



Documenting the human rights impact of retrogressive legislative and policy barriers on women's access to abortion in Macedonia: *Key findings and recommendations*

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. However, in 2013 and 2014 a series of new legal requirements were introduced which must be complied with before women can access abortion on request.¹ These requirements include a three-day mandatory waiting period that women must observe between the time when they request the abortion and when the procedure can be performed, 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 and introduced criminal sanctions for medical professionals.

Between April and July 2017, H.E.R.A. (Health Education and Research Association) and the Center for Reproductive Rights ("the Center") conducted in-depth interviews with 14 stakeholders in Macedonia in order to explore their views on, and experiences with, these new legal requirements. These interviewees included seven women who had an abortion after the introduction of the new legal requirements as well as two gynecologists, one social worker, one sociologist and three representatives of non-governmental organizations.² The interviewees were based in different cities in Macedonia, including Bitola, Kumanovo and Skopje. Interviews were conducted by representatives of H.E.R.A. and the Center. The interviews were recorded, with the prior consent of the interviewees, to ensure accurate transcription.

KEY FINDINGS

A number of key findings can be distilled from these interviews, which are summarized below and illustrated by quotes and excerpts from the interviewees.

I. Abortion stigma and harmful gender stereotypes persist and can undermine women's access to safe abortion care

Interviewees expressed the view that abortion continues to be stigmatized in Macedonia and that the stigma concerning abortion is closely connected with stereotypes about women's primary role in society as being mothers and wives.

“ Things are terribly messed up here. Having an abortion is not acceptable, having a baby as an unmarried woman is not acceptable, and it is not acceptable to be married but have no children.”
(Woman, 27 years old)

“ I think the general opinion is that abortion is socially unacceptable. Which is why it is rarely discussed in public [and] why there is lack of information.”
(NGO representative, Skopje)

“ I think the general position of society is that no woman should have an abortion, but should bear children.”
(Woman, 33 years old)

“ [O]nly a small number of women accept abortion as a personal choice, something one wants to do, and is free to do, without being censured or disgraced.”
(Woman, 31 years old)

While some women felt that they were supported by medical practitioners when they received abortion care, others said that medical practitioners sought to make them feel guilty for deciding to have an abortion.

“ Even the doctors impose a feeling of guilt; they blame the woman.”
(Woman, 36 years old)

“ We went there for the [ultrasound] examination, and what happened there was that the moment she [the gynecologist] picked up the baby's heartbeat she told me something like: ‘Why aren't you sorry?! Listen to the heartbeat, you are not so young, you are 30 already.’ I replied that my mind was made up. ... And she told the same things to ... my partner: ‘She isn't 20 any longer, now is her time to give birth, it would be just lovely.’”
(Woman, 33 years old)

II. The imposition of a mandatory waiting period delays women's access to services and undermines women's decision making

Since 2013, Macedonian law has required women to observe a three-day mandatory waiting period before they can obtain an abortion. This requirement does not apply to minors, women with restricted legal capacity, or when there is a medical justification for abortion.³

All of the women interviewed who had to observe the mandatory waiting period said that it had no influence on their decision-making process and that they did not find this requirement useful.

I guess that when this requirement was adopted, the idea was, perhaps, to make the women change their mind, but I found it additionally irritating and absolutely unnecessary because I had already made my decision. ... It was very irritating! This is, after all, my life, my body, my personal choice, and here I have somebody else—a political factor—that puts conditions on me, does not allow me to decide for myself. That's truly irritating. And on top of that, the requirement to talk to a counselor.”

(Woman, 31 years old)

This perspective was echoed by other interviewees:

I don't know what the purpose of the law is. Maybe increased birth rate. Or maybe those who created this law thought that the introduction of the three days [waiting period] and this kind of ... counseling would change the woman's mind. But it doesn't!”

(Social worker, Skopje)

I think that ... the three-day waiting period is actually about re-examining the [woman's] decision or discouraging women from having the abortion, or lastly, pushing the women into illegal abortion. Because a woman who already came determined to have an abortion already took that decision elsewhere, in her own three days. ... Why re-examine the decision when, until then, I presume, any woman who has thought this out, who has come requesting abortion, has her mind set?”

(NGO representative, Skopje)

In addition, some interviewees said that the mandatory waiting period delays the provision of abortion care and forces women to visit the relevant health facility several times. Some interviewees expressed the view that obliging women to visit health facilities on multiple occasions could impose particular barriers on working women and women coming from other towns. For example, one doctor said:

The three days' waiting period is a barrier for women coming from other cities, but we try to be forthcoming at least by organizing counseling right away, the same day they come to us.”

(Gynecologist, Skopje)

Interviewees expressed that the mandatory waiting period before abortion should be removed.

I would most certainly remove the mandatory three days. Let a woman have an abortion the very next day, or in five days, or on Friday, whichever way she decides.”

