Family Planning and Abortion Service Availability and Readiness Assessment

Analytical Report

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Disclaimer

The opinions expressed in the analytical report are those of the independent expert and should not be considered the position of any stakeholder involved in the evaluation process, unless otherwise indicated in the text. The author assumes responsibility for errors, inaccuracies, omissions, or any other inconsistencies herein.

Definition of Terms & List of Abbreviations

Relevant Healthcare Facilities - inpatient and outpatient facilities licensed to provide gynaecological services;

Ministry of Health (MOH) - The Ministry of Internally Displaced Persons from the Occupied Territories, Health, Labour and Social Affairs of Georgia;

SARA Instrument - A health facility assessment instrument developed by the World Health Organization and designed to assess and monitor healthcare service availability and readiness and generate evidence to support healthcare system planning and management.

NCDC - L. Sakvarelidze National Centre for Disease Control and Public Health LEPL

Abortion Protocol - A protocol for safe termination of pregnancy

UNFPA - The United Nations Population Fund

WHO - World Health Organization

MICS 2018 - The Multiple Indicator Cluster Survey, Georgia, 2018

SRH&R - Sexual and Reproductive Health and Rights

PHC - Primary Health Care

EHR - Electronic Health Record

ISSA - The Institute of Social Studies and Analysis

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Executive Summary

This report summarizes the study conducted from September 2021 to January 2022 by the Association HERA XXI, with the involvement of an independent researcher, to assess the availability and readiness of family planning and abortion services.

The study covered all healthcare facilities in Georgia, which, according to the data provided by the Ministry of Health, provide family planning and/or abortion-related services.

The methodology used in the study is a combination of quantitative and qualitative research tools and is based on the World Health Organization (WHO) SARA instrument for assessing service availability and readiness. The basic information needed for the study was obtained from representatives of healthcare facilities through individual, semi-structured interviews. The individual interviews were preceded by a mystery client format, on the basis of which the fact of abortion services being provided by healthcare facilities was confirmed.

The information needed for the study was also obtained from the recipients of abortion services, through participating in two focus groups conducted by a social worker representing the Association HERA XX.

The study aimed to assess the quality of family planning and abortion services provided to clients by healthcare facilities operating in Georgia, on the one hand, and to analyse availability of these services to beneficiaries, both geographically and financially, on the other hand. The report places emphasis on the level of awareness of the stakeholders involved in the field of sexual and reproductive health. The information needed for the study was also obtained from the recipients of abortion services, through participating in two focus groups conducted by a social worker representing the Association HERA XX.

Study findings, conclusions and recommendations are based on information provided by both users and providers of the respective services. Already existing studies were effectively used in the study process.

In 2016, Association HERA XXI conducted an almost similar study, which assessed abortion methods availability, women's reproductive healthcare, quality of safe abortion

services and family planning services and practices in Georgia, to highlight problematic aspects of these issues. The survey was carried out by the Institute for Social Research and Analysis (ISSA).

The study was based on the country-level health assessment indicators developed by the World Health Organization, which were adapted to the local context and needs to compile an adequate survey questionnaires.

The 2016 study confirmed that there are still many problems with safe abortion services in Georgia.

One of the objectives of the current study is to outline the trends in place since 2016 and compare some quantitative data drawn from the results of the two studies.

The purpose of the present study is to create a clear picture of what prevents the effective use of the most modern and safe methods of family planning in Georgia and why the demand for induced abortion is not minimized. In addition, the findings and recommendations of the study are intended to be used to create an environment where, if desired, induced abortion services will be made more available and performed in accordance with modern standards.

The findings of the study allow to evaluate, through a comparative analysis, the extent to which the current practices of family planning and abortion services meet the requirements of the abortion protocol and other international guidelines.

The methodology used to conduct the study also included the preparation of recommendations for various stakeholders. The recommendations proposed by the evaluator are focused on their appropriateness and feasibility.

Based on the findings of the study, the evaluator came to a number of conclusions, of which the most important ones are listed below:

- Women's rights to access family planning and abortion services are grossly and frequently violated.
- The clinical guideline for family planning obliges medical personnel to ensure that women makes a decision about sterilization independently, only of their own free will.

However, there is still an informal and illegal practice, inconsistent with Georgian legislation, which requires husband's consent for women to undergo sterilization procedure.

