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POSITION PAPER

Rethinking Abortion Policy in Georgia: From Restrictive Measures to Evidence-Based Approaches

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To reduce the abortion rate in Georgia, a recent ministerial decree introduced new guidelines for performing an abortion (Amendment to Order N01-74/N, 2023; World Population Review, n.d.-b). The amendment to the guidelines includes (1) pre-abortion counselling with an obstetrician-gynaecologist, a psychologist, and a social worker; (2) performing all medical and surgical post-seven-week abortions in an inpatient medical facility; (3) a mandatory ultrasound after the five-day waiting period in addition to the first ultrasound during the initial consultation; (4) reporting all abortions performed after 12 weeks to the Mother and Child Health Coordinating Council (Amendment to Order N01-74/N, 2023). The assumption that limiting abortion access will reduce the number of abortions and boost fertility rates lacks empirical support. Such restrictions are more likely to have detrimental effects, including delayed abortion care, unsafe abortions, and heightened social inequalities. To effectively counter the trend of declining total fertility rates, policy interventions should prioritize broader socio-economic and cultural considerations over misguided notions regarding the impact of abortion access.

Context

Across the globe, abortion legislation has been a topic of debate for more than a century. In 1920, the Soviet government was the first to decriminalize abortion (Avdeev et al., 1995; David, 1992). This legalization was seen as an 'unfortunate necessity', and following improvement in the Union's economic and social conditions abortion was re-criminalized in 1936. However, after Stalin died in 1953, abortion was liberalized in the region once again, including in Georgia. Contraception and other alternatives to abortion remained scarce for Soviet women. This could explain why, after the widespread independence in 1991 and increased access to modern contraception, post-Soviet Eastern Europe experienced the biggest abortion decline in the world (the abortion rate declined by 70% between 1990-1994 and 2015-2019) (Bearak et al., 2020). For instance, in Georgia and its South Caucasian neighbours, Armenia and Azerbaijan, the abortion rate declined by 47%, 75%, and 57%, respectively (Guttmacher Institute, n.d.). This is in sheer contrast to Western European countries such as Belgium, The Netherlands, and Sweden, whose abortion rates remained fairly stable throughout the same period.

Even though a 47% decline is significant, Georgia still had a Total Induced Abortion Rate (TIAR) of 0,9094 in 2018 (UNFPA, 2019). This corresponds to 26 abortions per 1000 women of fertile age. To reduce this rate, a recent ministerial decree introduced new guidelines for performing an abortion (Amendment to Order N01-74/N, 2014; World Population Review, n.d.-b). The amendment to the guidelines includes (1) a pre-abortion interview with an obstetrician-gynaecologist, a psychologist, and a social worker; (2) performing all medical and surgical post-seven-week abortions in an inpatient medical facility; (3) a mandatory ultrasound after the five day waiting period in addition to the first ultrasound during the initial consultation; (4) reporting all abortions performed after 12 weeks to the Mother and Child Health Coordinating Council (Amendment to Order N01-74/N, 2014). If this five-day waiting period is not respected, the doctor executing the procedure will be held accountable. This is succeeding the 2014 ministerial decree, which expanded the waiting period from three to five days and added a new provision on mandatory counselling by an obstetrician-gynaecologist (Amendment to Order N01-74/N, 2014).

