pregnancy, Annex N1, paras. 5-8.

191 Law on Health Care, Article 139.2.b.

192 Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N1 Article 3

193 Law on Health Care, Article 139.2.b.

194 Law on Health Care, Article 139.2.b.

195 Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N2, Article 2.a.b.c.d.

values.[196] The patient shall also be informed on medical issues related to abortion and post-abortion period[197] and on legal requirements related to abortion.[198] The patient makes the final decision on the method of abortion after she is fully informed about all possible methods, their advantages and the risks involved.[199]

Termination of pregnancy over 12 weeks based on medical conditions

From 12 to 22 weeks, abortion is allowed only for medical conditions (therapeutic abortion) and social reasons.[200] The list of medical conditions are provided in the respective order of the Minister of Healthcare and it covers both physical and mental health grounds.[201] In the cases that are not included in the list, where continuation of pregnancy poses the risk to the life of a woman, the decision on termination of pregnancy is taken by the medical commission at the relevant medical institution upon written application of the woman.[202] The decision on termination of pregnancy for medical reasons over 22 weeks of pregnancy is taken by the Coordination Council for Protection of Mother's and Child Health.[203]

Termination of pregnancy based on non-medical conditions over 12 weeks

The Order of the Minster of Health provides non-medical reasons for termination of pregnancy over 12 weeks:

a) pregnancy is the result of rape, as confirmed by a court;
b) the woman has not reached the age of 15;
c) the woman's age is over 49.[204]

The decision on terminating a pregnancy on these non-medical grounds is taken by the commission of the relevant medical institution based on a patient's written application. Termination of pregnancy of over 22 weeks for non-medical reasons is prohibited.[205]

The Order of the Minister of Health provides that abortion is not allowed for the purposes of sex selection, except for the purposes of preventing sex-specific diseases.[206] The compliance is monitored under the health services quality monitoring procedures of the State Agency for Regulation of Medical Activity. The MoLHSA has noted that the Agency has not identified any instances of sex-selective abortion.[207]

196 Order №01-74/n of the Minister of Labor, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy , Annex N2, Article N4.a.b.c.d.
197 Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, about the approval of the rules of artificial termination of pregnancy, Annex N2, Article 5.a.b.c.d.
198 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N2, Article 11.
199 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Annex N1, Art. 13.
200 Law on Health Care, Art. 140.2. Order №01-74/n of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N1, Article N2.b.
201 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N3.
202 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N3.
203 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N4, Article N1.
204 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N5.
205 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N6. If there are reasons for non-medical termination of pregnancy, not listed in the Order, the matter is decided by the Coordination Council for Protection of Mother's and Child Health, which is formed under the order of the Minster of Healthcare
206 Order №01-74/б of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N1, Article N14.
207 Letter of the Minister of Labour, Health and Social Affairs, 14 September 2017, N01/58047.

Informed consent

For performing abortion, written informed consent of a patient is required.[208] In case of medical interventions for minors below 16 years of age, there is a general rule that consent shall be obtained from the minor's parents/guardians.[209] However, abortion and non-surgical methods of contraception are exceptions to this rule. A minor aged 14-18 can provide consent (parental consent is not required), if the minor is seeking abortion or non-surgical methods of contraception and if she, in the opinion of the healthcare provider, realistically assesses her health status.[210] Information that the minor underwent an abortion or obtained non-surgical methods of contraception shall not be provided to a parent/legal representative, if the minor does not wish for this information to be shared.[211]

According to the MoLHSA Order, the patient must sign a consent form prior to undergoing an abortion to acknowledge that she has been informed of the moral and ethical aspects of abortion, as well as of its side effects, death risks stemming from abortion, and maternal mortality rate in Georgia and across the world as a result of abortion.[212] In contrast to this, the Safe Termination of Pregnancy Protocol provides that the woman shall be informed that abortion is a safe procedure, however, in rare cases, there can be severe complications and even lethal outcomes.[213]

Conscientious objection

The Protocol on Safe Termination of Pregnancy, established under the Order of the Minister of Health, provides for the referral of a patient in case of conscientious objection. Under the Protocol, if a medical service provider is against abortion based on ethical or religions grounds, the provider shall immediately refer the patient to other abortion service provider.[214] There are no other regulations on conscientious objection.

The Law on Abortion in Abkhazia

On 9 February 2016, a regulation entered into force in Abkhazia, completely banning abortion, even in cases when pregnancy poses risks to the health of the pregnant woman. The misguided purpose of the new law is to increase the birth rate in Abkhazia.[215] Abortion is not prohibited in South Ossetia.[216]

Discrepancies

Numerous aspects of the legal and regulatory framework governing abortion appear to be problematic and not aligned with Georgia's human rights obligations and the WHO guidance. While the Government is rightfully

208 Law on the Rights of Patient, Article 22.2.b.
209 Law on the Rights of Patient, Article 41.2.
210 Law on the Rights of Patient, Article 41.1.
211 Law on the Rights of Patient, Article 40.2.b.
212 Order №01-74/ბ of the Minister of Labour, Health and Social Affairs of Georgia, dated 7 October 2014, Tbilisi, on the Approval of the Rules of Artificial Termination of Pregnancy, Annex N2.2.
213 Protocol "Safe Termination of Pregnancy," approved by the orderr №01-182/o of the Minister of Labour, Health and Social Affairs of Georgia, dated 28 July 2014, is approved according to the decision of the National Council of Clinical Practice (Guidelines) and National Council for Development, Assessment and Implementation of State Standards for Disease Management (Protocols), №3 meeting, on May 20, 2014, chapter: 8.1.1, Informing, consultation and decision-making, para. 5. P. 9
214 Protocol "Safe Termination of Pregnancy," approved by the orderr №01-182/o of the Minister of Labour, Health and Social Affairs of Georgia, dated 28 July 2014, is approved according to the decision of the National Council of Clinical Practice (Guidelines) and National Council for Development, Assessment and Implementation of State Standards for Disease Management (Protocols),№3 meeting, on May 20, 2014, chapter: 8.1.1, para. 3, p.8
215 საქართველოს სახალხო დამცველის სპეციალური ანგარიში, ქალთა და ბავშვთა უფლებები კონფლიქტებით დაზარალებულ რეგიონებში, 2017, 2014-2016 წლების მიმოხილვა, გვ. 9. Special Report of the Public Defender of Georgia on the Rights of Women and Children in Conflict-affected Regions, 2017, Review of 2014-2016, p. 9
216 საქართველოს სახალხო დამცველის სპეციალური ანგარიში, ქალთა და ბავშვთა უფლებები კონფლიქტებით დაზარალებულ რეგიონებში, 2017, 2014-2016 წლების მიმოხილვა, გვ. 10. Special Report of the Public Defender of Georgia on the Rights of Women and Children in Conflict-affected Regions, 2017, Review of 2014-2016, p. 10.]

concerned about the high rates of abortion in Georgia, some aspects of the law and regulations appear to attempt to address this by undermining women's right to self-determination rather than empowering them in their reproductive decision-making.

While the MoHLSA Order provides a strong basis for respecting the woman's dignity and her decision, the mandatory five-day waiting period and the language in the law prioritizing the foetus contradicts international health and human rights recommendations.[217] The requirement in the Order of compassion, non-coercion and responding to women's desires and needs, contradicts the problematic and potentially harmful provision of the law requiring that priority be given to the foetus. In addition, the consent form for abortion providing information on the moral and ethical issues concerning abortion and the harm it may entail, appears to require biased counselling and misinformation focusing on the harms of abortion, contrary to international health and human rights recommendations. The WHO recognizes that 'when performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.'[218]

A report indicates that 23% of the clinics do not offer pre-abortion counselling in an unbiased manner, as prescribed by the Order. For example, it is reported that doctors attempt to dissuade patients from undergoing abortions. In most cases, such efforts fail; however there are reports of women deciding not to undergo an abortion after such dissuasion.[219] There is no oversight mechanism on implementation of the Order nor on pre-abortion counselling and the nature and quality of the information to be provided to patients.[220]

In addition, restrictions which only allow gynaecologists to perform abortions contravene latest WHO guidance. As with the 5-day waiting period, this requirement has the potential to impact more marginalized populations of women and adolescents, such as those who live in rural areas. An NGO report indicates that abortion services are not readily available in rural areas, and women have to travel long distances in order to obtain an abortion, which requires additional transportation costs and time. The report indicates that the mandatory five-day waiting period considerably adds to the costs as it requires additional visits to a medical facility.[221]

While the law allows for conscience-based refusals of care, there appears to be no regulation of the practice and no information on the number of providers refusing to provide services based on conscience and itsimpact on women. An NGO report indicates that the majority of gynaecologists in Georgia refuse to perform abortion based on religious reasons. Many clinics do not even provide for referral procedures because of conscience. Some clinics have prayer rooms in their facilities and religious symbols and icons are displayed in the buildings, serving inter alia to discourage abortion.[222] The Georgian Orthodox Church strongly opposes the legality of abortion and tries to influence public opinion and to exercise pressure on the Government to impose restrictions on abortion.[223]

217 Order №01-74/ნ of the Minister of Labor, Health and Social Affairs of Georgia, dated 7 October 2014

218 WHO Safe Abortion Guidance, page 20.

219 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 32.

220 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 34.

221 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 54.

222 Artificial Termination of Pregnancy in Georgia (Comparative Review), HERA XXI, 2014

223 Artificial Termination of Pregnancy in Georgia (Comparative Review), HERA XXI, 2014

An additional barrier to women's empowerment is that that they are not envisioned as a part of the decision-making process if they are undergoing abortion after 12 weeks gestational period. This undermines women's autonomy and self-determination. In addition, the law requiring a court confirmation in order to undergo an abortion on the grounds of rape past 12 weeks, could hinder victims access to abortion, even further stigmatizing them and the procedure, and is contrary to human rights obligations.

An NGO reports that there are discriminatory restrictions imposed by some clinics with regard to certain groups of women and girls seeking abortions, particularly persons under 16, 16-18 year olds, women with sexually transmitted infections, and sex workers.[224] For example, according to this report, 11% of the clinics surveyed (11 clinics) stated that they are providing abortion services to persons under 16 years of age.[225] One-fifth of the clinics (20 clinics) have established internal restrictions on the provision of abortion services to women with sexually transmitted infections, but the report indicates that they are not necessarily applied. In addition, there are 15 clinics (15%) that have no established restrictions but they still do not provide abortion services to this group of women.[226] Restrictions on the delivery of abortion services for sex workers exist in 9% of the clinics (9 clinics) surveyed, however, more than half of these clinics (5 clinics) still provide abortion services for the group, despite these established internal restrictions. In addition, there are 22 clinics (22%) which have no such restrictions, however, do not provide abortion services to sex workers.[227]

The report also shows that when patients think their rights are violated during the provision of abortion services or post-abortion care, they generally tend not to apply any legal remedies.[228]

In relation to the abortion ban in Abkhazia, Georgia there are no studies done on the extent to which women travel from Abkhazia to nearby regions to undergo abortions and the extent to which they can actually access abortion when they do travel.

224 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 55.

225 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 55.

226 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 56.

227 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 56.

228 Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015, p. 45.

Recommendations:

- Eliminate mandatory waiting periods and ensure that any counselling provided to women is evidence-based and non-directive.
- Ensure that information provided to women on abortion, both in and outside of counselling, is accurate, evidence-based and in line with WHO standards, including by revising the consent form to abortion to reflect WHO recognition of abortion as a very safe procedure when conducted by a trained provider in a legal setting. Ensure oversight mechanism for pre-abortion counselling.
- Revise the Law on Health Care to guarantee that women's rights take precedent over the interest of the foetus.
- Abolish the provision requiring a court authorization to obtain an abortion in case of a rape.
- Monitor the practice of conscientious objection so that it does not hinder women's access to abortion and that services are provided in a non-judgmental and respectful manner.
- Address the underlying causes of gender-biased sex-selective abortion, such as son preference and undervaluing of girls and women.
- Guarantee the provision of post abortion contraceptive counselling and commodities and ensure is covered as part of Primary Healthcare.
- Ensure that a broad range of health care facilities are authorized to provide abortions, so as to make the service geographically accessible for women in rural areas.
- Ensure an effective engagement of women undergoing abortions at all decision-making levels, including beyond 12 weeks' gestation.
- Ensure that the internal regulations and practices of medical facilities provide for non-discriminatory access to abortion services;
- Ensure that abortion providers are adequately trained, including in human rights in patient care and non-discrimination.
- Ensure that abortion is affordable for women, including for survivors of violence as well as for women with lower on socio-economic status.
- Conduct a study regarding extent of travels from Abkhazia, Georgia, to access abortion services in nearby regions. Ensure that women who travel to nearby regions are not hindered from accessing abortion.

MATERNAL HEALTH CARE

Health and Human Rights Considerations

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.[229] Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Reducing maternal mortality is a target of the Sustainable Development Goals, to which Georgia signed on. Eighty percent of maternal deaths worldwide result from severe bleeding, infections, high blood pressure during pregnancy and unsafe abortion: these causes are generally preventable if they are identified and properly managed in a timely manner. Although there is a range of critical interventions to reduce maternal mortality, access to emergency obstetric care has been recognized as being particularly vital. Antenatal care is also central to maternal health as it provides a window to supply information on birth spacing, management of anaemia during pregnancy and testing for HIV and STIs. WHO now recommends at least eight antenatal visits, as opposed to the previous recommendation of four, and for care to begin as early as possible in pregnancy.[230]

Access to quality maternal health care, including antenatal and postnatal care, is an element of women's right to the highest attainable standard of health, and to equality and non-discrimination, it is also connected to her right to life. States must address and remove barriers to access, such as high fees, and take measures to make the services acceptable to women, such as through ensuring that services respect the right of the woman to dignity and confidentiality, and are sensitive to the woman's needs and perspectives.[231]

States have an obligation to develop laws, policies, programs and practices to ensure women's and girls' health and well-being throughout pregnancy, delivery, and the post-partum period. Thus, states have an obligation to: collect, analyse and disseminate disaggregated data necessary to understand and to adequately respond to primary causes – both direct and indirect - of maternal mortality and morbidity; to address the underlying determinants of healthy pregnancy, including potable water, adequate nutrition, education, sanitation and transportation; to reduce maternal mortality rates by providing adequate interventions to prevent maternal mortality including by ensuring access to skilled birth assistance, prenatal care, emergency obstetric care, including effective referral systems in case of obstetric complications, and quality care for complications resulting from unsafe abortions; remove barriers to reproductive healthcare, such as high costs, provide free services in connection with pregnancy, childbirth and post-natal care; ensure that essential medicines for pregnancy-related complications are registered and available (e.g. misoprostol to treat post-partum haemorrhage and incomplete abortion); ensure the distribution of health care providers to ensure access to essential maternal health services, regardless of geographic location; ensure maternal health services meet the distinct needs of women and are inclusive of marginalized sectors of society, including those with elevated rates of maternal mortality, young, poor, rural, minority and migrant workers, for example; take measures to ensure that the life and health of the woman are prioritized over protection of the foetus; and to prevent and address abusive treatment of women and girls seeking reproductive health services, including maternal health care.[232]

229 World Health Organization, Maternal Health, http://www.who.int/topics/maternal_health/en/

230 WHO. 2017. WHO recommendations on antenatal care for a positive pregnancy experience available at: http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf?ua=1

231 CEDAW General Recommendation 24 (1999), CESCR General Recommendation 22 (2016).]

232 CEDAW General Recommendation 24; CESCR General Recommendation 22; U.N. OHCHR. Technical Guidance on the application of human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (2 July 2012); CEDAW Committee, *L.C v Peru* (2011); CEDAW Committee *Alyne da Silva Pimentel v. Brazil* (2011);

Early pregnancy heightens the risk of complications. Other important interventions to reduce early pregnancy, as well as unwanted pregnancy amongst all age groups, are enhanced access to education and information on sexual and reproductive health and family planning, access to contraceptive information and services, and efforts to enhance gender equality in society, including by eliminating child marriage.[233]

Georgia has an obligation to implement all of the above human rights standards, and has accepted UPR recommendations concerning taking steps to improve maternal health and make sure sexual and reproductive health services, including abortion, are affordable and accessible to all women in girls, especially those living in rural areas and amongst vulnerable groups. UN Human rights bodies have consistently called on Georgia to take measures to improve access to sexual and reproductive health services, which include maternal health care and to combat child marriage.[234]

Maternal Health in Georgia

Despite significant progress in reducing maternal mortality, Georgia still has one of the highest rates in the region.[235] According to the Maternal Mortality Estimation Inter-Agency Group (MMEIG), over the past 15 years, Georgia has made a significant progress in reducing its maternal mortality ratio. According to MMEIG, in 2000, the maternal mortality ratio (MMR) was 60/100,000 live births in Georgia, which by 2015 was reduced to 36/100,000 live births.[236] According to official statistics, MMR was 32.1 in 2015. The differences between official statistics and MMEIG estimations are significant and indicate that, firstly, the formula for estimation and calculation of national MMR are different and, secondly, this could mean that the country still has a problem with identification of maternal death cases. The latest figures on MMR from the government were 23/100,000 live births in 2016.[237]

The Reproductive Age Mortality Study (RAMOS) conducted in 2014 showed significant improvement of death registration of women of reproductive age. Nearly all deaths (98%) of women of reproductive age were registered by Georgia's vital registration system in 2012, compared with 2006 when only 84% of deaths of reproductive age women were registered. According to the same study, the level of underreporting of maternal mortality in vital statistics significantly reduced (65% in 2006 vs. 39% in 2012).[238] The lifetime risk of maternal death was 1 in 1,200 in 1990 and 1 in 1,500 in 2015.[239]

Between 2005 and 2010, 15.7% of women giving birth reported having pregnancy complications that required medical attention.[240] The most common complications cited were: risk of preterm delivery (7.9%), anaemia related to pregnancy (3.6%), water retention or edema (3.3%), and high blood pressure related

233 UNFPA State of the World Population Report, 2013, Motherhood in Childhood, Facing the Challenge of Adolescent Pregnancy (2013)

234 Committee on the Rights of the Child, Concluding observations on the fourth periodic report of Georgia, 9 March 2017, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GEO/CO/4&Lang=En; Human Rights Committee, Concluding observations on the fourth periodic report of Georgia, 19 August 2014, CCPR/C/GEO/CO/4, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/GEO/CO/4&Lang=En;
Committee on the Elimination of Discrimination against Women, Concluding observations on the combined fourth and fifth periodic reports of Georgia, 24 July 2014, CEDAW/C/GEO/CO/4-5, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GEO/CO/4-5&Lang=En

235 WHO. Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division available at: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1

236 Ministry of Labour, Health and Social Affair. "The National Protocol on C-section". 2013.

237 (NCDC Yearbook 2016, will be published soon).
[5]National Centre for Disease Control and Public Health, 2017,2017. Brief Summary of the Results of Research on Mortality in Women of Reproductive Age, 2014, available at:http://www.ncdc.ge/Category/Article/10884

238 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia

239 National Statistics Office of Georgia. 2016. Population

240 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia

to pregnancy (3.0%).[241] There were 11.2% women who experienced postpartum complications.[242] The most commonly cited post artum complications were: severe bleeding (3.5%), painful uterus (3.5%), high fever (3.3%), and breast infection (2.5%).[243] According to the National Centre for Disease Control, in 2015, 15% of hospital admissions were due to complications of pregnancy, childbirth, or the puerperium.[244] An active epidemiological surveillance of maternal mortality revealed that in most cases, the transportation of pregnant women with complications to medical facilities was quite problematic over recent years.[245]

In 2014, the Government approved the Georgian Healthcare System State Concept for 2014-2020, which defines the Universal Health Coverage (UHC) program as a pillar for the development of the health system in the country and which prioritizes maternal and child health.

The MoLHSA is the state agency which receives the general government health budget to purchase health care for the population, including maternal care, and from the private providers. Maternal care in Georgia is provided by a countrywide network of women's consultation centers (WCC) and maternity houses. WCCs are primary level facilities that provide only antenatal care. The maternity houses are secondary level facilities providing antenatal care, childbirth, Caesarian sections (C-section) and emergency obstetric care.

