Committee on the Elimination of Discrimination against Women, 71th Session
Information on the Former Yugoslav Republic of Macedonia for the adoption of the Concluding Observations

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SUBMITTING ORGANISATIONS

HERA – The Health Education and Research Association is a non-for-profit organization with a mission to advance the sexual rights of all people and enable improved access to sexual and reproductive health education and services, particularly for marginalized communities. HERA facilitates national policy and legislation changes for sexual and reproductive health (SRH) and gender equality through advocacy and evidence-based research; empowering women and young people by providing comprehensive sexuality education; and enabling access to equal and high-quality services for HIV, SRH and gender-based violence.
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Reactor – Research in Action is an independent think-tank based in Skopje. Reactor is committed to facilitating Macedonia's EU integration process by providing timely and relevant research, proposing evidence-based policy alternatives, and actively working with citizens, civil society organizations, and the policy community. Gender equality is one of the three areas where its research is focused, with specific attention on women's participation, inclusion, and economic integration, as well as ending violence against women.
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The Coalition "**MARGINI**" was formally established in 2010 as an alliance of five different organisations (HOPS, HERA, IZBOR, STAR-STAR, and EGAL). MARGINI promotes the protection and respect of the fundamental human rights of marginalized communities such as sex workers, drug users, people living with HIV, and the LGBTI community.
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INTRODUCTION

HERA, Reactor, and Coalition "MARGINI" present this joint submission to the Committee for its consideration of the sixth Periodic report of the Former Yugoslav Republic of Macedonia under the Convention on the Elimination of All Forms of Discrimination Against Women (the Convention).

This submission highlights a range of concerns regarding the State's compliance in the area of SRH and rights. It reiterates most of the concerns outlined in the PSWG submission we had presented in January 2018[1] that the State's replies to the List of Issues failed to sufficiently address or alleviate.

Articles 2, 5, 10, 12, 14 and 16 of the Convention: Women's Sexual and Reproductive Rights

The key concerns highlighted include:

I. Barriers in access to safe and legal abortion care;
II. Barriers in access to modern contraceptive methods;
III. Lack of Mandatory Comprehensive Sexuality Education.

At the end of the submission a number of recommendations are outlined.

I. Barriers in Access to Legal Abortion Care

1. As outlined in the PSWG submission, Macedonian law permits abortion on request during the first 10 weeks of pregnancy. After this time, abortion is legal when a woman's health or life is at risk, on certain socio-economic grounds, when pregnancy is a result of a criminal act, and in cases of serious fetal impairment.[2]

2. In 2013 and 2014, a series of new legal requirements were introduced which must be complied with before women can access abortion on request.[3] These requirements include a three-day mandatory waiting period, as well as mandatory biased counseling and a mandatory ultrasound prior to abortion. New legislative provisions have also increased the fines imposed on medical professionals and service providers who violate the law.

3. In 2013, **a 3-day mandatory waiting period** between the time when an abortion is requested and performed was introduced into the law. This requirement does not apply to minors, women with restricted legal capacity, or when there is a medical justification for abortion.[4] Previously, women seeking abortion on request did not have to observe a mandatory waiting period and, as such, by imposing new preconditions and restrictions on women's access to reproductive health services, the new law represents a retrogressive measure which contravenes the principle of non-retrogression as set out in Article 2 of the International Covenant on Economic, Social and Cultural Rights. In addition, denial or delay of safe abortion and post-abortion care may amount to torture or cruel, inhuman and degrading treatment.[5]

4. Practice, documented by HERA and the Center for Reproductive Rights in 2017, has shown that the mandatory waiting period requirement undermines women's decision-making, delays the provision of legal abortion care, and forces women to visit the relevant health facility several times.[6] These findings echo the World Health Organization (WHO) guidelines on safe abortion, in which the WHO stressed that "mandatory waiting periods can have the effect of delaying care, which can jeopardize women's ability to access safe, legal abortion services and demeans women as competent decision-makers." In addition, mandatory waiting periods often increase the costs of accessing abortion services. They usually require that women make at least two trips to a health facility. Additionally, when the commencement of a mandatory waiting period is linked to the provision of mandatory counseling or information, women could need to travel more than twice.[7] This can significantly increase the personal and financial costs involved in obtaining legal abortion and can have a heightened and disparate impact on some women.[8] As a result of these concerns, the WHO Safe Abortion Guidelines indicate that mandatory waiting periods should not apply to abortion services. It has underlined that "[o]nce the decision [to have an abortion] is made by the woman, abortion should be provided as soon as is possible" and without delay.[9]