- A large number of women of reproductive age, especially in regions and villages, cannot afford methods of contraception.
- Existing policies and legislation are not properly implemented. It can be said that the health care system is not performing its function properly and is not able to provide supportive supervision.
    - The majority of healthcare facilities do not comply with the 5-day waiting period.
    - Pills for medical abortion are not controlled in the pharmaceutical market, making them readily available to patients in case of self-induced abortion.
    - None of the healthcare facilities participating in the study evaluate the quality of the abortion services provided and the activities of the service providers;
- The health system fails to ensure adequate delivery of family planning and other reproductive health services, either quantitatively or qualitatively.
- Provision of family planning and abortion services in primary health care facilities is virtually non-existent or minimal. Out of the 66 facilities, which confirmed providing abortion services during the conversation with a mystery client, 25 are outpatient clinics, And out of the 55 healthcare facilities, which confirmed providing abortion services during the interview with the researcher, only 18 are outpatient clinics.

  According to the majority of survey respondents, the demand for family planning counselling from qualified professionals working in health facilities is low, and the small number of clients who need such counselling go directly to secondary or tertiary healthcare provides.
- Although full access to accurate information about family planning services, especially for adolescents, is of great importance, there is a severe shortage of comprehensive youth-oriented SRH&R services, primarily in the form of limited access to relevant information. At the same time, full access to such information is one of the fundamental human rights - the right to health. In addition, according to the Law on Patient Rights, patients aged 14-18 have the right to receive counselling about non-surgical

contraception methods, based on informed consent, without their parents being informed. (Source: Law of Georgia on Patient Rights, Article 41.1).

According to survey respondents, the vast majority of family doctors employed in primary healthcare facilities do not have adequate knowledge to provide family planning services. According to one of the respondents: "Most family doctors do not even know that this is part of their duties."

Family planning is not included in either formal or informal educational system in the country, which causes many problems. For example, as a result of this, due to the lack of proper instructions and information, women buy medicine for induce termination of pregnancies at the pharmacy without counselling with specialists, endangering their lives and health.

Introduction

Access to reproductive health services, including abortion services, is one of the important components for the realization of women's rights. According to the data of the World Health Organization, up to 22 million women of reproductive age resort to induced termination of pregnancy every year. In most cases, the barriers to receiving induced abortion services violate the right to health protection, privacy and physical self-determination of women.

According to the recommendations of the World Health Organization, the problems can be solved using a combination of several approaches: promoting competition in the market of medical service providers by increasing the number of service providers; lifting geographical barriers to service provision and raising awareness of women, which will make it possible to refer them to the medical facilities providing them with a desired method of abortion; regulating the price for service, through increasing competition among service providers in the direction of quality improvement.

It should be noted that the regulation of the mentioned issues and their implementation in practice, first of all, require an in-depth study and analysis of the situation in healthcare facilities operating in Georgia. For this end, in 2016, the non-governmental organization "HERA XXI" took the lead to evaluate the availability of methods of abortion, women's reproductive healthcare, the quality of safe abortion services, and the services and practices of family planning in Georgia, and to highlight the problematic aspects of these issues, through sociological studies. Due to the complexity of the issue, the changing social environment and the purpose of the study, we considered it appropriate to conduct a similar study with minor adaptations and prepare a comparative analytical report taking into account the contextual aspects of 2016 and 2022.

One of the objectives of the current study is to outline trends prevailing since 2016 and compare some quantitative data drawn from the results of the two studies. Induced termination of pregnancy is one of the methods of birth control, which is an important component of reproductive health. Sexual and reproductive health, in its turn, is an important determinant of community’s well-being. Although there have been major changes in reproductive health care and abortion practices in Georgia recently, a 2016

study confirmed that there are still many problems with safe abortion services in Georgia, and the introduction of legal safe abortion services is being carried out at a low pace.

In order to increase the level of awareness of and broaden the knowledge about family planning and establish the correct practice in Georgia, and also, in order to increase the availability and quality of safe abortion services, in general, and induced abortion services in particular, it is necessary to clearly and objectively describe the current challenges and the problems behind them.

1. Methods

1.1. Aims and Objectives

The aim of the study is to assess the availability of abortion services in Georgia and the availability and readiness of relevant clinics to provide services to women.

