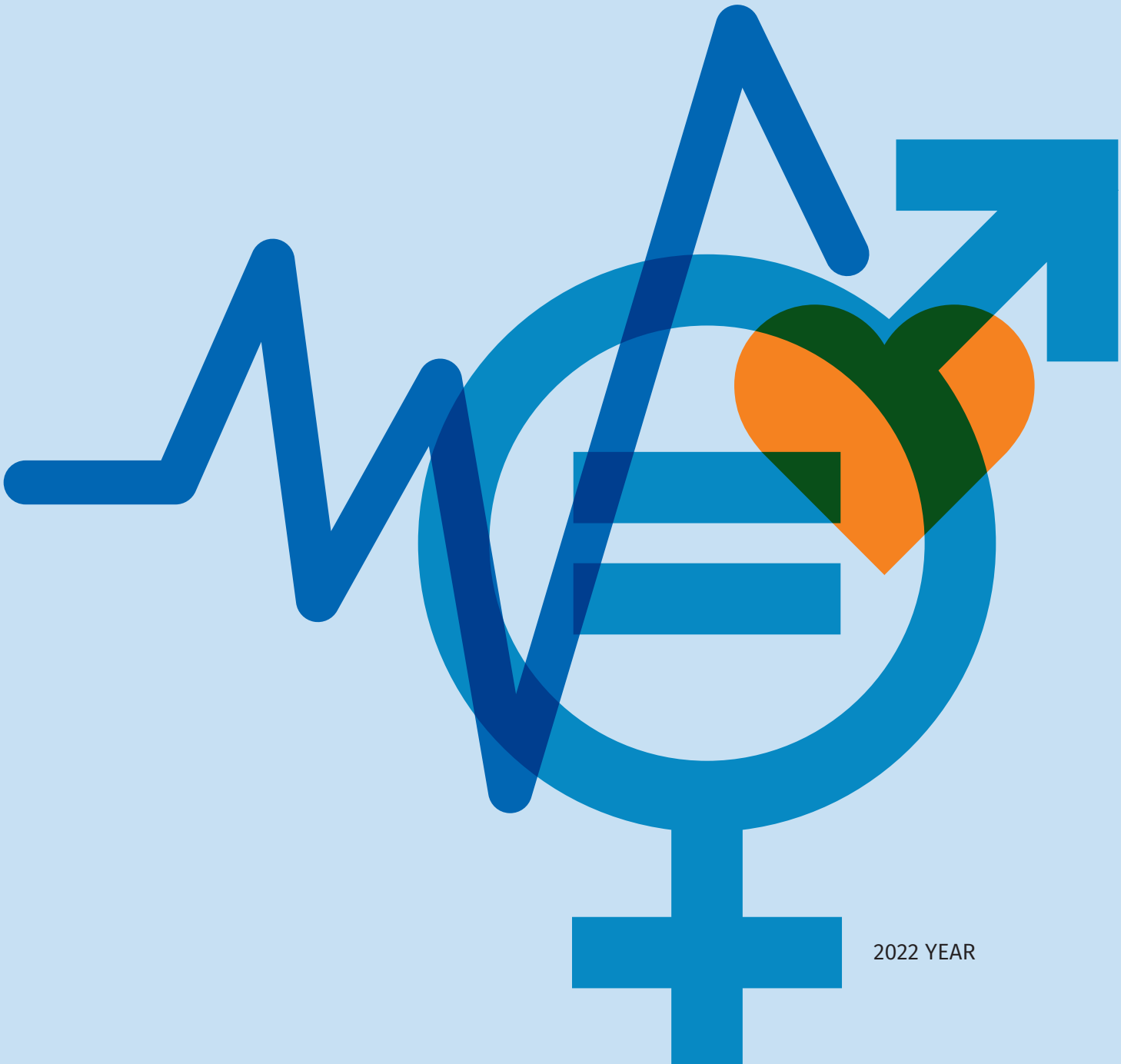
UN JOINT PROGRAMME
FOR GENDER EQUALITY

SPECIAL REPORT

ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN AND GIRLS FROM NON-DOMINANT ETHNIC GROUPS IN GEORGIA



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INTRODUCTION

This study is the first attempt to study state of the sexual and reproductive health and rights of women and girls from non-dominant ethnic groups living in Georgia, in order to identify key issues and to develop relevant recommendations for government agencies.

The study is based on surveys conducted by the Gender Department of the Public Defender's Office in 2017 and 2019[1], which obviously showed the challenges existing in the country in terms of sexual and reproductive health and rights, also identified particular vulnerable populations, including women and girls from non-dominant ethnic groups. The study of sexual and reproductive health and rights is particularly important among women and girls of the non-dominant ethnic groups, as female sexuality and reproductive practice are dictated by socio-cultural factors, and the protection of the rights of non-dominant ethnic groups is possible by identifying their special characteristics and recognizing of their equality.

The present research studies particularly the issues of contraception, maternal health and harmful practices and reaffirms the systemic challenges in this area and the urgent need to respond to them. The Public Defender of Georgia hopes that the state agencies will take into account the important problematic issues identified as a result of the research and will ensure the implementation of the recommendations necessary to deal with the mentioned problematic issues given in the research.

RESEARCH METHODOLOGY

The goal of the present research was to study the state of rights and reproductive health of women and girls from non-dominant ethnic groups[2] living in Georgia and the challenges existing in the country in this regard. In particular:

- To study the socio-economic and cultural characteristics that affect the sexual and reproductive health of women and girls from non-dominant ethnic groups living in Georgia; And
- To reveal barriers preventing to access sexual and reproductive health services by women and girls from non-dominant ethnic groups and the reasons generating such barriers.

To achieve this goal, it was supposed to get answers for the following questions:

1. What kind of challenges are facing women and girls from non-dominant ethnic groups in terms of sexual and reproductive health and rights?
2. Whether Georgian health programs and services consider the specific sexual and reproductive health needs of women and girls from non-dominant ethnic groups?
3. What should be done to develop health programs and services tailored to the sexual and reproductive health needs of women and girls from non-dominant ethnic groups?

1 The surveys were prepared by the Office of the Public Defender of Georgia with the financial support of the United Nations Population Fund (UNFPA) Georgia Office:
(1) Human Rights in the Context of Sexual and Reproductive Health and Welfare: Country Legal Status Assessment 2017. The research report is available at the following link: https://bit.ly/3qmQFEz [last viewed: 25.12.2021];
(2) National Survey on Sexual and Reproductive Health and Rights 2019. The research report is available at the following link: https://bit.ly/3FrCKn2 [last viewed: 25.12.2021].

2 For the identification of ethnic minorities in the research, detailed information is provided in the following section of the methodology: "Research target population and recruitment of survey subjects".

It should be noted that the study focused on the following issues of sexual and reproductive health and rights: (1) contraception, in terms of family planning; (2) maternal health; and (3) the impact of harmful prac tices on sexual and reproductive health and rights.

The research methodology was developed based on the framework outlined in the guide of the United Nations Population Fund (UNFPA)[3], which is a tool for human rights institutions to assess the state of sexual and reproductive health in the country and identify key human rights trends in line with international standards and indicators, issue recommendations and promote their implementation.

Based on the purpose of the present study, the research questions and the above framework of UNFPA, a research methodology was developed and a research protocol was written, based on which the research population, research tools were defined, and the research area was planned.

From the very beginning of the research methodology, population of the study was defined, for the identification was used definition given in the 2010 publication of the UN High Commissioner for Human Rights (OHCHR) - "Minority Rights: International Standards and Guidelines for Implementation", which in its turn is based on subjective (human beings name their ethnic identity by their own) and objective (common ethnos, religion and language) characteristics.[4] In addition, from the objective characteristics, the existence of a language barrier (cannot speak, or has difficulty communicating in Georgian) was selected as a necessary component of involvement in the study.

In addition to the main target population, other target groups were also defined for the research. These are: doctors (gynaecologist, village / family doctor), creators or implementations of state health policy, representatives of local self-governments and civil society.