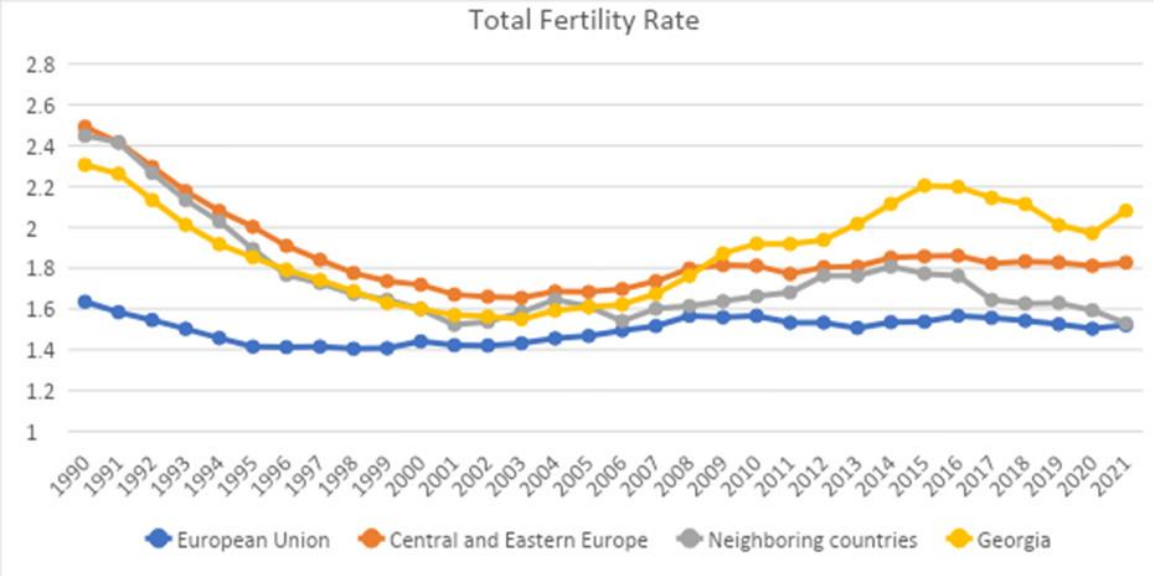
Although the Georgian government has suggested these measures as a means to reduce abortion rates, research indicates that the highest abortion numbers are in countries that have restrictive abortion policies or where the procedure is illegal (Bearak et al., 2020). Instead of decreasing overall abortion rates, legal restrictions on access to abortion care are likely to solely decrease the number of safe abortions (Joyce et al., 2009; WHO, 2012).

In 2021, the European Parliamentary Forum for Sexual and Reproductive Rights (EPF) and the International Planned Parenthood Federation (IPPF) conducted a large-scale, in-depth analysis of abortion policies in 53 European and Western Asian countries (EPF & IFFP, 2021). Considering the level of legality, access, clinical care, and service delivery, Georgia's legal framework to access safe abortion care ended up in the lower echelon with a score of 58%. Together with Russia's, the country's policies thereby scored the lowest of all post-Soviet states. UNFPA already mentioned in its 2014 policy paper that the World Health Organization (WHO) and the International Conference for Population and Development (ICPD) Programme of Action have specified that "where abortion is legal, states must ensure that it is available, accessible (including affordable), acceptable, and of good quality" (p. 4). More than 30 years ago, for instance, the ICPD Programme of Action (1994) stated that countries should " deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services [...] Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling" (p. 89). Similarly, WHO guidelines argue against mandatory waiting periods, counselling, and ultrasound scanning as a prerequisite for receiving abortion services (WHO, 2022). The planned amendment to abortion legislation in Georgia thus risks endangering these conditions even further across the nation. Below we present evidence and argue why the suggested amendments to the Georgian abortion law are not in the best interest of individual women nor society at large.

Why restricting access to abortion doesn't reduce abortion rates nor increase total fertility rates

Debates around abortion legislation often veer swiftly into discussions about their consequences for fertility rates, indicating a prevalent narrative that closely associates abortion access with population growth dynamics. The decline in total fertility rates (TFR) across Central and Eastern Europe since the late 20th century is indeed a notable demographic shift (see figure below), with many nations experiencing TFRs below the replacement level of 2.1 children per woman (UNFPA, 2023). Georgia presents an intriguing case: it mirrored the regional TFR drop initially, but recent data indicates a rebound, with current rates hovering around the replacement threshold. As of 2023, Georgia's TFR of 2.1 contrasts sharply with lower

rates in the European Union (1.5) and neighbouring states such as Armenia (1.6), Russia (1.5), and Azerbaijan (1.5).