The study aims to accomplish three main objectives:

- Perform assessment of availability of safe abortion methods and protection of women's reproductive health in Georgia;
- Perform assessment of the quality of safe abortion services and family planning services and practices in Georgia, and description and analysis of the challenges the country faces in this area. While analysing abortion services, the study focuses on abortion services as one of the family planning instruments. It is a well-established fact that self-induced and improperly performed abortions lead to infertility and maternal mortality.
- Highlight time-dependent trends and compare some quantitative indicators drawn from the results of two surveys conducted with the help of the SARA instrument.

The authors of the present study hope that the findings, conclusions and recommendations drawn as a result of the study will contribute to the creation of an environment where the knowledge and practice of effective use of the most modern and safe methods of family planning will be common and widespread and the need for induced abortion will be minimized. In addition, in case women desire, induced abortion services will be available and will be performed in compliance with modern standards.

1.2. Methods used in the Study

1.2.1. General Description of Methods

Based on the aim of the study, a triangulation approach was used, combining quantitative and qualitative components of the study. For the purpose of the qualitative research, 2 focus groups were conducted in East and West Georgia, and the obtained results were used to develop a quantitative research tool and develop the final research report. The second component of the qualitative research included face-to-face and online interviews with service providers using a semi-structured interview. Quantitative research was conducted using a survey method, a remote interview method and a self-administered questionnaire. In contrast to the study conducted in 2016, the triangulation approach of the current study contained the mystery client methodology, through which the primary information base on the service providers was compiled. The validity of the information obtained through mystery client method was verified by the chief researcher. A general report was prepared based on the results of quantitative and qualitative research. In addition, the method of experiment was also used during the study.

The study included all inpatient facilities operating in Georgia, which are licenced to practice gynaecology and also all healthcare facilities licenced to practice gynaecology on an outpatient/day care inpatient basis (hereinafter, both types of healthcare facilities will be referred to as relevant healthcare facilities).

The study methodology was designed to provide information on the quality and availability of family planning and abortion services, from both clients and providers of these services. In the planning and implementation of the study, the experience of the study “Assessment of the Availability and Readiness of Abortion Services” conducted by the Association HERA XXI in 2016, with the participation of the Institute of Social Research and Analysis (ISSA), which performed the fieldwork and prepared the analytical report, was used effectively. In particular, the semi-structured interview questionnaires largely repeat the questions and sequence of the 2016 survey.[1]

[1]See Appendix #3 for the semi-structured interview questionnaire.

At the first stage of the study, the Association HERA XXI provided the researcher with all important documents and publications that were needed for the effective implementation of the study. After studying the relevant material,[2] the researcher made some minor technical changes in the study plan.

1.2.2. An Overview of Qualitative Research Methods

The purpose of the research: to reveal the attitude of women of fertile age living in Georgia towards safe abortion.

The objectives of the research include the following:

- Identifying women's attitudes towards family planning practices and assessing the availability of relevant information;
- Determining the reasons for termination of pregnancy;
- Assessing access to safe abortion;
- Identifying women's attitudes towards abortion services.

Research method: focus group (group discussion). The duration of the discussions was 1.5–2 hours.

Research tool: a semi-structured guide (guideline) developed by the Institute for Social Research and Analysis. The guide covers 20-30 key issues, such as access to family planning information, awareness and availability of contraceptives, main reasons for abortion, availability and quality of abortion services, etc.

Target group: women of childbearing age living in East and West Georgia who have had at least one abortion since 2016. Due to pandemic restrictions, focus groups were conducted remotely using the ZOOM platform in November 2021.

Sampling method: snowball.

Sample: The sample included 16 women aged 20-45.

[2] See Appendix #4 for a list of relevant documents.

Data analysis: Group discussions were conducted online in a video format and recorded. Transcripts of the recorded material were made. The data was processed in several stages:

- ✓ Formal analysis of the text (differentiation between factual and evaluative components);
- ✓ Structural analysis of factual material (systematization of data based on various criteria);
- ✓ Analysis of evaluative data and identification of the most common schemes;
- ✓ Identifying generalized types of interpretive and factorial parts.

