Safe Abortion in Georgia

Policy Brief

Policy Brief about safe abortion in Georgia provides the overview of current legislation and policies on Abortion in Georgia. It reflects on experiences and models of abortion practices recent development in abortion care and international recommendations. It reviews principles and importance of pre and post abortion care and benefits of medical abortion and contraception. The document is designed to raise awareness on medical abortion, provides service providers and advocates/stakeholders with information and tools to strengthen the provision of safe abortion services. Document represents the current shortcomings/gaps on availability and accessibility of abortion services for women living with different social and economic status in Georgia. Discuss the unmet needs for contraception and safe abortion services and its influence on women and girl's health and wellbeing.

Introduction

Sexual and reproductive health and rights (SRHR) are based on the right and the ability of all individuals to make decisions about their own sexuality and body, and to live healthy and productive live.

Women's and girls' access to safe, high-quality abortion care is a key component of the right to reproductive healthcare, which all governments are obliged to guarantee. However, as we have seen, state legislators and service-providers impose numerous hurdles to this care, compromising the rights of women and girls in many countries.

The past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly. However, despite these advances, access to contraception and safe comprehensive abortion care remains uneven around the world and complications due to unsafe abortion are still significant causes of maternal morbidity and mortality. More than half of all pregnancies globally are unplanned, and one in every four, or 56 million pregnancies per year, ends in abortion. Of these, an estimated 25.2 million are unsafe abortions. The vast majority of these unsafe abortions – 97 per cent – occur in low- or middle-income countries, which are more likely to have restrictive abortion laws, high unmet need for contraception, shortages of trained healthcare providers and limited access to quality health care.

Lack of access to abortion services is likely to increase the number of women seeking illegal and unsafe abortions, leading to increased morbidity and mortality of women. Barriers/restrictions lead many women to seek services from unskilled providers or under unhygienic conditions, exposing them to a significant risk of death or disability. Conversely its is well evidenced fact that, laws and policies that facilitate access to safe abortion do not increase the rate or number of abortions. The principle effect is to shift previously clandestine, unsafe procedures to legal and safe ones. Additionally, the accumulated evidence shows that the removal of restrictions on abortion results in a reduction of maternal mortality from unsafe abortion and, thus, a reduction in the overall level of maternal mortality.
Where there are few restrictions on access to safe abortion, deaths and illness are dramatically reduced. To realize women's human rights, and to save their lives and health, programmatic, legal and policy aspects of the provision of safe abortion need to be adequately addressed.

Poor and young women are most affected by not having access to safe abortion. Nearly every death and harm from unsafe abortion can be prevented through sexuality education, use of effective contraception, provision of safe, legal abortion and emergency treatment of abortion complications. Comprehensive Sexuality Education (CSE), provision and use of effective contraception, liberalization of abortion laws and access to safe and legal abortions, in combination with prevention and treatment of complications, could prevent almost all abortion related mortality and disability.

Although there are significant steps to improve access to abortion and post-abortion care in Georgia, the issue remains challenging. The rate of abortions declined over last 25 years, and compared with the previous year, the rate declined by 9%. It is also notable that share of medical abortion has been increasing over past years, and shows highest rate in 2018 (38.9%), while it was 36.8% in 2017. In 2014, five-day waiting period requirement was imposed before obtaining an abortion on request. Under an order of Minister of Health, time can be reduced to 3 days, if woman applies for abortion in 12th week of pregnancy. According to WHO recommendation on safe abortion such "mandatory waiting periods" do not fulfill a medical purpose, undermine women's decision-making autonomy, delay access to timely, legal abortion care. They also increase financial and practical costs of abortion services. This can have a disparate impact on some groups of women, including those from rural areas, living in poverty, or at risk of domestic violence.

Legislation

The Law on Health Care provides that abortion can be carried out for any reason if the pregnancy does not exceed 12 weeks. 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.178 Abortion is permitted after 22 weeks

due to medical conditions only by the decision of a medical commission.179 It is prohibited to terminate a pregnancy after 22 weeks for nonmedical reasons.
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
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. Under an order of the Minister of Health, the period can be reduced to three days, if a woman applies for abortion in the 12th week of pregnancy and the term of 12 weeks is expiring.
The law provides that during counselling, the physician shall give priority to the protection of the life of the foetus. 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.

In Georgia 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.

Policy

Under the Law on Health Care, reducing the number of abortions is a priority objective of the State. 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.
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 health care 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. 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.
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.

Evidence based data

Abortion services are not available in rural areas, women have to travel long distances, which requires additional transportation costs and time.
In 2019 Association HERAXXI has developed research about barriers to accessing safe abortion service in Georgia. The research provides life story-based evidence about barriers that are related to the access of save abortion service in Georgia. The findings are actively used in advocacy process both on national and international level. The study has identified that women face a wide range of barriers when accessing safe abortion service, such as socioeconomic barrier, psychological and moral problems, geographical and legal obstacles and stigma exiting in Georgian society.
The research of the Association "HERA-XXI" which indicates that abortion services are not readily available in rural areas, and women have to travel long distances to have access to abortion. It presents a geographical and financial obstacle for women, which requires additional transportation costs and time. Another significant barrier for women to have access to safe abortion and quality reproductive health services is the low level of availability and readiness of medical facilities in Georgia. According to the findings of the research conducted by the Association "HERA-XXI", only 17 % of a total of 655 medical facilities provide abortion services. Furthermore, 95% of medical facilities that provide abortion services are secondary health care facilities. Generally, secondary health care facilities are multi-profile clinics and are located in cities. Only 5% of primary health care facilities provide abortion and family planning services.The financial, psychological problems and unfavorable social situation often serves as reasons for women to make decisions regarding termination of pregnancy or performing life-threatening actions, which results in violation of a number of reproductive rights. Widespread Conscientious objection of service providers 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
Post-abortion services is provided incompletely, e.g. patient either does not receive any kind of post-abortion care or receives superficial information (consulting) on further family planning options. Despite psychological support is mentioned in National protocol, such support is the weakest spot of post-abortion services provided to women. There is a gap in availability of informational materials on abortion