(Gynecologist, Kumanovo)

III. Mandatory biased counseling undermines women's decision-making and can lead to the dissemination of inaccurate and misleading information about abortion

The new counseling requirements introduced in Macedonia in 2013 and 2014 require women to undergo a mandatory ultrasound prior to obtaining an abortion and to be shown the ultrasound image of the fetus. These requirements 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.⁴ The law also requires health care institutions to ensure women seeking abortion care 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.⁵ In addition, relevant legislation also stipulates that health care providers should allow a woman to listen to the fetal heartbeat, and although this is not required by law, in practice it appears most women are compelled to do so as part of the mandatory counseling.

A number of interviewees articulated concerns about these new requirements and said that they are intended to dissuade women from obtaining abortion care.

“The starting point for this [mandatory counseling requirement] was the notion that the decision to abort is an impulsive decision and that a woman should think about it some more. And with this her ability to be a political intellectual actor, someone who can think for herself, is degraded from the very start. ... I believe that I would be right to assume that these regulations make some women change their mind; they can dissuade them from abortion. And if it doesn't dissuade them, it will certainly make them feel worse. So, I would say that not so much the abortion itself, but the counseling causes psychological trauma to women, because they are burdened with guilt.”

(Sociologist, Skopje)

All women whom we spoke to said that the counseling did not influence their decision to have an abortion. A few said that they found having to view the fetal image or listen to the fetal heartbeat to be a negative experience.

“I did not like the attitude, especially the heartbeat thing and when they tried to persuade me not to have an abortion, that is subtle persuasion.”

(Woman, 33 years old)

“As professionals, we find this [listening to fetal heartbeat and viewing fetal images] to be necessary only if the woman wants to hear it, accept and see it, only if she asks for it. But having to expose a woman who is determined to have her pregnancy terminated to this [experience] can also cause [her] additional trauma.”

(Social worker, Skopje)

Interviews also revealed that there can be considerable differences in how the mandatory counseling is provided, depending on the clinic or provider. A few women said that practitioners respected their decision to have an abortion and did not impose misleading or inaccurate information on them or try to persuade them to change their minds. In addition, although some women expressed satisfaction with the amount and quality of medical information provided to them by their gynecologists when they sought an abortion, others felt that their gynecologists did not provide full and accurate information to them.

Most interviewees said that counseling on abortion should not be mandatory and should be non-directive and non-judgmental.

“ I would say [counseling should be] optional. I wouldn't have gone to the counseling even if it had been optional. Because I was certain, but some [women] may have second thoughts.”
(Woman, 31 years old)

“ Everybody has a right to one's religious belief. Some believe, some don't. [But] you cannot impose your views, you can counsel [on medical issues]. Not calling me names, not humiliating me.”
(Woman, 36 years old)

Moreover, a few interviewees also felt that post-abortion counseling should be offered and should include information on contraceptive methods.

“ What I see as important, based on my personal impression and on feedback from patients, is that it seems that post-abortion counseling is missing. I think it would be useful in terms of contraception and maybe also for a follow-up on the [woman's] psychological and emotional wellbeing.”
(Social worker, Skopje)

IV. Women lack access to evidence-based practical and legal information about abortion

Many interviewees also described a lack of accurate information on abortion. They felt that this should be made available to all women, and should include information about legal regulation on abortion.

“ Those [women], from the villages, for example, they do not find out the information [on abortion] in a timely manner, such that they could know ... that the timing [for obtaining legal abortion] is crucial.”
(NGO representative, Tetovo)

Interviews also pointed to various misunderstandings and confusion about the requirements of Macedonian abortion law. There is no legal requirement that a woman's partner or husband be present when a woman requests an abortion. However, at times women received contrary instructions from their doctors.

“ They insisted that ... the partner who fathered the baby, would come, because it says in the law that the husband must come. ... [My friends] were required [to do so]. ... I myself was not required to bring my partner ..., but one of my friends told me that even a gynecologist, not just the commission, requires that the partner be present.”
(Woman, 36 years old)

V. 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

A number of interviewees also spoke about the chilling effect of the legal provisions that increase fines and impose criminal sanctions on medical providers who violate the relevant legal requirements. The fines can be as high as 50,000 euros for health care facilities and 6,000 euros for medical practitioners. The law also imposes a criminal penalty of up to three years' imprisonment for medical practitioners who violate the law.

What is also problematic in the law itself are the draconian fines for the doctors. The doctors are terrified; they are so out of their minds [with fear] that sometimes they even exaggerate things. So even when they do not need to apply legal provisions, they do so, because the law even stipulates a prison sentence in its penal provisions. [Shortly after the higher fines were introduced in 2013] ... out of fear from sanctions the doctor sent home [a woman who needed an abortion because the fetus was dead], asking her to lie in bed for three days and wait with a dead fetus inside her. Now, imagine how a woman may be feeling with a dead fetus inside her, having to wait for three more days.”

