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**Report on mistreatment and violence against women during reproductive health care and childbirth in Georgia**

**Info Submission**

**to the Special Rapporteur on violence against women, its causes and consequences**

**Submitted by**

**The National Human Rights Institution – Public Defender (Ombudsman) of Georgia**

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*(Information for The Special Rapporteur on violence against women, its causes and consequences,*

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The Public Defender (Ombudsman) of Georgia is a constitutional institution (NHRI with A Status), which oversees the observance of human rights and freedoms within its jurisdiction on the territory of Georgia. It advises the government on human rights issues and analyses the state’s laws, policies and practices, in compliance with the international standards, and provides relevant recommendations. The Public Defender’s status and competences are regulated by the Constitution of Georgia, the Organic Law of Georgia on Public Defender of Georgia, and other legislative acts.

Together with the Organic Law of Georgia on Public Defender of Georgia, the Law of Georgia on Gender Equality (Article 14 (1)) empowers the Public Defender to protect gender equality, monitor the given field and respond to the violations of gender equality within the framework of its competences. The mandate of the Public Defender was further strengthened by the adoption of the Law of Georgia on Elimination of All Forms of Discrimination (May 7, 2014) which authorizes the Public Defender to supervise the implementation of the law and eliminate all forms of discrimination and ensure equality (Article 6).

The Public Defender contributes to the elimination of gender inequality through effective and accountable management of cases and ensures the compliance of government and public institutions with national and international obligations on human rights and gender equality. To this end, in May 2013, the Public Defender set up a Gender Department that facilitates the work of Public Defender in combating discrimination based on gender. The Annual Parliamentary Reports of the Public Defender of Georgia includes special chapter on Gender Equality which examines situation regarding the human rights of LGBT+ persons, along with challenges and trends related to the protection of their rights.[[1]](#footnote-1)

It should be emphasized, that in cooperation with the Public Defender's Office and the United Nations Population Fund (UNFPA), it was possible to develop a complex approach aimed at ensuring universal access to sexual and reproductive health and rights. This cooperation guarantees the involvement of the NHRI in the process of monitoring and evaluating the implementation of ensuring universal access to sexual and reproductive health and rights. This, in turn, will facilitate activation of international mechanisms of human rights and analysis of evidence based on national, regional and global trends.

In 2017, the Public Defender's Office issued a special report assessing the state of sexual and reproductive health and rights in Georgia.[[2]](#footnote-2) Based on this assessment, the second phase of the evaluation was planned and implemented in 2018, whose main objective was to assess sexual and reproductive health and rights in practice through conducting enquiries with the target population.[[3]](#footnote-3)

The present information was prepared by the gender department of the Public Defender’s Office of Georgia and is based on the results of the main findings derived from the abovementioned reports.

1. **The cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth**

*Neglecting women during childbirth to suffer life-threatening, avoidable complications*

According to the desk research, carried out by the Public Defender in 2017, Georgia has one of the highest rates of maternal mortality in the region. Pursuant 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. As MMEIG indicates, 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. According to the official statistics, MMR was 32.1 in 2015. The differences between official statistics and MMEIG estimations are significant and point to the fact that, firstly, the formula for estimation and calculation of national MMR is 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.

Between 2005 and 2010, 15.7% of women giving birth reported having pregnancy complications that required medical attention. The most common complications cited were the following: (1) risk of preterm delivery (7.9%); (2) anemia related to pregnancy (3.6%); (3) water retention or edema (3.3%); and (4) high blood pressure related to pregnancy (3.0%). There were 11.2% of women who experienced postpartum complications. The most commonly cited post-partum complications were: (1) severe bleeding (3.5%); (2) painful uterus (3.5%); (3) high fever (3.3%); and (4) breast infection (2.5%). According to the National Centre for Disease Control, in 2015, 15% of hospital admissions were due to complications of pregnancy, childbirth, or the puerperium. 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 in recent years.

Despite the steps put forward by the relevant authorities on improving maternal health services, cases of maternal mortality and morbidity are still high. According to the preliminary data from 2018, the maternal mortality rate is 23.5 per 100 000 population.[[4]](#footnote-4)

*Systematic problems in the context of maternal health*

Georgia has the lowest percentage of women receiving post-partum care in the region, despite significant increase in the number of such needs. The proportion of women who received post-partum care was 11% in 1999, 22% in 2005, and 23% in 2010. In addition, since 2000 the share of caesarean section deliveries has quadrupled. In 2016, the share of caesarean section deliveries reached 43.2%.

In 2018 the Public Defender of Georgia conducted a Country Inquiry, which aimed at learning human rights violations in the context of SRHR directly from the affected populations. The results of this inquiry demonstrated that antenatal Service Package is basic and only covers the primary needs of pregnant women. Accordingly, a number of laboratory tests that are essential for the effective monitoring of pregnancy are left out from the Antenatal Service Package. As such, these tests result in additional expenses for pregnant women. Besides, psychological services (at both antenatal and postnatal care stages) are not included in the service package. The necessity of such services has been confirmed through analysis of cases of maternal mortality over last few years.