The proportion of births attended by skilled health personnel was 99.8% in 2015.[246] About 90% of maternity houses and women's consultation centers are private and provide antenatal care. Some of them do not participate in the State antenatal care program because subsidies provided by the State are too low to provide adequate services, according to these facilities.[247] For State program participants, 72% of women completed four antenatal care visits out of all women who gave birth in 2016. Countrywide coverage with antenatal care is quite high. The proportion of women who completed four antenatal care visits was 90% out of all women who gave birth had childbirth in 2016.[248]

Before 2016, the National Centers for Disease Control collected only aggregated data from health care facilities. Since 2016, the National Centers for Disease Control has collected both disaggregated as well as aggregated data. In 2016, the Georgian birth registry was launched, which collects case-based data from all maternal care facilities in the country (see below for details). The limited available disaggregated data which is in the Reproductive Health Survey of 2010 indicates that ethnic minorities, women in rural areas, and those who have not completed secondary school are utilizing antenatal care services less.[249]

Georgia has the lowest percentage of women receiving postpartum care in the region, despite significant increases.[250] The proportion of women who received postpartum care was 11% in 1999, 22% in 2005, and 23% in 2010.[251] In addition, since 2000 the share of caesarean section deliveries has quadrupled. In 2016, the share of caesarean section deliveries reached 43.2%.[252]

241 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia
242 Trends in Maternal Mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. P. 46
243 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia
244 Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients' Rights", Government of Georgia Ordinance No 724, 26 December 2014
245 National Center for Disease Control and Public Health of Georgia. 2017. Active epidemiological surveillance of maternal mortality.
246 Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients' Rights", Government of Georgia Ordinance No 724, 26 December 2014.
247 Shengelia L, Pavlova M. Groot W.Stakeholders' views on the strengths and weaknesses of maternal care financing and its reform in Georgia. BMC Health Services ResearchBMC series. Available at: https://doi.org/10.1186/s12913-017-2485-8
248 National Center for Disease Control and Public Health of Georgia, Health Care. Statistic Yearbook. 2016. (2016 Will be publish soon).
249 National Center for Disease Control and Public Health of Georgia. Reproductive Health Survey 2010
250 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia
251 National Statistics office of Georgia. 2016. Population
252 Health Care. Statistic Yearbook. 2016. National Center for Disease Control and Public Health of Georgia.

Government Action

The MoLHSA allocates a certain portion of the total Government health budget to implement maternal care through multiple agencies which are responsible for different maternal care programs. The State supports the following services: four antenatal care visits (soon to be eight antenatal visits, in accordance with new WHO guidance) and at least one screening visit; HIV, hepatitis B and syphilis screening, and antiretroviral treatment for mothers; services for children from 0-1 (including neonates); antenatal genetic screening (triple test and amniocentesis); delivery for all women covered under the Universal Healthcare Program, including management of complications during pregnancy; screening of newborns and children for hypothyroidism, phenylketonuria, hyper-phenylalaninemia and cystic fibrosis; hearing screening for newborns (only Tbilisi).[253]

Most recently, in 2017, MoLHSA endorsed the Maternal and Newborn Health Strategy for the period 2017-2030. The strategy is accompanied by an Action Plan (2017–2019) as an intervention guide for the next three years. The document provides a longer-term perspective on needed improvements in Maternal and Newborn Health (MNH) and some closely related reproductive health issues.[254] The goal of the strategy is to maintain and expand the coverage of evidence-based, high impact and cost-effective interventions for maternal and new-born survival, as well as in some related reproductive health fields, and to guarantee access to those services for all who need them. The strategy and action plan are divided into two dimensions: maternal and new-born health and family planning, and youth sexual and reproductive health.

Objectives of the strategy and action plan are, by 2020, to increase women's access to and utilisation of evidence-based pre-conception, antenatal, natal, post-partum, and neonatal care that meet their needs; to standardize and improve the quality of maternal and neonatal health services with full integration of these services; to improve the general population's awareness and knowledge of healthy behaviours, medical standards of high quality care, and the rights of patients. An important target includes reduction of the maternal mortality ratio from 32 per 100,000 live births in 2015 to 25 by 2020, and to 12 by 2030.

Another important step towards reducing the unacceptably high rates of maternal mortality and strengthening the maternal and newborn health care system in the country was the initiation of the Perinatal Care Regionalization Project, implemented by the MoLHSA with the support of donor organizations in 2015.[255] High maternal mortality and the weak referral system have led donors and the State to start implementation of this new project. This includes an organized transport system, the definition of levels of care, and the creation of roles and responsibilities for all levels so as to ensure effective operation of referrals. Additionally, in 2016, in collaboration with the UNFPA Eastern Europe/Central Asia Regional Office (EECARO), the UNFPA Country Office in Georgia co-supported piloting Near Miss Case Reviews (NMCR) in six selected maternal houses. The maternal houses each have a designated facilitator who coordinates activities and is in contact with a country reproductive health consultant in the area of NMCR. In 2017 a new regulation called "Selected Contracting", was implemented which allows only maternity houses/units with the appropriate level of care and at least 500 childbirths per year to participate in the State maternal and child health program.[256]

The Georgian Parliament recently adopted the Demographic Security Policy for the years 2017-2030. An objective of the Policy is to ensure "universal access to reproductive health care services, information and education." The policy notes that the most relevant priorities of the national health care system with regard to fertility and reproductive health include: improved access to quality reproductive health services, including

253 Georgian Healthcare System State Concept 2014 – 2020 "Universal Healthcare and Quality Management for Protection of Patients' Rights", GoG Ordinance No 724, 26 December 2014

254 Georgia Maternal & New-born Health Strategy 2017-2030. 2017. Ministry of Labour, Health and Social Affairs of Georgia.

255 Order N01-2/n of 15 January, 2015 of Ministry of Labour, Health and Social affair of Georgia.

256 Ministry of Labour, Health and Social affair of Georgia. 2017. selective contracting, available at:http://portal.sitecom.com/WLR-7100/v1002/upgrade/parent.php?lanIP=192.168.0.1&userRequest=www.moh.gov.ge

those oriented towards youth, maternal and child care services; and improved management and prevention of complicated pregnancy and childbirth.[257]

There are numerous surveillance mechanisms connected to maternal and reproductive health. For example, in January 2016, the MoLHSA and the National Center for Disease Control and Public Health of Georgia launched an electronic registry "Mother's and neonate's health surveillance system", or so called "Georgian Birth Registry" (GBR) supported by UNICEF. The system contains information on all cases of pregnancy, delivery-, postpartum-, abortion, including maternal deaths, stillbirths and early neonatal deaths. However, a functioning and user-friendly health information system that will assist in data collection, as well as improve communication and coordination between levels of care, and between providers and patients, still needs further development.[258]

The State has also taken steps to eliminate harmful practices that can contribute to high-risk pregnancies, such as female genital mutilation (FGM) and early or forced marriages. In 2017, the Georgian government approved a package of amendments to outlaw (FGM) in the country, and according to the Georgian Civil Code Article 1108, the legal minimum age of marriage is now 18.

Several laws address safe motherhood. The Law of Georgia on Health Care guarantees safe motherhood and determines that the MoLHSA is the main responsible institution for activities related to safe motherhood. The law also includes provisions concerning maternity leave during employment, public awareness raising on the rights of mothers and children, counseling and care for pregnant women, and postnatal care.[259] The Law on the Rights of Patients includes a chapter on the rights of pregnant women and breastfeeding mothers, including granting women the right to choose their health provider for perinatal care and allowing for women to have a husband/partner/family member in the room during delivery, amongst other rights.[260]

Discrepancies

The State has taken numerous laudable steps to improve maternal health and reduce maternal mortality. It has addressed the three main delays that often result in preventable maternal mortality and morbidity: universal health coverage, antenatal care programs, and improvement of information systems. Yet, Georgia still has one of the highest rates of maternal mortality in the region.[261] The main reasons for this high maternal mortality in Georgia are the low quality of antenatal and perinatal care, a weak transportation system, a weak regulatory and monitoring system, and a lack of trained professionals in maternity houses and consultation centers, especially in the regions. The population's low awareness about reproductive health, particularly about pregnancy and pregnancy related complications, also negatively influences pregnancy outcomes.[262]

Since 1997, Georgia has offered four free antenatal services in accordance with WHO recommendations, and plans to offer eight, as per WHO's new guidelines.[263] However, many maternity houses do not participate in the program for two reasons: first, because of insufficient compensation per package, and second, the service content of the antenatal care package does not cover all antenatal care needs. The State only pays 55 GEL for four antenatal visits, for all women, regardless of income. Those maternity houses and women's consultation centers which do not participate in the State program provide antenatal programs for a fee and women purchase services based on what they want and can afford.[264]

257 *The Demographic Security Policy* for the years 2017-2030
258 Health Care. Statistic Yearbook. 2016. National Center for Disease Control and Public Health of Georgia.
259 Law of Georgia on Health care. 1997. Chapter XXII – Safe Motherhood and Child Health Care, Article 131
260 Law of Georgia on the Rights of Patients. 2000. Chapter VII right of pregnant women and breastfeeding mothers, Article 35-38
261 Trends in Maternal Mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division p.46
262 National Center for disease control and public health of Georgia, Active epidemiological surveillance of maternal mortality. 2014.
263 World Health Organization. 2017. WHO recommendations on antenatal care for a positive pregnancy experience http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf?ua=1 pages 12,101,120
264 National Center for Disease Control and Public Health of Georgia. Maternal and Child Health State program

According to RHS 2010, although the coverage for institutional deliveries increased significantly and there are welcome commitments towards improving ante-natal care, there are, to date, no adequate mechanisms for timely detection of high-risk pregnant women (antenatal care visit records do not require classifying pregnancy risks), there is a lack of proper referrals to the appropriate levels of care, and a lack of information sharing and feedback between the various levels of care (village ambulatory, women's consultation centres, maternity hospitals and emergency obstetric care facilities (EmOC)). Often, perinatal health care centers, particularly in rural areas, which lack the capacity to deal with obstetric and neonatal emergencies (due to a shortage of personnel, medicine, equipment, blood banks, etc.) either do not perform referrals to a higher level facility, or perform it with substantial delays.[265]

The epidemiological active surveillance of maternal mortality shows that, in most cases, the transportation of pregnant women with complications has been problematic over the last years.[266] A well-organized and centrally coordinated transportation system is an essential part of an effective referral system. While the State has taken steps to improve referral systems in maternal healthcare services such as emergency obstetric care, these kinds of services are not available at the community and primary health care level. Family or village doctors are not providing related services for maternal care. According to the order by the MoLHSA, antenatal care and maternal care services are provided only by maternity houses and women's consultation centers.[267]

According to the available disaggregated data, however limited, ethnic minorities, women in rural areas, and those who have not completed secondary schooling have lower utilization of antenatal services. This is due in part to a of lack of accessible information about the importance of health seeking behavior targeting these groups of women, and a lower economic status which pushes them to avoid the direct and indirect costs of seeking health care services.[268] However, the extent of the problem is unclear since comprehensive data which is disaggregated by ethnicity, age, geographical location and other characteristics are not available. In addition, a functioning and user-friendly health information system to assist in data collection, as well as communication and coordination between levels of care, and between providers and patients, needs further development.

As to the increase in C-section procedures, a study showed that increases are partially due to women opting to reduce pain during the delivery and a lack of information regarding the benefits of natural delivery and the complications involved in caesarean sections.[269] Another study also indicated that the influence of doctors (who have interest in increasing their own income and saving time) impacts women's decisions to opt for C-sections.[270] These challenges raise serious concerns about the extent to which informed consent is respected.

In addition, Georgia has a low percentage of women receiving postpartum care. In fact, it is the lowest in the region.[271] This may be due to the lack of programs and low awareness of the need for postnatal care.

265 Perinatal Care Report. 2016. National Center for Disease Control and Public Health of Georgia

266 National Center for Disease Control and Public Health of Georgia. 2017. Active epidemiological surveillance of maternal mortality, 2014

267 USAID. (2015). SUSTAIN Final Report: Sustaining Family Planning and Maternal and Child Health Services in Georgia. Boston, MA: John Snow

268 National Center for Disease Control and Public Health of Georgia. 2010. Reproductive Health Survey Georgia. Available at: http://unicef.ge/uploads/1._GERHS_2010__Final_Report_ENGL_resized.pdf

269 Jurgens E., Shengelia L, Asatiani T., Bijlmakers L. 2011 Clients' and providers' perspectives on Caesarean sections: An operational study into the high Caesarean Section rate in Georgia. Conducted in the framework of the Association HERA XXI's project: "Enhancing quality of care: Upgrading the knowledge and skills of midwives in Georgia" funded by MATRA Programme, Ministry of Foreign Affairs of Netherlands. Also included in the research: Midwives Association of Georgia (MAG), Georgian Obstetrician's & Gynecologists Association «GOGA», ETC Crystal.

270 Betrán, A. P., Ye, J., Moller, A.-B., Zhang, J., Gülmezoglu, A. M., & Torloni, M. R. (2016). The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014. PLOS ONE, 11(2), e0148343.

271 NCDC, Reproductive Health Survey 2010

During the launch of the MNH Strategy in 2017, the deputy Health Minister mentioned that the budget for maternal health care will be adequate. However, to date, there is no available information concerning budgeting for the action plan.

Article 37 of the Law on the Rights of Patients provides for overriding a woman's decision related to childbirth, even if it consists of minimal risks. This provision raises concerns regarding women's autonomous decision-making and quality of care.

Recommendations

- Improve early identification and adequate management of pregnancy related complications, two of the main ways to avoid preventable maternal deaths.
- Improve postpartum care so as to address the low percentage of women receiving such care.
- Train primary health care providers on a range of maternal health services, including ante-natal care.
- The Ministry of Health should promote the routine use of the Robson Classification to guide decisions about recourse to cesarean section and monitor whether clinics are using these criteria in practice. The Ministry of Health should support the provision of information for the public on the appropriate use of caesarian sections.
- Improve the availability of broad maternal health care services at the primary and village health care level, particularly in rural areas.
- Evaluate and if appropriate expand the Near Miss Case Reviews program throughout the country.
- The Ministry of Health should develop and implement programs and guidance that ensures timely detection of high-risk pregnant women and ensure proper referrals to the appropriate levels of care and information sharing and feedback between the various levels of care (village ambulatory, women's consultation centers, maternity hospital and emergency obstetric care facility (EmOC)).
- Ensure perinatal health care centers, particularly in rural areas, are adequately equipped to provide emergency care or to provide timely referrals to higher level facilities, ensuring the implementation of the perinatal regionalization programme across the country.
- Ensure quality information flow and continuum of care in perinatal care and across all maternal health care.
- Ensure the budget adequately supports reaching targets set forth in the Maternal and Newborn Health Strategy (2017-2030).

Provide greater subsidies towards antenatal visits and other maternal health services so that women do not need to pay for services out of pocket, and increase antenatal visits to four to eight as per new WHO recommendations on antenatal care.

- Put systems in place to collect comprehensive data which is disaggregated by ethnicity, age, geographical location and other characteristics and develop targeted programs to address challenges facing vulnerable groups.
- Raise awareness about available maternal health services amongst the general public and implement specific campaigns targeting marginalized populations, such as ethnic minorities and women living in rural areas.
- Ensure that respecting women's decision-making is at the center of quality of care programming.

PREVENTION AND TREATMENT OF HIV/AIDS

Health and human rights considerations

The right to the highest attainable standard of health, amongst other rights, gives rise to obligations to provide information and education to the population on HIV/AIDS and other STIs, as well as access to voluntary counselling and treatment (VCT).[272] Accurate knowledge about the transmission of HIV and how to prevent transmission, as well as access to VCT, is axiomatic for reducing HIV infection. States must take measures to provide information on HIV/AIDS, including scientifically accurate information on transmission, prevention and treatment. They should implement prevention strategies such as promoting condom use and access to condoms, and public awareness-raising campaigns. Accessing adequate healthcare is essential to individuals living with HIV/AIDS. Antiretroviral medications should be available, affordable and accessible to all in an equitable manner. States should take measures to eradicate barriers to antiretroviral treatment access, including high cost. States should also ensure that appropriate resources are allocated to HIV/AIDS programs, and the effectiveness of programs should be monitored and evaluated. Human rights require that testing and treatment should be carried out on a voluntary basis, respecting the rights to dignity, autonomy, privacy and confidentiality. States must ensure that all people, including people living with HIV/AIDS and key affected populations have nondiscriminatory access to health services, including reproductive health services.[273]

States must also take a gender-sensitive approach to the HIV epidemic, emphasizing the rights and needs of women and eliminating the social and cultural factors that exacerbate women and girls' increased risk of contracting HIV, including gender based violence, gender stereotyping, lack of or inadequate sexuality education for both young women and men, and child marriage.[274] Human rights require that all individuals living with HIV can access reproductive health information, goods and services, including access to perinatal care, skilled attendance during birth, emergency obstetric care and other reproductive health medicines and technology without discrimination. States must ensure people living with HIV can make informed and voluntary decisions about reproduction and childbirth, including contraception and abortion, and eliminate policies or practices that promote or permit, directly or indirectly, the involuntary sterilization or abortion of people living with HIV.[275]

States must pay particular attention to the rights of those at higher risk of HIV, such as sex workers, intravenous drug users (IDUs), and men having sex with men (MSM). The criminalization of people who are at higher risk of infection, such as sex workers and IDUs drives them underground and away from HIV related services. This increases their vulnerability to HIV, as well as to stigma, discrimination, marginalization and violence.[276] Importantly, human rights standards require the reform of criminal laws, amongst them, ending the overly broad criminalization of HIV non-disclosure, exposure and transmission, which also fuels discrimination and abuse.[277] In his report to the 2016 High-Level Meeting on HIV and AIDS, the U.N. Secretary General recognized the negative health and human rights impact of the criminal law:

272 CESCR General Comments 14 and 22; CRC General Comment 3 on HIV/AIDS and the rights of the child (2003); CRC General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) ICPD Programme of Action.

273 CESCR General Comments 14 and 22; CRC General Comment 3 on HIV/AIDS and the rights of the child (2003); CRC General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) ICPD Programme of Action.

274 CRC General Comment 3 on HIV/AIDS and the rights of the child (2003); CRC General Comment 15 on the right of the child to the enjozyment of the highest attainable standard of health (2013).

275 CESCR General Comment 22.

276 *Report of the Secretary-General on the fast track to ending the AIDS epidemic,* UN Doc. A/70/811 (2016), para. 53 and 75(f)

277 Grover A, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN. Doc. A/HRC/14/20 (2010), available at: http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.20.pdf; see also Joint United Nations statement on ending discrimination in health care settings (2017).