The survey was conducted in the two regions most tightly populated with non-dominant ethnic groups: Samtskhe-Javakheti (ethnically Armenian population) and Kvemo Kartli (ethnically Azerbaijanian population). In particular, field work was carried out in two municipalities of Samtskhe-Javakheti region - Akhalkalaki and Akhaltsikhe, and in one municipality of Kvemo Kartli - Gardabani municipality.

Prior to the fieldwork, research tools were developed for each target group - an in-depth interview and focus group guide.[5] Fieldwork was conducted in September-October 2021 by interviewers from the target groups in a language chosen by the respondents themselves. Each in-depth interview and focus group discussion, except few in-depth interviews, was conducted face to face.[6] During the interviews and focus group discussions, audio recordings were made, transcripts were prepared, and the interviews were translated into Armenian and Azerbaijanian languages (by the interviewers themselves). The information obtained from the prepared transcripts was processed, thematic coding applied and the data obtained as a result of coding was analysed.

3 UNFPA¬ Guide "Guide to Supporting Human Rights Institutions: A Country Human Rights Assessment and National Survey on Sexual and Reproductive Health and Welfare" (UNFPA¬ Guide).

4 Source available: https://www.refworld.org/docid/4db80ca52.html last seen: 30.07.2022

5 Research tools and informed consent forms designed for the main target population have been translated into Armenian and Azerbaijani.

6 Due to the Covid pandemic, several in-depth interviews with professional groups were conducted online.

LIMITATIONS AND SPECIFICATIONS OF THE RESEARCH

This research is one of the first attempts to study the issues of sexual and reproductive health and rights of women and girls from non-dominant ethnic groups in Georgia. Accordingly, it is a valuable document for the development of health policies and programs tailored to the sensitive and specific needs of this group, as well as for further in-depth research of the issue. In addition, it is noteworthy that this is the first research studying the issue of reproductive and gynaecological violence in Georgia. Considering this fact, the information obtained from the research is of special importance not only for the research target groups, representatives of the non-dominant ethnic group, but also for the population in general. The importance of the research is caused by the fact that due to the social and cultural norms established in the country, this type of violence is not rare, especially among women from non-dominant ethnic groups.

Besides, research has numerous specifications, the consideration of which is important for the correct interpretation of the results and further planning of the relevant actions. In this regard, first of all, it worth to mention that the information provided in this report does not allow comprehensively analyse and evaluate of the health care system. The present research focus and used methodology examines only the specific needs of women and girls from non-dominant ethnic groups and the relevance of measures taken by the state to respond to these needs, but it is possible that the challenges facing the target group are duplicating the challenges of general population.

It should also be noted that the used research methodology used is qualitative in nature, and reveals the main trends around the research issue, but fails to examine the severity of the prevalence of the identified trends. In addition, the study covers the two largest non-dominant ethnic groups living in Georgia - ethnic Armenians and Azerbaijanis - and leaves other ethnic groups out of focus. Therefore, the results of the research cannot be generalized to all ethnic groups without further analysis and discussion.

And in the end, it is necessary to mention the challenges posed by the Covid pandemic that have affected the course of the study. In particular, due to the epidemiological situation in the country, field work was carried out in only three municipalities instead of the four planned.

RESULTS OF THE RESEARCH

Main findings of the research

Research has shown that a number of socio-cultural factors, predominantly gender norms and stigma associated with sexuality, often lead to violations of the right to sexual and reproductive health of women and girls from non-dominant ethnic groups. It is important to note that a number of circumstances causing human rights violations are common for general population living in Georgia. However, some experiences are unique, referring to the need of use different approaches to the sexual and reproductive rights of the target group.

- The study highlighted the tendency that it **is culturally unacceptable for women to take care of their own health** as society places them primarily responsible for caring for household, children and other

family members. This is one of the reasons for women not to go to medical facilities, even when needed. Pregnancy and childbirth-related medical services are exceptions in this regards, regular visits to medical services by women are more encouraged by society and family members in the best interests of the foetus. However, the study found some cases where women, especially during second and subsequent pregnancies, seek for medical services at the late stage of pregnancy (due to the same culturally determined factor);

- Research has also shown that **motherhood is a woman's primary responsibility**, having many children is culturally highly encouraged and the need for contraception is not properly seen by society; consequently, *this circumstance is one of the barriers to access contraception*. In addition, the tendency of the importance of female reproduction often encourages *marriage of women at the young age,* which is more likely to increases the risk of early and forced marriage;
- **The taboo on sexuality** often *leaves women beyond much-needed information, services and products.* In particular, because of the taboo-induced shame, women often find it difficult to ask a doctor, discuss contraception, or other issues with their partner, and establish effective communication to obtain financial resources to meet their own medical needs;
- **The neglect of a woman's physical autonomy and the frequent practice of interfering in the decision-making process by a partner and older family members** often lead to violations of the sexual and reproductive rights of women and girls from a non-dominant ethnic group. Research has shown that such practices *encourage reproductive violence and its contributing factors* in the population under research. In addition, culturally determined behaviors neglecting of female autonomy are manifested not only in the family but also in medical institutions - *violations of patients' privacy and autonomy, and gynecological violence.*
- **The control of female sexuality**, as it turned out, is another common practice in non-dominant ethnic groups, which is *manifested in certain customs related to marriage and leads to acts violating the dignity of women.*

In addition to the above mentioned, research has revealed that a **lack of information, which is more often found among women from a non-dominant ethnic group due to language barriers**, also underlies a violation of the right to sexual and reproductive health. According to the research, the lack of information is mainly due to the following factors:

- **Lack of school-based comprehensive education on human sexuality** is one of the most important factors fo the lack of knowledge, which is not limited to the lack of health-related information, but also does not provide women with information about sexual and reproductive rights; The result of this factor may be that access to contraception, maternal health, and other services due to cultural and social factors that lead to gender-based violence against women and neglecting of their sexual and reproductive rights;
- **Inadequate qualifications of medical staff** also have a negative impact on women's sexual and reproductive health. In addition, insufficient knowledge of health professionals is usually expressed in the absence of scientific medical knowledge, as well as in the lack of communication skills with patients and appropriate knowledge;
- **Limited access to information in a language understood by non-dominant ethnic groups of women and girls** is another important barrier to access quality and confidential sexual and reproductive health services for women.

The scarcity of state sexual and reproductive health programs and services, along with lack of gender-sensitivity, non-inclusiveness, low-quality, and administrative problems in existing programs, also significantly prevent access of women from non-dominant ethnic groups to needed sexual and reproductive health services. In particular:

- Public maternal health services neglect postnatal medical and, in general, maternal mental health services;
- Lack of state contraceptive and family planning services, becomes a special burden imposed on women and girls from non-dominant ethnic groups, as research has shown that women in this community are not financially independent and their access to family planning entirely depends on their husbands or other family members;
- In addition to the lack of state funding, another barrier for women from non-dominant ethnic groups is the unequal geographical distribution of contraception and family planning services and products, as moving far from home is problematic for them. In this regard, the vulnerability of the research target group, in addition to the above mentioned financial factor, is caused by restriction to leave home for a long time by family;
- The need to visit a medical facility before the thirteenth week of pregnancy to use antenatal services, as research has shown, for women of a non-dominant ethnic group, often becomes a hindering reason for using free services. According to the study, due to the language barrier, women are not able to receive information about the program in a timely manner;
- The study also showed that quite often, due to problems related to the quality of financial and medical services, women from non-dominant ethnic groups go to Azerbaijan and Armenia to receive maternal health services.

Research has also shown that despite funding for antenatal services, a financial barrier for pregnant women is the environment in which, during complicated pregnancies, the state does not fund a number of nosologies. This, according to women from the non-dominant ethnic group, puts a heavy financial burden on them.

1. Contraception access and barriers

For the purposes of the study, contraception is considered in the context of family planning and, therefore, reviews the practice of protecting women and girls from unplanned pregnancies in a non-dominant ethnic group and the challenges they face in this regard.