A widely shared assumption suggests that the liberalization of abortion, by eliminating legal penalties associated with the procedure and reducing the individual barriers to accessing this form of birth control, leads to fewer unintended births and, ultimately, a decrease in overall birth rates. This notion, connecting the legality of abortion with population trends, has significantly influenced policy discussions since the 1950s. In fact, throughout the past seventy years, numerous nations have implemented abortion legislation reforms, viewing them as a key component of their population strategies, aimed at either curbing or stimulating population growth (Guillaume et al., 2018).

Romania's experience with abortion policy changes under Nicolae Ceaușescu's regime (1965-1989) illustrates this point starkly. Before 1966, Romania's liberal abortion policies led to high abortion rates and declining fertility. However, Ceaușescu's 1966 Decree 770 severely restricted abortions along with access to contraception, causing a brief spike in birth rates before leading to long-term adverse outcomes like increases in orphanage populations, unsafe abortions, and maternal mortality (Hord et al., 1991). This case highlights how even significant policy shifts, like those in Romania, have only a temporary effect on fertility rates, but at the cost of women's and children's health.

Recent **evidence robustly demonstrates that restricting abortion does not necessarily impact the number of children that women bear**. A comprehensive global analysis spanning 185 countries from 1970 to 2019 by Fernandez and Juif (2023), for example, found no consistent correlation between abortion policy reforms and fertility rates. This finding aligns with other recent longitudinal studies, such as Sedgh et al. (2016), which noted minimal differences in abortion incidence between countries with liberal versus restrictive abortion laws. Studies suggesting a contrary conclusion are often restricted to case studies, shorter time spans, and suffer from other methodological limitations, particularly in failing to account for other influential factors, thus leading to potentially misleading correlations (Fernández and Juif, 2023).

So what explains declining fertility rates in European societies? A wealth of evidence points to socioeconomic changes, such as increased levels of education among women, greater workforce participation, and the broader economic challenges that prompt many to delay or limit childbearing (Mills et al., 2011; Neels et al., 2017). **Cultural shifts are also at play**. Many European societies are increasingly

embracing individualism, where personal aspirations and the desire for self-growth often take precedence over traditional family models. The increasing acceptability of remaining child-free or having fewer children is indicative of these evolving norms. **Advances in contraceptive technology** have also played a crucial role, offering more control over reproductive choices and enabling effective family planning. The Netherlands serves as a prime example, where abortion is legal but infrequent, with women predominantly opting for contraceptive pills (Levels et al., 2012). This trend is mirrored in countries with restrictive abortion laws, where legal forms of contraception are often not available.

Many of these trends can also be identified within Georgia, where we find steady increases in both the Human Development Index (from 0.656 in the year 2000 to 0.794 in 2003) and the Gender Development Index (from 0.957 to 1.007). The mean age at first birth has increased from 23,9 in 1994 to 28,7 in the year 2022 (Geostat, 2023), and more women than men are obtaining a degree in higher education. At the same time, gender disparities in the labour market continue to persist (UN Women, 2020), and the gender wage gap is above the global average (ILO, 2023). Available family-work reconciliation policies are relatively limited in scope and more focused on supporting the traditional male-breadwinner model (Asatiani and Verulava, 2017). For these reasons, along with the international demand for female labour in the caregiving sector (Vanore, 2015; Hoffman, 2017), **a substantial portion of women of reproductive age have emigrated** to countries with better employment opportunities (OECD, 2023). A vast body of research (e.g., White, & Potter, 2013; Gjonca et al., 2008; Marchiori et al. 2010; Anelli and Balbo, 2021) has demonstrated that higher emigration rates result in lower fertility rates in the country of origin.