Misuse of criminal law often negatively impacts health and violates human rights. Overly broad criminalization of HIV exposure, non-disclosure and transmission is contrary to internationally accepted public health recommendations and human rights principles. Criminalization of adult consensual sexual relations is a human rights violation, and legalization can reduce vulnerability to HIV infection and improve treatment access. Decriminalizing possession and use of injecting drugs and developing laws and policies that allow comprehensive harm reduction services have been shown to reduce HIV transmission. Similarly, decriminalization of sex work can reduce violence, harassment and HIV risk. Sex workers should enjoy human rights protections guaranteed to all individuals, including the rights to non-discrimination, health, security and safety.[278]

In light of this recognition, the U.N. Secretary General called on states to:

Leave no one behind and ensure access to services by removing punitive laws, policies and practices that violate human rights, including the criminalization of same-sex sexual relations, gender and sexual orientation diversity, drug use and sex work, the broad criminalization of HIV non-disclosure, exposure and transmission, HIV-related travel restrictions and mandatory testing, age of consent laws that restrict adolescents' right to health care and all forms violence against key populations.[279]

Stigma and discrimination can often obstruct the ability of people living with HIV/AIDS to enjoy all their human rights. Public information campaigns are required to prevent stigma and discrimination against people living with HIV/AIDS and key affected populations. People living with HIV/AIDS and key affected populations must also enjoy their right to a remedy when they have faced discrimination.[280]

Georgia has an obligation to implement all of the above human rights standards and most recently, the Children's Rights Committee recommended that Georgia improve access to quality, age-appropriate, HIV/AIDS and sexual and reproductive health services and improve follow up treatment for HIV-infected mothers and their infants to ensure early diagnosis and early initiation of treatment.[281]

Prevention and Treatment of HIV/AIDS in Georgia

There is low prevalence of HIV/AIDS in Georgia. It is estimated that in 2016 the prevalence of HIV was 0.4% among the adult population.[282] A USAID report from 2014 estimated the HIV prevalence in the general adult population in Georgia to be 0.07%.[283] Information from 2014 notes that approximately 45% of all prevalent cases in Georgia were unaware of their HIV positive status when they got tested for the first time.[284] According to official sources, in 2015 the incidence of HIV among the tested population was 19.3 per 100,000.[285]

Access to anti-retroviral treatment (ART) is universal in Georgia.[286] According to UNAIDS data, Georgia has the highest ART coverage in the region of Eastern Europe and Central Asia (EECA).[287]

278 Report of the Secretary-General on the fast track to ending the AIDS epidemic, UN Doc. A/70/811 (2016), para. 53.
279 Ibid. para. 75 (f).
280 UNAIDS, Confronting Discrimination, Overcoming HIV-related stigma and discriminatin in health care settings and beyond (2017)
281 Committee on the Rights of the Child, Concluding observations on the fourth periodic report of Georgia, 9 March 2017, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GEO/CO/4&Lang=En
282 Interview with key-informant, Infectious Diseases, AIDS and Clinical Immunology Research Centre.
283 USAID, Georgia HIV Prevention Project – Sustainable HIV Prevention in Georgia: Challenges, Opportunities and Recommended Actions, 2014.
284 Global AIDS Response Progress Report: Georgia Country Progress Report 2014
285 National Center for Disease Control and Public Health of Georgia. Health Care Statistics Yearbook. 2015
286 NCDC, Health Care Statistics Yearbook. 2015
287 UNAIDS GAP report 2014

As of June 2017, a total of 6,441 HIV/AIDS cases have been registered in Georgia; 4,797 men and 1,644 women.[288] The majority of these individuals are aged 29-40. As of the same date, 3,562 of those cases have developed AIDS and 1,301 of those have died.[289]

HIV new cases, by transmission (%), Georgia, 2015[290]

Injecting drug use (IDU)	28.0
Heterosexual contacts	50.2
Homo/bisexual contacts	19.8
Vertical transmission (from mother to child)	0.8
Blood or blood products transfusion	0.6
Unknown	0.6

In 2016, compared to 2015, those infected with HIV through heterosexual contact increased by 1.3%; through homo/bisexual contact, it decreased by 3%; through injection drug use, it increased by 2.3%; and registered cases of vertical transmission decreased by 0.2%.[291]

The HIV prevalence among female sex workers ranges from 0.8% to 1.3%.[192] The HIV prevalence among MSM in the capital, Tbilisi, rose from 7% in 2010 to 13% in 2012.[293] The estimated number of IDUs in Georgia is 45,000, with an HIV prevalence between 0.4% and 9.1%.[294] Another USAID study from 2014 estimated the prevalence of HIV in IDUs to be 1.9% in Tbilisi, 5.6% in Batumi, 2.1% in Kutaisi and 9.1% in Zugdidi.[295] The number of annually registered cases of HIV among youth aged 15-24 increased from 18 in 2008 to 60 in 2013.[296] In addition, according to the NCDC's publication focusing on youth and adolescent health, the number of new cases of HIV in the 15-24 age group almost doubled in 2013, compared to previous years.[297] As of 2014, the HIV prevalence in pregnant women was 0.04%.[298]

There is no data available on HIV prevalence in transgender people. Prevalence and incidence data among those who were tested disaggregated by sex, age (smaller age categories), gender and race/ethnicity is available, but the same data disaggregated by economic quintiles and location is not available.

According to information published in 2014, more than 70% of the people tested annually represent low-risk populations such as pregnant women and blood donors. Of concern is the low testing rate of the high-risk group of injecting drug users (IDUs). In 2013, 5,000 IDUs were tested, but the size of the IDU population in Georgia is estimated to be more than 10 times that size, and the coverage rate is estimated to be a mere 14, 68%.[299]

Knowledge that HIV/AIDS exists is high for some groups of women, and while high in adolescents, it has decreased significantly from the latest data available. From the 2010 Reproductive Health Survey, overall,

288 *Infectious Diseases, AIDS and Clinical Immunology Research Centre.* HIV/AIDS epidemiology in Georgia, *2017.*
289 *Infectious Diseases, AIDS and Clinical Immunology Research Centre.* HIV/AIDS epidemiology in Georgia, *2017.*
290 *Infectious Diseases, AIDS and Clinical Immunology Research Centre.* HIV/AIDS epidemiology in Georgia, *2017.*
291 I*nfectious Diseases, AIDS and Clinical Immunology Research Centre.* HIV/AIDS epidemiology in Georgia, *2017.*
292 Global AIDS Response Progress Report: Georgia Country Progress Report 2014
293 Global AIDS Response Progress Report: Georgia Country Progress Report, 2014
294 Global AIDS Response Progress Report: Georgia Country Progress Report, 2014
295 USAID, Georgia HIV Prevention Project – Sustainable HIV Prevention in Georgia: Challenges, Opportunities and Recommended Actions, 2014.
296 USAID, Georgia HIV Prevention Project – Sustainable HIV Prevention in Georgia: Challenges, Opportunities and Recommended Actions, 2014.
297 NCDC, Health of Young Adults and Young People in Georgia,2015, available at: http://www.ncdc.ge/AttachedFiles/NCDC%20Youth_Health_Statistical%20Overview_20.02.2014_d68e1957-a8f2-45af-a143-1af5a3e890c8.pdf
298 Global AIDS Response Progress Report: Georgia Country Progress Report 2014
299 WHO, HIV/AIDS treatment and care in Georgia. 2014.

96% of the women surveyed had heard of HIV. However, these percentages were lower in rural women (93%) and women with incomplete secondary or lesser education (88%), women in the lowest wealth quintile (90%), Armenian women (88%), and significantly lower in Azeri women (60%).[300] From the 2009 Adolescent Reproductive Health Survey, 86% of adolescents surveyed (girls and boys) were aware of HIV/AIDS. In addition, 81.3% of boys and 74.6% of girls were aware of the ways in which HIV can be transmitted.[301] The 2012 USAID survey determined that 93.6% of youth aged 15-24 in Tbilisi had heard of AIDS. The same survey found that 75.1% of youth had heard of the HIV infection.[302]

However, there is low level of knowledge concerning HIV prevention practices and misconceptions around transmission. The 2010 Reproductive Health Survey shows that 69% of reproductive aged women were aware that HIV transmission is preventable, and this knowledge was lower in rural than in urban areas (60% vs. 77%), and among women in the 15-19 age group (58%), those with the least education (50%), those in the lowest wealth quintile (53%), those with no sexual experience (65%), Azeri women (24%) and Armenian women (44%). Only 71% of respondents knew that HIV infection can be asymptomatic, and this number was significantly lower in those living in rural communities (60%), those in the 15-19 age group (64%), those with incomplete secondary or less education (50%), in the lowest wealth quintile (53%), and especially Azeri women (18%)[303] Thirty-one percent of women were unable to list any method of preventing HIV. The majority of women surveyed held misconceptions about the ways through which HIV can be transmitted, with rural women, women with lower education or income status, and Azeri women having more misconceptions.[304] Twenty-seven percent of reproductive-aged women knew that drugs existed to prevent vertical transmission of HIV.[305]

The majority of adolescents understand that HIV can be transmitted through contact with infected blood (i.e., through transfusions), the use of unsterile syringes/needles, and any type of sexual intercourse between a man and a woman. However, a large percentage of adolescents hold misconceptions about HIV transmission, including beliefs that HIV can be transmitted through kissing, mosquito bites and use of things belonging to someone who is HIV positive.[306] One study found that incorrect beliefs about HIV/AIDS by young people (age 14-17), such as the idea that "mainly gay people get AIDS," led to an increased risk of not practicing HIV-preventive practices, such as irregular condom use and injecting drug use.[307]

Information on the number of individuals using different preventive measures is not available for any group, including men or women, in any category.

Government and other actions

In 2009, Georgia adopted the Law on HIV Infection/AIDS. The law guarantees the human rights of persons infected with HIV and/or ill with AIDS and explicitly prohibits discrimination in access to goods and services and in the context of employment.[308] It also guarantees equitable access to all persons permanently or temporarily residing or staying in the territory of Georgia to voluntary and informed counselling, testing and treatment on HIV. The law also grants the right to anonymous testing.[309] However, according to the law, HIV

300 NCDC, Reproductive Health Survey, 2010.
301 Kristesashvili et al., Adolescent Reproductive health Survey, 2009.
302 USAID Georgia HIV Prevention Project, Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices Among School Pupils and University Students in Tbilisi, Georgia (2012)
303 NCDC, Reproductive health Survey 2010
304 NCDC, Reproductive health Survey 2010
305 NCDC, Reproductive health Survey 2010
306 Kristesashvili et al., Adolescent RH Survey 2009; see also USAID Georgia HIV Prevention Project, Youth Behavioral Surveillance Survey: HIV/AIDS Knowledge, Attitudes, and Practices Among School Pupils and University Students in Tbilisi, Georgia (2012)
307 Goodwin et al. Psychological predictors of high-risk sexual behavior and drug use among adolescents in Georgia. *Current HIV Research.* 2010; 8(3):207-211.
308 HIV Law, Article 10
309 HIV Law, Article 6.

testing is mandatory for blood, organ or tissue donors, and for newborns without parental consent if the HIV status of both parents are unknown, and if they refuse such testing and there are reasonable grounds to believe a parent may be infected.[310] While the law recognizes confidentiality of testing and treatment, it does require a person who is infected to notify their spouse and/or sex partners of their status.[311] If they fail to do so, the service provider institution is obligated to inform the spouse or sex partners, if they are known.[312]

The criminal code of Georgia criminalizes the following conduct related to the transmission of HIV/AIDS:

creating a threat of intentional infection of another person with AIDS, which is punishable by imprisonment for up to three to five years; intentionally infecting another person with AIDS, punishable by imprisonment for up to four to seven years; and infecting by negligence another person with AIDS when performing professional duties, punishable by imprisonment for a term of two to five years, with deprivation of the right to hold an official position or to 'carry out a particular activity' for up to three years. Intentional transmission to a pregnant woman or a minor in any of the above cases is punishable for a term of five to nine years, with deprivation of the right to hold an official position or to 'carry out a particular activity' for up to three years, if applicable.[313]

Pursuant to administrative and criminal laws, the use of drugs in Georgia is criminalized. Article 45 of the Administrative Offences Code states that the first offense of drug use without a prescription, or the possession of drugs in small amounts (e.g. for personal use) without intention of sale, carry a fine of 500 GEL (220 €) or in exceptional cases, administrative imprisonment for up to 15 days. If an individual is caught using drugs more than once during the same 12 months, he or she they will be punished under the Criminal Law (Article 273 of the Criminal Code of Georgia) and subject to a range of fines and up to 12 months of imprisonment.[314]

In 2015, the Georgian National HIV/AIDS Strategic Plan (NSP) for 2016-2018 was adopted. The Plan's aim– is to develop effective prevention and continuum of care programs. Its goal is to turn the HIV epidemic in Georgia to the reversal phase through strengthened outreach and interventions targeting key affected populations (KAP) including: injecting drug users and their sexual partners; men having sex with men and their female sexual partners; sex workers- particularly female sex workers and transgender individuals- their clients and regular sexual partners; prisoners and detainees; and pregnant women. It also has the goal of significantly improving health outcomes for people living with HIV (PLHIV). The strategy has three objectives: HIV prevention and detection, HIV care and treatment and leadership and policy development to sustain strong response through government commitment, an enabling legislative and operational environment, and greater involvement of civil society.

Some of the Plan's main targets are: increased funding of HIV response from the State budget from 32% (in 2013) to 70% (in 2018); by the end of 2018, HIV prevalence among injecting drug users, sex workers, and prisoners is contained under 5% each; by the end of 2018, HIV prevalence among MSM is contained under 15%; the rate of late HIV detection is reduced from 62% to 30% by 2018; and AIDS related mortality is reduced below 2.0 deaths per 100,000 population. The strategy includes a list of detailed services to be offered to specific key affected populations (KAPs) in accordance with identified needs. The NSP places a special emphasis on the importance of community-based care and support services for people living with HIV, both for those who already receive clinical services and for those who are preparing for future treatments.

310 HIV Law, article 6
311 HIV law, artilcle 11 (2)
312 HIV law, artilcle 11
313 Law of Georgia. Criminal Law of Georgia, Article 131. Available at: https://matsne.gov.ge/en/document/download/16426/157/en/pdf
314 The Drug Situation in Georgia. Annual Report. 2014.

The Georgia National HIV/AIDS Monitoring and Evaluation Framework was adopted in 2011 to improve the monitoring and evaluation system and to work with the National Centers for Disease Control and the Country Coordinating Mechanism (CCM) to identify the data flow gaps and develop the recommendations for system improvement.[315]

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the major donor in the field of HIV. Antiretroviral drugs procurement was fully funded in 2015 (1.16 million GEL) from the State budget; first line antiretroviral drugs costs (1.5 million GEL) were included in the 2016 State budget; by the end of 2017 the opioid substitution therapy (OST) program is planned to be funded by the State budget; the State fully procures HIV, Hepatitis B and C rapid diagnostic tests and ART monitoring tests (CD4; Second–line ARV drugs are 25% co-financed by the government in 2016, which in 2018 will be raised to 75%).[316]

Some non-governmental organizations are working with key affected populations such as MSM, sex workers and prisoners. They are providing anonymous, voluntary testing, counseling and treatment with the help of contracting health institutions. They also provide free condoms and information booklets for the targeted population. They work not only in Tbilisi but all over the country. Some of these organizations cover adolescent and youth populations.[317]

Discrepancies

Data on HIV comes from different sources, gathered by different actors in different settings. Despite this, research indicates that there are discrepancies between Georgia's human rights obligations and its actions. It also indicates the critical need to gather comprehensive disaggregated data on HIV.

The HIV law adopted in 2009 has improved the overall legal environment for national response and the national strategy is laudable in setting forth goals addressing some of the barriers to HIV prevention, testing, treatment and care. However, formidable barriers still exist both in regulations and in practice, especially for some KAPs. These stem from various problems, including the criminal code of the country, as well as the requirement to show an ID to be tested, and stigma attached to KAPs, for example, against men having sex with men (MSM) and sex workers.

The overly broad criminalization of HIV transmission in Georgia can hinder people from undergoing testing and obtaining appropriate treatment if needed. UNAIDS recognizes that overly broad criminalization of HIV non-disclosure, exposure and transmission can undermine public health efforts and lead to a miscarriage of justice. They recommend that overly broad laws be revised.[318] In addition, a strict drug law environment represents a severe obstacle for effective implementation of the NSP program. The criminalization of drug users makes it difficult to reach this population as they are hidden. There is a high fine if someone is found in possession of drugs, and reports that the police often circle around opioid substitution therapy centers in order to identify drug users is very counterproductive.[319] WHO has recognized that care of people who inject drugs presents a substantial challenge in Georgia as they are the most affected risk group and traditionally the most difficult to retain in care.[320]

315 UNAIDS.Global AIDS Response Progress Report. 2014. available at: http://ghdx.healthdata.org/record/georgia-global-aids-response-progress-report-2015 16/08/2017

316 The Global Fund to Fight AIDS, Tuberculosis and Malaria Supported HIV and TB Program in Georgia available at: http://www.ncdc.ge/AttachedFiles/Khonelidze_b8a399f5-f484-42bf-b194-b3516b906309.pdf

317 Interview with representative of NGO "Tanadgoma"

318 UNAIDS Guidance Note: Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: Criical Scienfific, medical and legal considerations (2013) http://www.unaids.org/sites/default/files/media_asset/20130530_Guidance_Ending_Criminalisation_0.pdf

319 WHO, HIV/AIDS treatment and care in Georgia (2014) available at http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2014/hivaids-treatment-and-care-in-georgia-2014

320 WHO, HIV/AIDS treatment and care in Georgia (2014) available at http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2014/hivaids-treatment-and-care-in-georgia-2014

WHO notes that persons living with HIV in Georgia do not wish to disclose their status to primary care doctors and dentists, and it is commonly more accepted to say that one has hepatitis C rather than HIV. This seems to be a particular problem in the regions outside Tbilisi with examples given of patients being transferred to Tbilisi because doctors refused to treat them for other conditions because of their HIV status.[321] This is a form of discrimination against persons living with HIV.

Identification of new infections within the surveillance system depends on HIV testing patterns and thus misses people with no access to testing. It is plausible that the real incidence of HIV prevalence may be considerably higher, given that HIV testing coverage remains low and does not adequately cover the groups most at risk of infection.[322] According to WHO, low testing coverage of people at risk is at the core of the problem in Georgia. This may be in part due to the widespread stigma towards people living with HIV and KAPs among the general public as well as relevant professionals, including health care workers, and the non-protection of anonymity in testing.

Such risk groups are generally hard to reach under normal circumstances, and given the levels of social inequality and stigma which seem to be present, gathering data on these sub-populations in order to understand the extent of the size and characteristics of the epidemic remains very challenging.[323]

There is lack of information on the extent to which the strategies or interventions described in the NSP are being implemented.

Recommendations:

- Gather disaggregated data, including on key affected populations.
- Ensure that strategies in the NSP are fully funded and implemented, including but not limited to, strengthening preventative services with a focus on key affected populations.
- Community-based testing should be prioritized as it is crucial to reach at-risk populations. Ensure collaborative effort among community-based organizations and the health care system so as to ensure access to testing among the most at-risk populations and to appropriate linkages to care in case of a positive test result.
- Revise the criminal code to eliminate the overly broad criminalization of HIV.
- Consider decriminalizing drug use, particularly the possession and use of injecting drugs, as it is hampering access of IDUs to HIV testing
- Cease police monitoring of opioid substitution therapy centers for the purposes of identifying drug users.
- Information and de-stigmatization education for health care providers is needed to ensure the proper care of persons living with HIV and other key affected populations.
- Implement the scale-up of harm reduction and OST programs with the implementation of voluntary testing and counseling within the programs
- Implement HIV testing at the primary level, including ensuring accessibility for key populations
- Make information available to the public on HIV, especially targeting young people both in and out of schools, including on transmission methods and ways of preventing HIV and eliminating stigma and discrimination against key populations. This information should also be part of mandatory school curriculum on life skills education/comprehensive sexuality education.
- Ensure effective remedies when persons living with HIV and other key affected populations KAPs have been discriminated against.

321 WHO, HIV/AIDS treatment and care in Georgia (2014) available at: http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2014/hivaids-treatment-and-care-in-georgia-2014

322 WHO, HIV/AIDS treatment and care in Georgia (2014) available at http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2014/hivaids-treatment-and-care-in-georgia-2014

323 WHO, HIV/AIDS treatment and care in Georgia (2014) available at: http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2014/hivaids-treatment-and-care-in-georgia-2014

LIFE SKILLS EDUCATION/COMPREHENSIVE SEXUALITY EDUCATION

Health and Human Rights Considerations

Life skills education/comprehensive sexuality education provides people with the knowledge and skills to be healthy. It limits vulnerability to sexual ill-health, through reducing unwanted pregnancy, unsafe abortion, STIs and HIV. In order to make informed, healthy decisions about sexuality and reproduction, individuals, including adolescents, need accessible, comprehensive, and high quality information.[324]

Comprehensive sexuality education (CSE) has been defined by UNFPA as a "rights-based and gender-focused approach to sexuality education, whether in school or out of school".[325] It embraces a holistic vision of sexuality and sexual behavior, not only focusing on prevention of pregnancy and sexually transmitted infections (STIs).[326] According to UNESCO's guidelines on sexuality education, comprehensive programs include information on the following: growth and development; sexual anatomy and physiology; reproduction, contraception, pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality, and gender roles; sexual behavior; sexual diversity; sexual abuse; gender-based violence; and harmful practices.[327] However, inadequate counseling services, limited or non-existent absence of sexuality education in and out of schools, and little or no information, or even wrong information, hinder the ability of individuals to make informed decisions concerning sexuality and reproduction and to enjoy a satisfying and safe sex life.