The Public Defender has also identified a high percentage of cases of caesarean section. Additionally, the monitoring revealed a lack of human resources, such as obstetricians, midwives, and anesthesiologists, in small towns and villages. This has a negative impact on the availability and quality of services. The study also disclosed that effective implementation of the referral system remains challenging among maternal health service providers. In particular, timely identification, management and correct and timely referral for post-childbirth or cesarean section-related complications is a significant challenge.

The study also revealed the absence of a systemic vision for postnatal services, which negatively affects the quality of maternal health services. To be precise, the problem is related to the conceptualization of the importance of post-childbirth visits and care by health care policy makers, which is necessary for the prevention of maternal mortality and for maintaining women's mental and physical well-being.

Moreover, the non-binding nature of lifelong medical education in the country constitutes a huge challenge. There are no further training/long-term education requirements for obstetricians and mid-level medical personnel (midwives, nurses) that align with modern medical achievements. This significantly reduces the quality of maternal health services.

The non-homogenous quality and accessibility of maternal health care services in the country is another issue that should be stressed out. This remains to be a major problem in terms of timely and efficient delivery of appropriate healthcare services.

*Lack of Confidentiality*

The language barrier remains a challenge for women of ethnic minorities while receiving maternal health services. In particular, the absence of a professional translator/interpreter in medical facilities operating in regions populated by ethnic minorities is a barrier to accessing high quality and confidential medical services.

It should be underlined, that gynecological services for women with hearing and speech impairments are problematic as medical institutions do not have a sign language interpreter; thus, the women with disabilities are obliged to take their own interpreter (or a family member who will function as an interpreter) with her, which prevents confidentiality of the service.

*Human Rights Violations in context of Surrogacy*

The State’s perception of surrogacy as a social event, rather than a significant component of the healthcare system, is also problematic. Georgia does not have legislation regarding modern reproductive health technologies, including surrogacy and in vitro fertilization. Consequently, women involved in these services do not have the legal means of protection.

*Profound Humiliation and Verbal Abuse*

According to the abovementioned Country Inquiry, conducted by the Public Defender in 2018, participants of the inquiry (respondents) who were not receiving services from private service providers, mentioned, that they were treated “harshly”/“rudely”. Some women also indicated that they were ignored during childbirth related services.

*Refusal of Admission in Health Facilities*

An important barrier to receiving family planning services for disabled women is the inaccessibility of clinics. Gynecological examination rooms and gynecological chairs throughout the country are not adapted for women with wheelchairs, which makes it impossible to conduct proper gynecological examinations. In addition to this, entrances to medical facilities are typically accessible, but the facility’s inner premises are not adapted for wheelchair users;

*Coercive or Unconsented Medical Procedures*

The gender department of the office of Public Defender of Georgia has been studying the case of violence against woman, particularly, case of coercive abortion since January 28, 2018.

Pursuant to the information provided, the head of one of the Divisions of the Ministry of internal Affairs of Georgia (MIA) forcibly brought his ex-girlfriend to the hospital and forced her to have an abortion. Reportedly, the employee of the MIA initially threatened the woman and demanded from her to get rid of the unwanted pregnancy by her own will. After refusing to do so, he forcibly took her to the clinic and forced her to have an abortion on the 4th month of pregnancy.

The victim stated that employee of the MIA used his status and influence to persuade the doctors to do coercive abortion. Reportedly, after this incident, the woman tried to commit suicide. The same policemen of MIA studied and soon closed the case of incitement to suicide.

Regarding this case, the gender department of the office of Public Defender of Georgia addressed Division of Human Rights Protection of the Prosecutor General of Georgia and LEPL State Regulation Agency for Medical Activities and requested information. The Division of Human Rights Protection of the Prosecutor General of Georgia informed the Office of the Public Defender of Georgia that the investigation was ongoing on incitement to suicide, coercion, illegal abortion, threat, violence and coercion of a witness to provide a false testimony (Articles 115, 150 (2) (a), 133 (1), 151 (1), 126 (1), 372 (2), Criminal Code of Georgia).

1. **The issue of full and informed consent**

According to Article 22 (2) of the Law on Patient’s Rights, informed consent is required for the following reproductive health related procedures:

* All cases of surgical interventions, except for minor ones (that include caesarian section);
* Abortion;
* Surgical contraception (sterilization);
* Extracorporeal fertilization.

Informed consent is not required in case of natural birth, since the procedure is a natural process rather than a surgical procedure.