Challenges Imposed by Georgia's New Abortion Guidelines: Analysing the Impact on Access to Care

The effect of a mandatory waiting period

The WHO safe abortion guideline was last updated in 2022. The guideline aims to enable evidence-based quality abortion care globally, including a quality of care and human rights perspective (WHO, 2022). In this last version, **the WHO recommends against mandatory waiting periods for abortion**. A systematic review of 33 studies from 2010 to 2020 revealed that mandatory waiting periods complicate and delay access to abortion, they lead to increased costs and the inaccessibility of abortion care, particularly for vulnerable women (de Londras et al., 2022; Finer et al., 2006; Jones & Jerman, 2016; Van de Velde et al., 2019). They can also lead to forced disclosure of pregnancies and the continuation of unwanted pregnancies (White et al., 2017). Next to the negative impact on abortion-seekers, mandatory waiting periods ensure at least two visits to the facility and therefore don't benefit healthcare facilities by increasing complications (by delaying care), costs and creating logistical challenges (Mercier et al., 2015). Mandatory waiting periods thus infringe on the availability, accessibility, acceptability, and quality of sexual and reproductive health services, and might force clients to resort to unsafe abortions.

The effect of mandatory multi-actor counselling

Regarding pre-abortion counselling, **the WHO states that counselling before (or after) an abortion should be available, but voluntary** (2022). It's important to stress that counselling should be made available and accessible, and it should be client-centred but voluntary. Mandatory counselling creates unnecessary logistical hurdles to abortion care (Mercier et al., 2015). These restrictions can cause increased financial costs, need for travel, waiting times, additional clinic contacts, and emotional distress (WHO, 2022).

Furthermore, the WHO also makes recommendations concerning the type of healthcare worker that can provide services. Based on a systematic review of studies published between 2010 and 2019, results show that restrictions on the type of healthcare workers that can provide services can cause delays and burdens

in accessing abortion. Pre-defining a combination or number of certain types of healthcare workers restricts access to abortion care. Instead, a wide range of caregivers can provide this counselling. Allowing counselling to be provided by different healthcare workers, can guarantee accessible and safe abortion and reduce system costs. It may even prevent unsafe (self-induced) abortions (Afework et al., 2015). **The WHO, therefore, recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance (WHO, 2022)**. Mandatory pre-abortion counselling with an obstetrician-gynaecologist, a social worker, and a psychologist, would be a violation of these two principles. Introducing requirements for abortion seekers to see specific cadres of health workers, in settings with health worker shortages (e.g. psychologists) will impose a major barrier to access abortion care. Such measures are not evidence-based, and when they are introduced anyway, it should be clear who, for example, will cover the costs of such services. In addition, the counselling should then be focused on providing information and offering counselling in a way that abortion seekers can understand, to allow them to make their own decisions about whether to have an abortion.

The effect of a mandatory ultrasound upon the expiration of the waiting period

The WHO also **recommends against the use of ultrasound scanning as a prerequisite for providing abortion services**, for both medical and surgical abortions (2022). Unless there are clinical justifications for utilizing ultrasound scanning before an abortion, decisions in this regard should be made on a case-by-case basis. On the one hand, in many settings, an ultrasound when presenting for abortion, isn't so much contested from a medical point of view. On the other hand, **there is a strong argument against a mandatory ultrasound upon expiration of the waiting period**. This implies a need for a second ultrasound although this is not evidence-based. Instead, a mandatory (second) ultrasound prior to the abortion treatment creates unnecessary barriers to access to safe and timely abortion care and dramatically increases costs (Lee et al., 2023). Additionally, since ultrasounds are only obtainable on-site in medical facilities, it prevents the implementation of telemedicine, although this service option is recommended by the WHO (2022). However, there's an important contradiction between what is mentioned in the National Protocol on Safe Termination of Pregnancy (2014). This protocol does not prescribe mandatory ultrasound at the end of the waiting period. Even stronger, it recommends the service option of telemedicine for medical abortion. Telemedicine has been introduced in the newly updated National Protocol approved by The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs in 2023.