1.1. The practice of contraception/planning of family

Access to contraceptive information, services or products is part of human rights, which provides the opportunity to avoid a number of negative consequences, especially for women. In particular, family planning and avoiding unwanted pregnancies help improve maternal health and reduce pregnancy-related deaths. These benefits are of particular importance to certain groups of people, for whom pregnancy and childbirth are associated with additional risks. For example, this could be a woman's age (minors, or older women), short intervals between pregnancies, health problems, consumption of certain types of medications, and etc.[7] In addition to the above-mentioned risks to maternal health, access to family planning services reduces the number of risky abortions, as well as the illness and mortality of new-borns and children. In addition to

7 MSD Manual Professional Version. Professional, Gynecology and Obstetrics, "Risk Factors for Complications during Pregnancy". Information is available online: https://www.msdmanuals.com/professional/gynecology-and-obstetrics/high-risk-pregnancy/overview-of-high-risk-pregnancy?query=Overview%20of%20Disease%20During%20Pregnancy. [Last viewed: 15.12.2021].

avoiding health risks, the prevention of unwanted pregnancies and voluntary pregnancies is a prerequisite for girls and women to receive education, professional development, independent living and full realization of their abilities.[8]

Knowledge related to contraception: Research has shown that knowledge of family planning and contraception in a non-dominant ethnic group of women, girls, and physicians themselves is scarce in both regions. Lack of information and a superficial approach to the issue increase the risk of unplanned and unwanted pregnancies. This fact in its turn increases the risk of risky abortions and complicated pregnancies, and ultimately the risks to women and child health. The links between these processes have been repeatedly confirmed by the information obtained from interviews with each representative of the research population and the focus group discussions.

Research has shown that a significant proportion of women and girls in the non-dominant ethnic group cannot interpret the word "contraception",[9] including they do not have adequate knowledge of modern family planning methods. The most familiar methods of contraception for the respondents are the so-called terminated sexual intercourse, calendar method, intrauterine devices, hormonal pills and condoms; Relatively few of them know - permanent contraceptives and some respondents are familiar with "some injections" and implants. It is noteworthy that the respondents' knowledge about the rules, indications, contraindications and side effects of using modern methods of contraception is even scarce. Moreover, there are numerous myths that modern means of contraception (especially hormonal pills and intrauterine means) have a significant negative impact on a woman's health, regardless prescribed by a doctor or not. Lack of knowledge in this area was revealed among the doctors themselves.[10]

Sources of information on contraception: As it turns out, the main sources of information for women and girls on contraception or sexual and reproductive health are following: Internet (including social network groups), parents, other family members, relatives, and to a less extent, health professionals and educational institutions. In addition, the analysis of interviews and focus group discussions made it clear that the most frequently sources of information named by women, in their view, are not sufficient, credible and reliable. Respondents believe that parents and other family members should play a more active role in the process of providing information, especially in process of informing young people. Despite the fact that respondents do not trust the information posted on the Internet, most of them often uses this resource to get information; And most rarely seek advice from those they trust most - doctors. The most frequent use of less reliable information resource - the Internet, according to the respondents themselves, is explained by the easiness of obtaining information in online space and the lack of discomfort, that often exists because of taboo on sexuality and reproduction, while talking with women, doctors, relatives or family members. All this, in the end, leads, on the one hand, to the rare practice of using modern methods of contraception, and, on the other hand, if such practice exists, to arbitrary use of contraception.

While talking about awareness on contraception and family planning, it is important to mention the difference between female and young girl respondents. In particular, unlike women, young people (in both regions) explicitly expressed concern about the lack of information and stressed the importance of having information

8 World Health Organization. Contraception. Information is available online: https://www.who.int/health topics / contraception # tab = tab_3. [Last viewed: 10.12.21].

9 After the interviewer explained, they were able to name at least one method of contraception

10 Information confirming the lack of knowledge among medical staff in this area is presented in details in the following section of the research report: 1.2. Barriers to contraception / family planning practices: Lack of information.

for them. It was also stressed, that even when information is provided to them in some form, the emphasis is mainly done on encouraging reproduction. In addition, the young people talked about the great role of the state and parents in awareness. Doctors also focused on the special need to inform women on modern methods of contraception.

Practice of usage of contraceptives: As it turned out, the lack of information on modern methods of contraception has a negative impact on the attitude of both women and doctors towards contraceptives and, consequently, on the practice of their use. The survey showed that the majority of respondents do not use modern methods of contraception to prevent unplanned pregnancies, and those who use – use on irregular basis. Interviews with doctors also had shown that a large proportion of pregnancies are unplanned and therefore there is the high of high risk of pregnancies and deliveries with complications. According to the study, women from the non-dominant ethnic group most often use the following methods of contraception - terminated sexual intercourse and the calendar method; relatively less - hormonal pills, intrauterine devices and even more rarely - condoms.[11] Research has also shown that the practice of abortions is quite common, despite the use of traditional methods of contraception, which is considered by some women as one of the means of contraception. It is noteworthy that despite the lack of knowledge and negative attitudes towards modern methods of contraception, access to contraception is considered by women as a necessary and important means of preventing undesirable pregnancies.

1.2. Barriers related to contraception / family planning practices

Despite the fact that contraception and family planning have a positive impact on many aspects of women and girls' lives, access to them, due to a number of political, socio-cultural, economic or religious factors, is still a significant challenge in many countries around the world, including Georgia. Unfortunately, state obligations under numerous international or state legal and strategic instruments to ensure the dissemination of family planning practices and thus reduce the number of undesirable pregnancies is not being fulfilled. According to a multi-indicator cluster survey published in 2018, about one third (32%) of women in Georgia have an unsatisfied demand to contraception. It should be noted that the rate is higher in the case of rural women.[12] According to the same study, public awareness about modern methods of contraception is quite low. In addition, the results also show that the number of abortions resulting from undesirable pregnancies is also high.[13] Contraception-related problems and the increased number of abortions caused by this fact are also mentioned in the report of the study published by the Public Defender of Georgia in 2019, where ethnic Armenian and Azerbaijani women, along with other vulnerable groups, are named as the ones with the most specific needs in terms of access to contraception.[14]

Lack of information: The analysis of the research results showed that the main barrier to access modern methods of contraception is a lack of information, as well as geographical, socio-economic and cultural factors. It is noteworthy that during research, language issue has not been named by women themselves as a direct barrier to access to modern methods of contraception; but this is not surprising, as research has shown that socio-cultural and economic factors play such a huge role as barriers to access modern methods of con-

11 It should be noted that the practice of using condoms in an ethnically Azerbaijani community has not been identified in the study. Moreover, their knowledge on the barrier methods of contraception is quite low.

12 National Statistics Office. 2019. Georgia Multi-Indicator Cluster Survey 2018, Survey Results Report. Tbilisi, Georgia: National Statistics Office. P. 100-117.

13 IBid

14 Public Defender of Georgia. Sexual and Reproductive Health and Rights: A National Assessment. 2019. p. 38-39. https://ombudsman.ge/res/docs/2019072913513745197.pdf

traception that women are practically unable to reach the stage of consuming a service or product. Accordingly, actualizing the problem of communication and informing due to the language barrier and realizing of it, is quite rare. However, it should be noted that, in general, limited access to information in the desired language, both online and through medical services, is likely to be an unconditional barrier to informing women about modern methods of contraception and, consequently, to their use. The existence of the language barrier and its negative impact was actively discussed by the representatives of non-governmental organizations. The study reaffirmed the problem identified several times before. In particular, interviews and focus group discussions have shown that, like in general population, the lack of information on modern methods of contraception is based on the lack of appropriate education in schools. The respondents themselves spoke about the impact of the lack of proper education in the formal education space and about the lack of knowledge. The study showed that the lack of information was significantly affected by the inadequate qualifications of medical staff, which was confirmed by interviews with women and girls from non-dominant ethnic groups, as well as by doctors. As it turned out, many myths about modern methods of contraception can be found among the medical staff themselves. Healthcare professionals were often mentioning that contraceptives because hormonal changes in a woman's body, infertility, inflammatory processes, changes in blood counts, etc.[15] Unfortunately, part of the medical staff, during the interviews, admitted that they were urging patients to refrain from using modern methods of contraception.

Socio-cultural barrier: Research has shown that, in general, non-dominant ethnic groups are less distinguished with their health care practices, which is even rarer in relation to such taboo areas as women's sexual and reproductive health. The study revealed trend that taking care of health by women and regular visits to doctor are somehow considered a luxury and less acceptable and are socially unacceptable.

