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The Permanent Mission of Georgia to the United Nations Office and other international organizations in Geneva presents its compliments to the Office of the United Nations High Commissioner for Human Rights and in reference to Note Verbale, dated 1 December 2017 (ref: WRGS/LOH/Res33/18), has the honour to transmit herewith an information from the Government of Georgia according to the Human Rights Council resolution 33/18 on preventable maternal mortality and morbidity and human rights.

The Permanent Mission of Georgia to the United Nations Office and other international organizations in Geneva avails itself of this opportunity to renew to the Office of the United Nations High Commissioner for Human Rights the assurances of its highest consideration.

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PERMANENT MISSION OF GEORGIA, GENEVA

Encl. 5 pages.

Office of the United Nations
High Commissioner for Human Rights
Geneva

1. **What steps has your Government or organization taken to utilize human rights based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? How has the technical guidance assisted your Government or organization in designing, implementing, revising and/or evaluating such policies and programmes?**

The Government of Georgia has the intention to substantially improve Maternal and New-born Health (MNH) in the coming 14 years. To this end it has developed a long-term strategy (2017-2030) and a closely related short-term Action Plan (2017-2019). Because MNH is closely related and strongly influenced by quality of Family Planning and of Sexual and Reproductive Health of young people, these two fields are also included in this MNH strategy.

Over the last decade, the government made significant efforts to improve maternal and child health care in the country. This was done under the ongoing general healthcare reforms as well as through reforms addressing maternal and child health in particular. Several State funded maternal and child healthcare programs have emerged related to antenatal care provision; identification and management of high-risk pregnancies; early detection of congenital anomalies; screening of pregnant women for HIV, hepatitis B and C, and syphilis; free provision of folic acid and iron supplements for pregnant women; free childbirth and caesarean section services as part of UHC. Further, the UHC program covers all health needs of children (0-18 years).

The initiative of starting the perinatal care regionalization process from May 2015 is a significant step forward in strengthening the maternal and newborn health care system, which considers defining the levels of perinatal service providers and their role and responsibilities in order to provide the correct timing of the correct patient to a correct medical institution and, if necessary, effective referral. Regionalization has been completed in 2017. 105 facilities were assessed, 82 facilities have designated level of care. All 82 facilities strengthened their capacity for infrastructure/equipment and competencies of service providers according to the level requirements.

In 2016, Ministry of Labour, Health and Social Affairs of Georgia in alliance with NCDC launched the nationwide electronic registry "Mother's and neonate's health surveillance system", so called "Georgian Birth Registry" (GBR). The system tracks information on all cases of pregnancy, delivery, postpartum, neonatal care and abortion.
The GBR provides an opportunity:

- to get comprehensive knowledge on a wide area of indicators, related to the maternal and newborn health, morbidity and mortality along with the quality of antenatal, obstetric and neonatal care;
- to make evidence-based policy decisions.

The GBR also allows monitoring the regionalization of perinatal care services through providing data on selected maternal and neonatal health indicators.
The coverage of pregnancy and childbirth by GBR increased from 47% in 2016 to 96 % in 2017.

In March, 2017 Ministry of Labour, Health and Social Affairs of Georgia initiated a selective contracting of facilities providing perinatal care services. Social Service Agency contracts only facilities which demonstrate required compliance with pre-defined quality criteria. Currently 30 facilities, providing perinatal care services from three largest cities of Georgia (Tbilisi, Kutaisi and Batumi) are involved in selective contracting process. The existed contract includes 10 quality indicators, covering the critical issues related to obstetric and neonatal care in Georgia.
In 2012, NCDC&PH implemented an active surveillance of death of reproductive age women (15-49y). Since 2015 the system also covers under -5 child mortality. The notifications are recorded by local public health offices that are responsible to collect information from local health facilities through Electronic Integrated Disease Surveillance System (EIDSS).
The routine clinical audit of cases of stillbirth and maternal and neonatal mortality has been introduced by the MoLSHA in 2017 with aim to advance practice of obstetrics and neonatal care and improve the quality of services through detailed clinical analysis of selected mortality cases. The comprehensive audit process allows identification of root causes of gaps and deficiencies in existing practices and in the health system and planning the corrective policy and practice measures at the local and national level.