Human rights bodies have noted that under the rights to health, information, education, and freedom from discrimination, States have the following obligations in relation to comprehensive sexuality education: make comprehensive sexuality education programs part of the standard school curriculum, provided throughout schooling in an age-appropriate manner and without parental consent;[328] provide information that is physically accessible, understandable and appropriate to the age and educational level of children;[329] ensure that individuals have access to both in and outside formal education systems;[330] develop public education campaigns to raise awareness about sexual and reproductive health issues thorough medical and other alternative forums;[331] ensure that education programs do not censor or withhold information or disseminate biased or factually incorrect information;[332] make sure that curriculum is non-discriminatory in both content and teaching methodologies, including on the grounds of gender and sexual orientation;[333] ensure that

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324 United Nations, Committee on the Elimination of Discrimination against Women. *General recommendation no. 21: Equality in marriage and family relations,* 1994, para 22.; Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, (2000).

325 UNFPA, Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health, 2010, available at: http://www.unfpa.org/comprehensive-sexuality-education

326 UNFPA, Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health, 2010, pp. 15-20

327 UNESCO, International Technical Guidance on Sexuality Education (2009).

328 Report of the UN Special Rapporteur on the Right to Education, paras. 87 (c), Doc. /A/65/162 (2010); CESCR GENERAL COMMENT 22; UN Special Rapporteur on the Right to Health Report on the Right to Health of Adolescents (2016).

329 Committee on the Rights of the Child, General Comment 15: On the Right of the Child to the highest attainable standard of Health, para. 59 (2013); UN SR on Health Report on Adolescents (2016);

330 Committee on the Rights of the Child, General Comment 15: On the Right of the Child to the highest attainable standard of Health (2013): Committee on the Rights of the Child, General Comment 4 on Adolescent Health paras 26, 28, 39(b) (2003); CEDAW General Recommendation 24 on Women and Health, Article, para 18 (1999).

331 Committee on the Rights of the Child, General Comment 15: On the Right of the Child to the highest attainable standard of Health, para. 28 (2013): Committee on the Rights of the Child, General Comment 4 on Adolescent Health para. 28, (2003)

332 Committee on the Rights of the Child, General Comment 3 HIV and the rights of the Child, para 16 (2003); Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health, para. 34* (2000). Report of the UN Special Rapporteur on the Right to Education, para. 39, Doc. /A/65/162 (2010); CESCR GENERAL COMMENT 22 (2016);

333 Report of the UN Special Rapporteur on the Right to Education, para. 63, Doc. /A/65/162 (2010) The UN Special Rapporteur on the Right to Education has noted that states take steps to ensure that programs are free from harmful sex or gender based or heteronormative stereotypes of those based on mental of physical ability. (para 63)

curriculum materials do not perpetuate harmful or discriminatory stereotypes, paying special attention to diversity and gender issues, including addressing gender role stereotyping;[334] and ensure that teachers are effectively trained to provide sexuality education and that youth are involved in the development of such education programs.[335]

Georgia has an obligation to implement all of the above human rights standards. Most recently, the Children's Rights Committee raised concerned during its review of Georgia's compliance with the Convention on the Rights of the Child, over the high rate of early pregnancies and absence of 'sexual and reproductive health education in school curricula'. It recommends that Georgia 'Introduce sexual and reproductive health education into the mandatory school curriculum for adolescent girls and boys, with special attention paid to preventing early pregnancy and sexually transmitted infections; Reinforce measures to raise awareness of and foster responsible parenthood and sexual behavior, with particular attention paid to boys and men.'[336]

Life skills/comprehensive sexuality education in Georgia

Life skills/comprehensive sexuality education is not part of the official school curriculum in Georgia. Several subjects contain some general aspects of life skills education, such is "civic education" and biology, but it is by no means comprehensive. According to a recent report commissioned by UNFPA, even in the course on biology, "teachers skipped the reproductive health related chapters, or discussed them very briefly."[337] There appears to be no information provided in the educational material on eliminating gender stereotypes and promoting equality and non-discrimination regarding women and girls, nor on the grounds of sexual orientation and gender identity.This is particularly troublesome given the low use of modern methods of contraception and the stigma, taboos and stereotypes surrounding gender, sexuality, women and LGBTI persons in Georgia.[338] For example, according to a study carried out in Georgia, "the level of formal education is not explicitly linked with homophobic attitudes – unlike in other countries, [which means that] formal education does not contribute to increasing tolerance towards LGBTI persons."[339]

According to data from 2010, 48-49% of Georgian and Armenian students received some sexual education in school, while only 18% of Azeri respondents reported receiving sexual education in schools. Forty-six percent of young women under the age of 18 had at least one single school-based class that addressed a sexual education topic.[340] Respondents living in urban areas were more likely to have had such a class than those living in rural areas (50% vs. 41%) and prevalence of sex education at school was correlated with respondents' socio-economic status – only 35% of respondents with the lowest socio-economic status reported having had any sex education at school, compared to 45% of middle socio-economic status and 57% of highest socio-economic status respondents.[341] Topics covered in the sexual education class appeared to be more oriented towards biology than prevention of pregnancy, STIs or promoting gender equality. For example,

334 Report of the UN Special Rapporteur on the Right to Education, paras. 21-23, 87 (d), Doc. /A/65/162 (2010).

335 CESCR GENERAL COMMENT 22 Report of the UN Special Rapporteur on the Right to Education Doc. (2010); UN Special Rapporteur on the Right to Health Report on the Right to Health of Adolescents (2016).

336 Committee on the Rights of the Child, Concluding observations on the fourth periodic report of Georgia, 9 March 2017, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GEO/CO/4&Lang=En

337 Evert Ketting, "Possibilities for developing Youth-Friendly Sexual and Reproductive Health Services in Georgia - A Situation Analysis", Report of a consultancy mission on behalf of UNFPA Country Office Georgia, 16-20 November 2015, p.22

338 See for example, Evert Ketting, Possibilities for developing Youth-Friendly Sexual and Reproductive Health Services in Georgia - A Situation Analysis, Report of a consultancy mission on behalf of UNFPA Country Office Georgia, 16-20 November 2015, p. 22; 30,

339 E.Aghdgomelashvili "From Prejudice to Equality – Study of Societal Attitudes, Knowledge and Information Regarding the LGBT Community and their Rights in Georgia, WISG, 2016, p.237, available at: http://women.ge/data//WISG%20HomoBiTransPhobia%20Study_for%20web.pdf

340 NCDC, National Reproductive Health Survey, Georgia, 2010, pp. 249-250

341 Ibid.

topics included female reproductive biology (41% of respondents note that they were taught this), male reproductive biology (38%), the menstrual cycle (28%), how pregnancy occurs (20%), HIV/AIDS (17%), STIs (3%) and contraception (3%). Women aged 15-17 reported higher levels of exposure to sex education than women aged 18-24.[342]

In the 2010 RHS, 80% of women surveyed support sex education in school.[343] This is higher in younger, more educated, urban, employed women with higher socio-economic status, and is weakest amongst Azeri (50%) women and women with low socio-economic status (67%). Fifty-two percent of those surveyed felt that sexual education should begin at 14-15 years of age, 35% thought that it should being at age 16 or older, and only 12% thought it should be provided for adolescents under the age of 14.[344] The overwhelming majority (58.6%) of adolescents surveyed consider it 'more or less' acceptable to talk about issues concerning sex, an additional 30% consider it completely acceptable, while only 11.4% of adolescents consider it completely unacceptable.[345]

According to a recent report commissioned by UNFPA, the vast majority of those interviewed agreed that schools must offer sexual and reproductive health education and are responsible for providing it. As underlined in the study, schools are the only source off structured, systematic and correct information.[346] Yet despite this support and the important health and human rights benefits of comprehensive sexuality education, there are sectors of society with negative attitudes towards sexuality education which have played an influential role in attempting to hinder the development of state programs in this area.[347]

According to the Reproductive Health Survey, the most important source of sexual health information for young women age 15-24 were friends (32%), parents (23%), radio/TV (12%) and teachers (10%). Teachers were the most important source of information for 15% of women aged 15-17. These numbers only refer to the woman's *most important* source of information, meaning that it is likely that young women are receiving information from many of these other sources in addition to the one they ranked as being most important.[348]

Information on the number of health providers trained to provide sexual and reproductive health counseling is not available. Information on the number of teachers trained to teach life skills education or the number of teachers actually teaching this subject is not available. However, the National Center for Professional Development of Teachers has elaborated a training program on "Prevention of Bullying at Schools and the Development of a Tolerant Culture".[349] This envisages two main directions: "Violence" and "Domestic Violence", under which the issues of violence against women is included. In 2016 and 2017 respectively, 282 and 253 teachers participated in the training. Sexual and reproductive health and rights are not addressed in this training program but their inclusion is planned after the approval of the new National Curriculum.[350]

342 Ibid.
343 Ibid, pp. 247-248
344 Ibid.
345 Kristesashvili et al., Adolescent RH Survey. 2009
346 Evert Ketting, Possibilities for developing Youth-Friendly Sexual and Reproductive Health Services in Georgia - A Situation Analysis, Report of a consultancy mission on behalf of UNFPA Country Office Georgia, 16-20 November 2015, p. 22; 30.
347 "Levan Vasadze and Society", Netgazeti, Available only in Georgian: http://netgazeti.ge/life/99457/; Also, "Georgian Patriarch: We have asked to put out some of the terms from the "Me and Society" project", available only in Georgian: http://netgazeti.ge/news/72572/; "Levan Vasadze's 120 comments to Ministry of Education", available only in Georgian: http://liberali.ge/news/view/21238/levan-vasadzis-120-shenishvna-ganatlebis-saministros
348 NCDC, Reproductive health Survey Georgia, 2010
349 Letter from the Ministry of Education and Science No: MES 0 17 00988233
350 Ibid.

Early pregnancy rates in Georgia are high, at 48.6 per 1,000 women age 15-19 in 2015.[351] According to Geostat data from 2012 the abortion rate has declined in the 15-19 age group. In 2012 the abortion rate was 1,955, in 2013 1,833 abortion cases were recorded, in 2014 there were 1,387, in 2014 and in 2015 1,335 cases were documented.[352] This decline has also been observed in individuals under 15 years of age; in 2013 there were 34 documented cases, in 2014- 20 cases were recorded and only 9 cases were identified in 2015.[353] This might indicate that rates of modern contraceptive use have increased,[354] however, in 2016, the abortion rate among adolescents was still relatively high.[355]

Contraceptive use is low: one survey found that 30% of sexually active unmarried female adolescents (aged 17-19) used contraception at first intercourse (in all cases condoms) and 70% used no contraception.[356]

Government Actions

Numerous recent policy documents address the importance of the provision of life skills education/ comprehensive sexuality education in and out of schools. Yet, to date there is no comprehensive sexuality education provided in schools.

Georgia's National Youth Policy for 2015-2020[357] recognizes the importance of information on sexual and reproductive health and rights for young people. According to this youth policy "young peoples' increased awareness and knowledge of reproductive health and modern methods of family planning contributes to the reduction of the incidence of abortions and sexually transmitted infections (STIs), including HIV. In addition, it contributes to the reduction of the incidence of early marriages, and adolescent pregnancy and negative consequences, and related maternal and child health risks."[358] The objectives of the policy include[359] *inter alia* supporting development of modern education programs regarding sexual and reproductive health issues and rights based on the best modern international standards for formal and informal education systems.

The Ministry of Sports and Youth Affairs noted that during 2013, under an informal educational program, it implemented awareness raising campaigns on healthy lifestyles, which included trainings and sport activities in different cities of Georgia.[360] However, no details have been provided indicating if the program included issues related to sexual and reproductive health and rights.

The Government's Human Rights Action plan for 2016-2017 sets an objective to prepare age-appropriate guidelines for education on reproductive health, violence against children and the problem of early marriage. These guidelines should be executed by the Ministry of Education and Science.[361] In order to prepare this document 36,000 GEL is allocated.[362] There is no available information on the implementation status of this objective.

351 Government's Maternal & New-born Strategy for 2017-2030 years
352 Geostat, Gender Statistics, p. 7, available at: http://geostat.ge/cms/site_images/_files/english/Gender%20Statistics.pdf
353 ibid.
354 Public defender's office, special report on women's right and gender equality, Tbilisi, 2016, p. 25
355 Ibid
356 Kristesashvili et al., Adolescent RH Survey, 2009.
357 The Georgian National Youth Policy Document, Approved by #553 Decree, dd April 2 2014, of the Government of Georgia, Available at: http://msy.gov.ge/files/Youth_Policy_(Engl)_Final_July_2014.pdf
358 Ibid., Para. 3.2.
359 Ibid., p. 13
360 Letter of Ministry of Sports and Youth N06/2619, 19 September, 2017
361 Government's Human Rights Action plan for 2016-2017 years, p. 12.1.3.2. available at: https://matsne.gov.ge/ka/document/view/3350412
362 Ibid, p. 12.1.

In May 2017 the Ministry of Education and Science of Georgia and the UN Joint Program for Gender Equality signed a Memorandum of Understanding to assist in the ongoing revision of the national curriculum and help integrate the issues of human rights, gender equality and healthy lifestyle into educational programs.[363] This initiative is also included in the Government's Maternal and Newborn Strategy for 2017-2030, which underlines the need for advancing the education of young people on SRH issues. According to the Strategy, the MoLHSA will collaborate closely with the Ministry of Education and Science to further develop, pilot, and implement a school-based healthy lifestyle education program.[364] The Program will include topics like responsible sexual behavior, gender relationships, violence towards teenagers, responsible family planning, and prevention of STI/HIV infection. This intervention will be followed by the development of all educational materials needed for implementation of the program and to elaborate on a relevant system of teacher training courses.[365] According to the strategy, the program will be gradually integrated into the school curricula, so that by 2030 all schools (including vocational schools) are implementing the program.[366] Under the Strategy, the government also plans to launch public information campaigns for young people on various sexual and reproductive health issues, using social media. It also plans to develop and implement educational activities in communities and specifically for parents on the topic of providing guidance to their children about sexual and reproductive health.[367] Budgeting for these programs is not specifically defined.[368]

To date, two major subjects have been revised for the integration of healthy lifestyles in the formal education system: Biology and Civic Education. The curriculum for grades 1-4 has been adopted, and the curriculum for grades 7-9 are planned to be adopted by the end of 2017. The Ministry of Education and Science has announced a competition for the design of new books based on the revised standards for grades 1-4 and new books should be available beginning in September 2018.

Meanwhile, a compulsory school subject as a standalone course, for third and fourth grade pupils will be introduced in public schools throughout the country. The course is called 'Me and My Society' and according to the Ministry of Education and Science, the piloting of the subject should have begun in the 2017-2018 educational year in several public schools in Georgia. From the 2018-2019 school year, the subject will be obligatory for every public and private school in Georgia. In the meantime guidelines are being written to help teachers in the planning of the curriculum.[369] The new subject aims to address issues related to family, society, state, school environment and citizenship.[370] A number of stakeholders have worked on the content, including local teachers, various international organizations (UNFPA, UN Women), and local NGOs.[371] Opposition to the program by informal groups argued that it threatened the development of Georgian children and was "against the fundamental values of Georgian society."[372] Despite this resistance, the Ministry of Education and Science

363 The initiative is supported by the Government of Sweden. Covers three main areas of secondary education – formal education in schools; non-formal education, including for optional courses and parents' education; and vocational education and training. "Focusing on both content and delivery of education, the United Nations will assist the Ministry to analyze school and college curriculum from the gender equality perspective, develop new educational programs, upgrade teaching methodologies, train teachers and career counselors, and share best international practices in promoting human rights, gender equality and healthy life-style through general education." available at: http://www.ge.undp.org/content/georgia/en/home/presscenter/pressreleases/2017/05/15/georgian-schools-embrace-human-rights-and-gender-equality-/

364 Governments New Maternal and New-Born Health Strategy for 2017-2030 , P. 31

365 Ibid, P. 32

366 ibid

367 ibid

368 GEORGIA Action Plan 2017-2019 on Maternal & Newborn Health and Immediately Related RH Issues

369 Letter from the Ministry of Education and Science No: MES 0 17 00988233

370 Ibid

371 Letter from the Ministry of Education and Science No: MES 0 17 00988233

372 Levan Vasadze's 120 comments to Ministry of Education Available only in Georgian: http://liberali.ge/news/view/21238/levan-vasadzis-120-shenishvna-ganatlebis-saministros: See also: https://www.kvirispalitra.ge/public/28407-gangashis-zarebi.html

approved the new subject, and its introduction is planned for the 2018-2019 year as a mandatory course. It has been reported that prior to approval, the content underwent several changes after consultations with the Georgian Patriarchate and civil society organizations. It should be noted that the terms "Liberalism", "Democratic values", "Gender" and "Tolerance" underwent changes, and some of the terminology and explanations have been removed from the course.[373]

Discrepancies

Despite the laudable initiatives highlighted above, to date there is no comprehensive and compulsory program of age-appropriate life skills/sexuality education in Georgia. The existing information provided in some courses are primarily focused on biological aspects of reproduction and do not reach all students in Georgia. For example, according to the information received from the Ministry of Education and Science,[374] in the current National Curriculum approved by decree N36/N of the Ministry of Education on March 11, 2011, the issues of reproductive health and sexually transmitted infections are included in the subject of Biology and cover the issues of the STI's, their symptoms, transmission and consequences. It also covers the issue of early marriage and its societal causes and accompanied risks, but mainly focuses on health issues of girls and new-borns. Issues of domestic violence, trafficking and other types of violence, and children's rights are also included.[375] However, the way that the textbooks address these issues and the way in which they are interpreted by teachers is not known.

Existing programs do not address the need for comprehensive information that will empower youth to engage in healthy and respectful lifestyles. In addition, there is a lack of comprehensive teacher training on the subject matter throughout the country, and also a lack of teaching materials, both in terms of the materials for students and also teaching methodologies for teachers. Not all school doctors are trained on the subject matter and there is no mechanism to make such training mandatory. The Ministry of Education and Science approved a parent education and school doctors program to engage parents and school doctors on the subject matter but despite specific budget allocated for this program in 2017, the Ministry decided not to move forward with it.

While the parliament has adopted a resolution, based on the Public Defender's Office parliamentary report for 2016, recommending revisions to some aspects of the existing limited information provided in schools in this area, this cannot be seen as an introduction of the comprehensive life skills/sexuality education in schools.[376]

Public information campaigns to reach all youth, including those out of school, are also lacking, as are peer education programs, which are often effective avenues for dissemination of sexual and reproductive health information to adolescents and youth.[377]

This dearth of information puts youth at risk for unwanted pregnancies, HIV and other STIs, and does nothing to address the harmful gender stereotypes that are prevalent in society.

373 Levan Vasadze and society, Available only in Georgian: http://netgazeti.ge/life/99457/ ; Also, see only in Georgian: http://netgazeti.ge/news/72572/

374 Letter from the Ministry of Education and Science No: MES 0 17 00988233

375 Letter from the Ministry of Education and Science No: MES 0 17 00988233

376 Resolution N 1181-IIს, 30.06.2017, available only in Georgian: https://matsne.gov.ge/ka/document/view/3744739

377 International standards on peer education programs are available at: https://www.fhi360.org/sites/default/files/media/documents/Peer%20Education%20Toolkit_Standards%20for%20Peer%20Education%20Programmes_0.pdf

Recommendations

- The Ministry of Education and Science should ensure that a strategy and action plan for age appropriate comprehensive life skills/sexuality education, including in schools and out of school, is developed and implemented as a matter of priority.

- The Ministry of Education and Science must ensure that age-appropriate comprehensive life skills/ sexuality education is provided as compulsory to all children in schools in Georgia. This should be an explicit commitment in the curriculum framework for different levels of education and reflected in relevant strategies.

- Life skills/comprehensive sexuality education should be in line with international standards and UNESCO guidelines (see above). Age-appropriate learning materials for comprehensive life skills/ sexuality education should be developed for pupils.

- The Ministry of Education and Science must ensure that all teachers who will be delivering comprehensive life skills/sexuality education receive training on the provision of age-appropriate and comprehensive life skills/sexuality education. Human rights-based training materials will be developed for teachers.

- Mandatory programs for teachers and school doctors should be developed and implemented as per commitments made in 2017 (see above).

- Life skills/comprehensive sexuality education for out of school adolescents and youth should build on existing infrastructure, engaging with civil society organizations working in this area. Peer education national standards on comprehensive life skills/sexuality education should be developed/adapted according to international standards.