Furthermore, legal gestational age restrictions on abortion access should help avoid unnecessary pre-abortion ultrasounds. It should enhance abortion accessibility in regions where obtaining ultrasound services is challenging. From this, we can deduce that the same principle applies to waiting times and demanding a mandatory ultrasound at the end of this waiting time as a prerequisite for receiving abortion care.

Consequences of restrictive abortion regulations

Regulations that impede (timely) access to abortion care, lead abortion-seekers to delay accessing abortion, increase the risk for complications, increase the rate of continuation of unwanted pregnancy, high opportunity costs, and unsafe (self-managed) abortions. On the provider side, regulations in violation of WHO guidelines cause higher workloads and higher system costs. Although abortion, in general, is a very safe procedure, abortions performed later in pregnancy have higher medical risks (Bartlett et al., 2004; WHO, 2022). Unsafe self-induced abortions pose even greater risks, e.g. infections leading to secondary infecundity and maternal death (Grimes et al., 2006). It speaks for itself that these events are to be avoided when wanting to raise a country's fertility levels. Again, research points to the importance of family planning such as the wide availability of modern family planning methods to replace abortion as a birth control method with modern methods of contraception (see below).

Recommendations on good practices in access to abortion care

The question then remains: What can be done to protect the future health and well-being (including fertility) of women and society? How can we make abortion services safer, but also reduce unplanned and/or unwanted pregnancies in the first place? As described above, limiting access to safe abortions by installing more hurdles such as obligatory and longer waiting times, unnecessary ultrasounds, and mandatory counselling by a scarce group of healthcare providers, does not lower the need for abortions (Medoff, 2007). On the contrary, limiting access to abortions will negatively affect maternal and child health (Bartlett et al., 2004). Therefore, the next paragraphs highlight which measures - according to international guidelines and scientific research- contribute to sexual and reproductive health.

Provide optional unbiased abortion counselling and let clients decide if they need more time

Research has identified the potentially harmful effects of mandatory waiting times (de Londras et al., 2022; Finer et al., 2006; Jones & Jerman, 2016; Mercier et al., 2015; Van de Velde et al., 2019; White et al., 2017). There is however no research confirming any harmful effects of reducing or abolishing mandatory waiting times. On the contrary: a review of 34 studies on waiting periods published between 2010 and 2021, found that people requesting an abortion know when they need more time (de Londras et al., 2022). It also found that when people decide to end their pregnancy, they have a high level of decisional certainty on this matter, and rarely regret their decision afterwards (de Londras et al., 2022). Additionally, people living in places where there are mandatory waiting periods, do not show a higher level of decisional certainty compared to people living in places without mandatory waiting periods (Jovel et al., 2021). This is in line with the WHO recommendation against mandatory waiting periods for abortion (WHO, 2022). Several European countries, such as France, the Netherlands, Sweden, and the U.K., follow this guideline and do not enforce mandatory waiting times. Rather than a pre-set waiting time, women need optional, unbiased counselling services that are tailored to their needs (Foster et al., 2012; WHO, 2022). With voluntary access to trained staff that can respond to individual questions and worries with unbiased information concerning unwanted pregnancies and abortions, women can decide for themselves if they need more time to make the decision.

Ensure an adequate number of medical and professional personnel to provide counselling

The WHO states that 'States must ensure an adequate number of medical and professional personnel and skilled providers in the health system as well as adequate stocks of essential medicines' (WHO, 2022). Rather than imposing counselling by a specific (possibly scarce) medical professional such as a psychologist, this can be accomplished by broadening the type of healthcare workers that can provide counselling. The WHO recommends the provision of counselling by community health workers, traditional and complementary medicine professionals, auxiliary nurses/ANMs Nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners, or specialist medical practitioners. These counsellors should be adequately trained, not only in the clinical aspects of abortion care but also concerning human rights in patient care and non-discrimination. Additionally, providing counselling only to those who need counselling, will also reduce the pressure on the healthcare system and allow nations to effectively spend resources where needed. When asked, pre- or post-abortion counselling can be used to assess an individual's fertility goals and need for contraceptive services (WHO, 2022).