Georgia maintains a strong commitment to prevent mother-to-child transmission of HIV and syphilis (EMTCT) and integrated EMTCT into the National MNH Strategy. The specific plan for meeting elimination targets has been developed by the national elimination committee. EMTCT interventions are part of the national maternal and child health care programs and are offered to the population free-of-charge.

Breast and cervical cancer are the main killers for women of reproductive age in Georgia. since 2013 the State is financing, to some extent. cancer treatment through the Universal Health Care (UHC) program, including chemotherapy, hormonotherapy, radial therapy and all related diagnostic testing, the screening programs have not been integrated in the primary health care services that is why there are geographical and financial barriers for utilization of screening programs. Some steps were also taken by the Georgian government to respond Adolescent health and women's violence.

Georgia has achieved remarkable progress in reducing under–five and neonatal mortality rates to 10.2 and 6.1 per 1000 live births respectively by 2015 thus accomplishing the Millennium Development Goal #4 (MDG) set at the 2000 Millennium Summit: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

While significant progress has been made in reducing child/infant mortality rates, more efforts are needed to improve maternal mortality figures. Maternal Mortality Ratio in Georgia has fluctuated widely over the past decades. In 2015 it was 32.1 per 100 000 live birth, which is higher than average rate both for European region and the CIS. The rate decreased to 22.9 per 100 000 livebirth in 2016.

2. **Has the technical guidance assisted your Government or organization in building enhanced understanding of the requirements of a human rights-based approach? If so, please expand upon the impact that such enhanced understanding bas for the design and implementation of policies and programmes in this area.**

The technical guidance provided great assistance in the process of identification and measure of problems, to the development of the strategy and the process of defining the budget of the activities. By the methodology provided in the guidance was developed Monitoring and evaluation framework.

At ICPD (Cairo 1994) a definition of Reproductive Health was adopted, which is still the international standard. This definition indicates that reproductive health includes three overlapping areas: sexual health, family planning and mother & new-born health. The same definition has also been the starting point of the MCH strategy mentioned above. The same starting point has led to the conclusion that family planning and adolescent SRH (a very important topic in ICPD/PoA) should be integrated in this strategic document on maternal and newborn health. Family planning is not only the right of parents to decide on the number and spacing of their children, but is also an important strategy for reducing the burden of unintended pregnancies and thereby incidence of induced abortion and abortion-related morbidity and mortality. Adolescents are more likely to engage in unprotected sex, which can result in sexually transmitted infections (STIs) or pregnancy, most of which are unwanted and are more likely to end in induced unsafe abortions, particularly among those who are around 20 years old . It should be stressed that, for a broad variety of reasons, Family Planning and Adolescent SRH have until now remained relatively neglected fields in Georgia that urgently need to be brought in focus in the coming years in view of life-course approach to reproductive health.

3. **What challenges does your Government or organization face in implementing a human rights based approach in policies and programmes to eliminate preventable maternal mortality and morbidity? Please elaborate on the nature of these challenges and steps taken to address them.**

Reducing maternal and neonatal mortality requires coordinated long term efforts. Many factors affect the ability of women and newborns to survive pregnancy and childbirth. It is increasingly recognized that high rates of maternal and newborn mortality are the result of problems in the health sector. However a variety of other issues related to gender, socio-cultural values, and the economic circumstances of households, communities and national political will also contribute to the high rates of maternal and newborn mortality. Other factors which also contribute to maternal and newborn deaths are: delays in recognizing problems, deciding to seek care, reaching care and receiving care. All aforementioned factors are the major elements of "Three delays" described in Thaddeus and Maine's model[1] and still present real challenges facing pregnant women and newborns in Georgia. Therefore, collective and creative strategies are needed to mobilize resources and generate popular support and political will that are critical to bringing about changes at multiple levels and achieving sustainable improvements in maternal and newborn health.