> **"This issue is very serious here, our women have a lot of complexes, they are not free, and they cannot go to the doctor and get examined for such an issue, so they have problems before pregnancy, then they have infections and other problems. We have such kind of problems "- Akhalkalaki, local self-government**

Respondents remembered specific facts when mothers-in-law complained about a woman visiting a gynaecologist.[16] It is more likely that such public attitudes, along with economic factors, should also be another significant barrier to access the contraception, especially in the absence of women's financial independence, when they cannot go to the doctor without the financial support of family members.

> **"For example, women in Akhalkalaki and rural areas of our region do not have their own jobs and do not have their own money. So they need to ask their head (husband or father-in-law is considered here) to give them money. There is also a common practice that they may ask you what you are going to do with this money? And it's a little hard to tell what you're going to buy. Because of this they do not use [contraception], they do not have their own money. If they have their own money, all the information is on the Internet and they will buy what they need "- a focus group woman, Akhalkalaki**

15 It should be noted that these facts were more often attributed to the side effects of hormonal pills in the Samtskhe-Javakheti region, while the negative attitude towards intrauterine devices was more common among the respondents in the Kvemo Kartli region.

16 This applies not only to the services required for contraception, but also, in general, to any visit to the doctor.

In addition to the above mentioned, the study identified a number of other barriers determined by socio-cultural factors of contraceptive use. Among them is the shame associated with sexual and reproductive health, which makes it difficult for women to talk about the needs related to means of protection against pregnancy, both with partners and with representatives of the health sector. This is, of course, another important barrier to access contraception.

"For example, if I go and buy in a pharmacy, if I know the pharmacy employee, I may be ashamed. She will then think about me "she came to buy contraception" - a woman participating in an in-depth interview, Akhalkalaki

Another barrier driven by cultural factors may be the less common practice to use condom, which in its turn, is the result of men's refuse to use them. Some of the respondents, both women and girls and doctors, said that there are frequent cases when women refuse to use this or that method of contraception (most often - a condom) based on the desire of their partners.

"If he [the wife] refuses, I will not do it. My spouse will never say anything that will be harmful"- in-depth interview participant woman, Akhalkalaki

An analysis research results revealed that the shame and taboo associated with sexuality, as well as the social pressures associated with having many children and motherhood, views access to contraception as an alternative, and not as a basic need for women and men in general. Consequently, neither the society, nor the medical sector, or state is proactive at any stage of service delivery and consumption aiming to meet individual needs, which is often ineffective at both the individual and community levels.

"I advise them to have as many children as they can. The only special need to be taken into account is their social status ", Samtskhe-Javakheti region, village doctor

Geographical barrier: geographical factor was named as another important barrier to access to contraception by rural women. This group of respondents mentioned that contraceptives and appropriate medical services are not available in most of the villages, and it is difficult for them to go to nearby towns. In addition, due to the shame associated with the issue, they cannot ask relative or neighbour to buy means of contraception, when such practice is common for example in relation to any other medicine. While talking on geographical issue, it is important to note that in this regard, women are particularly vulnerable group.[17]

Financial Barrier: Financial accessibility was named as another important barrier to access contraception during the study. Respondents often mentioned that women rarely have a job and their own income, which makes their access to modern methods of contraception even more difficult, especially in conditions when in the opinion of society protection from unwanted pregnancy is mainly considered as a woman's responsibility.

17 Difficulties with movement are discussed in more detail in the section on abortion.

It is also important to note the fact that, for some unknown reason, financial problems were less named as the barrier to access contraception in Azerbaijanian community. This may be due to the existence of other more powerful (informational) barriers to access contraception in this community, or to less common financial problems. However, no obvious circumstances for this have been identified in the study and require further research for accurate analysis.

1.3. Termination of pregnancy

The study clearly revealed the negative attitudes towards abortion in the society and on the other hand despite these negative attitudes the frequent practice of abortion of unwanted pregnancies, which can be considered as another proof of the extremely low prevalence of modern methods of contraception. It is important to note that the negative attitude towards abortion extends not only to its moral but also to its medical side. In particular, there has been a tendency that myths about serious complications of abortion exist in society, including the medical community, which are completely devoid of scientific evidence and lead to the demonization of abortion. But it is interesting to mention, that this type of attitude towards abortion does not reduce its number, but increases the number of abortions beyond medical institutions and, consequently, leads to the risks associated with women's health.[18] This trend, highlighted in the study, is confirmed by a number of large-scale international studies. Interviews or focus group discussions have shown that the issue of abortion is problematic in different directions, and it is important to discuss each of this directions, for further response.

When talking about the negative attitudes towards the medical aspects of abortion, one cannot fail to mention the particularly negative attitude of doctors towards abortion with medicines, which is probably caused by the lack of evidence-based information. In particular, doctors noted that abortion (especially during the first pregnancy) is a cause of post-abortion infertility in women (due to a number of hormonal changes, damage of the uterus and, more often, the need to cut it); Also, in their opinion, it often causes life-threatening complications such as strong bleeding and sepsis. This, naturally, along with other negative consequences, makes it even more difficult for women, and especially their most vulnerable groups, to access abortion services, as it has been proved that the widespread use of abortion with medicines greatly facilitates access to services for women.[19]

"We make them scare, because these are now pills terminating pregnancy. We use these pills for uterine contractions after the childbirth. Someone, most probably doctor, has probably taught one of the patients that if she takes this pill while pregnancy, the uterus will be compressed and this will lead to an abortion, thus it is possible. We are often frightening patients, telling them - that if I find out that you have taken a pill, I will call the police - or warning - that if you take these tablets, you may bleed so much that you will not be able to get to the clinic. So we limit consumption"- Gynecologist, Kvemo Kartli region

18 World Health Organization. Abortion. Key Facts. Information is available online: https://www.who.int/news-room/fact-sheets/detail/abortion. [Last viewed: 10.12.2021].

19 Iyengar, K., Iyengar, S.D. improving access to safe abortion in a rural primary care setting in India: experience of a service delivery intervention. Reprod Health 13, 54 (2016). https://doi.org/10.1186/s12978-016-0157-5.

As already mentioned, due to low access to modern methods of contraception, abortion is often the only way for women to control their own reproduction, which, despite the negative attitude towards it, is not uncommon. Women themselves mention several reasons for abortion, these include undesirable pregnancy, sex of the foetus, and health issues of woman or foetus itself. It is important to mention, that negative attitudes toward abortion in general, both by women and physicians, are less negative in abortions performed for a third reason; Relatively common negative attitude is while sex-selective abortions, but negative context is less oriented towards abortion and is more directed towards the gender selection; And, the most severe attitude is in the case of abortions performed for the purpose of terminating an undesirable pregnancy. This type of attitude towards abortion may indicate a double standard in society and a common practice of control of women's reproduction.

The most severe of the barriers to receiving abortion services, which study identified, were financial, geographical, and stigma barriers to abortion. When talking about this issue, it is important to note that among sexual and reproductive health services, abortion service is one of the most inaccessible services, which is primarily caused by abortion-related stigma and also by the lack of funding for abortion within the scope of the state services. When discussing abortion-related stigma, it is important to consider the stigma that exists in the community, and among health care providers, and the barriers to receiving the services that result from it.

Research has shown that because of stigma, women hide their abortion decisions even from family members and generally find it difficult to talk about this issue. Unlike maternal health services, for which the all financial and human resources of the whole family are mobilized, women have to receive abortion services alone and often, secretly. Accordingly, while receiving the service, they lose both social and financial support. This has vital importance especially for women because, as mentioned above, they for the most part do not have financial independence and do not have their own transport. In such a situation, moving from their village to the municipal centre and receiving paid services is practically impossible for them.

Interviews with physicians among health care providers have clearly highlighted its negative impact on abortion stigma and service delivery. As it turned out, gynecologists always try to persuade women not to do abortion and at the same time present abortion in an extremely negative context. All of this is most likely is another barrier for a woman to visit a medical facility and benefit from safe abortion services.