As a result of the analysis, a qualitative research report was prepared, based on which the questionnaire was modified. Qualitative research data were also used to develop the final research report.

It is noteworthy that a woman was selected as the facilitator of the focus groups in order to take into account the gender aspect and avoid unnecessary barriers. A social worker of Association HERA XXI was specially trained for this purpose.

1.2.3. An Overview of Quantitative Research Methods

The purpose of the research: to assess the availability and readiness of abortion services in healthcare facilities licensed to provide the service

The objectives of the research include the following::

- Assessment of access to safe abortion and reproductive health care in Georgia;
- Assessment of the quality of safe abortion services and family planning services and practices in Georgia.

Research method: face-to-face interview

Research instrument: semi-structured questionnaire (see Appendix 3), which includes closed, semi-closed and open questions. The Service Availability and Readiness

Assessment (SARA) instrument[3] developed by the World Health Organization was used to compile the questionnaire, which was modified based on the data obtained as a result of the focus group. The questionnaire includes the following sections:

- General information about the clinic
- Clinic infrastructure
- General information about abortion services
- Affordability and access to abortion services
- Safety and access to abortion services
- Post-abortion period
- Clients' awareness and satisfaction; confidentiality
- Clinic staff
- Family planning services
- Statistical data on abortion services

Target group: clinics across Georgia that offer abortion services to clients

General sample - 66 healthcare facilities throughout Georgia, which provide abortion services in practice;

Size of the sample: 30 healthcare facilities throughout Georgia providing abortion services

Sampling method: Purposive sampling

In contrast to the study conducted in 2016, within the framework of this study, the general sample and the sample selected do not coincide with each other, as some of the healthcare facilities refused to participate in the survey. The validity of responses from facilities that declared that they did not provide abortion services was verified using the mystery client method. The database of healthcare facilities of the Ministry of Labour, Health and Social Protection of Georgia was used as the sampling base.

Data analysis: at the first stage, grouping and formalization of the responses given by the respondents to the open questions included in the questionnaire was carried out through

[3] Questionnaire of Service Availability and Readiness Assesment (SARA), World Health Organization (WHO), accessed on 24.11.2021 http://www.who.int/healthinfo/systems/SARA_Reference_Manual_Chapter2.pdf?ua=1

assigning codes (quantitative indicators) to them. The coded responses were entered into a computer grid of variables created for each specific survey. The data were then cleaned, weighted, and cleaned. During processing and analysis, methods of univariate and bivariate analysis such as frequency (one-dimensional) distribution, measures of central tendency, correlation analysis, cross-tabulation analysis were used. The final report was prepared by summarizing the qualitative and quantitative research results. Protocols[4], guidelines[5] and Georgian laws were used for data analysis.

Fieldwork: Fieldwork was conducted from November 1, 2021 to January 16, 2022. In light of the restrictions due to the pandemic, only a small part of the healthcare facilities were interviewed on the spot. Information was obtained from the remaining 26 healthcare facilities participating in the study through the Zoom platform, telephone interviews or through sending a completed questionnaire.

1.2.4. Methodological Differences with Respect to the 2016 Study: a Mystery Patient Survey and an Experiment

An important difference between the two studies is the use of the mystery patient instrument in the current study, which was performed by volunteers representing the Association HERA XXI, who had received appropriate training and instruction. Within the framework of the study, each of the six volunteers - young women – made phone calls to healthcare facilities, telling them, according to a pre-designed guide[6], that her relative had decided to have an induced abortion and needed information about the methods and price of abortion services available in the healthcare facility. 66 healthcare facilities confirmed providing abortion services during the conversation with a mystery client. Besides, several healthcare facilities replied to the mystery clients that they could get this information only by coming to the place, which was an indirect confirmation of the fact of them providing the service.

[4] State standard of clinical condition management (protocol) - clearly defined stages of clinical condition management and sequence of actions developed on the basis of national recommendation (guideline) of clinical practice.
[5] National Clinical Practice Recommendation (Guideline) - a clinical condition (nosology/syndrome) management recommendation developed on the basis of evidence-based medicine, which is a document reflecting state policy and approved by the Ministry of Labor, Health and Social Protection of Georgia.
[6] See Appendix 1.