- Adolescents and young people should participate in the design of life skills/comprehensive sexuality education in school and non-school settings and delivery of this education through peer-to-peer initiatives.

- Implement relevant recommendations issued by international human rights bodies, including recent recommendations by the Committee on the Rights of the Child.

VIOLENCE AGAINST WOMEN

Health and human rights considerations

Violence against women is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[378] It encompasses, but it is not limited to, "physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical sexual and psychological violence perpetrated or condoned by the state, wherever it occurs."[379] Forced examinations, such as virginity testing and harmful practices are also recognized as forms of discrimination and violence that must be eliminated.[380]

International human rights bodies have recognized that violence against women is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men.[381] Key rights affected include: the rights to life; health; not to be subject to torture or cruel, inhuman and degrading treatment and punishment; liberty and security of the person; equal protection under the law, including equal protection according to humanitarian norms in time of international or internal armed conflict; equality in the family; just and favorable conditions of work and; equality and non-discrimination.[382]

International human rights standards, including the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) and the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), give rise to state obligations to fight violence against women, including: to prevent and eliminate violence against women and girls in both the public and private spheres; to adopt adequate, comprehensive legislation and other measures, including sanctions where appropriate; to prevent and punish all forms of violence against women and girls; to investigate, prosecute and punish instances of gender-based violence; to ensure that programs addressing gender-based violence take into account underserved and vulnerable groups such as persons with disabilities to ensure they, as well as all women, have access to essential services and redress; to provide survivors of sexual violence with access to emergency contraception; to incorporate efforts to combat gender-based stereotypes and other underlying causes of gender-based violence in programs aimed at addressing gender-based violence; to ensure effective access to justice for survivors of violence against women, legal aid and remedies, including compensation and rehabilitation.[383]

In addition, sexual violence can result in HIV, other STIs and unwanted pregnancies, as well as functional disorders such as irritable bowel syndrome; gastrointestinal disorders; and various chronic pain syndromes, including chronic pelvic pain. It also has mental health consequences. States have an obligation to implement policies that protect victims from further abuse such as the establishment of social, psychological and health services for victims.

378 Declaration on the elimination of violence against women, A/RES/48/104, Article 1.
379 U.N.Declaration on the elimination of violence against women, A/RES/48/104, Article 2.
380 Joint CEDAW-CRC General Recommendation on harmful practices (2014)
381 Committee on the Elimination of Discrimination against Women, General Recommendation 19 (1992) on violence against women, para. 1.
382 Committee on the Elimination of Discrimination against Women, General Recommendation 19 (1992) on violence against women, para. 7.
383 Council of Europe convention on preventing and combating violence against women and domestic violence (2011); CEDAW General Recommendation 35 on gender based violence against women (2017).

States also have an obligation to address early marriage as a form of sexual and gender-based violence and its consequences of early pregnancy, which has a higher risk of complications.[384] Studies have also linked early marriage to an increased risk of intimate partner violence. The Convention on the Elimination of All Forms of Discrimination Against Women states that "the betrothal and the marriage of a child shall have no legal effect" (article 16.2); the Committee on the Elimination of Discrimination Against Women and the Committee on the Rights of the Child consider that the minimum age of marriage should be set at 18 for both men and women.[385]

Georgia has an obligation to implement all of the above human rights standards. In 2016, after a visit to Georgia the UN Special Rapporteur on Violence against Women issued a report on the situation in Georgia, offering detailed recommendations which Georgia should implement (see summary of recommendations in Chapter 1).[386] The CEDAW Committee has also made numerous recommendations to Georgia on violence against women which are set forth below.

Violence against women in Georgia[387]

Violence against women and particularly domestic violence is a widespread problem in Georgia. National research conducted in 2009[388] shows that, among women interviewed, one woman in 11 had experienced physical or sexual abuse, either perpetrated by her husband or intimate-partner, and 34.7% had been injured as a result of physical or sexual violence.

Application of protection mechanisms against domestic violence (protection orders, restrictive orders, and prosecutions) has substantially increased since 2014, with the following trends:[389]

	2014	2015	2016
Protection Orders	**87**	**173**	**179**
Restrictive Orders	**902**	**2726**	**2877**
Prosecutions under Art. 11 (domestic crimes) and 126 (domestic violence) of the Criminal Code	**350**	**728**	**1356**

Regarding psychological abuse, research in 2009 shows that insults (14.3%), belittling/humiliations (5.3%) intimidation (5.1%) and threats (3.8%) were the most common components of psychological abuse reported by women interviewed. Almost 40% of women reported their exposure to acts intended to control their behaviour, with a higher prevalence among women with incomplete secondary education (60%) than those having completed their secondary, technical or higher education (35%) and among women who do not earn money (76.6%).

384 OHCHR, information series on sexual and reproductive health and rights violence against women, available at http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_VAW_WEB.pdf

385 CEDAW and Committee on the Rights of the Child Joint General Comment 31 on harmful practices (2014).

386 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3

387 This section deals with select issues on violence against women in particular, and not all gender-based violence.

388 National Research on Domestic Violence against Women in Georgia, 2010, pp.33 and 44., available at: http://www2.ohchr.org/english/bodies/cedaw/docs/AdvanceVersions/GeorgiaAnnexX.pdf

389 Special Report of the Public Defender of Georgia, the Situation of Women's Rights and Gender Equality, 2016, p. 29, available at: http://www.ombudsman.ge/uploads/other/4/4451.pdf

According to the 2010 Reproductive Health Survey, verbal and/or physical abuse in marriage was, in general, greater among women with less formal education and with the lowest socioeconomic status, as well as among Azeri women or women from other ethnic backgrounds. Domestic violence is considered to be more prevalent in minority groups, in particular Azeri and Armenians, in rural areas.[390]

The United Nations Special Rapporteur on Violence against Women (UNSR on VAW) noted in her report on Georgia that among the factors that most likely increase the risk of intimate-partner violence are discriminatory gender stereotypes and patriarchal attitudes, women's low awareness of their rights, the occurrence of child and forced marriages and the lack of economic independence, among others. In addition, the consumption of alcohol, economic problems and unemployment are factors that contribute to reinforcing the occurrence of domestic violence.[391]

A study issued by UN Women shows that this increase can also be attributed to a shift in public awareness and attitudes towards domestic violence. This problem used to be perceived as a "family issue" (78.3% in 2009), where victims or their relatives were reluctant to report it to the relevant agencies, even in quite extreme cases – but now this attitude has changed. According to this study on the perceptions of violence against women and domestic violence in Tbilisi, Kakheti and Samegrelo-Zemo Svaneti (2013), only 25% now believe that DV is a family matter, while 69% believe DV is a crime.[392]

Other VAW issues

In 2016, incidents of female genital mutilation were revealed in three villages of the Kakheti region of Georgia. There, the practice of female genital mutilation was revealed as part of a "baptism" ritual involving cutting off a small part of the clitoris. The ritual is performed under home conditions. The information obtained by the Public Defender of Georgia reveals that the local population is not aware of the complexity, risks, and complications inherent to female genital mutilation. In addition, the purpose of the practice is not uniformly understood. Many members of the community relate it to tradition and/or religious custom.[393]

According to the information provided by the Ministry of Justice of Georgia, in 2015, 611 child marriages were registered. In 2016, there were only five. The decrease is likely due to amendments to the Civil Code of Georgia initiated by the Public Defender (see below). The number of parents who were still minors when registering the birth of a child also declined from 1,449 in 2015 to 1,278 in 2016. Figures for the number of minor parents having children considerably exceed the figures on early marriage.[394]

Due to social pressure, among other reasons, women undergo virginity tests to prove their virginity to their husbands and relatives. The UN Special Rapporteur on Violence against Women expressed her concern about the lack of safeguards for the protection of women's right to privacy and fully informed consent, in addition to the concern that many such tests are performed due to negative stereotypes about women's sexual behaviour.

390 NCDC, Reproductive Health Survey 2010

391 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3

392 UN Women, a Study on the Perceptions and Attitudes of Violence Against Women and Domestic Violence in Tbilisi, Kakheti and Samegrelo-Zemo Svaneti (2014) http://georgia.unwomen.org/en/digital-library/publications/2014/11/perception-of-violence-against-women-and-domestic-violence-in-tbilisi

393 Public Defender of Georgia, Special Report on Women's Rights and Gender Equality, 2016, Pp. 33-34, available at: http://www.ombudsman.ge/uploads/other/4/4452.pdf

394 Public Defender of Georgia, Special Report on Women's Rights and Gender Equality, 2016, p.35, available at: http://www.ombudsman.ge/uploads/other/4/4452.pdf

Government and other actions

Georgia is a party to all major international and regional human rights treaties outlawing violence against women. Importantly, in April 2017 Georgia ratified the Council of Europe Convention on preventing and combating violence against women and domestic violence, which entered into force on 1 September 2017 and led to significant changes in domestic laws to comply with the Convention (amendments enacted on 1 June 2017).

The Law on Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence (currently the Law on Elimination of Violence against Women/Domestic Violence), was enacted in 2006 and outlines measures to detect and respond to domestic violence and to provide assistance to the victims.[395] Domestic violence became a distinct crime in the Criminal Code of Georgia in 2012, which defined the scope and categories of the crime.[396] The Law on Gender Equality came into force in 2010, outlining equal rights and freedoms for men and women.[397] In 2014, the Law on the Elimination of All Forms of Discrimination was enacted, prohibiting discrimination on different grounds, including sex, and providing redress mechanisms.[398]

There are a number of policies and strategies adopted by the Government to fight violence against women, including aw of Georgia on Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence 2016-2017. The Plan covers domestic violence and sexual violence issues and its objective is the realization of gender equality through the empowerment of women and the fight against domestic violence.

The Government has also approved the National Action Plan on Gender Equality for 2014-2016, as well as the National Human Rights Strategy.

Since 2015, through the support of UN Women, there has been an increase in services for victims of domestic violence in the form of provision of shelters and crisis centers. Most of the State institutions have conducted awareness raising activities on domestic violence and have held a significant number of information meetings for the public at different locations.

Some State institutions have also conducted awareness raising activities on domestic violence – the Ministry of Internally Displaced Persons,[399] the Ministry of Corrections and Probation,[400] the Chief Prosecutor's Office,[401] the Ministry of Education,[402] the State Fund[403] and the Legal Entity under Public Law (LEPL) Public Broadcaster have held several information meetings with the public at different locations.

395 Law on Elimination of Domestic Violence, Protection and Support of Victims of Domestic Violence, 25/05/2006, available at: https://matsne.gov.ge/ka/document/view/26422

396 Article 1261 (Domestic Violence) of the Criminal Code of Georgia, available at: https://matsne.gov.ge/ka/document/view/16426 Accessed 28.07.2017

397 Law on Gender Equality, 26/03/2010, available at: https://matsne.gov.ge/ka/document/view/91624 Accessed: 28.07.2017

398 Law on Elimination of All Forms of Discrimination, 02/05/2014, available at: https://matsne.gov.ge/ka/document/view/2339687 English version of the Law available at: https://matsne.gov.ge/en/document/view/2339687 Accessed: 28.07.2017

399 The Ministry of Internally Displaced Persons conducted information meetings on domestic violence with internally displaced persons at 5 locations, and with asylum seekers at 1 location, including on the topics of early marriages at 2 locations. The LEPL Legal Aid Service lawyers conducted 10 information meetings on domestic violence and women's rights at locations inhabited by ethnic minorities. 36 meetings were conducted with internally displaced persons and 1 meeting with asylum seekers.

400 The Ministry of Corrections and Probation of Georgia reported no public awareness activities so far conducted. On the other hand, the Ministry of Justice of Georgia, together the Office of the State Minister of Georgia for Reconciliation and Civic Equality, conducted 1 information meeting with ethnic minority youths in Marneuli.

401 The Chief Prosecutor's Office conducted 11 information meetings on domestic violence, violence against women, early marriages, with local populations, university and high school students in the regions of Georgia, including 1 location of ethnic minorities.

402 The Ministry of Education conducted 9 information meetings on child marriages with parents, religious leaders and community leaders at secondary schools in the areas inhabited by the Muslim population.

403 The State Fund conducted 31 information meetings/public lectures on domestic violence in different regions of Georgia (including areas inhabited by ethnic minorities), reaching 907 participants in total.

A number of trainings have been conducted by the Ministry of Internal Affairs,[404] the Chief Prosecutor's Office[405] and the High School of Justice[406] to train police, prosecutors and judges on domestic violence. Domestic violence topics were integrated into programs preparing candidates for judges and for the training of judges and other employees of the courts.

The minimum age of marriage in Georgia is 18 years. Beginning on 1 January 2017, no exception is allowed to this age requirement. Accoring to the legislation, coercion into marriage is criminalized (Art. 150.1) and sexual penetration of a minor (marriage is not an exception nor a mitigating circumstance) is punishable under the Criminal Code (Art. 140). Coercion into marriage is punishable by community labour from 200 to 400 hours, or by deprivation of liberty for up to 2 years. If the crime is committed against a minor (Art. 1501.2), it is punishable by imprisonment from 2 to 4 years. Sexual penetration of a minor is punishable by imprisonment from 7 to 9 years. Article 150.1 came into force on 17 October 2017 and Article 140 was amended on 4 May 2017 ("sexual intercourse" was replaced with the wording "sexual penetration"). The purpose of the amendments was to bring Georgian legislation in conformity with the Istanbul Convention.

Female Genital Mutilation was criminalized on 4 May 2017 also to bring the legislation in conformity with the Istanbul Convention. Under Art. 1332 of the Criminal Code, it is punishable by imprisonment from 2 to 6 years. If committed against a minor, the punishment is imprisonment from 3 to 7 years.

Discrepancies

Despite the laudable efforts made by the Government of Georgia and the recent legislation adopted, numerous discrepancies still exist, both in law and in practice.

The estimation of cases of domestic violence is based on the number of restrictive orders and protection orders issued and on the prosecutions under Art.126.1 and all the articles falling under Art.11. on domestic crimes, leaving invisible an undefined number of cases.[407] In this respect, the UN Special Rapporteur on violence against women noted concern that some cases are registered by the police under 'family conflict', which may leave cases of domestic violence invisible.[408] The lack of public awareness, the fear of retaliation and stigmatization, the lack of trust in law enforcement agencies and the protection mechanisms for victims, including rehabilitation services can also be contributing factors to underreporting of domestic violence.[409] The same reasons for underreporting would apply to sexual violence, which many women also may not know is a separate form of violence under the law, especially if they are subject to sexual violence by their husbands or partners.

Numerous gaps exist in legislation. Psychological violence outside the family is not separately criminalized, despite Article 33 of the Istanbul Convention expressly providing for the criminalization of psychological

404 The Ministry conducts regular trainings for police officers, information available on the web-page of the MIA: http://police.ge/ge/projects/odjakhshi-dzaladoba

405 The Chief Prosecutor's Office of Georgia conducted 6 trainings on violence against women, training 116 prosecutors in total. In cooperation with the Council of Europe, a training module was developed for prosecutors on women's rights and access to justice.

406 The High School of Justice conducted 2 trainings for the High School of Justice judges and other employees of courts, in which 9 judges and 13 assistants of judges participated.

407 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3, para. 12.

408 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3, para. 12.

409 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3, para. 10.

violence regardless of the context in which it takes place. Despite the CEDAW Committee recommendation to Georgia, no definition of femicide (gender-related killing of a woman) is included in criminal legislation.[410]

Criminal Code definitions of rape and other forms of sexual violence, amended in 2017,[411] are still not in line with the requirements of CEDAW[412] and the Istanbul Convention.[413] Despite the fact that the Criminal Code now defines rape as any form of sexual penetration, the definition is not focused on the commission of a sexual act without the victim's consent, as expressly required by the Istanbul Convention.[414] Rather it qualifies the crime as conducted with violence, threat of violence and taking advantage of the helplessness of the victim. Relatedly, Georgian court practice interprets victims' consent restrictively and does not consider "coercive circumstances" in examining the issue of consent. Additionally, in practice, in the overwhelming majority of cases, physical injuries are required for criminal prosecution of rape, contravening well established international and regional human rights law.[415] Marriage is not a mitigating circumstance for rape; however, there are no statistics of prosecutions of rape committed in marriage.

Even though the Law on Gender Equality provides the definition of sexual harassment in labor relations,[416] the law does not include an explicit penalty nor any civil law remedy for such an act. And sexual harassment is not recognized as a form of discrimination. The U.N. Special Rapporteur on Violence against Women was informed that sexual harassment at the workplace is frequent, but underreported, which stigmatizes women.[417] However, there appears to be no data available on the prevalence of sexual harassment and other forms of harassment.[418]

The Labour Code of Georgia states that harassment is a form of discrimination, however, the provision does not refer to sexual harassment and requires a comparator for the act to be established (Art. 2.4 of the Labour Code). The CEDAW Committee has recommended to the State to strengthen measures to prevent and combat sexual harassment of women in the workplace by establishing labour inspectorates for effective labour law reporting and enforcement mechanisms.[419]

None of the laws recognize violence against women as a form of discrimination against women.

410 Follow-up letter of the CEDAW Committee, sent to the Government of Georgia regarding fourth and fifth combined reports of Georgia, dated 26 April 2017, available at: http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/GEO/INT_CEDAW_FUL_GEO_27290_E.pdf

411 Criminal Code of Georgia, Article 137.

412 See Karen Tayag Vertido v. The Philippines, CEDAW, Communication N18/2008, UN Doc CEDAW/C/46/D/18/2008 (2010), para. 8.9(b)(ii).

413 See Article 36 of the Istanbul Convention

414 Art.36 (1) (2) of "1 Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalized: an engaging in non-consensual vaginal, anal or oral penetration of a sexual nature of the body of another person with any bodily part or object; b engaging in other non-consensual acts of a sexual nature with a person; c causing another person to engage in non-consensual acts of a sexual nature with a third person. 2 Consent must be given voluntarily as the result of the person's free will assessed in the context of the surrounding circumstances", Istanbul Convention, Art.36 (1) (2).

415 This was evidenced by studying 12 randomly selected first instance court judgments by GYLA, delivered in 2013-2015, for the purposes of this report.

416 Law on Gender Equality, Article 6.1.b.

417 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3, citing to Annual Report, Public Defender of Georgia, 2014.

418 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, 9 June 2016, A/HRC/32/42/Add.3, para 18

419 Committee on the Elimination of Discrimination against Women, Concluding observations on the combined fourth and fifth periodic reports of Georgia, 24 July 2014, para. 29.d

Regarding public awareness campaigns, although many of the State institutions have taken measures to raise public awareness of violence against women and domestic violence, patriarchal attitudes on violence and gender equality are still deeply entrenched within society. Consequently, violence against women and domestic violence are only taken seriously when the violence results in serious physical injury, while psychological violence, coercion or physical violence that does not cause physical injury is generally overlooked.

Furthermore, in light of the information available on training activities of state employees, it is not known whether the training modules included training on gender stereotypes and on the Optional Protocol of CEDAW and the Committee's general recommendations (including General Recommendation No. 19 and its updated General Recommendation 35 (2017) on gender based violence against women).

The Georgian Young Lawyers' Association (GYLA)'s criminal trial monitoring in the periods between February-July 2016 and August 2016-January 2017 has indicated some recent improvements in the approaches of courts in certain areas of domestic violence proceedings; however, systemic and individual gaps in responding to violence against women still remain. In cases of domestic violence and domestic crimes, the courts still fail to assess threats and risks posed to victims and do not apply adequate or any preventive measures, for instance with regards to: the number of inadequate preventive measures, which increased – in 8 out of 17 cases (47%) the applied preventive measures appear to be insufficient to ensure the prevention of continued violence and the protection of the victim();[420] the proportionality of sentencing, which remains problematic – between February-July 2016 custodial sentences were imposed in only 6 out of 22 cases (27%);[421] and in downgrading of the classification of these offences.[422] In practice, it appears that courts still view domestic violence as a private matter between the abuser and the victim, which deserves less punishment than crimes committed outside the family.[423]

Compensation mechanisms for victims of violence against women and domestic violence are envisaged under Art. 17 of the Law on Violence against Women and Domestic Violence; however, State award of compensation will not enter into force until 2022.