5. The new mandatory counseling requirements introduced in 2013 and 2014 require women to undergo an ultrasound prior to obtaining an abortion and to be shown the ultrasound image of the fetus. They also specify that women must be told about "all anatomical and physiological features of the fetus at the given gestational age" and about the effects an abortion will have on the fetus.[10] The law also requires health care institutions to ensure that women seeking abortion services are provided with information and counseling on the "possible harm" abortion can cause to a woman's health, including her psychological health, and on the "possible advantages" of continuing a pregnancy.[11] In addition, relevant legislation also stipulates that health care providers should allow a woman to listen to the fetal heartbeat.[12]

6. Practice, documented by HERA and the Center for Reproductive Rights in 2017, has shown that these requirements have very little influence on women's decision-making about their pregnancy. Instead, they impose additional barriers to women's timely access to legal abortion care, undermine women's right to autonomous decision-making, and contribute to stigma about abortion.[13]

7. Under international human rights law, women's right to health necessitates that women be afforded access to acceptable, good-quality reproductive health services and information.[14] This requires that states guarantee women's access to reproductive health information that is scientifically and medically appropriate, and refrain from censoring, withholding, or misrepresenting such information.[15] States must also ensure such information is "delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[16]

8. Informed consent requires that a patient's medical decision-making be free of threat or inducement, and that a patient's consent to medical procedures, including abortion, be given freely and voluntarily after receipt of understandable, adequate, accurate, and evidence-based information on the purpose, method, duration, expected benefits, possible risks and side effects of the proposed treatment, and on alternative modes of treatment.[17] It is implicit in the principle of informed consent that patients must also be entitled to refuse such information yet still undergo the requested procedure.[18] For example, the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable

standard of physical and mental health has specified that "[j]ust as a patient has the right to receive information in giving consent, a patient has the right to refuse such information in giving consent, providing disclosure of such information has been appropriately offered."[19]

9. Biased counseling or information requirements contradict the principle of informed consent. First, by imposing counseling or information on women as a precondition to abortion, they implicitly contradict the necessity that counseling be entered into freely and voluntarily and that individuals be entitled to refuse information related to their health and proceed to treatment without it. Second, by requiring that women receive "medical information" that in fact is misleading, and by exposing them to judgmental and stigmatizing attitudes, biased counseling and information requirements undermine women's right to receive scientifically accurate and medically appropriate information concerning abortion and also contravene the requirement that medical decision-making be free from inducement, coercion, or discrimination.[20]

10. The WHO Safe Abortion Guidelines advise against mandatory counseling requirements, specifying that "[m]any women have made a decision to have an abortion before seeking care, and this decision should be respected without subjecting a woman to mandatory counseling." The WHO has also stressed that women making decisions about pregnancy need to be treated with respect and understanding and be provided with information in an understandable manner, so that they can make such decisions without inducement, coercion, or discrimination. As such, the WHO has noted that counseling about abortion should be voluntary and non-directive and that "healthcare providers should be trained to support women's informed and voluntary decision-making." It has made clear that "censoring, withholding, or intentionally misrepresenting information about abortion services can result in a lack of access to services or delays, which increase health risks for women" and "States should refrain from…intentionally misrepresenting health-related information." Further, "information must be complete, accurate, and easy to understand, and be given in a way that facilitates a woman being able to freely give her fully informed consent, respects her dignity, guarantees her privacy and confidentiality and is sensitive to her needs and perspectives."

11. The CEDAW Committee has repeatedly urged state parties to eliminate medically unnecessary mandatory waiting periods and mandatory and biased counseling required to access abortion care.[21] With respect to the Former Yugoslav Republic of Macedonia, the Committee on Economic, Social and Cultural Rights and the Human Rights Committee have recently urged the Government to review the restrictive provisions of the abortion law and to eliminate procedural barriers to abortion.[22]

12. In 2017, HERA and the Center for Reproductive Rights documented the human rights impact of the retrogressive Macedonian legislation on women's access to abortion services.[23]. The study showed that (i) abortion stigma and harmful gender stereotypes persist in the country and can undermine women's access to safe abortion care; (ii) the imposition of the mandatory waiting period delays women's access to services and undermines women's decision-making; (iii) mandatory biased counseling undermines women's decision-making and informed consent and can lead to the dissemination of inaccurate and misleading information about abortion; (iv) increased fines and sanctions on medical practitioners and service providers can have a chilling effect on medical practice and undermine women's access to safe abortion care; and (vi) financial barriers and lack of access to medical abortion can undermine women's access to safe abortion care, particularly for women living in rural areas, women with low incomes and women living far away from medical institutions providing abortion care.