As part of the fieldwork phase of the study, the mystery clients tried to contact all the inpatient facilities operating in Georgia that are licenced to practice gynaecology and also all the healthcare facilities licenced to practice gynaecology on an outpatient/day-care inpatient basis (hereinafter, both types of healthcare facilities will be referred to as healthcare facilities). The Ministry of Health provided the organization with a list of healthcare facilities practicing gynaecology (total number of these healthcare facilities was 624) based on a request for public information.

Mystery client managed to get in touch with the 374 healthcare facilities, the rest were either no longer functioning, or had changed their profile or the contact info provided was either incorrect or non-existent.

66 out of 374 healthcare facilities, including 25 outpatient clinics, confirmed providing abortion services during the conversation with a mystery client.

Out of the 66 healthcare facilities, which confirmed providing abortion services during the conversation with a mystery client, 55 healthcare facilities confirmed practicing these services during the interviews with the researcher, of which 18 were outpatient clinics.

Out of the 55 healthcare facilities that confirmed during the interviews with the researcher being engaged in the practice of providing abortion services, 30 healthcare facilities agreed to participate in the study (see Figure 1).

In the study, the healthcare facility was represented by either the head of the healthcare facility or by an obstetrician-gynaecologist (in some cases, the head of Obstetrics and Gynaecology (OB/GYN) Department);

Representatives of 21 of the healthcare facilities participating in the study were interviewed face-to-face, by phone or via the Zoom platform. 9 healthcare facilities refused to be interviewed and agreed to fill in the questionnaire and send it by e-mail. The reason for refusal was lack of time.

In addition, in contrast to the 2016 study, an experiment was conducted on the availability of abortion-related medication to determine whether or not it is possible to purchase the appropriate medication without a doctor's prescription. As part of the experiment, the

possibility of purchasing mifepristone and misoprostol without a prescription through a pharmacy was checked.

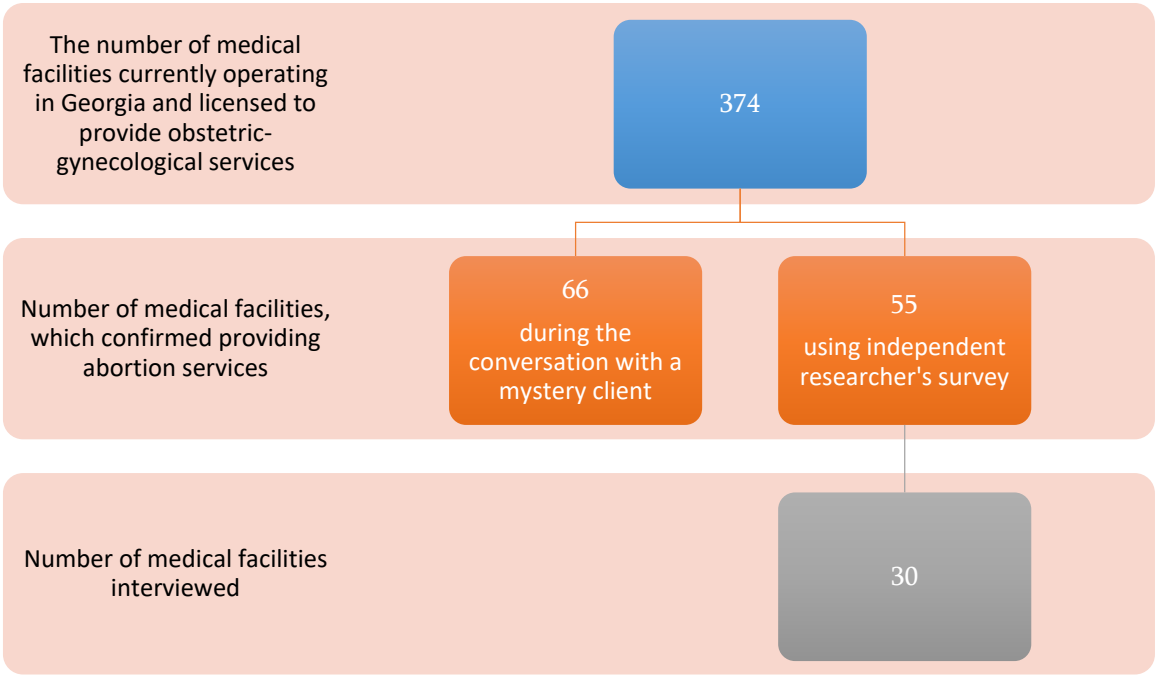

Figure 1. Medical facilities operating in Georgia and providing abortion services.