"A woman should realize that this (fetus) is a gift from nature, as to the contraception, she should use it from the beginning so that she does not have to choose whether to have an abortion" - in-depth interview with a doctor

"Everyone knows that whoever comes to me, I start talk by saying that abortion should not be done, because abortion is a matter of three minutes, but pregnancy is nine months, damage is easy thing, while creating is difficult. Many of them then come to me with the children, telling me -look this is your child, it is your gift and I have many such children "- in-depth interview with the doctor

Although the study did not explicitly identify violations of patient privacy and confidentiality in a medical facilities, there was still a tendency among women who came to health care facilities to have no hope of full

protection of their privacy and confidentiality. Women have often pointed out that it is difficult not to meet an acquaintance at a medical facility who will ask you for sure, or then ask someone else the reason of your visit to the medical facility. Therefore, it is almost impossible to protect privacy.

> **"But I generally think that even in this case, this [confidentiality] in the villages might be more problematic. I have a nurse whom I know and she said, that it is possible to say for what one visited the doctor by the manner they enter and exist doctor. Therefore, confidentiality cannot be maintained here. Probably it is more protected in the city"- In-depth interview with a woman, Gardabani Municipality**

Because of all of the above-mentioned barriers, the practice of self-termination of pregnancy is common in women. According to the recommendations of the World Health Organization, women can manage medical abortion independently, but only with proper knowledge and in cases where abortion services are not accessible under the supervision of a doctor. The practice described by women during interviews is even more likely to show that they have no any knowledge or professional supervision, which, in the event of possible complications, significantly increases the chances of developing a woman's health risks.

1.4. Sexual and reproductive health services for minors

It is interesting to see the practice of providing abortion, contraception and, in general, sexual and reproductive health services to minors. The study showed that doctors have no information on the Articles 40 and 41 of the Law of Georgia on Rights of Patients, which allows the provision of sexual and reproductive health services to a person under the age of 18 without permission of parents and provision information to them. Due to lack of information, this right granted by law is violated in almost all cases. It is noteworthy that the obligation to inform the parent and the police is explained by the doctors mainly by the law prohibiting the marriage of minors. At the same time, there has been revealed a tendency that informing the police, due to the accompanying punitive measures, is an undesirable action for doctors, and they do it only under compulsion out of obligation. Based on this information and the established practice by which society often tries to conceal the facts of marriage of minors, we can assume that law enforcement in relation to minors is a vicious practice. In particular, we can assume that law enforcement agencies are not informed of the alleged facts of violence, but only in a situation when there is no other way (e.g., a minor's pregnancy). Without assessing the possible fact of violence, informing the police about each case of a juvenile pregnancy and avoiding it in other cases is ultimately likely to not even protect the juveniles, but creates a barrier to the use of necessary and quality services. In addition, it should be considered that one of the motives for the termination of unwanted pregnancies by underage girls might be to avoiding a marriage at an early age.

1.5. Reproduction violence

Reproductive violence is a covert form of violence against women and includes actions involving the control of a woman's reproductive autonomy and aiming to prevent or to force her to become pregnant.[20] Reproductive violence usually has three main forms. These are: coercion of pregnancy (when a woman becomes a victim of pressure or violence to get pregnant against her will); contraceptive sabotage (intentional harm, concealment, or other action during contraception) and control of pregnancy outcome (forcing a woman to

20 Laura Tarzia and Kelsey Hegarty, "A Conceptual Re-Evaluation of Reproductive Coercion: Centring Intent, Fear and Control," Reproductive Health 18, no. 1 (December 2021): 87, https://doi.org/10.1186/s12978-021-01143-6.

terminate or continue a pregnancy against her will).[21] It is noteworthy that there is a difference of opinion around the term reproductive violence. The same is said in the article[22] published a few years, it is mentioned that there is no common opinion on what exactly can be considered as reproductive violence. For example, some of the authors believe that structural forms of discrimination and violence that control reproduction against women' will can also be considered as reproductive violence. There is also no consensus in the literature on who can be considered a perpetrator of reproductive violence - only a partner or another family members, relative or other person. Despite such differences of opinion, experts in the field believe that the forms of reproductive violence, the determinants and the perpetrators, depending on the geopolitical, social, cultural and economic factors of the country, can be significantly different.[23]

Research has shown that socio-cultural norms and gender inequality established in society create an environment conducive to reproductive violence and ultimately lead to the practice of this type of violence. It should be noted that the vast majority of respondents do not perceive such cases as violence, which is not surprising, as the causes and manifestations of this type of violence are firmly established in society and are often considered a social norm. Besides, due to the sensitivity of the issue, this is a topic that is rarely discussed, which, in turn, further complicates the possibility of detecting such cases and further study. When talking about reproductive violence and factors contributing to it, it is important to mention expectations of the society that a woman needs to become pregnant shortly after marriage. In particular, respondents to the study, talked about the fact that the expectation of the first child from the community and family members is so high that the vast majority of women do not even consider using contraception before having their first child. A similar attitude was expressed among physicians. Part of the interviewed gynaecologists mentioned that they did not recommend the use of contraception to women (including minors) until the first pregnancy.

"Well, before the first child, none of the contraception methods are used in the villages. On the contrary, everyone rushes the couple to find out the pregnancy news from them as soon as possible. Already after giving birth, the older members of the family, be it the mother, sister-in-law or the mother-in-law advise to use contraception "- Village doctor, Gardabani municipality

"You know, the first pregnancy should come at least, if the first and second pregnancies already took place, the interval before third pregnancy can be prolonged through contraception. I would not recommend to use contraceptives to teenager in the beginning. If they married, etc. they should give a birth at least to one [child] "- gynaecologist, Kvemo Kartli region

In addition, research has shown that a partner and other family members are actively involved in women's pregnancy decisions, which is particularly acute in the case of abortion.

21 Karen Trister Grace and Jocelyn C. Anderson, "Reproductive Coercion: A Systematic Review," Trauma, Violence, & Abuse 19, no. 4 (October 2018): 371–90, https://doi.org/10.1177/1524838016663935.\\uc0\\u8220{}Reproductive Coercion: A Systematic Review,\\uc0\\u8221{} {\\i{}Trauma, Violence, & Abuse} 19, no. 4 (October 2018

22 Karen Trister Grace and Christina Fleming, "A Systematic Review of Reproductive Coercion in International Settings: International Reproductive Coercion," World Medical & Health Policy 8, no. 4 (December 2016): 382–408, https://doi.org/10.1002/wmh3.209.

23 Ibid

"The head of the family [meaning an older person] may say that we do not need that child and should remove it, or vice versa. As for protective means, they also say that you do not need them, and you should be more restrained "- Akhalkalaki, girl from focus group

"The spouse and often her family members, especially the mother-in-law, play an important role in the final decision on abortion" - Doctor, Gardabani Municipality

"In general, social pressure is quite strong and the influence of other family members, so it often happens that a woman is not allowed to terminate a pregnancy despite her desire" - Doctor, Gardabani Municipality

The practice of active intervention of family members in reproductive decisions (often against the will of women) and one of the manifestations of the normalization of this practice can also be considered the actions of physicians. In particular, research has shown that when providing abortion services, doctors often involve female family members in the decision-making process, as they call themselves, "asking for an opinion" or "just keeping them informed". Moreover, in one of the interviews, the gynaecologist mentioned that they did not perform female sterilization without the consent of her spouse.

In general, the study identified a number of circumstances that indicate the existence of a common practice of direct or indirect control of female reproduction and, therefore, can be considered as contributing factors to reproductive violence. Research has revealed that women are often deprived of the opportunity to freely, without any violence or coercion, control when, how much and at what interval to have children. Pregnancy and motherhood are often encouraged against their will, both by partners and other family members. Consequently, they constantly have to justify and explain why they are not having children, sometimes to hide that they are pregnant, or are using contraceptives. In addition, the unequal geographical distribution of necessary services and the problem of women's financial access to these services, especially in the absence of their economic independence, ultimately makes them even more vulnerable to reproductive violence.