Implement telehealth solutions as an alternative to in-person care

In 2021, the Center for Reproductive Rights wrote recommendations to guarantee access to sexual and reproductive health services during the COVID-19 pandemic and beyond. Access to sexual and reproductive health services through telemedicine and/or self-managed alternatives was one of the key

recommendations in this report (Center for Reproductive Rights, 2021). In their 2022 abortion care guidelines, the WHO also recommends the option of telemedicine for abortion specifically (WHO, 2022). Telemedicine can improve the availability and accessibility of pre-abortion counselling and therefore can serve as an alternative to in-person interactions with the health worker. The WHO recommendation even advises telemedicine as an option for the delivery of medical abortion services in whole or in part (WHO, 2022). Several other institutions, such as the Royal College of Obstetricians & Gynaecologists (2022) in the UK, have adopted these ideas in their abortion guidelines. Empirical research reviewed both by the WHO and by independent researchers has found the advised telemedicine solutions to be effective: These studies conclude that self-managed abortions through telemedicine are well received by clients and that the outcomes are overall positive and similar to in-person care (Aiken et al., 2021; Endler et al., 2019; Erlank et al., 2020; Gibelin et al., 2021; WHO, 2022). It is however important that telemedicine services include referrals for medicines, face-to-face counselling, and post-abortion follow-up if required. These referrals should be tailored to the client's needs and available and accessible to them (WHO, 2022).

Reduce unnecessary costs and barriers

Following the WHO guidelines on abolishing obligatory counselling and ultrasound scanning, will not only increase costs for the clients but also for the healthcare system. Both the WHO and clients of abortion clinics do not evaluate obligatory counselling as necessary. Requiring women to undergo counselling would thus divert resources from those who do wish to obtain counselling (Brown, 2013; WHO, 2022). Also, ultrasound scanning is not necessary to ensure safe abortion care (Kapp et al., 2013). Research by Schmidt-Hansen and colleagues (2020) showed that there was no difference in missed ectopic pregnancies, ongoing pregnancies, or complete abortion without surgical intervention between initiation of medical or surgical abortion before or after ultrasound evidence of an intrauterine pregnancy. By erasing these barriers, women can have access to safe abortion care faster, and it would reduce the costs for both women and the healthcare system.

Implement the safest medical and surgical abortion practices

Legal abortion procedures are generally safe, and following the WHO (2022) guidelines helps to consolidate the safest practices that protect the future fertility of women (Faúndes & Shah, 2015). To be safe, in the first place, abortion care needs to be accessible to everyone, including those living in rural areas. Ensuring that a broad range of healthcare facilities are authorized to provide abortion care and offering medical abortions will help to reach this goal. In the second place, the abortion procedures need to be executed safely. The WHO guidelines support medical abortions, both in medical facilities and at home through telemedicine. The guidelines define which medications should or should not be given and how the procedure can be managed, both in medical facilities and at home. If surgical abortions are needed or preferred by the client, they should be executed by trained medical professionals in a well-adapted environment. For surgical abortion at < 14 weeks, the WHO recommends using vacuum aspiration and against the practice of dilatation and sharp curettage (D&C), including sharp curette checks (i.e., to "complete" the abortion) following vacuum aspiration. For surgical abortion at ≥ 14 weeks dilatation and evacuation (D&E) is recommended. When eligible, a client should have the choice between a medical or surgical abortion, and for both medical and surgical abortion, follow-up care should be available and accessible but optional. Women need to be aware of this option, and follow-up care cannot be punishable (Kapp et al., 2013; WHO, 2022).