Some of the differences between the two studies were due to the limitations caused by the Covid-19 pandemic, due to which the independent researcher was unable to monitor the infrastructure of the healthcare facilities on site.

The findings of the study provide an opportunity to evaluate, through a comparative analysis, the extent to which the current practice of family planning and safe abortion services meets the requirements of the abortion protocol and other international guidelines.

The methodology also included the preparation of recommendations for various stakeholders. The proposed recommendations are focused on their appropriateness and feasibility.

2. Key Findings of the Study

2.1. Findings from Focus Groups with Clients

Below are the main findings drawn as a result of the focus group discussions conducted (on-line) with women living in Poti and Tsilkani IDP settlement:

Participants in the focus groups unanimously expressed their satisfaction with the fact that someone has taken a serious interest in this issue and hope that this study would help to solve at least some of the many problems with family planning and safe abortion;

The meeting was the first of its type for everyone and they had not participated in any conversations/discussions;

In the case of all participants, the term of pregnancy was determined by ultrasound examination;

According to the participants, the sanitary-hygienic conditions were perfect everywhere at the abortion service reception places;

None of the participants had any complications;

A large majority of the participants admitted that they had personally never planned pregnancies and the majority of people around them had the same experience, that is, “they became pregnant naturally”- as they said.

According to absolutely all participants, neither they nor anyone around them had received any theoretical and/or practical knowledge or been trained to acquire skills or received any counselling regarding family planning as part of school programme. Therefore, they believe that much more non-formal education activities, trainings and sessions are needed to establish good practices.

All participants of the focus group refrained from answering the question about which contraceptives they used at that time. Therefore, it is not clear whether they did not have an answer or they avoided talking about this topic. Finally, one participant said that she used oral contraceptive pills following the advice of a gynaecologist;

According to the focus group participants, the use of contraceptives is higher in big cities because doctors there are more qualified and the level of awareness of the population is higher. According to some participants, there may be many in big cities with low level of awareness, but in big cities, unlike in rural areas, access to a gynaecologist is greater and specialists convince them to adopt the correct practice;

According to some participants, the high cost of contraceptives or financial inaccessibility is one of the main reasons for low use of contraceptives;

According to focus group participants, men often do not realize how much frequent childbirth and/or abortions harm women's health. The level of awareness of Georgian men in this matter is very low. Therefore, women are the ones who should take care of this in the first place.

None of the focus group participants knew of the existence of the Association HERA XXI or any other organization that could help women with this issue, both with advice and contraceptives;

For some of the participants, the presence of a third person at the counselling with the gynaecologist is unacceptable, and for some, the presence of an assistant does not create a problem.

Among the reasons for the low use of contraceptives, distrust in their quality was also mentioned. In addition, participants did not know how long they could use different contraceptives without harming their health.

In the end, the participants unanimously noted that they really needed to talk about these topics, but they always felt uncomfortable discussing them. Even during the focus group, they could not say much because they could not speak openly. During the focus group, it became clear that the women were uncomfortable talking about this topic, and the focus group moderator needed a lot of effort to get information from them. The majority did not even dare to use the terms “contraceptive” or “condom”.

The topic of family planning, and especially abortion, is tabooed in a large part of society. For example, all participants of the focus group refrained from answering the question about which contraceptives they used at that time.

2.2. Information obtained by Mystery Patients and the Researcher[7] from the Representatives of Outpatient and Inpatient Facilities and Relevant Findings

The main part of the data for the study report was obtained as a result of interviews with representatives of relevant healthcare facilities. In order to facilitate perception, the information received from the respondents is divided into thematic blocks.

Affordability of Contraception

Some of the healthcare facilities admitted that financial access to quality contraception for the majority of their clients is limited, especially in recent years, when none of the healthcare facilities participating in the study cooperated with international donors.

Several healthcare facilities admitted with the researcher that in 2020 and 2021 there were several cases when they implanted already expired IUDs (contraceptives received as part of humanitarian aid before 2015, which were expired by 2019). This fact shows that there were systemic problems in terms of logistics and utilization in the healthcare system.