According to another report elaborated by the Association HERA-XXI, there are discriminatory restrictions imposed by some clinics concerning certain groups of women and girls seeking abortions, particularly persons under 16, 16-18-year-old. 11% of the surveyed clinics (11 clinics) stated that they are providing abortion services to persons under 16 years of age. The report also showed 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.

Planning and managing Abortion

The increasing use of medical abortion has revolutionized ease of access to safe abortion services. Research has led to progressively less medicalized, low-cost, safe and effective medical abortion treatment methods. Safe abortion care has transitioned from tertiary and secondary health facilities to the primary care level and is increasingly administered by mid-level providers including nurses and midwives, or by women themselves in their homes.
Task shifting of safe abortion care to non-physician providers has proved cost-effective even in high-income contexts.5 An increasing number of abortions are performed earlier, even as soon as a pregnancy test is positive, with lower risk of complications for the woman.6 In recent years abortion has shifted from outdated and often unsafe methods, or resource intensive care, to simple, safe, cost-effective and affordable care, even in settings with restrictive access.

Safe abortion methods

There are two main methods of safe abortion:
Medical abortion, where medication (Misoprostol and Mifepristone) is used to end a pregnancy. It can be initiated as soon as pregnancy is confirmed, through the second trimester of pregnancy and beyond that to induce labor. A medical abortion can either be self-administered or administered by a trained health professional up to gestational week. After this week, medical supervision is necessary due to the increased risk of complications.
Medical abortion, with the combination of mifepristone and misoprostol, or with misoprostol alone, can be used to induce abortion at any gestational age and is an alternative to primary surgical abortion. Misoprostol alone is not as effective as the combined regimen to achieve complete abortion. Almost all women are eligible for medical abortion, with gestational-age-appropriate services, irrespective of age, parity and underlying health conditions. Previous caesarean section or multiple pregnancies are not contraindications to medical abortion. Contraindications to medical abortion should be reviewed before treatment but these are rare. They may include allergy to mifepristone or misoprostol, chronic adrenal failure or long-time treatment with oral corticosteroids, porphyria and ectopic pregnancy. Caution should be taken in women with coagulation disorders or those taking anti-coagulant drug
Medical abortion is a less costly and less invasive method than surgical methods of abortion and does not require surgical training.

Surgical abortion is a procedure performed up to gestational week 12–14 by a trained professional. WHO recommends Manual Vacuum Aspiration (MVA) as the safest surgical method.
When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure. Unsafe abortion and associated morbidity and mortality in women are avoidable. Safe abortion services should be readily available and affordable to all women to the full extent of the law. This means services should be available at primary care level, with referral systems in place for all required higher-level care.
Actions to strengthen policies and services related to abortion should be based on the health needs and human rights of women and a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context.

Accessibility and Affordability barriers for women

Accessibility and availability barriers, limit the availability of services and their equitable geographic distribution contribute to unsafe abortion because they deter both women from seeking care and providers from delivering services within the formal health system and cause delays in access to services, which may result in denial of services due to gestational limits on legal grounds; create complex and burdensome administrative procedures; increase the costs of accessing abortion services
Failing to assure referral in case of conscientious objection; requiring mandatory waiting periods; failing to guarantee confidentiality and privacy, including for treatment of abortion complications;
respect, protect and fulfil the human rights of women, including women's dignity, autonomy and equality,
promote and protect women's health as a state of complete physical, mental and social well-being;
minimize the rate of unintended pregnancy by providing good-quality contraceptive information and services, including a broad range of contraceptive methods, emergency contraception and comprehensive sexuality education. prevent and address stigma and discrimination against women who seek abortion services or treatment for abortion complications and meet the particular needs of women belonging to vulnerable and disadvantaged groups, such as poor women, adolescents, single women, refugees and displaced women, women living with HIV, and survivors of rape.

Recommendations:

Ensure that Laws and policies on abortion should protect women's health and their human rights;

Remove regulatory, policy and programmatic barriers that hinder access to and timely provision of safe abortion care should be removed.

Ensure All health facilities are equipped to provide medical abortion as a method of choice for women;

Ensure SRH service providers routinely educate, counsel and support women who choose medical abortion, including for self-administration;

Work with national and sub-national stakeholders, including governments and civil society organizations, to overcome structural, social and cultural barriers, including stigma, and lack of training of providers and denial of care;

Ensure policies girding to respecting, protecting and fulfilling the human rights of women; to achieving positive health outcomes for women; to providing good-quality contraceptive information and services; and to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV.

Develop the mechanisms to provide information on sexual and reproductive health, as well as mechanisms to ensure that all women, including adolescents, have access to information about legal abortion services

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