[1] Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med 1994; 38: 1091-1110

4. **With evidence indicating that a majority of maternal deaths occur ill fragile and humanitarian settings and that pregnant women may have increased medical risks in crises settings, how does your Government or organization work to apply a human rights based approach to reducing maternal mortality and morbidity in these contexts? Please elaborate on good practices and challenges in this regard.**

The Disaster Management Country Team (DMCT) promoted emergency response preparedness to enable concerted action by all national and international actors to optimize the speed and volume of critical assistance delivered immediately after the onset of a humanitarian emergency.

In partnership with UNFPA country office MoLHSA elaborate Minimum Initial Service Package (MISP) Emergency Preparedness/Contingency Action Plan for its further integration into the MoLHSA's Sectorial Response Plan to Disaster and Emergency Situations and consequently into the National Emergency Response Plan on provision of sexual and reproductive health services as per MISP recommendations. The plan is designed to respond life-saving activities at the onset of every humanitarian crisis for the people affected by Flooding and related Water-caused threats.

The conflict-affected population in Abkhazia, Georgia is deprived of the minimal safeguards for the protection of their rights provided by the international conventions. Reproductive Health (RH), including Maternal Health is of particular concern, with a lack of services, programmes and information for youth, women and mothers. A 2012 UNICEF assessment identified that care during normal pregnancy, delivery and neonatal period, as well as management of the most common obstetrical and neonatal conditions and complications, does not comply with international standards and evidence-based guidelines. Three out of five women do not go for a routine health exam for their child or themselves after birth, and 23% of women do not see an OB&GYN for consultations before giving birth. At the same time, Family Planning (FP) services are limited due to high informal payments and the absence of contraceptive commodities in pharmacies, as well as in public stocks. Modern contraceptive methods prevalence remains at low, as abortion is still used as a common method of family planning (FP). According to the available information publicized by de facto authorities, over 700 abortions have been performed in 2015; 1 in 11 women undergoing an abortion is an adolescent (2013). Also, due to unsafe abortions, 20% of families experience secondary infertility. On Feb-2016 de facto Parliament has outlawed abortion in an apparent effort to boost the number of population. The legislation includes a full ban on pregnancy terminations from the moment of conception.

Against this background, since 2006, UNFPA/Georgia CO has been supporting provision of basic RH/FP services in the "break-away" region of Abkhazia, Georgia, and since 2012 - provision of the cervical cancer screening services that would otherwise remain uncovered for the local conflict-affected population neither by local healthcare system, nor by international aid. Specifically:

- Introduction and endorsement of the 7 WHO FP clinical protocols adapted for Abkhazia, Georgia context; protocols were endorsed by the de facto Ministry of Health in Sep 2015.

- Free-of-charge cervical cancer screening services provided to the 25-60 age women at the RH Centre in Sukhumi and 10 affiliated facilities Abkhazia-wide. Screening services management follows the practice and experience of the similar programme in other parts of Georgia. The reference check and quality assurance of cytology diagnostics and morphology of samples is conducted in Tbilisi.
- Capacity development training of local RH/FP service providers delivered by International Russian-language speaking experts/trainers; over 60 RH specialist and nurses and over 100 PHC doctors have been trained on in modern methods of FP and other RH issues.
- Procurement and distribution of the modern methods of Family Planning (contraceptives), STI tests and basic medical equipment.

- Development, production and dissemination of Information Communication and Education (IEC) materials and TV ads/shows regarding RH/FP topics.
- Confidence Building workshops are organized biannually to foster networking and direct people-to-people contacts among the leading RH professionals from Tbilisi and Sukhumi. Usually, these workshop(s) are followed by exchange of visits of professionals to get first-hand information and experience and share knowledge and practices.

In overall, through UNFPA support over 5,000 women benefit each year from increased access to quality RH/FP services in Abkhazia, Georgia.

5. **Does your Government or organization regularly collect data on sexual and reproductive health in crisis settings? Please elaborate on good practices and challenges in this regards**

MoLHSA regularly does not collect data on sexual and reproductive health in crisis. As mentioned above, Minimum Initial Service Package (MISP) is elaborated, which include accountability mechanisms.