Consequently, neither outpatient nor inpatient facilities have been able to provide free contraceptives and information (illustrated) materials for several years. An exception is only a few healthcare facilities, which, as partner clinics, are involved in projects implemented by the Association HERA XXI.

Awareness and Practice Regarding Contraception

According to some respondents, the population has become more informed about contraception methods with the help of the Internet in recent years. However, this does

[7] The findings included by the researcher in the research report are based on the information provided by the respondents, as the research methodology did not provide for on-site data verification by the researcher through direct observation.

not mean that the level of awareness of family planning issues and the effective use of this knowledge has increased significantly. Since the provision of verified information in the form of formal education does not actually take place, it is difficult to say how well this information is used in practice.

Some of the respondents note that the functions of family doctors include counselling about contraceptives, and if family doctors had the appropriate knowledge, the demand for such counselling would be high, because counselling with family doctors are financed through the universal health care programme. Accordingly, the correct practice of family planning would be introduced at the wider level of the society.

Actually, family doctors refer clients for contraception counselling to a gynaecologist in the same outpatient clinic, and the price for the service is partially covered by the state and partially by the client.

Almost all obstetricians and gynaecologists told the researcher that the provision of family planning services in primary health care facilities is virtually minimal, and the small number of clients who request such counselling go directly to secondary and/or tertiary health care facilities. The main reason for this is that the vast majority of family doctors do not even consider it their duty to advise on such services, and probably do not have the proper knowledge.

In individual interviews with the researcher, interviewees reported that the most common form of family planning services in most outpatient and inpatient facilities is oral contraception (pills) and IUDs. However, the latter is used relatively less, because women's condition sometimes did not allow for their use and, in addition, there is the problem of financial access to IUDs.

According to the personal observation of some gynaecologists, a large part of the population, who do not receive counselling on family planning issues from healthcare facilities, mainly use condoms as a means of contraception. An obstetrician-gynaecologist working in one of the regions told the researcher the following: "Some of my patients, before coming to me, did not even know about the existence of other contraceptives, if they had not used them."

Only a small number of healthcare facilities confirmed providing an emergency contraception service. According to the majority of the respondents, this service is either not available at all or only periodically available in their healthcare facility.

There is an informal and, according to Georgian law, illegal practice, that requires a woman to have her husband's consent for the sterilization procedure. The Family Planning Clinical Guideline obliges medical personnel to ensure that a woman makes the decision about sterilization independently, only of her own volition.

Accordingly, the practices described above constitute discrimination against women in the healthcare facility, which violates women's rights to equality, their right to full capacity, with regard to informed consent and patient confidentiality, and promotes stigma and prejudice against women's ability to make independent, autonomous decisions about their own bodies.

(Source Law of Georgia on Patient Rights, Article 22.1, 22.2, 139 Family Planning, National Recommendations for Clinical Practice (Guideline), p. 149

2.3. Abortion Service Availability and Readiness

In order to determine the availability of abortion services in those outpatient and inpatient clinics that provide gynaecological services, within the framework of the study, a survey was conducted using the method of mystery patients[8], interested in abortion services.

Below are the general statistical data regarding the availability of services compiled through the survey:

Table #1 - Statistical data on the availability of abortion services in healthcare facilities

	Data from the Ministry of Health	Number of healthcare facilities contacted by mystery clients	Number of healthcare facilities confirming provision of abortion services during a conversation with a mystery client	Number of healthcare facilities confirming provision of abortion services during interviews with the researcher
Total number of healthcare facilities	**624**	**374**	**66**	**55**
Outpatient facilities			**25**	**18**

[8]See Appendix 1 - The Text of a Mystery Patient Interested in an Abortion Service

To assess recent trends in access to safe abortion services, it is worth noting that according to a 2016 survey, 100 healthcare facilities confirmed providing abortion services, and according to the current survey, only 66 healthcare facilities confirmed providing the service.

Refusal of clinics to provide abortion services significantly reduces the availability of and accessibility to abortion services.

Almost all healthcare facilities confirm that the demand for selective abortion has decreased significantly in recent years, including in municipalities populated by ethnic minorities.