420 Georgian Young Lawyers' Association, ; Author: Goga Khatiashvili, Monitoring Criminal Trials of Violence against Women and Domestic Violence in Tbilisi, Kutaisi, Batumi, Gori and Telavi courts. Monitoring report N10. (2016).

421 Georgian Young Lawyers' Association, Author: Goga Khatiashvili, Monitoring Criminal Trials in Tbilisi and Kutaisi City and Appellate Court, February-July 2016, pp. 19-20

422 See above, pp. 23-28, Georgian Young Lawyers' Association, Author: Goga Khatiashvili, Monitoring Criminal Trials of Violence against Women and Domestic Violence in Tbilisi, Kutaisi, Batumi, Gori and Telavi courts; Monitoring report N10, period: August 2016 – January 2017.

423 Georgian Young Lawyers' Association, Author: Goga Khatiashvili, Monitoring Criminal Trials of Violence against Women and Domestic Violence in Tbilisi, Kutaisi, Batumi, Gori and Telavi courts;. Monitoring report N10, period: August 2016 – January 2017.

Recommendations

- Adopt provisions/legislation which prohibit and sanction sexual harassment in the public sphere, including within educational institutions and at workplace. Make the protection mechanisms for victims/survivors more effective and flexible to all forms of violence against women, including stalking and sexual harassment.
- Amend the definition of rape in the Criminal Code to bring it in compliance with the CEDAW and Istanbul conventions, including by stressing the element of the absence of consent by the victims.
- Provide support services for victims of violence available in the language of all ethnic minorities and easily accessible to women living in the areas inhabited by ethnic minorities.
- Intensify mandatory training across the country and enhance the already existing training programs for public officials, including law enforcement officers and members of the judiciary.
- Intensify training for social workers, teachers and doctors on the identification of cases of domestic violence.
- Intensify awareness-raising campaigns and programs, including in co-operation with civil society, to increase awareness and understanding among the general public and professionals on different forms of manifestations of violence against women, their causes and consequences, and available remedies, with the aim of prevention.
- Organise awareness-raising activities and campaigns to combat discriminatory gender stereotypes in society, including in the media.
- Collect disaggregated data on all forms of violence against women, including sexual harassment, and collect and analyse data on suicides among women victims of violence.
- Collect disaggregated data by sex and age on all de facto child marriages.
- Enforce the criminal law provision on the ban of forced marriages and collect data on prosecution rates.
- Ensure sanctions are imposed for crimes related to child marriages (sexual intercourse with a minor, deprivation of liberty, etc.) and are commensurate to the gravity of the crime.
- Implement relevant recommendations issued by international human rights bodies, including recommendations by the UN Special Rapporteur on Violence against Women and the CEDAW Committee.

REPRODUCTIVE SYSTEM AND BREAST CANCERS

Health and human rights considerations

A program of universal screening of the target age group (women age 30-49) and younger women at risk and treatment of pre-cancerous lesions, can prevent the majority of cases of cervical cancer. Universal cancer screening can help detect cancer at earlier stages.[424] Treatment for both cervical and breast cancer can support the right to the highest attainable standard of health, particularly of older women.

Human rights require that all individuals and groups have the right to evidence-based information on all aspects of sexual and reproductive health, including reproductive cancer.[425] States have an obligation to adopt appropriate legislative, administrative, budgetary and promotional measures in this area and to aim to ensure universal access without discrimination, including for those from disadvantaged and marginalized populations, to a full range of quality sexual and reproductive health care, including reproductive cancers.[426]

Reproductive system and breast cancer in Georgia

Breast and cervical cancer are the main killers off women of reproductive age in Georgia. Among all reproductive age deaths, cases of breast cancer were 12.6% and about 12.2% died due to cancer of other reproductive organs such as cervical cancer (6.5%), uterus cancer (4.1%) and ovarian cancer (1.6%).[427]

According to the National Centers for Disease Control, the incidence of breast and cervical cancer has increased from 51.9 per 100,000 women in 2014 to 94.8 per 100,000 women in 2015.[428] During the last five years there has been an increase in the number of persons participating in cancer screening and management programs, which is why the number of cancer cases has increased. This is due primarily to improved public awareness. For example, in 2011, 17,576 women participated in the breast screening program, and in 2015 the number of women increased to 21,511. The number of men participating in the prostate screening program nearly tripled during same period. However, the number of women who received cervical screening in 2015 decreased.[429] After the implementation of the national cancer screening program (see below) the share of cancer detected at an early stage increased among all cases, but cancer defined at a late stage is still quite high, at 56% in 2015.[430]

Government and other actions

The aim of the national cancer screening program is to identify individuals with abnormalities suggestive of a specific cancer or pre-cancer who have not developed any symptoms, and to refer them promptly for diagnosis and treatment. The screening programs for reproductive cancer have the following eligibility criteria:

- Breast cancer screening provides free breast screening every two years for all women in Georgia aged 40 to 70.

424 WHO, Global Action Plan for Prevention and Control of Non-communicable Disease 2013-2020 available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1
425 CESCR GENERAL COMMENT 22, para 18
426 CESCR GENERAL COMMENT 22, para 45
427 National Center for Disease Control and Public Health of Georgia, Reproductive Age Mortality Survey. 2014.
428 MoLHSA., Palliative care of incurable patients, 2017available at: http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=822&info_id=859 Accessed 21.08.2017
429 National Center for Disease Control and Public Health of Georgia, Statistics Yearbook. 2015.
430 National Center for Disease Control and Public Health of Georgia, Health Care. Statistic Yearbook. 2015.

- Cervical cancer screening provides free cervical screening every three years for all women in Georgia aged 25 to 60.
- Prostate cancer risk management offers a PSA test every year to all men in Georgia aged 50 to 70.[431]

These screening programs have been provided throughout the country since 2011.[432]

In 2013, the State implemented the Universal Health Care (UHC) program for the entire population. The program covers planned out-patient, emergency in- and out-patient services, elective surgery, obstetric care as well as cancer treatment.[433] Cancer screening, follow-up to positive screening tests and the treatment of pre-invasive or in-situ disease is provided free of charge to all target populations. Cancer treatment coverage through the Universal Health Care (UHC) program, includes chemotherapy, hormonotherapy, radial therapy and all related diagnostic testing with an annual limit of 12,000 GEL. There is a 20% co-payment for those 18 years of age and older, and all treatment costs are covered for those under 18. Those whose income exceeds 40,000 GEL are not covered.[434]

In order to improve the epidemiological surveillance of cancer, the Population Based Cancer Registry (CPR) was established and implemented since 2015. The registry has contributed to a better understanding of cancer epidemiology in terms of prevalence of cancer and distribution within clinical stages of different types of cancers.[435]

WHO recommends vaccination against human papillomavirus (HPV), if cost-effective and affordable, according to national programs and policies.[436] While Georgia has not yet provided the HPV vaccine across the country, vaccination of nine year old girls will start in four regions. The Global Alliance for Vaccines and Immunization (GAVI) is implementing a two-year project, providing the possibility to countries to provide free vaccinations for about 15,000 girls. The project will be implemented during 2017-2019 in Georgia.[437] Georgia starting implementation of this project in 2017.

Discrepancies

Availability and accessibility, including affordability, are the main barriers to cancer screenings and treatment in Georgia. The screening programs have not been integrated into the primary health care services. Consequently, there are geographical and financial barriers for utilization of screening programs. For example, PAP smears, clinical breast examinations and mammograms, radiotherapy, chemotherapy, and community home care for people with advanced stages of cancer are generally not available at the primary health care level because at this level there are inadequate technical facilities and equipment and a lack of trained providers with the technical capacity to perform such screenings.[438] These conditions require persons to travel in order to receive services, increasing their indirect costs linked to accommodation and travel.

431 The National Cancer Screening Program.2017. National Cancer Screening Committee, available at: http://gnsc.ge/?lang=en

432 The National Cancer Screening Program.2017. National Cancer Screening Committee, available at: http://gnsc.ge/?lang=en

433 Universal healthcare, Ministry of Labour, Health and Social Affairs of Georgia see: http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=888. Universal Health Care. 2017

434 National Center for Disease Control and Public health of Georgia, National Cancer Strategy. 2017-2020.

435 MoLHSA., Palliative care of incurable patients 2017. available at: http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=822&info_id=859 Accessed 21.08.2017

436 WHO, Global Action Plan for Prevention and Control of Non-communicable Disease 2013-2020 available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

437 National Center for disease control and public health, 2017 (unpublished document)

438 Ministry of Labour, Health and Social Affairs. Treatment of breast cancer by Herceptin. 2016

The utilization of the cancer screening programs (breast, cervical, prostate and colorectal) is significantly low. One of the barriers was that until 2013 the government did not finance treatment and people avoided utilising screening programs. However, while Georgia has implemented cervical cancer screening with PAP-smear free of cost, as per WHO recommendations,[439] treatment of pre-cancerous lesions is not free of charge,[440] which has dissuaded people from getting tested in the first place.

Earlier public information campaigns related to cancer screening have been discontinued and currently there are no public awareness programs funded by the state or by municipal programs.

Recommendations:

- Integrate screening programs into primary health care services across the country.
- Develop and implement public awareness raising programs on reproductive and breast cancers that also inform people about available screening and treatment programs.
- Introduce HPV vaccination programs on a country-wide basis, guaranteeing that vaccinations are based on informed consent and without coercion or discrimination.

439 WHO, Global Action Plan for Prevention and Control of Non-communicable Disease 2013-2020 available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

440 WHO, Global Action Plan for Prevention and Control of Non-communicable Disease 2013-2020 available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1

ARTIFICIAL REPRODUCTIVE TECHNOLOGY (ART): THE SITUATION CONCERNING SURROGACY

Health and Human Rights considerations

Medical progress and new technologies have made it possible to save mothers and children who, only a few years ago, would have perished. Developments make new treatments possible and existing forms of treatment more accessible, and increase women's ability to have safe and healthy pregnancies, even if previously infertile. However, certain technological developments in the field of assisted reproductive technologies (ART) and assisted pregnancies raise a number of ethical issues.[441] Among these is the practice of surrogacy, which is permitted under the laws of Georgia.

Surrogacy indicates the relocation of a fetus into a woman's body for the purpose of further nurture and transfer to other persons. It can follow either *in vitro* or natural fertilization and it can be done through embryo transplantation. The 'surrogate mother' (or gestational carrier[442]) carries the pregnancy for nine months after which, at birth, the child will be transferred to another individual or couple.[443]

Surrogacy can be either partial – when the surrogate mother is also the genetic mother – or full – when donor's *in vitro* fertilized egg is implanted in the surrogate mother.

Altruistic surrogacy consists of the voluntary bearing of the pregnancy by the surrogate mother, who receives no financial compensation beyond the coverage of expenses related to the pregnancy. Conversely, commercial surrogacy, which is prohibited even in some of the countries allowing for altruistic surrogacy, involves a pre-agreed remuneration which motivates the gestational carrier to enter the surrogacy agreement for financial purposes.[444]

From a human rights' perspective, human rights guarantee the right to benefit from scientific progress, and the right to private and family life, to which surrogacy can be considered a part, amongst other rights. Surrogate motherhood requires careful considerations with respect to the rights of all the subjects involved: the surrogate mother, the client parent(s) and the child.

Government and other actions

In Georgia, surrogate motherhood is regulated by the Law on Health Care (Article 143), the Law on Civil Acts (Article 30) and the Law on Registration Procedure of Civil Acts (Article 19).

441 UNFPA, OHCHR, The Danish Institute for Human Rights, Reproductive rights are human rights. A handbook for national human rights institutions.

442 Gestational carrier definition: a woman in whom a pregnancy resulted from fertilization with third-party sperm and oocytes. She carries the pregnancy with the intention or agreement that the offspring will be parented by one or both of the persons that produced the gametes. See WHO, Current Practices and Controversies in Assisted Reproduction
Report of a meeting on "Medical, Ethical and Social Aspects of Assisted Reproduction" held at WHO Headquarters in Geneva, Switzerland, 17–21 September 2001, Edited by Effy Vayena, Patrick J. Rowe, P. David Griffin.

443 Nino Kariauli, Surrogacy and its legal consequences according to the legislation in Georgia, European Scientific Journal, December 2016, pp.215-222.

444 UNFPA, Sama Resource Group for Women and Health, Surrogacy information brief, 2014, available at http://india.unfpa.org/sites/default/files/pub-pdf/SurrogacyInfobrief-1.pdf

Article 143 of the Law on Health Care on *in vitro* fertilization (IVF) provides that: in vitro fertilization shall be allowed 'to treat infertility, if there is a risk of transmitting a genetic disease from the 'wife' or the 'husband' to the child, using the gametes or embryo of the couple or a donor, if a written consent of the couple has been obtained; if a woman does not have an uterus, by transferring the embryo obtained as a result of fertilization to the uterus of another woman ('surrogate mother') and growing it there; obtaining a written consent of the couple shall be obligatory.' The law notes that 'If a child is born, the couple shall be deemed parents, with the responsibilities and authorities proceeding from this fact; the donor or the 'surrogate mother' shall not have the right to be recognized as a parent of the born child.'

Article 30 of the Law on Civil Acts provides that the birth registration of a child born as a result of extracorporeal fertilization shall be carried out in accordance with the Law on Civil Acts itself, the Law on Health Care and the dispositions set out in the Civil Acts Registration Procedure, detailed in Article 19, which provide that the following documentation needs to be submitted to the civil acts registration entity: a document certifying the extracorporeal fertilization issued by the medical center directly upon the embryo implantation and an agreement concluded and notarized prior to the extracorporeal fertilization. Article 19 further clarifies that it is prohibited to refer to the donor or surrogate mother as to the child's parent in the civil birth record.

Discrepancies and developments

In order to improve national legislation, a consultation meeting in 2014 organized by the MoLHSA, the Ministry of Justice, the Healthcare and Social Affairs Committee of the Parliament and the Maternal and Child Health Coordination Council with the technical support of the UNFPA Country Office in Georgia was held to exchange views and collaboratively build a regulatory framework for surrogate motherhood in Georgia.[445] One of the concerns regarding the current domestic legal framework is that it does not recognize any right to the gestational carrier, thus appearing to encourage commercial surrogacy.[446]

A consensus was found over developing a regulatory system of control designed not to encourage surrogacy arrangements but to restrain their harmful effects on individuals and wider society to which uncontrolled surrogate motherhood arrangements and incentives might lead.[447] The participants concluded that while a theoretical case might be made for the legal prohibition of surrogate motherhood arrangements, such prohibition could result in aggravating the risk of harm to vulnerable young women, as a result of the prohibition's likely circumvention and the subsequent development of uncontrolled clandestine surrogacy. For this reason, the participants concluded that an absolute prohibition of surrogacy agreements should not be recommended as national policy.

The framework provides for a regulatory agency to be established where IVF licensed clinics and practitioners would be required to register the surrogacy agreement and also sets out a number of criteria to be respected for the surrogacy agreement to be valid, aiming at guaranteeing the human rights of the surrogate mother and the child: intended parents' infertility (to discourage surrogacy pursued for trivial reasons), legal marriage of the client couple, established residence in Georgia (to avoid reproductive-tourism), age criteria (to promote the young woman's greater maturity and understanding of the possible consequences of her action for her own future health and childbearing), payment (in order for it not to amount to an undue inducement to provide surrogacy services), data gathering (by the government).

To date, however, this framework has not been implemented.

445 Bernard M. Dickens, University of Toronto, Report on the UNFPA Consultation on Surrogate Motherhood Law in Georgia, 9-10 June 2014.

446 Nino Kariauli, Surrogacy and its legal consequences according to the legislation in Georgia, European Scientific Journal, December 2016, pp.215-222.

447 Bernard M. Dickens, *Ibidem.*

Recommendations

The following are recommendations defined during the Consultation of 9-10 June 2014:

- Establish a Regulatory Agency within or accountable to an appropriate ministry endowed with both a monitoring role with respect to the surrogacy agreements and a proactive function in drafting a template for surrogate motherhood arrangements.
- Entrust the regulatory agency with a monitoring function with respect to payment arrangements, in order to ensure that they are equitable, sufficient to cover the costs related to the pregnancy and not exploitive of the vulnerability of potential surrogate mothers but not so generous as to amount to an undue inducement to surrogacy services.
- Entrust the regulatory agency with a counseling function consisting of: advising prospective participants in surrogate motherhood arrangements, inter alia, on the risks related to pregnancy and natural or surgical childbirth to potential surrogate mothers and on the implications of surrendering a child at birth, particularly one's own genetic child in traditional surrogacy; disclosing to potential parents information, inter alia, on the chances of spontaneous or medically justified induced miscarriage and the emotional and financial burdens of such misfortune and of receiving and being responsible for a severely disabled child due to a genetic inheritance, or to congenital causes.
- Establish criteria of infertility as to ensure that recourse to surrogate motherhood is a last resort in the search for parenthood.
- Ensure non-discrimination in access to surrogacy arrangement, including on grounds of marital status and sexual orientation.
- Include established residence in Georgia as a necessary requirement in order to enter a surrogate motherhood arrangement, in order to prevent the emergence of possible "reproductive-tourism" practices.
- Establish a minimum age threshold for the gestational carrier, superior to the age of adult-status corresponding to 18 years of age as of the Convention on the Rights of the Child (CRC), in order to promote the surrogate mother's maturity and understanding of the possible consequences of her decisions on her own future health and childbearing; to possibly establish age criteria also for the client parents, while respecting the human rights standards which prohibit discrimination on grounds of age.
- Establish data collection and its periodic submission to the regulatory Agency or to other appropriate national institutions as a necessary condition for the granting of a license to provide medically assisted human reproduction services.

RIGHTS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH AND PARTICULARLY MARGINALIZED AND DISADVANTAGED GROUPS

Equality and non-discrimination in the enjoyment of human rights are fundamental principles expressly recognized in all the international instruments protecting human rights and fundamental freedoms. They are also enshrined at the national level in the Constitution of Georgia and in national laws such as the Law on the Elimination of all forms of Discrimination (2014) which also protects, *inter alia,* the right to health. Yet, persons belonging to marginalized and vulnerable groups face many obstacles which prevent them from enjoying the human rights they are entitled to, including the right to the highest attainable standard of health which comprises the right to sexual and reproductive health.

The full enjoyment of the right to sexual and reproductive health remains a distant goal for millions of people, especially for women and girls, throughout the world.[448] Certain individuals and population groups experience multiple and intersecting forms of discrimination that exacerbate exclusion in both law and practice, and that States must address. Among these are, lesbian, gay, bisexual, transgender and intersex persons (LGBTI), women with disabilities, women sex workers, women who use drugs, internally displaced women and conflict-affected women, women members of ethnic minority groups, youth and adolescents.[449]

In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distributions of power based on gender, ethnic origin, age, disability and other factors. Poverty and income inequality, systemic discrimination, and marginalization are all social determinants of sexual and reproductive health, which also impact the enjoyment of an array of other rights, including the right to an effective remedy, access to justice, the right to an adequate standard of living and the right to social security.[450]

As the right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health, it must include the four essential elements identified by the Committee on Economic, Social and Cultural Rights in its General Comments No. 14 and 22. Non-discrimination must therefore be guaranteed by States with respect to the accessibility (physical accessibility, affordability, and information accessibility), acceptability and quality of all sexual and reproductive health services. (See section above)

For example, physical accessibility to hospitals, shelters and other healthcare facilities should be ensured especially for persons belonging to disadvantaged and marginalized groups. Essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses.

All individuals and groups, including adolescents and youth, have the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections and HIV prevention, safe abortion and post abortion care, infertility and fertility options, and reproductive cancers. Such information must be provided in a manner consistent with the needs of the individuals and community, taking into consideration, for example, age, gender, language ability, educational level, disability, sexual orientation, gender identity and sex characteristics. Information

448 CESCR GENERAL COMMENT 22, 2016.
449 CESCR General Comment 22, 2016; UN Special Rapporteur on the Right to Health report on the right to health of adolescents (2013).
450 CESCR GENERAL COMMENT 22, 2016.

accessibility should not impair the right to have personal health data and information treated with privacy and confidentiality.

All facilities, goods, information and services related to sexual and reproductive health must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender, age, disability, and sexual diversity and life-cycles requirements.