2. Maternal Health

According to the World Health Organization, maternal health combines women's health issues during pregnancy, childbirth, and the post delivery period.[24] The last usually continues for 6 weeks; however, taking into account various individual, socio-economic and cultural factors, it is possible to determine the term up to 1 year.[25] This time is characterized by a series of rapid physiological changes in a woman's body, accompanied by the emotional lability caused by these changes and the birth of a child, and the difficulties associated with the process of adjusting to new family member. In addition, for women, during pregnancy, childbirth and the post-delivery period, a special burden is imposed on women in the circumstances of the socio-cultural factors and gender roles, placing them in an unequal position compared to men. These include, for example, gender-based violence, the obligation to care for children and other family members, lack of financial

24 World Health Organization. Maternal Health. Information is available online: https://www.who.int/health-topics/maternal-health#tab=tab_1. [Last viewed: 15.12.2021].

25 Kenneth Finlayson et al., "What Matters to Women in the Postnatal Period: A Meta-Synthesis of Qualitative Studies," ed. Christine E. East, PLOS ONE 15, no. 4 (April 22, 2020): e0231415, https://doi.org/10.1371/journal.pone.0231415.

independence, and so on. Therefore, in order to ensure the health of mothers, in the process of planning and implementation of state programs or services, it is necessary to take into account each of these factors. Only such an approach to the issue might reduce maternal and child illnesses and mortality.

Unlike other components of sexual and reproductive health, the issue of maternal health in Georgia is one of the exceptions, which is integrated into state health programs. The annual reports of the National Centre for Disease Control and Public Health show that the introduction of public maternal health services and the standardization of perinatal care facilities have significantly improved maternal and child illness and mortality rates in recent years.[26] The above-mentioned reports of the research conducted by the Public Defender of Georgia in 2017 and 2019 also talked about the usefulness of state programs for maternal health services.

Unfortunately, despite the steps taken, a number of maternal health issues still remain unaddressed. For example, the issues of both physical and mental health and social well-being of women in the post-delivery period are practically neglected. Moreover, two latter are not covered by any component of public maternal health services and the health care system in general.[27]

2.1. Access to antenatal services and existing barriers

Barrier related to management of antenatal care program: Research has shown that, unlike other sexual and reproductive health services, maternal health services are actively used, as a result of socio-cultural norms related to motherhood and existence of state funding for these services. All of this will ultimately have a positive effect on a pregnant woman's health and financial well-being.

According to the study, despite the active use of services, there are frequent cases when women, especially women living in rural areas, are unable to visit a medical facility for antenatal care until the 13th week of pregnancy. This issue is noteworthy for several reasons. Delayed visits, on the one hand, increase health risks and, on the other hand, deprive pregnant women of the opportunity to benefit from the state program.[28] Here, it is important to consider the reasons for the delayed visits, as they are related to the difficulties, the elimination of which is primarily the responsibility of the state. Among the named reasons for delayed visits was named language barrier and the difficulties to keep society informed due to this reason. There should be mentioned additional circumstances that may, in some cases, be reasons for the practice of late referrals. Although the direct link between the events was not mentioned by the respondents themselves, the study found a tendency among women to pay much less attention to their own health during the second and subsequent pregnancies rather than for the first pregnancy – they visit medical facility less frequently and pay less attention to the doctor's advice, especially when it comes to financial costs. It should also be noted that the risks associated with pregnancy and childbirth do not decrease inversely with the increase of the number of pregnancies, and antenatal care during the second and subsequent pregnancies is as important as in the first case.

26 Annual statistical reports are available electronically: https://www.ncdc.ge/#/blog/blog-list/f10b3ffb-da47-4488-94df-2f03764cf365.

27 Healthcare infrastructure, qualification of medical staff, arrangement of services, etc. It is not sensitive to respond to women's sexual and reproductive health needs and to provide the right, non-discriminatory services. This is confirmed by a number of research or monitoring reports, which are mainly prepared by NGOs working on sexual and reproductive health and rights issues. This is confirmed by the reports of the Public Defender of Georgia.

28 The antenatal state program can be used only if the pregnant woman is registered before the 13th week of pregnancy.

Barrier related to the quality of medical services: In addition to the above mentioned, the study also identified problems related to the quality of medical services. In this regard, we should consider problematic of the issue in different directions. In particular, if we consider the quality of medical services in terms of two - human and technical (medical infrastructure) resources, two main trends emerge. As it turned out, in both regions, gynaecologists working in municipal centres had more or less trust among population, especially during uncomplicated, physiologically ongoing pregnancies and childbirth. However, trust towards physicians is less common in complicated cases and also there is the less trust to medical infrastructure. Respondents often said that in the event of a health problem, they had to go to a qualified and trusted doctor in Tbilisi or other nearby large cities, and in almost all cases said that the equipment available in the regions was not sufficient even for routine examinations during uncomplicated pregnancy. As expected, this fact is associated with limited consumption of basic medical services and increased financial costs to the population. The fact poses an even greater burden for women in circumstances, when pregnant women do not have the right to change medical facilities while antenatal monitoring, and therefore the cost of services provided at the changed medical facility as a result of improper services is not reimbursed. The low quality of medical care and low level of trust may be indicated by the fact that the respondents remembered how carefully they sought information about the doctor, or how they had to change medical facilities because they did not receive a quality medical service. It was obvious from their talk that women have less trust for health services, especially in the regions, and this often raises certain types of problems. As mentioned, it creates the problem of geographical access and increases financial costs. In this regard, the facts were revealed when women had to go to a neighbouring country to receive quality and cost-effective service.

Financial barrier: In addition to poor quality medical care, the increase in direct and indirect medical costs is due, on the one hand, to high prices in private clinics and, on the other hand, to the need for a number of medical services related to abnormalities during pregnancy left beyond state programs. All respondents noted that despite the large share of state-funded services, they systematically have to pay extra, to receive all desired services which they often fail to do and therefore remain without proper medical supervision. In addition, according to the study, increased medical costs resulted from above mentioned circumstances may cause catastrophic costs for families, several respondents said that in order to receive the necessary services during pregnancy and childbirth, it became necessary to “pawn their belongings”.

Barriers related to cultural and non-friendly services: The facts of breach of patient’s privacy and the interference in private environment were revealed with the least severity within the study. However, most probably that this result of the study is caused by disqualification under the influence of social, cultural and state policy factors, rather than the lack of facts. This is based on the analysis of interviews with both doctors and respondents. Although the respondents’ response to the question, “Is your privacy protected while receiving maternal health services” was positive (not violated, protected), but different information was provided during various stages of the interviews. In particular, some of the respondents spoke about the ill-treatment of medical staff - “they are rude”; It was said that everyone in the villages and small towns knew each other and that “everyone understands everything easily” about the medical need of a woman who came for medical care.

“As for the visits, I do not see a problem here to enter together with a relative or a friend, for example, because they come with a person who already knew the situation and it does not create any problems. She comes with a person she trusts, I think so“- gynaecologist, Kvemo Kartli region

It is noteworthy that respondents perceive similar facts more strongly when receiving contraception and abortion services than when receiving maternal health services. This may be another clear demonstration of the less severe perception of the facts of neglecting the boundaries of women's personal space and breach of confidentiality.

When talking about cultural barriers, it is important to note, one gynaecologist during one of his interviews shared information, that in a particular region, at the beginning of his career, women from a non-dominant ethnic group had less trust towards him and it took a lot of effort to gain this trust. The respondent himself explained this by different ethnic backgrounds. It is true that a similar fact was not repeated in the study, but the question of women's trust to the medical staff was clearly revealed. That is why it is important to conduct in-depth research on the issue of trust towards public health professionals and to find out links between reasons and results of the current situation.

It is interesting to note the fact that respondents often talked about the discomfort caused by receiving medical care and the fear associated with it. Most of the women specifically outlined that visiting a medical facility with an accompanying person while using gynaecological services is much more convenient for them as they act as a supporter. This type of attitude towards medical services was evident in the case of almost all female respondents, which makes it highly probable that gynaecological services provided by health care providers are unfriendly and cause strong stress to the beneficiaries of the service. This do not exclude the fact that this factor may be a reason for refusing to receive the services needed by a significant number of women. Especially when several respondents talked openly about it.

«No, just visiting a gynaecologist is a big stress for me, I am very ashamed. My only problem is this, so I prefer not to go, «- an in-depth interview

Research has shown that for a large proportion of women, male gynaecologists are also a significant barrier while receiving of gynaecological services, which often becomes a reason for refusing to use the service. In addition, there have been cases where women have refused male gynaecologist services based on the wishes of their family members, not their own.