(NGO representative, Skopje)

The worst thing about the law now, which is far worse than before, are the high fines for gynecologists in case of failure to report an illegal abortion.”

(Gynecologist, Skopje)

VI. Affordability shortcomings and lack of access to medical abortion can undermine women's access to safe abortion care

Interviewees also expressed concern about the lack of safe abortion services in the country. They drew particular attention to certain issues, including the insufficient number and distribution of skilled abortion providers and the unavailability of medical abortion. They also pointed to situations where surgical abortion is performed without adequate pain-relief and the continued use of dilatation and curettage—an obsolete method of surgical abortion that, according to the World Health Organization, should be replaced by vacuum aspiration and/or medical methods.⁶

Medical abortion should ... be introduced. It is efficient, safe, better for women. ... There is not enough staff, because all the patients are being referred to [our clinic]. There should be decentralization [of abortion service provision].”

(Gynecologist, Skopje)

Interviewees also expressed concerns about the exclusion of abortion care from national health insurance when women seek abortion on request. They pointed to the high cost of abortion on request and the significant price differences between public and private health facilities. They said that including the costs of abortion on request in national health care insurance coverage would be instrumental in facilitating access to those services for many women.

ILLUSTRATING THE IMPACT OF STIGMA AND POOR QUALITY CARE

One interviewee, a 36-year-old woman living in Skopje, explained that she had carried an unwanted pregnancy to term because her doctors refused to provide her with legal abortion care and information about where and when she could obtain an abortion. Instead, they expressed judgmental attitudes toward her.

The woman decided to seek an abortion because she could not afford to support or care for a child. At first, when she was in her 5th or 6th week of pregnancy, she went to a private hospital. Although their services were relatively expensive, she thought that they would be willing to perform an abortion:

“I went to see the gynecologist because I knew, right away, what I wanted to do. I didn’t want to think, I didn’t want to wait or have somebody reasoning with me; I wanted to do it immediately, because I am, after all, a grown woman. ... [The doctor said] it [abortion] ran counter to her religious beliefs ... and that she cannot give an approval for abortion.”

After she was refused care in the private hospital, she attended a private specialized health institution for obstetrics and gynecology:

“After that I went to [the private health institution], where I was labelled as a murderer. ... [There] I was told, no, it can’t be done, was I aware what I was doing, that at my age I should not abort? And eventually they went so far as to tell me that I was a murderer, called me this and that.”

The woman explained that she did not even begin filling in a request form for an abortion because *“I went in and sat down and they started putting me to shame. They don’t know anything about you, nothing.”*

After three weeks of searching for a way to obtain a legal abortion, the woman decided to carry her pregnancy to term. She attributed her decision mainly to the lack of information available to her:

“I couldn’t find anybody, and time was passing. ... I didn’t know. I thought that one cannot have an abortion after the 10th week. ... The woman [at the private hospital] refused any discussion on the subject of abortion. And I got the same treatment from [the private health institution]. ... There’s no information, unless the gynecologist provides it. ... Nor in [those facilities] was I given additional instructions about where to go if I wanted to learn some more. ... I left both these places literally raging.”

As she could not care for the child, she chose to give him up for adoption. This had profound effects on her mental health, yet she did not receive psychological support from health professionals or social workers during or after this process.

RECOMMENDATIONS

The following recommendations identify a number of specific actions that Macedonian authorities should take to address the concerns that emerged from the interviews, and that should be taken in close cooperation and consultation with civil society. They do not present an exhaustive list of necessary measures.

Abortion stigma and gender stereotypes

- Take steps to modify and transform abortion stigma and harmful gender stereotypes, including by ending public campaigns that stigmatize abortion services or undermine women's ability to make informed and autonomous decisions about pregnancy.
- Organize training programs for medical practitioners intended to address, modify and transform stigma and gender stereotypes in the context of abortion services.

“[The government] could put an end to the negative campaigns [about abortion]. And open centers in the rural areas and generally outside Skopje, bring the service closer to us.”
(Woman, 31 years old)

Mandatory waiting period and mandatory counseling

- Repeal legal provisions that require women to observe a mandatory waiting period and undergo biased counseling prior to abortion.
- Require that all counseling on abortion is voluntary, non-directive and responsive to the needs and wishes of each individual woman.
- Ensure that women seeking abortion services also have access to information on the full range of contraceptive options.
- Guarantee that medical practitioners provide only medically accurate, evidence-based information on abortion and are trained on the importance of informed consent in conformity with the World Health Organization guidelines.