Non-discrimination and equality require not only legal and formal equality but also substantive equality. Substantive equality requires that the distinct health needs of particular groups, as well as any barriers that particular groups may face, are addressed. The sexual and reproductive health needs of particular groups should be given tailored attention. For example, persons with disabilities should be able to enjoy not only the same range and quality of sexual and reproductive health services but also those they would need specifically because of their disabilities. Further, reasonable accommodation must be made to enable persons with disabilities to fully access sexual and reproductive health services on an equal basis, such as physically accessible facilities, information in accessible formats and decision-making support, and States should ensure that care is provided in a respectful and dignified manner that does not exacerbate marginalization.[451]

Earlier this year, UN agencies issued a joint statement recognizing that discriminating in health care settings is a violation of the most fundamental human rights protected in international treaties and in national laws and constitutions. The statement notes that discrimination in health care settings is directed towards some of the most marginalized and stigmatized populations and calls on states to end such discrimination through legal and regulatory measures and training of the health care work force.[452]

Whereas discrimination affects access to health and to other social services and the enjoyment of the human rights of persons marginalized on many different grounds, in this report we have selected marginalized groups which are particularly vulnerable in their access to sexual and reproductive health services. Since the focus is on sexual and reproductive health and related rights, which impact women in particular, due to prevalence of violence and biological and social factors, a focus has been placed on groups of marginalized women experiencing intersectional discrimination. Further information on the health and rights of the marginalized groups addressed below can also be found in other chapters of this report. Note that information on persons living with HIV is included in the section on HIV.

In addition to these human rights obligations that Georgia must implement, human rights bodies have repeatedly made recommendations to Georgia to address the health and social needs of vulnerable populations, including adolescents and youth, rural women, ethnic minorities, Roma, LGBTI, women who use drugs, etc. and to work towards eliminating discrimination and prejudices in law and in practice against such vulnerable groups (see Chapter 1).[453]

451 CESCR General Comment 22.

452 Joint United Nations Statement on ending discrimination in health care settings (2017).

453 Committee on the Rights of the Child, Concluding observations on the fourth periodic report of Georgia, 9 March 2017, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/GEO/CO/4&Lang=En; Human Rights Committee, Concluding observations on the fourth periodic report of Georgia, 19 August 2014, CCPR/C/GEO/CO/4, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR/C/GEO/CO/4&Lang=En;
Committee on the Elimination of Discrimination against Women, Concluding observations on the combined fourth and fifth periodic reports of Georgia, 24 July 2014, CEDAW/C/GEO/CO/4-5, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GEO/CO/4-5&Lang=En; Committee on the Elimination of Racial Discrimination, Concluding observations on the sixth to eighth periodic reports of Georgia, 13 May 2016, CERD/C/GEO/CO/6-8, available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD/C/GEO/CO/6-8&Lang=En

1. LGBTI

Lesbian, gay, bisexual, transgender and Intersex (LGBTI) persons represent one of the most marginalized and least visible groups in Georgia. Despite achieving a degree of success in recent years with the adoption of the Law on the Elimination of All Forms of Discrimination (2014) with the explicit indication on sexual orientation and gender identity (SOGI) as a prohibited ground of discrimination, members of the group continue to face violence, oppression and harassment from the general public, as well as from specific institutions, including medical facilities and the workplace.[454] Bias-motivated violence based on SOGI frequently goes unreported and, hence, remains without proper investigation and reparation.[455]

Discrimination of marginalized groups and violations of sexual rights can lead to limited access to health and education because of an individual's non-conforming sexual behavior, expression, and identity. Physical aggression against LGBTI people creates insecurity, especially for poor and already powerless people. Discrimination on the basis of SOGI in healthcare can prevent access to health insurance or proper medical care, which can leave many people outside social networks and may push them into poverty.[456]

With regards to legislation on access to healthcare and non-discrimination, in addition to the Constitution of Georgia[457] and the Law on the Elimination of All Forms of Discrimination, the prohibition of discrimination is also enshrined in the Law of Georgia on the Protection of the Right to Healthcare, according to which discrimination on the grounds of sexual orientation or negative personal attitude is prohibited.[458] Additionally, the Law of Georgia on the Rights of Patients, which aims to protect the rights of citizens in the healthcare system, further prescribes the respect for the dignity of all patients.[459]

Nonetheless, several studies conducted in Georgia show existing practices of discrimination and violation of the rights to private life and confidentiality of LGBTI persons by health-care professionals and health service providers in general.[460] A lack of awareness among medical personnel, existing negative stereotypes towards LGBTI persons, and ignorance of the specific medical needs of transgender persons constitute barriers for patients to get quality medical services.[461]

According to such studies, members of LGBTI groups often refrain from seeking medical services and choose self-medication in order to avoid the negative attitudes of doctors.[462] In certain cases, expectations of a negative or indifferent attitude from doctors result in destructive actions, such as giving incorrect information to doctors that would influence the medication or treatment methods chosen by them.[463]

It is worth noting that healthcare needs of LGBTI groups are not analyzed and assessed by the State in Georgia.

454 L. Jalagania "Legal Situation of LGBTI Persons in Georgia», EMC, 2016, available at: https://emc.org.ge/2016/06/03/emc-78/ / ლ.

455 L. Jalagania, "Operational Guideline on Investigation and Prevention of Crimes based on Sexual Orientation and Gender Identity", EMC, 2017, available at: https://emcrights.files.wordpress.com/2017/05/gender-crime-web.pdf

456 See generally, OHCHR, Born Free and Equal; N. Gvianishvili, The Needs of Transgender Persons in Health Care Sphere, WISG, 2015. Available at: http://women.ge/data//WISG%20Needs%20of%20Transgender%20persons%20in%20Healtcare%20(policy%20paper).pdf

457 Article 37

458 Art.6

459 Art. 1

460 L. Jalagania "Legal Situation of LGBTI Persons in Georgia», EMC, 2016, available at: https://emc.org.ge/2016/06/03/emc-78/ , N. Gvianishvili, The Needs of Transgender Persons in Health Care Sphere, WISG, 2015. Available at: http://women.ge/data//WISG%20Needs%20of%20Transgender%20persons%20in%20Healtcare%20(policy%20paper).pdf Additionally, see Tanadgoma, HIV Infection/AIDS and its Connected Stigma and Discrimination Among Homosexual Men in Georgia, 2012, see: http://new.tanadgomaweb.ge/upfiles/dfltcontent/1/110.pdf.

461 E. Aghdgomelashvili et al., Discrimination and Hate Crime against LGBT Persons, WISG, 2015. See: http://women.ge/data/docs/publications/WISG_discrimination_and_hate_crime_against_lgbt_persons_KA_EN_2015.pdf

462 Ibid, p. 144

463 N. GvianiSvili "Situation of Transgender People in Georgia", WISG, 2015, p. 59, available at: http://women.ge/data/docs/publications/WISG_Transgender_survey_2015.pdf

Although homosexuality was removed from the International Classification of Diseases (ICD) by the World Health Organization in 1990, it is still considered a disease and deviation by some medical personnel in Georgia – individual representatives of the healthcare sector view homosexuality as a problem requiring medical intervention.[464] Furthermore, some medical textbooks view homosexuality as a behavioral disorder.[465]

Access to healthcare services for transgender persons is substantially limited due to the medicalization of "transgender" identity and stigma. Currently, the healthcare system in Georgia uses an internationally recognized classification system ICD-10, which classifies "transgenderism" as a mental disorder;[466] thus, the existing healthcare system in Georgia assumes "a completely medicalized and pathological approach towards transgender persons and does not recognize its wide spectrum"[467] and that not all transgender people want and/or need surgical interventions to be comfortable in their own body. Furthermore, "Terminological confusion of sex and gender is a prevailing problem in the ICD-10 Georgian publications, which is a key issue in the process of de-pathologization of transgenderism."[468]

Furthermore, national legislation does not address possibilities for sex change, but according to existing practice, medical interventions (including, sex reassignment surgery) are set as a prerequisite for changing the gender marker in identification documents. As a result, expensive and intrusive medical procedures are not at all financed by the state and more importantly, may be unwanted. Transgender people are thus left without identification documents which accurately reflect their gender identity, resulting in social exclusion violating their rights to health and privacy, and creating major obstacles to the enjoyment of many other fundamental human rights.[469]

2. Female sex workers

Even if discrimination is prohibited on open-ended grounds by the Law on the Elimination of All Forms of Discrimination (2014), such principle is not enforced with regards to sex workers, in any setting.

One NGO estimates that there are 6,785 female sex workers in Georgia[470] and they experience some of the most insidious forms of violence and discrimination and lack of access to justice and health services, including sexual and reproductive health. They are particularly vulnerable to physical, psychological, sexual and economic violence and intersecting forms of discrimination.[471]

Although sex work is not a criminal offence, sellers (not buyers) of sex are subjected to administrative penalties under the Administrative Offences Code of Georgia. Under Art. 172^3 of the Code, 'prostitution' shall carry a warning or a fine of up to one half of the monthly minimum wage, which amounts to 40 GEL.[472] The same act committed within one year after the imposition of an administrative penalty – shall carry a fine from one half to one minimum wage. The Code provides no definition of 'prostitution'.

464 (E.Aghdgomelashvili et al. "Discrimination and Hate Crimes against LGBT persons in Georgia", WISG, 2015, p. 145

465 For an example see also the residency curriculum in pediatrics. Article 3. Module 3. Pediatrics of Development and Behavior. o) "Sexual behavior/sex identification disorders: masturbation, trans-sexuality, transvestism, homosexuality"(as cited in E. Aghdgomelashvili et.al "Discrimination and hate crimes against LGBT persons", WISG, 2016, p. 140)

466 WHO, ICD-10, F64. available at: http://apps.who.int/classifications/icd10/browse/2016/en#/F64

467 N. Gvianishvili, "The Healthcare Needs of Transgender People, a public policy document', WISG, 2015, p. 33

468 E. Aghdgomelashvili et.al "Discrimination and hate crimes against LGBT persons", WISG, 2016, p. 140, ref. 108.

469 L. Jalagania "Legal situation of LGBTI persons in Georgia", EMC, 2016; CESCR General Comment 22; Council of Europe Commissioner for Human Rights, Discrimination on Grounds of Sexual Orientation and Gender Identity in Europe (2011).

470 Population Size Estimation of Female Sex Workers In Tbilisi and Batumi, Georgia 2014, Study Report August 2014 Prepared by: Curatio International Foundation and Center for Information and Counseling on Reproductive Health – Tanadgoma, p.23 available at: http://new.tanadgomaweb.ge/upfiles/dfltcontent/1/150.pdf

471 Alternative mid-term report of the Georgian Young Lawyers' Association to the CEDAW Committee, dated 19 August 2016

472 The minimum wage is defined by the Decree of the President of Georgia, N351 on the Minimum Wage, 4 June 1999, Art. N1 and N3 (translated from Georgian).

Legislative amendments that came into force on 1 June 2017 as a result of the ratification of the Council of Europe Convention on Preventing and Combatting Violence against Women and Domestic Violence (Istanbul Convention) made it possible for every woman victim of gender-based violence to apply for restrictive and protective orders against the batterers, and not just for victims of domestic violence, as provided by past legislation. These mechanisms are applicable regardless of whether violence happens within the family or in the public sphere, thus enabling sex workers to apply for restrictive and protective orders against their clients, in cases where they are perpetrators of violence.[473]

Interviews conducted by NGOs show that sex workers mainly experience physical, verbal and sexual violence by their clients.[474] They also report verbal abuse by the police, particularly transgender sex workers, and incidences of police asking them for sex in return for not imposing fines on them.[475]

Sex workers face a number of obstacles in accessing justice for gender-based violence, including: lack of legal awareness; fear off administrative penalties and police persecution for sex work; fear that they will be coerced by the police to identify persons who commit criminal offences related to sex work (e.g. persons from whom they rent property); social stigma preventing them from seeking remedy (fear that sex work will become known by their friends and relatives); ineffective response of the police when sex workers report violations; abuse by the police (mostly verbal) when sex workers seek protection; fear of retaliation by the abuser before charges are brought against him.[476]

With regards to sexual and reproductive health data, sex workers are the least informed about treatment methods of sexually transmitted infections (only 27% claim to be well-informed on this).[477] About 40% of sex workers undergo health checks for STIs once every 3 months, and 49% only once every 6 months. Also, 77% of sex workers have never taken a Pap Smear Test (Cervical Screening) and 78% have never been administered the HPV vaccine.[478]

3. Women who use drugs

Available figures show that there are 45,000 injecting drug users in Georgia.[479] An earlier report indicates that approximately 10% are women.[480]

In Georgia, women who use drugs experience some of the most hidden forms of violence. They face double stigma based on their sex and their drug use, and face gross human rights abuses as a result of punitive drug policies. Some available data shows that 80% of women who use drugs have suffered abuse in their home.[481]

473 Article 10.1 of the Law of Georgia on Elimination of Violence against Women, Domestic Violence, Protection and Support of Victims of Domestic Violence

474 Among these, GYLA published an Alternative mid-term report of the Georgian Young Lawyers' Association to the CEDAW Committee, dated 19 August 2016, para. 35;

475 Alternative mid-term report of the Georgian Young Lawyers' Association to the CEDAW Committee, dated 19 August 2016, para. 35.

476 Alternative mid-term report of the Georgian Young Lawyers' Association to the CEDAW Committee, dated 19 August 2016, para. 37.

477 Research on the needs of sex workers and causes of discrimination, Hera XI, 2014, p. 15. available at: http://en.calameo.com/read/004110021894c3ad2d39d

478 Research on the needs of sex workers and causes of discrimination, Hera XI, 2014, p. 15-17. available at: http://en.calameo.com/read/004110021894c3ad2d39d

479 Global AIDS Response Progress Report: Georgia Country Progress Report 2014

480 Sirbiladze. T., *Estimating the prevalence of injecting drug use in Georgia: Consensus report.* Bemoni Public Union, 2010.

481 Bidzinashvili K. (2012), *'Results of domestic violence survey conducted within the framework of the Step+ project'.* Union «Step to the Future: Gori, Georgia p.11. On the question who is more frequent aggressor in their family – 55% of women answered that husband, 19% named permanent partner, 17% – mother or father in-law, 7% – other relatives and 2% – society.

Apart from a punitive drug policy and pervasive gender inequality, ineffective responses to violence against women who use drugs is rooted in the belief that these women "fail" to fulfill their traditional gender roles because of drug use; they are thus subjected to severe judgment and double standards as compared to men. As a result, violence against them is oftentimes considered acceptable and even justified as compared to other groups of women. Stigma and discrimination fosters violence, which, coupled with repressive state response, make these women particularly vulnerable to various forms of abuse.

Poverty and financial dependence on male partners is one more important barrier to ending domestic violence. As it was shown in the Formative Study of Drug-using Women in Georgia, women who use drugs are typically economically dependent on their male partners.[482] Lack of employment opportunities and having young children often leave drug using women to choose between two impossible situations: to remain in violent relationships compromising their safety or face potential homelessness.[483]

Reports show that women who use drugs in Georgia experience a number of obstacles to accessing health services, including: lack of information regarding treatment opportunities; hostile and judgmental attitude of health service providers; lack of confidentiality; stigma related to treatment entry; lack of services based on the needs of women drug users.[484]

Reports also show that drug users face discrimination in the access to State shelters for victims of domestic violence. Although the access to these services is not expressly prohibited to drug-using women, they are practically unavailable to them due to their failure to meet their needs, including with regards to methadone substitution treatment; women who use drugs also avoid applying to them due to lack of information and to fear of being identified as a drug user and facing criminal prosecution.[485]

Despite the heightened vulnerability of women who use drugs, Georgia lacks guidelines at the national level on providing reproductive health services to drug users. Therefore, women who use drugs do not have access to quality antenatal care and the drug treatment that they need during pregnancy and the postnatal period, which significantly increases the risk of poor maternal and child health and mortality.[486]

4. Internally displaced and conflict-affected women

Under the statistics of the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia, there are 273,411 internally displaced persons in Georgia.[487] 2015 data shows that 141,215 of them are women.[488]

482 Kirtadze, I., *A Formative Study if Drug-using Women in Georgia: Setting the Stage for an RCT,* Available at: http://www.slideshare.net/IrmaKirtadze/a-formative-study-of-drugusing-women-in-georgia-setting-the-stage-for-an-rct 14/28

483 Harm Reduction International, *Briefing paper on Violence against Women who use Drugs and Access to Domestic Violence Shelters,* March 2013, Available at: http://www.ihra.net/files/2013/03/19/Briefing_Paper_-_Access_to_Shelters_-_with_correct_fonts_07.03_.13_.pdf p. 3

484 I. Kirtadze, D. Otiashvili, K. O'Gradi, W. Zule, E. Krupitsky, W. Wechsberg, H. Jones, *'Risk and stigma in seeking care and policy implications', 2013 available* at: http://www.slideshare.net/IrmaKirtadze/risk-and-stigma-in-seeking-care-and-policy-implications

485 M. Khmelidze, Report on the Human Rights Situation of Women Who Use Drugs. Identification of Trends of Violations – Systemic, Domestic, Sexual and Other Forms of Violence, ACESO, Tbilisi, 2016 and Georgian Young Lawyers' Association, Alternative Report to the Committee on the Elimination of Discrimination against Women, Implementation of the Concluding Observations on the combined 4th and 5th periodic reports of Georgia on the Convention on the Elimination of All Forms of Discrimination against Women, 19 August 2016, Para. 32-33, p. 11.

486 Joint Submission of Georgian Harm Reduction Network and Eurasian Harm Reduction Network to the Committee on the Elimination of All Forms of Discrimination against Women, 58 Session, June 2014, P. 6-7

487 Information available at the web-page of the Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia, available at: http://www.mra.gov.ge/geo/static/55

488 Information available at the web-page of IDFI, available at: https://idfi.ge/ge/number-of-provided-living-areas-for-idps

The Law on Internally Displaced Persons from the Occupied Territories of Georgia (2014), provides for the determination of the legal status of an IDP, the basis and the procedure for granting, terminating, withdrawing and restoring the IDP status, the legal, economic and social guarantees, and the rights and duties of an IDP.[489] The Law provides for measures for protection of rights related to living accommodation of an IDP, including the provision of a living accommodation with satisfactory safety, health and sanitary conditions, and respect for the family unit.[490] Expenses for treatment at a medical institution of an IDP/IDP family registered in the unified database of socially vulnerable families are covered through State programs.[491]

The Maternal Health Strategy envisages that by 2030 women will have full access to and will utilize evidence-based preconception, antenatal, obstetric, neonatal, and post-partum care that meets their needs. One of the priority interventions identified to meet this goal is the development and implementation of a tailor-made, culturally-sensitive program to ensure improved undisrupted accessibility and availability of services for under-served groups in their own settings, including Internally Displaced Women.[492] In spite of this, IDP women living in IDP settlements lack access to sexual and reproductive health and services information. Women in IDP settlements can receive gender-specific health services, such as gynecological examination, either in the settlement or in other cities. They note that sometimes traveling for health services could be problematic. In addition, the ban on abortion in Abkhazia (see above section on abortion) poses serious problems for women in need of such services. Availability of state-funded psychological services is problematic in all the areas.[493]

The Mental Health Strategy and Action Plan of 2015-2020[494] states that one of its guiding principles is to meet the needs of particularly vulnerable groups, including women and IDPs. However, the Strategy and the Action Plan do not envisage any specific measures tailored to the needs of women, IDPs and people living in the conflict-affected areas (including women) and they do not specifically address mental health consequences of conflict-related sexual violence. IDP and conflict-affected women, including the ones living adjacent to the Administrative Boundary Line (ABL) with South Ossetia, report that they lack information and access to psycho-rehabilitation services.[495]

5. Ethnic minorities

Based on the results of 2014 General Population Census, 86.8% of the population of Georgia consists of ethnic Georgians, with Azeri and Armenians being the two largest minority groups.[496] Azeris account for 6.3% of the total population and they constitute a significant group in the region of Kvemo Kartli, which borders Armenia and Azerbaijan to the south. The Armenian minority accounts for 4.5% of the total population and it is a significant group in the region Samstkhe Javakheti bordering Turkey and Armenia in the south.[497] Other smaller ethnic groups include Russians, Ossetians, Yezidis, Ukrainians, Chechens, and Greeks.[498] Moreover, Georgia has small populations of ethnic Roma and Meskhetians.[499]

489 The Law on Internally Displaced Persons from the Occupied Territories of Georgia (2014), Article 2
490 The Law on Internally Displaced Persons from the Occupied Territories of Georgia (2014), Art. 14.6. c
491 The Law on Internally Displaced Persons from the Occupied Territories of Georgia (2014), Art. 16.2
492 Georgia Maternal & New-born Health Strategy 2017-2030, P. 18.
493 Written information provided by the Public Defender on 5 September 2017.
494 Resolution of the Government of Georgia №762, 31 December 2014, (translated from Georgian) available at: https://matsne.gov.ge/ka/document/view/2667876
495 Written information provided by the Public Defender on 5 September 2017.
496 GEOSTAT, 2014 General Population Census, Main Results, 28.04.2016, p. 8, see: http://geostat.ge/cms/site_images/_files/english/population/Census_release_ENG_2016.pdf
497 Ibid
498 Ibid
499 The Norwegian Country of Origin Information Centre – Landinfo, Query response Georgia: The situation of ethnic minorities, 14 FEBRUARY 2017, p.1, available at: http://www.landinfo.no/asset/3550/1/3550_1.pdf

The Georgian Constitution states that all citizens of Georgia shall be equal in social, economic, cultural and political life, irrespective of their national, ethnic, religious or linguistic belonging. Protection from discrimination based on the ethnic origin of a person is also included in the Georgian anti-discrimination law.[500] In addition, Article 6.1 of the Law on the "Rights of the Patients" explicitly states that "discrimination of the patient based on […] national, ethnic origin should be prohibited".