Problems associated with the language barrier: Respondents of the research did not name language as a significant barrier while access to medical services. Although a significant proportion of respondents did not speak Georgian, they said that this did not pose a problem for them because they have doctors in the municipality who speak Armenian / Azerbaijani or Russian. Nevertheless, language barrier problems were identified when receiving services provided not locally but in other municipalities (mainly Rustavi and Tbilisi). Respondents mentioned that in such a case they are assisted by other Armenian / Azerbaijani language medical staff or a Georgian language family member. For some women, they say, this is not a problem, while others say they are less informed because of the language barrier. In addition, there have been some cases where a family member was present at the service due to a language barrier and the woman, despite her health complaints, was unable to ask doctor questions, because she was ashamed of accompanying person.

When talking about the use of maternal health services, it is important to mention the cases of payment for services funded through state programs. Such practices have been identified in both antenatal and childbirth

services. Respondents, including one representative of the medical field, noted that health care facilities often use the language barrier of non-dominant ethnic groups and charge for antenatal services funded by the state program. It should be noted that this type of practice was revealed only in the Kvemo Kartli region; but we cannot say the same about so-called "money gifts" practice which has been equally relevant in both regions and involves paying money (as a gift) to medical personnel during childbirth, and which, despite its informal nature, is considered an established rule and therefore places an additional financial burden on families.

2.2. Access to childbirth services and barriers

The study showed that the funding of maternity medical services under the state program and its quality has a positive impact on the health and financial well-being of women from non-dominant ethnic groups. However, at the same time, a number of circumstances have been revealed that neglect the needs of women during childbirth and often lead to humiliating practices.

As with other sexual and reproductive health issues, childbirth problems are largely driven by existing gender and cultural norms. An obvious example of this is the normalization of delivery related pain in the target community, which, in turn, is seen as an accompanying necessity for a woman to have a biological child as a special gift from nature. That is why the pains experienced during childbirth are perceived by the society as an unavoidable experience, after which it is believed that a woman will feel better the joy caused by motherhood. Presumably, this must be the reason why, even in the case of medical necessity, women feel guilty for not being able to play the role of a "perfect mother" (in the form of a physiological birth) for a new-born. In addition to the above factors, geographical and language issues were identified as barriers, but with less severity, while receiving childbirth services. The problem of geographical access was discussed, especially by rural women, and noted that transportation during childbirth often requires a great deal of effort and resources.[29] Respondents also talked about the existence of a language barrier and the discriminatory treatment caused by this barrier. It should be noted that this problem was mainly identified in the case of respondents who had a maternity experience not in a local but in another city hospital.

"I had felt when I was in the hospital, that Georgian women were more often visited by a doctor and they were more attentive to them than to us" - Focus group member, Gardabani

"I think that the main factor here is the knowledge of the language, and not the ethnic identity. If you do not know Georgian, then you will be treated with indifference. Sometimes it happens that the doctors do not answer you at all, if you ask something in Russian. The language barrier is a problem for us in many ways," said focus group participant from Gardabani

2.3. Gynaecological violence

According to the World Health Organization, gynaecological violence is a humiliating and violent treatment towards a woman during childbirth in a medical facility, which can manifest itself in the following actions: physical violence, shame and verbal violence, coercion or doing medical manipulation (including consent, sterilization) without consent, violation of privacy, not getting of informed consent, refusal to use pain management medication, significant violation of privacy, refusal to let enter a medical facility, neglect of

29 One respondent recalled a case of childbirth at home when an ambulance failed to deliver and the woman gave birth at home (village of Kulikami).

life-threatening, avoidable complications, and keep mother and child in medical facilities due to non-payment.[30] The same list includes any type of manipulation, the effectiveness of which has no scientific evidence, and the implementation of which leads to a violation of a woman's dignity or deterioration of health.[31] Due to the fact that gynaecological violence is often manifested in various forms of gynaecological examination, it usually becomes impossible for a large proportion of women to detect them. Moreover, there are frequent cases when a woman, while examining a patient by a doctor, becomes the object of sexual harassment or violence in a way that she herself cannot understand. It should be noted that the determinants of gynecological violence are quite complex in nature and have an individual, structural and political basis.[32] Therefore, the state has a great role to play in combating gynecological violence. For this, first of all, it is necessary to establish gynecological violence as a legal term, to study the prevalence or manifestation of these forms of violence and to set appropriate standards in medical institutions.[33]

Research has shown that during the whole period of pregnancy and childbirth, a woman's individual needs are often ignored, as well as the right to comprehensive information about her own health and to make independent choices based on this information. More specifically, pregnant women and women on delivery are not proactively provided with evidence-based scientific information. Moreover, there are frequent cases when first and foremost partners and other family members of women participate in decision making process, before the women themselves do. All of this ultimately neglects the autonomy of the women's body and the right to make informed decisions.

"The doctor on duty is obliged to decide for himself within 24 hours [implies a decision on medical manipulation]. He explains to the family members depending on the patient's health condition, for example, if a caesarean section is needed at this stage or not and if the life of the mother and baby is in danger. In any case, the family members who came with her are also informed "- Gynecologist, Kvemo Kartli region

In addition to these facts of mistreatment, respondents also talked about the many unnecessary medications and examinations prescribed by doctors during pregnancy or childbirth. This, in addition to unnecessary costs, is likely to increase health risks as well.

Finally, when talking about gynecological violence, it is important to note the common practice identified in the research, which is related to the child birth process and is considered as a harmful practice that violates the dignity of women instead of protecting scientific values. Research has shown that during childbirth, women's ability to act seems to be questioned, while decisions made are based on violent and authoritarian actions.

30 World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth. 2014. p.1. (afterwords: World Health Organization, 2014) Information available online: http://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1. Last viewed: [12.12.2021].

31 The Parliamentary Assembly of the Council of Europe. Committee on Equality and Non-Discrimination. Obstetrician and Gynecological Violence 2019. Information available online: http://www.assembly.coe.int/LifeRay/EGA/Pdf/TextesProvisoires/2019/20190912-ObstetricalViolence-EN.pdf. Last viewed: 12.12.2021].

32 Anna Annborn and Hafrún Rafnar Finnbogadóttir, "Obstetric Violence a Qualitative Interview Study," Midwifery 105 (February 2022): 103212, https://doi.org/10.1016/j.midw.2021.103212.

33 World Health Organization, 2014. p. 2.

"Sometimes the patient says that she does not want a child or a husband and I am bad. Then I say, well, I do not also care if the child chocked, so, it's individual. Every patient is different. Some patients sometimes behave inadequately and endanger the fetus as well. Then pour water [should be poured], cold water. Because a person cannot think at this time and this chock child. Doctors explain this action like this" – gynecologist, Kvemo Kartli region

The study also found that unnecessary and harmful procedures such as pressure on the base, bowel cleansing procedures, episiotomy, shaving of the pelvis, sometimes - the use of physical force, etc. are still common. Respondents, both women and doctors, noted that according to the information at their disposal, this type of practice has also gradually declined in recent years, although it still exists, especially in the regions. It is also noteworthy that the existence of unnecessary medical manipulations (practices) that are caused by cultural norms and gender inequality and violate a woman's bodily autonomy has been revealed.

"Sometimes a patient tells us not to sew and I answer, not for you, I do it for your husband. Visually, it is completely unnoticeable "- gynecologist, Kvemo Kartli region.

2.4. Post-delivery period and social factors affecting maternal health

Research has shown that women's access to medical services is quite low during the post-delivery period. Only a small proportion of women visit a medical facility during this period, even in the case of health-related complaints. However, it should also be noted that pronounced health problems are not always a sufficient reason for women to see a doctor. Several respondents of the study noted that despite the complaints, she was unable to come to the medical facility due to some household work. In the case of some women, this reason was also named as the barrier to get antenatal services.