13. At the end of 2017, following the expert panel organized by HERA and the Gender Platform in September, the Ministry of Health (MoH) established a working group assigned to review the law and prepare amendments that would make the law in line with public health and human rights on abortion care. Representatives of civil society organizations working to advance reproductive rights in Macedonia are members of the working group.

14. In its replies to the List of Issues (paragraph 105), the Government states that it plans to draft a new law on termination of pregnancy in 2018 taking into account the recommendations of the Human Rights Committee. However, the drafting process has been challenging particularly due to limited capacities on the side of the MoH authorities and misinterpretation to the WHO standards on safe abortion by the health professionals - members of the working group, to fully and adequately incorporate international human rights standards and the WHO guidelines into the draft law. Such challenges can delay the preparation and adoption of the new abortion legislation beyond 2018.

15. In the latest progress report for the country accession to EU, the European Commission articulated its concerns about the restrictive provisions of the abortion law stating that "women continue to risk resorting to illegal abortions due to restrictive procedural rules in the Law on Termination of Pregnancy".[24]

16. Implementing of new technologies for safe abortion, including introducing medical abortion is one of the national strategic priorities in order to ensure comprehensive abortion care in Macedonia.[25] However, medical abortion is still not legally available in Macedonia. Research from 2011 shows that 29,4% of gynecologists in the country had an experience performing medical abortions and 2/3 of them were in a situation when their patients requested a medical method to be used for the termination of their pregnancy.[26] In addition, most hospital gynaecologists recommend that medical methods abortion should be legally available in Macedonia and that the government should register drugs Misoprostol and Mifepristone.[27]

II. Barriers in Access to Modern Contraceptive Methods

17. Although the latest Multiple Indicator Cluster Survey shows some recent improvements in the use of modern contraceptives in Macedonia, the usage rate among women continues to be very low at just 12.8% in 2011.[28]

18. Many women in the country face financial barriers in access to modern contraception. Contraceptive methods are not covered by the state Health Insurance Fund. The 2013 Market Segmentation Research on contraceptives showed that the lack of health insurance coverage for modern contraceptives particularly impacts people living in poverty who cannot afford to buy contraception.[29]According to the Law on Health Insurance, there is no legal basis for covering the cost of contraceptives since they are used for pregnancy prevention and under the law the Health Insurance Fund can only cover expenses related to injuries and illnesses.[30]

19. In the replies to the List of Issues, the Government states that it plans to place at least one type of oral contraception on the positive list in the period of the Government's mandate.[31] However, the MoH has not yet established a new national commission for approval of drugs on the positive list-- a

measure that has been planned as part of the health sector reform. The establishment of the new commission can impact the possibility of including oral contraception into the public health insurance scheme. In addition, the Government's reply contravenes the National Strategy for Sexual and Reproductive Health 2010 – 2020 (hereinafter "the Strategy") that proposes to include three types of modern contraceptives on the positive list by the end of 2020.[32] At the same time, an action plan for the period of 2018-2020, that has been prepared to implement the Strategy, includes a task to cover contraceptives under the MoH preventive programs for socially-excluded groups of women and to cover one type of oral contraception under the public health insurance scheme for all women.[33] However, the action plan has not yet been adopted by the MoH.

20. Many women lack access to evidence-based information on modern contraceptives. Due to poor communication by medical providers and inadequate sexuality education in schools, women are often misinformed about the impact and side effects of hormonal contraceptives. Most family doctors do not give information on family planning, and the most frequent reason for not engaging in family planning is the high number of patients and increased administrative work.[34]

21. In 2013, the CEDAW Committee recommended that the country should "take all measures necessary to improve women's access to quality health care and health-related services, within the framework of the Committee's general recommendation No. 24 (1999) on women and health, and raise awareness, through public education campaigns, education on SRH in schools, and enhanced counselling services, about the importance of using contraceptives for family planning, and increase efforts to provide adequate family planning services and affordable contraceptives."[35] In 2016, the Committee on Economic, Social and Cultural Rights urged the state to "…ensure that modern contraception methods are affordable to all, including by adding contraceptives to the list of medicines covered by the Health Insurance Fund."[36] However, as described above and below, these recommendations have not been adequately implemented thus far.

22. In its Sixth Periodic Report to the CEDAW Committee, the Government states that "[c]ounseling offices on SRH continuously work in the centers for public health."[37] However, in practice the counseling offices do not operate well. According to the Institute for Public Health,[38] the main reason for the low attendance at counseling centers is the inaccessibility of adequately equipped premises for this purpose, lack of qualified staff and the lack of gynecological services. Furthermore, in the counseling centers, there is a lack of condoms, oral contraceptives and promotional materials.