Nonetheless, persons belonging to ethnic minorities face obstacles in their access to rights, remedies, public services (e.g. healthcare, social assistance), employment and higher education, which seem to be enhanced by their lack of proficiency in the Georgian language.[501]

Women who are part of minority communities are particularly challenged in their access to healthcare facilities and medical services; as stated in a study conducted in 2014, "minority communities, and particularly minority women, do not have proper access to the healthcare system. Existing medical facilities do not allow for adequate medical services to be delivered."[502] In addition, there are no specialized medical services for women.[503]

Although hospitals operate in most of the areas residing by ethnic groups (Akhalkalaki, Ninotsminda, Akhmeta, Telavi, Kvareli, and Lagodekhi,) they often lack necessary medical equipment and hence the local population is forced to travel in order to visit larger medical institutions in regional centers or in the capital.[504] This is an additional burden particularly for women and especially when they are in need of timely SRH services.

Higher abortion rates among rural women, less educated women, and women of Azeri descent[505] suggest that access to services is unequal and that Georgia's family planning program needs to expand its reach to disadvantaged subgroups. Rates of unplanned pregnancy were higher among women with the lowest education level and those with the lowest wealth quintile. They were also higher among women with an Azeri (36.3) or Armenian (31.6) background than among Georgian women (24.7).[506]

The Reproductive Health Survey issued in 2010 shows that Azeri women are almost twice as likely as Georgian women to experience violence within their marriages.[507]

Women living in rural areas, which include ethnic minorities, do not enjoy the same access to information that women living in urban areas do regarding their rights, service provision for victims of violence, economic empowerment and access to employment that would allow them to leave abusive situations and break the cycle of violence.[508] Additionally, existing language barriers among minority groups prevents some women from reporting cases of violence, in particular because of the lack of interpretation services.[509]

500 Article 1

501 Report By Nils Muižnieks Commissioner For Human Rights of The Council of Europe Following His Visit To Georgia From 20 To 25 January 2014, Strasbourg, 12 May 2014 , Par. 77, available at: https://www.ecoi.net/file_upload/1226_1400594411_com-instranetgeorgia.pdf

502 Un Women, ECMI, Commissioned Study, Needs Assessment Of Ethnic Minority Women In Georgia, Tbilisi, 2014, pp. 31-32, See: http://ecmicaucasus.org/upload/Ethnic%20Minority%20Women_Eng.pdf

503 Ibid.

504 Ibid.

505 NCDC, Reproductive Health Survey, 2010, Table 5.2.1, p. 76

506 Ibid, P. 47; p. 57-Table 4.6

507 NCDC, Reproductive Health Survey, 2010, p.312

508 Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to Georgia, A/HRC/32/42/Add.3, June 9 2016, Para. 36

509 Ibid.

There are no specific statistics on the practice of Female Genital Mutilation (FGMs) in Georgia.[510] However, according to the information provided by the Prosecutors Office of Georgia, FGM exists among the Avari community living in Kvareli, Kakheti region, for example.[511] Based on the information received from MoLSHA, local communities have been covering information on FGMs due to the increased interest from the society and the media.[512]

A special emphasis should be placed on the situation of the Roma community in Georgia, who face extreme marginalization and discrimination, leading to poverty, unemployment, lack of access to education and healthcare. Due to a lack of access to proper documentation, Roma people are also excluded from social security programs.[513]

Also, due to dense cohabitation, in areas inhabited by Roma communities there are often outbreaks of diseases among women and children. In such situations, access to treatment is rather discriminatory:

Roma women often suffer from unequal treatment and are not admitted to maternity wards. They are forced to give birth at home, as hospitals do not accept them.[514]

6. Persons with disabilities

Although Georgia ratified the United Nations Convention on the Rights of Persons with Disabilities in 2014, which contains explicit provisions guaranteeing sexual and reproductive rights and ensuring non-discrimination in access to services, major challenges in the process of effective implementation of the Convention remain. In addition, despite recommendations from the Public Defender, the Optional Protocol to the Convention has not been yet ratified and no substantial changes have occurred in terms of harmonization of the national legislation with the requirements of the Convention.[515]

National laws and programs protecting the rights of persons with disabilities include the Law of Georgia on Social Protection of Persons with Disabilities (1995), the Law on the Elimination of All Forms of Discrimination (2014) and the Labor Code of Georgia (2010). However, the Non-Discrimination provisions of the Constitution of Georgia (1995), the Law on the Rights of Patients (2000) and the Law on Health Care (1997) do not explicitly include disability as a protected ground from discrimination, and most state policies in the field of health and human rights do not address women and girls with disabilities as independent target groups.[516]

While persons with disabilities are covered by State medical insurance,[517] it is reported that women with disabilities, including mental health-related disabilities, do not have access to disability-sensitive health, including reproductive and sexual health services. The Coalition for Independent Living reports that in Georgia women with physical disabilities cannot access gynecological services, as gynecological wards are not adapted for wheelchair users and they also lack access to information about reproductive health and rights.[518]

510 Letter from the Ministry of Internal Affairs of Georgia, No: 158824.
511 Letter from the Prosecutors Office of Georgia, No: 08-2/504
512 Letter from the MoLSHA, No: 01/4252
513 Heidrun Ferarri "Partnership for all? Measuring the impact of eastern partnership on minorities", p. 17, available at: http://minorityrights.org/wp-content/uploads/old-site-downloads/download-1373-Policy-paper-English.pdf
514 Un Women, ECMI, Commissioned Study, Needs Assessment Of Ethnic Minority Women In Georgia, Tbilisi, 2014, pp. 50-51
515 PDO, Report on the Rights of Persons with disabilities, 2016, available at http://www.ombudsman.ge/uploads/other/4/4563.pdf
516 PDO, Report on the Rights of Persons with disabilities, 2016, available at http://www.ombudsman.ge/uploads/other/4/4563.pdf
517 The social package for persons with disabilities in Georgia provides free healthcare insurance and, in some cases, an additional monetary allowance.
518 Interview, with Ketevan Khomeriki, Chief Lawyer at the Coalition for Independent Living, dated 01.08.2017

Moreover, women with psycho-social needs are locked up in homes by their families to prevent them from having sexual contacts and are administered medication to refrain from sexual activity. Doctors also advise women with disabilities not to have children, as they are not "physically fit" for pregnancy.[519] Such practices are in violation of the Convention on the Rights of Persons with Disabilities.

Also, it appears that the shelters for victims of violence against women and domestic violence are fully adapted for all kinds of disabilities.[520]

Data collection on persons with disabilities in Georgia is limited to the statistics gathered by the Social Service Agency on persons who receive assistance from the State based on their disability status. Therefore, the statistics are generated on the grounds of information provided by persons with disabilities themselves, based on self-identification, which cannot give complete and precise information about persons with disabilities and their needs.[521]

The Government Action Plan 2014-2016 for Ensuring Equal Opportunities for Persons with Disabilities provides for conducting surveys on the identification of social needs (among them the specific needs of women and children) and setting of priorities.[522] As to reproductive health issues, the Action Plan provides for conducting a survey on reproductive health knowledge, understanding and behavior in all the relevant age groups of persons with disabilities.[523] The Action Plan also provides for raising awareness among persons with disabilities on reproductive health issues, including on life skills education through trainings. These trainings should consider the specific needs of persons with various disabilities and take into account their age.[524] As of September 2017, it does not appear that these activities have been implemented.[525] In addition, the state has yet to ratify the optional protocol on individual complaints and inquiry procedures to the Convention on the Rights of Persons with Disabilities.

7. Youth and adolescents

As of January 2016, there were 746,100 young people aged 15-29 in Georgia, constituting 20.05% of the total population.[526] According to the National Youth Survey conducted in 2013, young people in Georgia have limited knowledge about their rights and duties and only 10.9% participate in decision-making.[527]

In 2011, the pregnancy rate among adolescent girls aged 15-19 was 6.2%, with a 4.2% birth rate.[528] According to the Reproductive Health Survey from 2010, contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status.[529] Despite awareness and knowledge of how to use and where to obtain contraceptives, the number of young people who actually use some form of contraception is very low.[530]

519 Interview, with Ketevan Khomeriki, Chief Lawyer at the Coalition for Independent Living, dated 01.08.2017

520 PDO Monitoring Report of shelters for victims of domestic violence and trafficking, 2017, p. 10 and 31, available at: http://www.ombudsman.ge/uploads/other/4/4617.pdf

521 Data available at: http://ssa.gov.ge/index.php?lang_id=GEO&sec_id=1238

522 Chapter X, para. 1., available at: http://disability.ge/images/stories/pdfs/samgegma.pdf English version available at: file:///C:/Users/Administrator/Downloads/ActionPLAN.pdf

523 Chapter Vii, para. 2.3.

524 Chapter Vii, para. 2.4.

525 Letter of the Ministry of Labor, Health and Social Affairs of Georgia, 11 September, 2017, no. 01/57385.

526 Geostat, Gender Statistics, Pg. 2, see: http://geostat.ge/cms/site_images/_files/english/Gender%20Statistics.pdf

527 UNICEF, National Youth Survey, Analysis Of The Situation And Needs Of Youth In Georgia, 2014, p. 12, available at: http://unicef.ge/uploads/Final_Eng_Geostat_Youth_SitAN.pdf

528 Sedgh, G., Finer, L. B., Bankole, A., Eilers, M. A., Singh, S. Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends, 2015, *Journal of Adolescent Health,* 56(2): 223–230. doi:10.1016/j.jadohealth.2014.09.007

529 NCDC, Reproductive Health Survey, 2010, p. 261

530 Final_Geo_Adolescents_and_Youth_in_Georgia.pdf / UNICEF, National Youth Survey, Analysis Of The Situation And Needs Of Youth In Georgia, 2014, p. 73, see: http://unicef.ge/uploads/Final_Eng_Geostat_Youth_SitAN.pdf

In relation to abortion, according to Geostat, from 2012, the abortion rate progressively declined in the 15-19 age group, with 1,955 abortions occurring within this group in 2012 and 1,335 in 2015.[531] This declining tendency has also been observed in the adolescents under 15 age group,[532] possibly indicating that usage of modern contraceptive methods increased.[533] However, in 2016 the abortion rate among adolescents high. For still quite high..[534]

With regard to adolescents with HIV, between July 2012 and June 2013, 112 new cases of HIV infection in young people aged 15-29 were identified, of which 8.7 % acquired HIV infection through intravenous drug use.[535] It is also important to note, that according to the NCDC's publication focusing on youth and adolescent health, the number of new cases of HIV in the 15-24 age group almost doubled in 2013, compared to previous years.[536]

A focus on youth-friendly SRH service delivery in Primary Health Care units and youth involvement is contained in the Maternal and New-born Health (MNH) Strategy for 2017-2030[537] and in the MNH action plan.[538] Nonetheless, currently there are no specific public youth-friendly SRH services in Georgia.[539]

Under Georgian legislation, 14-18 year old patients who fully understand their health status have a right to provide informed consent on medical procedures if they are requesting consultation or treatment regarding STIs or drug dependence, or for non-surgical contraception, abortion or HIV/AIDS.[540]

In a situation where a patient is found to be HIV positive, information on the patients' health status shall be provided to the parents/legal representatives only if the patient allows for this and/or the patient refuses to undergo relevant treatment, and when the patient is not considered as legally capable.[541]

Georgia's National youth policy for 2015-2020 adopted by the Government of Georgia in April 2014[542] focuses on participation, education, employment and mobility.[543] In the field of sexual and reproductive health and related rights, the youth policy includes a commitment to increase awareness among young people about existing sexual and reproductive health programs and services; to deliver high-quality sexual and reproductive health services to young women and men; to improve affordability and accessibility to sexual and reproductive health services for young people and ensure service delivery in a youth friendly environment with guarantees of confidentiality; and to support the development of modern educational programs regarding sexual and reproductive health and related rights based on best international practices.[544]

531 Geostat, Gender Statistics, p. 7, available at: http://geostat.ge/cms/site_images/_files/english/Gender%20Statistics.pdf
532 Ibid.
533 Public defender's office, special report on women's right and gender equality, Tbilisi, 2016, p. 25
534 Ibid.
535 UNICEF, National Youth Survey, 2014, pg. 71-72
536 NCDC, Health of Young Adults and Young People in Georgia,2015, available at: http://www.ncdc.ge/AttachedFiles/NCDC%20Youth_Health_Statistical%20Overview_20.02.2014_d68e1957-a8f2-45af-a143-1af5a3e890c8.pdf
537 Georgia Maternal and New-born Health Strategy 2017-2030, pp. 31-32
538 Georgia Action Plan 2017-2019 on Maternal & Newborn Health and Immediately Related RH Issues, Objective 4, Par. 4.5.5.
539 Evert Ketting, "Possibilities for developing Youth-Friendly Sexual and Reproductive Health Services in Georgia, A situation Analysis" Report of a consultancy mission on behalf of UNFPA county Office Georgia 16-20 November
540 Law of Georgia "on the Right of the Patients", Art. 41.1
541 Ibid., Art. 40.2 (g)
542 The Georgian National Youth Policy Document, Approved by #553 Decree, April 2 2014, of the Government of Georgia, Para. 3.2. available at: http://msy.gov.ge/files/Youth_Policy_(Engl)_Final_July_2014.pdfSee:
543 Ibid.
544 Ibid, p. 13

On 5 March 2015, a State Youth Policy Development Action Plan for 2015-2020 was adopted[545] which includes important activities on sexual and reproductive health and related rights to be implemented by the Ministry of Education, MoLSHA, the Ministry of Sports and Youth Affairs and the NCDC. Among these are increasing awareness and education on these issues, inter alia among adolescents with special needs, parents, medical personnel and pedagogues, including on the importance of prevention of STIs and HIV/AIDS; ensuring the delivery of high quality sexual and reproductive health services to young people, including for groups with special needs, including obligations to integrate sexual and reproductive health services under the national healthcare programs and ensuring the delivery of antenatal, modern methods of family planning services and methods through primary health care networks; and promoting the development of educational programs on sexual and reproductive health, including by introducing informal education and Health Promotion Clubs for youth.[546]

Recommendations on Marginalized Groups

- Collect disaggregated data on access to sexual and reproductive health services by all the marginalized groups.
- Effectively investigate, prevent and record cases of violence based on sexual orientation and gender identity and ensure effective remedies to the victims.
- Provide appropriate (mandatory) training to all healthcare professionals so as to ensure that lack of awareness and existing negative stereotypes do not undermine access to healthcare of LGBTI individuals.
- Adapt and introduce international clinical guidelines focused on the needs of transgender, transsexual, and gender non-conforming persons for securing transgender persons' access to quality healthcare.
- Grant legal recognition for the preferred gender of transgender persons, based on self-identification, without need of any medical, including surgical, or psychological interventions.
- Study and assess the social needs of LGBT people and reflect their needs the state plans and healthcare strategies.
- Train police officers in order to combat and prevent inappropriate conduct in relation to women sex workers and to ensure proper investigation in cases of alleged abuse.
- Ensure effective and impartial investigation of all cases of abuse of power by police officers in relation to sex workers and create relevant statistics.
- Organize campaigns in order to combat the social stigma faced by sex workers, which results in them being victims of violence.
- Organize information campaigns addressed to sex workers on treatment methods for STIs.
- Organize awareness-raising activities with a view to combatting social stigma and gender stereotypes which negatively affect the life and prevent access to services, including healthcare services of women who use drugs, and all women.,
- Equip shelters for the victims of domestic violence with the necessary infrastructure and tools receive women who use drug, and provide them with access to relevant services, such as methadone substitution treatment.

545 Appendix N1/ Available only in Georgian: https://matsne.gov.ge/ka/document/view/2766763
546 Ibid., para. 3.2.

- Elaborate national guidelines on reproductive health services specifically for women who use drugs.
- Ensure effective and impartial investigation of all cases of abuse of power by police officers in relation to women drug users and gather relevant statistics.
- Consider decriminalizing drug use, particularly the possession and use of injecting drugs.
- Conduct information campaigns to raise awareness on sexual and reproductive health services among internally displaced women.
- Guarantee non-discrimination in law and practice against persons with disabilities, and all marginalized groups.
- Ensure that hospitals operating in the local areas inhabited by ethnic minorities do not lack the equipment necessary to provide basic and sexual and reproductive health services.
- Develop programs to prevent discrimination against ethnic groups, including in the provision of health care, and to close the gaps in access to health care services by such groups.
- Investigate and address discrimination against all marginalized groups, including Roma women's lack of equal access to maternal health care services.
- Develop programs to prevent discrimination against ethnic groups, including in the provision of health care, and to close the gaps in access to health care services by such groups.
- Ensure that Georgia's family planning and other sexual and reproductive health programs, including on HIV, include specific programs for disadvantaged groups.
- Adapt gynecological wards as to ensure physical access to wheelchair users.
- Adapt all shelters for victims of domestic violence to be accessible to women with various disabilities, including women with psycho-social needs.
- Train healthcare professionals and conduct awareness-raising campaigns in order to combat discrimination against people with disabilities and all other marginalized groups.
- Conduct research on the barriers to services faced by women with all types of disabilities with the aim of developing effective policies and programs.
- Cease practices which hinder the realization of reproductive rights of women and young people with disabilities, including control over voluntary sexual activity.
- Ensure that youth friendly, confidential services are included in SRH programs, especially for disadvantaged groups.
- Ensure effective mechanisms exist that guarantee access to justice for marginalized groups when their rights have been violated.
- Ratify the Optional Protocols on individual complaints and inquiry procedures to the Convention on the Rights of Persons with Disabilities and the Convention on Economic, Social and Cultural Rights.

CONCLUSION

This assessment focuses on key human rights in the context of sexual and reproductive health and well-being issues, as well as on the health system more broadly. It also focuses on important related cross-cutting themes and rights, including accountability and non-discrimination and gender stereotyping. The government has made significant progress in many areas, including the development of a generally strong legislative and policy framework, building a new health system and institutions, and specific progress in some areas. There is further need to, among other things: update, implement and monitor the implementation of laws and policies to ensure their compliance with human rights standards; ensure that disaggregated data is routinely collected; ensure the provision of age-appropriate compulsory comprehensive life skills education/sexuality education in all schools across the country; improve privacy and confidentiality in healthcare settings, including in the context of HIV; enhance knowledge of and access to modern methods of contraception; support implementation of the legislative and policy framework on violence against women; remove barriers to abortion services; eliminate barriers to reproductive and breast cancer screenings and treatment; regulate surrogacy; and address the rights related to sexual and reproductive health of marginalized groups. To ensure the human rights of all people in its territory, the Georgian government must make every effort to implement its international human rights obligations.