According to the abovementioned Country Inquiry, women are not being informed well-enough about negative and positive aspects and outcomes of caesarian section and so called natural childbirth, therefore, women who consent formally to the procedure are still not fully informed about the procedure. Due to the lack of information, there is a high rate of caesarian sections in Georgia.[[5]](#footnote-5)

 Additionally, the Country Inquiry revealed that adolescent girls face problems in the context of informed consent. According to the Law on Patient’s Rights, service providers should not inform parents/legal guardians of adolescents who seek consultation and services about non-surgical contraception and abortion. Despite this, there is an illegitimate practice among service providers, that they not only inform parents in abovementioned cases, but also require their informed consent for providing services to adolescents. This practice represents an important barrier in terms of accessibility of contraception related services for adolescent girls.[[6]](#footnote-6) Additionally, the Country Inquiry displays that, there is an illegitimate practice among service providers on requesting a third party to consent when a woman asks for sterilization. It is important to mention that this practice has no legal basis in Georgia.

1. **Accountability mechanisms within the health facilities (to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, and acknowledgement of wrongdoing and guarantees of non-repetition)**

It should be noted, that there is a governmental agency in place (LEPL State Regulation Agency for Medical Activities[[7]](#footnote-7)) in Georgia, operating under the Ministry of IDPs from the Occupied Territories, Health, Labour and Social Affairs of Georgia that regulates healthcare activities and studies individual complaints in this direction.

In addition to that, the Public Defender of Georgia is authorized to address and study human rights violations which occur in the field of sexual and reproductive health related services. Public Defender is mandated to monitor the effectiveness of government entities (such as LEPL State Regulation Agency for Medical Activities, Prosecutor’s Office, MIA , etc.) and in case of necessity, provide relevant recommendations and general proposals to the government entities, which have committed the violation themselves and/or have not addressed the initial violation effectively.

1. **Policies that guide health responses to VAW (in line with WHO guidelines[[8]](#footnote-8))**

The definitions of rape and other forms of sexual violence under the Criminal Code of Georgia as amended in 2017, are still not in line with the requirements of CEDAW and the Istanbul Convention. Despite the fact that the Criminal Code of Georgia currently classifies the 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. 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. Marriage is not a mitigating circumstance for rape; however, there are no statistics of prosecutions of rape committed in marriage.

In the system of the Ministry of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia, there is a special commission which is responsible for deciding on financing different procedures. The regulation that defines the work and mandate of this commission also defines specific groups of people who are eligible to address the commission. Survivors of sexual violence (only Georgian Citizens) are also included in the list of possible beneficiaries of the program. However, there is no specific mention of financing abortion services for survivors of sexual violence and no guidelines in terms of how to address specifically victims in the context of providing them with health-related services. Other than that, Georgian health system has no guidelines in place for health responses to VAW.

It has to be mentioned, that the The Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia in cooperation with the UNFPA has been exercising a project on health responses to DV/VAW. The project includes development of standard operational procedures (SOP) for the health service providers and the trainings of heath service providers on VAW[[9]](#footnote-9) Within this framework, the Ministry has also elaborated a guideline on post coital contraception as an STD prevention.

*Harmful practices, including FGM and early marriage*

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 revealed 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 the tradition and/or religious custom.

Early marriages/engagements remains a problem in Georgia. According to the information provided by the Ministry of Justice of Georgia, in 2015, 611 child marriages were registered, while in 2016, there were only five. The decrease is likely due to amendments to the Civil Code of Georgia initiated by the Public Defender. 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. It should be underlined that unfortunately, figures for the number of minor parents having children still considerably exceed the figures on registered early marriage.

Harmful practices attached to the female bodies include so called “virginity tests”: due to the social pressure, among other reasons, women undergo virginity tests to prove their virginity to their husbands and relatives.

1. Annual Report of Public Defender of Georgia, “The Situation of Human Rights and Freedoms in Georgia”, available at: <http://www.ombudsman.ge/uploads/other/5/5337.pdf> [↑](#footnote-ref-1)
2. Human Rights in the Context of Sexual and Reproductive Health and Well-being in Georgia: Country Assessment, 2018. Full report available at: <http://www.ombudsman.ge/res/docs/2019040211031497196.pdf> [↑](#footnote-ref-2)
3. Sexual and Reproductive Health and Human Rights: National Assessment Key Findings, 2019. Full report available at: <http://www.ombudsman.ge/res/docs/2019050712234856064.pdf> [↑](#footnote-ref-3)
4. This is a preliminary indicator that may change, as every case of maternal mortality is investigated both through medical records and an autopsy. The letter N 06/727, February 28, 2019, Legal entity of Public Law L. Sakvarelidze National Center for Disease Control and Public Health. In 2017 maternal mortality rate was 13.1 per 100 000 per live birth. [↑](#footnote-ref-4)
5. Information is available at: <http://www.ombudsman.ge/res/docs/2019042214532696372.pdf> [↑](#footnote-ref-5)
6. *Ibid*. [↑](#footnote-ref-6)
7. Information available at: <http://rama.moh.gov.ge/> [↑](#footnote-ref-7)
8. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers is available at: <https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf;jsessionid=87D2C09FA4E78A6C623ADA9989B2E34E?sequence=1https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/> [↑](#footnote-ref-8)
9. Information available at: http://atipfund.gov.ge/res/docs/UNFPA.pdf [↑](#footnote-ref-9)