“In principle, I think that it is necessary to remove everything that prevents a woman from making the decision and getting the service in the shortest possible period of time.”
(Woman, 31 years old)

Access to evidence-based information about abortion

- Ensure that women can easily access accurate and evidence-based information about abortion, including information on relevant laws and policies.
- Introduce mandatory, age-appropriate, evidence-based and comprehensive sexuality education curricula into elementary and secondary school curricula.

“They should draft a law which won’t treat abortion as a crime. But not just the law, the entire social perception of this issue should change, and the government as the social policymaker is in any case responsible for this. They can help remove the stigma through campaigns ... and they should not place barriers at all when implementing the procedure itself. There should be general sexuality education. I think that many young people are not well informed and do not use contraceptives enough. ... I think the [abortion] law should be friendlier towards women, and serve women and their needs!”

(Woman, 33 years old)

“I think contraception [and] abortion should ... be free of charge. And all this should be in a package with sexuality education in elementary schools, secondary schools and universities, supported by government campaigns aimed at providing real information on health services, [and] using government websites to post such information.”

(Sociologist, Skopje)

Availability of affordable safe abortion care

- Ensure the dispersal and availability of an adequate number of skilled abortion providers across public and private facilities, including throughout both rural and urban areas.
- Ensure medical abortion is included in the clinical protocol for safe abortion.
- Establish and implement standard training curricula for obstetricians and gynecologists on safe abortion methods, including for medical abortion, in accordance with the World Health Organization guidelines.
- Ensure universal coverage by national health insurance of all costs related to legal abortion, including abortion on request, as well as the cost of the full range of modern contraceptive methods.
- Ensure the systematic, human rights-compliant, collection of comprehensive data on women’s sexual and reproductive health disaggregated by gender, age, socioeconomic status, and ethnicity; and periodically analyze the differential impacts that laws, policies, and practices have on women and marginalized groups in reproductive health care settings.

RELEVANT RECOMMENDATIONS TO MACEDONIA BY UNITED NATIONS TREATY MONITORING BODIES

In 2015 and 2016, U.N. Treaty Monitoring Bodies issued concluding observations to Macedonia with the following recommendations:

Committee on Economic, Social and Cultural Rights (2016)

“The Committee recommends that the State party take all measures necessary to increase the number of gynaecologists in the country and to ensure that all women have access to gynaecological health services within their municipality, particularly in Suto Orizari; make information on sexual and reproductive health available to the general public; improve school education on sexual and reproductive health that is up to date, age appropriate and based on a human rights perspective; and ensure that modern contraception methods are affordable to all, including by adding contraceptives to the list of medicines covered by the Health Insurance Fund. It also recommends that the State party review the restrictive provisions of the Law on Termination of Pregnancy. It draws the attention of the State party to its general comment No. 22 (2016) on the right to sexual and reproductive health.”⁷

Human Rights Committee (2015)

“The State party should avoid pursuing any further campaigns used to stigmatize those who undergo abortions. It should take concrete measures, including amending the Law on Termination of Pregnancy, to eliminate all procedural barriers that could lead women to resort to illegal abortions, which could put their lives and health at risk.”⁸

ENDNOTES

- 1 Law on Termination of Pregnancy (Official Gazette of the Republic of Macedonia, Nos. 87/2013 & 164/2013); Ministry of Health, Rulebook on the Content and the Manner of Counseling for the Pregnant Woman Prior to the Termination of Pregnancy: Based on Article 6 Paragraph 4 of the Law on Termination of Pregnancy (Official Gazette of the Republic of Macedonia, Nos. 87/2013 & 164/2013) (Oct. 6, 2014).
- 2 Eight interviewees were identified through H.E.R.A.'s contacts. In addition, six women, who participated in a short online survey, were also interviewed. The survey was prepared by H.E.R.A. and the Center and posted on a number of Macedonian websites in June 2017. The survey consisted of ten questions to women who have recently sought access to abortion services or abortion-related information. The purpose of the survey was to obtain basic, anonymous information about women's experiences of and perspectives on the newly introduced mandatory waiting period and counseling requirements. A total of 314 women participated in the survey.
- 3 Law on Termination of Pregnancy, *supra* note 1, art. 6.
- 4 Rulebook 2014, *supra* note 1; Law on Termination of Pregnancy, *supra* note 1, art. 6.
- 5 Law on Termination of Pregnancy, *supra* note 1, arts. 6, 9, 21; Rulebook 2014, *supra* note 1.
- 6 WORLD HEALTH ORGANIZATION, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 31 (2d ed. 2012).
- 7 Committee on Economic, Social and Cultural Rights, *Concluding Observations: the former Yugoslav Republic of Macedonia*, para. 50, U.N. Doc. E/C.12/MKD/CO/2-4 (2016).
- 8 Human Rights Committee, *Concluding Observations: the former Yugoslav Republic of Macedonia*, para. 11, U.N. Doc. CCPR/C/MKD/CO/3 (2015).