"Sometimes, due to family circumstances, I could not get these services, but later I was going. I would call and tell him that I had a good reason and the doctor would tell me, it's okay, you can come in 2-3 days "- the woman, participant of in the in-depth interview

Research has also shown that the post-delivery period is entirely fits the interests of the new-born and the needs of the mother are neglected. In addition to this all house hold work mostly falls on the shoulders of women. It turned out that women, especially women living in rural areas, have to live in difficult living conditions. They often mentioned problems with water supply, gasification that is resulting in increased domestic labour, which, especially during the winter season, complicates women's work and poses serious health risks.

The study also found that in the post-delivery period, women often experience mental health problems, mainly due to new responsibilities due to the birth of a child and difficulties in relationships with new family member.

3. Harmful practices in terms of sexual and reproductive health and rights

Harmful practices are human rights violations and can take many forms. For example, female genital mutilation, child and forced marriages, so called test of virginity and other similar practices, radical dietary restrictions, including during pregnancy (forced feeding, food-related taboos), corporal punishment, beating, etc. Such practices are discriminatory against women and adolescents and put their sexual and reproductive health, rights, and lives at serious risk. The existence of harmful practices is closely linked to discrimination based on sex, gender, age, disability status or other grounds. Women and girls from various marginalized groups are particularly vulnerable to it. That is why the right to protection of women and girls from harmful practices is recognized by a number of international legal instruments protection rights of women and children, recalling the states to eliminate such practices.[34]

Early marriage: It is noteworthy that the respondents highlighted the common practice of early marriage, which, as it turned out, despite the recent declining trend, still remains a significant challenge for young people.

While the negative consequences of early marriage are obvious to all respondents of research, their perceptions differ in relation to the definition of early marriage and the negative consequences it entails. In this regard, it should be noted that the vast majority of the youth group and only a small proportion of the remaining respondents correctly explained early marriage, adding that readiness for marriage is rarely directly related to a person's biological age and more closely related to a person's level of individual development. It is interesting to note that respondents perceive the damage done by early marriage differently in terms of gender, and say that at such times women suffer much more than men. It is interesting that, despite this, for the vast majority of respondents, the upper limit of early marriage is much lower for women than for men. It is also interesting to note that when talking about the negative consequences of early marriage, respondents with such experiences were much more radical and specific than those who did not have such experiences. It is true that all respondents pointed to the negative impact of early marriage on the physical health of women and children and a woman's reproductive ability, however only respondents with this experience talked about problems to get education, economic independence, professional development in case of early marriage. The girls actively recalled their own and others' experiences of health problems during early marriage and pregnancy.

Research has also shown that women's autonomy, the exercise of their right to sexual and reproductive health is more likely to be violated in the case of early marriage, which is best perceived by women with such experiences. It has been supposed that women often form a family against their will, without clear understanding, as a result of direct or indirect influence of society.

> **"Some may not want to marry, some study, want to work after studying, the society does it so that some people are forced to get married and leave everything they had started" - a girl participating in the focus group, Akhalkalaki**

34 UN Human Rights Office of the HIgh Commissioner. Harmful Practices 2020. p 1-2. Information available online: https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Harm_Pract_WEB.pdf. [last viewed: 15.12.2021].

Among the reasons for early marriage, respondents named the problem of access to education, especially in the case of rural girls, socio-cultural characteristics - they noted that after a certain age a woman is considered "old" for marriage, as well as financial problems. In addition, one of the reasons for early marriage was the methods of strict / violent parenting, during which girls make the decision to marry to free themselves from the chains of their parents.

"Yes, it also comes from elder ones. Here, now the girl turns 18 years old. They start talking, why are you keeping her at home? The others call her remained. They use the word and start getting marry fast. For example, 22 years is more normal for me "- in-depth interview, Akhalkalaki

Gender Selection: When talking about harmful practices, it is important to mention gender selection, which respondents say is still a common practice. As research has shown, there are frequent cases when a woman is forced by her husband, or another member of the family (most often named mother-in-low) to have an abortion when the fetus is female. This circumstance, in addition to being one of the forms of gender-based violence and clearly needs to be addressed, is also important in the sense that women, for this very reason, are often victims of reproductive violence. According to the respondents, due to the desire to have boys prolonging "family name", partners and other family members prevent women from using the contraception, and in case of pregnancy, they are forced to have an abortion if the sex of the foetus is not acceptable to them.

Other Harmful Practices: Another harmful practice that can have a significant negative impact on a woman's mental and sexual health is the so-called tradition of virginity testing during marriage, which, is a common practice in both ethnic groups, but in different forms. Survey respondents noted that this tradition means gross interference in their personal lives and is humiliating to them.

"I do not think women want it, I tell you from my experience, it is very difficult and elder ones force us" - In-depth interview, Akhalkalaki

CONCLUSION

The information presented in the report replicates the results of the research conducted by the Public Defender of Georgia in the field of sexual and reproductive health and rights in previous years and once again confirms the severity of the challenges in the country in this regard. In addition, it identifies a number of social and cultural factors that create specific needs and barriers while accessing sexual and reproductive health services for the research target group and that are important to consider when developing policies, programs, and services.

RECOMMENDATIONS

To Georgian Government

- Ensuring family planning and contraceptive services' integration in the public healthcare programs; In particular, covering modern contraceptive methods for the target population (including non-dominant ethnic groups) within the basic package of the universal health coverage. Apart from that, providing information for them in the language of their preference; providing culturally acceptable contraceptives for them, and provide geographical access to services and products for rural women.
- Ensuring the integration of mental health issues into maternal health programs and, at the service implementation stage, in order to avoid refusal to use services due to cultural attitudes among women, provide a specific, active information campaign on the importance of mental health and need of the program.
- Ensure the integration of effective and evidence-based postnatal medical care services into the maternal health program.
- Ensuring profound understanding of gynaecological and reproductive violence and, based on the results of the research, developing appropriate programs and policies.
- Start working on legislative amendments to prevent and fight hidden forms of gynaecological and reproductive violence.
- Information providing and awareness raising of those who are responsible for prevention of and response to early marriage, in order to effectively enforce the law against early marriage.

To Ministry of Internally Displaced Persons from the Occupied Territories, Labor, Health and Social Affairs of Georgia:

- Developing a quality assessment standard for medical institutions providing maternal health services and an effective monitoring mechanism for its implementation.
- Ensuring the development of a system of compulsory continuing medical education and promote the continuing qualification of physicians, where, in addition to receiving evidence-based medical information, physicians learn the principles of communication with patients, diversity, and the importance of social ethics while managing medical ethics and health.
- Developing and / or updating national contraceptive guidelines in accordance with established national guidelines for abortion, including medical abortion, antenatal, maternity and postnatal care; also, in parallel with these processes, the developing patient manuals in a language understandable to members of the non-dominant ethnic groups.

- Providing information and training of medical staff according to updated / newly developed guidelines and protocols.
- Systematically informing the medical staff on the current legislative changes in the field of healthcare, if necessary, ensure their training.
- Introducing a mandatory professional translator system in medical institutions to provide quality medical services to non-dominant ethnic groups.
- In cooperation with the Government of Georgia, developing an effective mechanism for the prevention and control of any form of violence and discrimination in medical institutions, including reproductive and gynaecological violence.
- Providing training for rural and family physicians on modern methods of contraception and their active participation in the delivery of family planning services.
- When collecting data in state programs, breaking down information by ethnic group and conduct systematic analysis of this information to address potential barriers, study the use of sexual and reproductive health services by women from non-dominant ethnic groups, and conduct in-depth research as needed.

To Ministry of Education and Science of Georgia:

- Ensuring full integration of school-based comprehensive education on human sexuality into curricula, train teachers - provide effective, results-oriented training. In particular, in addition to the medical aspects, the teaching of the legal aspect of sexual and reproductive health and by informing in this way the weakening of the cultural, gender and social factors that give rise to the widespread practice of violations of rights in the direction of sexual and reproductive health of women and girls;
- Ensuring the introduction of a standard in the medical and healthcare faculties in higher education institutions to teach students the ways to engage in right-based communication with patients from different marginalized groups and groups with special needs.

To Local governments:

- Studying the existing needs of sexual and reproductive health and rights of women and girls from the non-dominant ethnic groups living in their own municipal units and developing appropriate health and social programs tailored to these needs.
- Actively conducting information campaigns on state programs related to sexual and reproductive health in a language understandable to non-dominant ethnic groups.