23. In the 2018 preventive programme for mother and child health, the MoH has for the first time allocated budget for procurement of modern contraception, including oral contraceptives, IUDs and condoms, for women who are socially deprived.[39] This measure is limited to women who seek reproductive health care in hospitals but not in primary healthcare. Moreover, the MoH has still not operationalized this policy that was introduced already six months ago.

III. Lack of Mandatory Comprehensive Sexuality Education

24. In its replies to the List of Issues (paragraph 107), the Government provides that according to the National Action Plan for Gender Equality 2018-2020 the introduction of comprehensive sexuality education is envisaged. In February 2018, the Bureau of Educational Development established a working group on development of individual competencies and educational models for integration of sexuality education in school settings. By the end of 2018 the working group shall propose to the Ministry of Education several educational models on how to best integrate sexuality education into the school system, including implementation of a pilot program in schools to test its efficiency.

25. Under the current education system young people learn about some health aspects related to SRH during Biology classes. The topics mostly include information on human reproduction, puberty, the physiology of the reproductive organs, and protection against HIV/AIDS. Evidence-based information on modern contraceptive methods and abortion is rarely included in these classes[40].

26. SRH issues are to some extent also covered during a subject called "Life Skills". This subject covers health-related issues such as physiological changes of the reproductive organs, contraceptives, STIs, HIV/AIDS, abortion, personal intimate hygiene, sexual difference and orientation, sexual harassment, human trafficking, gender sensitivity, and personal relationships. According to a research conducted in 2014, 81% out of 330 students stated that they received information related to SRH during Biology classes, while only 39.14% of the information was received during "Life Skills" classes. However, SRH and rights issues are rarely covered during the classes, and if they are, some of the information provided is outdated, and information about the concepts of gender and gender equality, sexual pleasure, homophobia, and discrimination based on sexual orientation is insufficient[41]. Although "Life Skills" is mandatory, it is up to the teachers to choose which topics should be taught during this subject. The topics about SRH and rights are rarely discussed with students, and 46% of the teachers are lacking manuals and additional information in order to cover these and other sexuality education topics[42].

27. The National Strategy of Education 2016–2020 recognizes that Life Skills has not been regularly taught in schools.[43] Due to the lack of implementation, it is questionable if Life Skills is a suitable model for introducing comprehensive sexuality education in schools. The National Comprehensive Strategy for Education for the period of 2016-2020 highlights that in most schools the Life Skills classes are not appropriately implemented and suggests that further steps should be taken to ensure a proper implementation. However, there are no specific measures or mechanisms outlining how this should be done in practice.

28. Many teachers do not feel comfortable teaching young people about SRH and rights topics, or they do not feel equipped to do so and need additional trainings and teaching materials. The lessons they teach mostly focus on puberty and physiology of the reproductive organs, reproduction, HIV/AIDS, and children's rights, and significantly less on contraception, gender, diversity, relationships and pleasure.

29. According to HERA's research conducted in 2014 54% of 330 students stated that they received information about SRH and rights topics mainly from the internet.[44] The research also showed that only 13% of school students were informed about condoms and only 2% about oral contraceptives. [45]

30. In 2016, the Committee on Economic, Social and Cultural Rights recommended the Former Yugoslav Republic of Macedonia to "make information on sexual and reproductive health available to the general public; improve school education on SRH that is up to date, age appropriate and based on a human rights perspective."[46]

IV. Recommendations

In light of this information, we respectfully recommend the country, to:

- Reform, without further delay, the Law on Termination of Pregnancy adopted in 2013 to ensure women's unhindered access to legal abortion care and to remove the requirements for a mandatory waiting period, mandatory and biased counseling, as well as other regulatory barriers, in line with the World Health Organization Safe Abortion Guidelines.

- Ensure that information on abortion provided by health care professionals is non-directive, medically accurate, evidence-based, and easy to understand and that it is given in a way that facilitates a woman being able to freely give her fully informed consent, respects her dignity, guarantees her privacy and confidentiality and is sensitive to her needs and perspectives.

- Make medical abortion available and accessible throughout the country, in line with the World Health Organization Safe Abortion Guidelines.

- Adopt, without further delay, the Action Plan for Sexual and Reproductive Health 2018 – 2020, allocate sufficient human, technical and financial resources for its implementation, and ensure active participation of women's organizations, in particular those working on women's sexual and reproductive health and rights, in the implementation and monitoring of such action plan.

- Take effective measures to improve access to modern contraceptive methods, including by ensuring universal coverage by the state health insurance of all costs related to modern contraceptive methods for the prevention of unplanned pregnancies.

- Develop an appropriate educational model and teaching curricula for comprehensive sexuality education and pilot the model throughout the country to measure its effectiveness prior to ensuring comprehensive sexuality education is mandatorily provided in elementary and secondary schools.

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