Make sexual and reproductive health care available and accessible to all

Finally, ensuring availability and access to high-quality sexual and reproductive healthcare for all women and men will have a substantial positive effect on the public health of a country (Fathalla, 2020). Next to safe abortion care, this includes comprehensive sexuality education, unbiased contraception counselling, and availability of and access to affordable (modern) contraception. Comprehensive sex education in

schools has a wide range of positive outcomes, such as increased knowledge of sexual and reproductive health, better relationship-building skills, media literacy, and reduced risk of unprotected intercourse and STIs in early adulthood (Goldfarb & Lieberman, 2021; Vivancos et al., 2013). Counselling and access to modern contraception will improve the effective use of contraception and thus prevent unplanned pregnancies and give people control over family planning (Birgisson et al., 2015). Rather than reducing fertility levels, this will reduce abortions on request (Marston & Cleland, 2003). Additionally, it has a positive impact on maternal and child health (Tsui et al., 2010). If a person is interested, contraception counselling should also be a part of the pre- or post-abortion counselling, and can even be initiated right after the abortion (WHO, 2022). Special care should be taken to make these services and products available and accessible to youth and people with fewer economic means.

A concrete example

The case of Norway can help us to understand the positive impact of the above-mentioned recommendations. Norway has a liberal abortion policy: Abortion on request is available in the first 12 weeks of pregnancy. A request can be submitted to any gynaecology department in a hospital, without a referral. Women are not asked to explain themselves and there is no mandatory reflection period/waiting time or counselling. Healthcare professionals will, however, inform the client about the procedure and ask if more information and guidance would be helpful. Abortion is also free of cost, modern contraceptives are available and information on sexual and reproductive health is widely available (EPF, 2023). At the same time, maternal mortality in Norway is low (see, for example, Diguisto et al., 2022), and although, like all European countries, Norway has seen a decline in fertility in recent decades, there is concrete evidence that access to abortion care can facilitate future pregnancies. Mølland (2016) studied the effects of abortion on teenage women and found that although the availability of abortion delayed fertility, it did not reduce completed family size. Access to abortion care thus gave young women the opportunity to space or delay childbirth, which also resulted in higher educational attainment and positive outcomes (lower teen pregnancy rates, lower welfare use, and higher educational attainment) for the next generation (Mølland, 2016).

Conclusion

In conclusion, the recent amendments to Georgia's abortion legislation are misaligned with empirical evidence and global best practices. Research has consistently shown that restrictive abortion policies do not effectively reduce abortion rates or increase fertility in the long term. Instead, they lead to unintended consequences, including increased risks to women's health and exacerbating social inequalities. The imposition of mandatory waiting periods, multi-actor counselling, and ultrasound requirements, as stipulated by the Georgian Ministry, not only contradicts WHO guidelines but also imposes unnecessary burdens on abortion-seekers. These measures are likely to create barriers to access, leading to delays in care, increased costs, and potentially driving abortion-seekers towards unsafe abortion practices.

Moreover, the focus on restrictive abortion policies overlooks the broader determinants of fertility rates. Research points to factors such as women's education, workforce participation, and broader cultural shifts towards individualism and personal choice as significant drivers of declining fertility rates. These factors, coupled with increased access to contraception, have led to a natural decrease in abortion rates, as observed in the post-Soviet region, including Georgia.

Therefore, it is imperative that Georgia, and countries with similar contexts, consider evidence-based, human rights-focused approaches to reproductive health policy. This involves not only easing restrictions

on abortion but also investing in comprehensive family planning services, sexuality education, and ensuring access to modern contraceptives. These strategies are proven to empower women, reduce the incidence of unwanted pregnancies, and contribute to the overall health and well-being of society.

The experience of various countries shows that liberalizing abortion laws, coupled with comprehensive sexual and reproductive health services, leads to better health outcomes for women and society. As Georgia revises its abortion policies, it has an opportunity to adopt a more progressive, evidence-based approach that not only respects women's rights but also contributes to the nation's overall social and economic development.

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