The table below shows the distribution of facilities providing abortion services by regions of Georgia.

Table #2 - Regional distribution of the 66 medical facilities, which confirmed providing abortion services during the conversation with a mystery client.

Region/ Medical Facility	Outpatient Clinics	Inpatient Medical facilities	Total
Tbilisi	17	26	43
Imereti	1	2	3
Guria	0	1	1
Adjara	1	4	5
Samegrelo-Zemo Svaneti	3	1	4
Racha-Lechkhumi & Kvemo Svaneti	0	0	0
Shida Kartli	1	5	6
Kvemo Kartli	0	0	0
Kakheti	1	1	2
Mtskheta-Mtianeti	0	0	0
Samtskhe-Javakheti	1	1	2

In many healthcare facilities, they stated that they do not perform induced abortion due to moral considerations, but only in case of spontaneous termination of a pregnancy or bleeding, that is, when the foetus is no longer alive or cannot be saved.

In several healthcare facilities, they said that they do not provide abortion services, although the gynaecologist working with them does so elsewhere. Whereas the gynaecologists said that they do not provide abortion services anymore or had never provided them.

The study has shown that provision of abortion services in primary healthcare facilities is minimal. In the interview with the researcher, a large part of outpatient clinics stated that if the pregnancy is confirmed by a ultrasound examination, the client ir referred to an inpatient facility to receive an abortion service;

In almost all facilities, which confirmed providing abortion services during the conversation with a mystery client and even provided information on the price of various methods, the obstetrician-gynaecologists asked permission from the head of the facility to participate in an interview with the researcher;

In a few of such cases, when an obstetrician-gynaecologist was finally allowed to participate in an interview after much effort, their answers were almost always the same: the evaluator was told that they only perform abortions in case of a spontaneous termination of a pregnancy or in emergency cases (medical or surgical abortions, depending on the gestational age and condition of a pregnant woman). There is a reasonable suspicion that induced abortion services are actually being provided, but they are trying to hide the fact;

Several healthcare facilities are listed as aesthetics centres, but have a gynaecologist as a staff member or as a visiting doctor. They do not confirm provision of abortion services in any such healthcare facility;

Several gynaecologists stated that they were aware of some cases of gynaecologists providing abortion services at home because the management of the healthcare facility where they are employed is either against the provision of abortion services altogether or tries not to publicize the fact.

Several gynaecologists confidently stated that they are aware of several healthcare facilities where abortion services are provided, although the condition of the space, where the procedures are performed, does not meet the sanitary-hygienic safety requirements. Therefore, they suggest that such facilities do not openly admit to be providing abortion services.

There are almost no restrictions on the provision of family planning and abortion services to different groups of clients. An exception is women infected with HIV/AIDS, whose condition is not managed by the healthcare facility and they are referred to the appropriate healthcare facility in Tbilisi[9]. This practice is common in almost all regions, and according to some obstetrician-gynaecologists, it represents a discriminatory approach and is a manifestation of a systemic problem.

2.3.1. Religious Stigma and Refusal to Provide Abortion Services due to Religious Beliefs

In an interview with the researcher, several obstetrician-gynaecologists noted that, in recent years, they have felt increased pressure from various groups of society (including religious ones) opposing induced abortion. This is partly connected with the Epistle of the Catholicos-Patriarch of Georgia issued in 2014, condemning abortions and abortion service providers. After the text of the Epistle was published, one of the gynaecologists decided to attend a meeting organized by a civil society organization to discuss the issues concerning the Epistle, where the gynaecologists tried to convince the audience, including clergy, that there are cases when induced abortion is the best solution, for example, when a woman threatens to commit suicide in case the fact of her being pregnant is revealed.

The Epistle also states that up to a million abortions are performed in Georgia per year, which is far from the real figures. To illustrate, below are the numbers and percentages of abortions (both induced and spontaneous) taken from a 3-year report published by the NCDC:

In 2018 - 22 733 cases (30.8% from the total number of pregnancies);

[9] Infectious Diseases, AIDS and Clinical Immunology Research Center

In 2019 - 21 599 cases (31.0% from the total number of pregnancies);

In 2020 - 19 039 cases (29.2% from the total number of pregnancies).

Obstetricians and gynaecologists involved in the study told the researcher that a large number of clinics, based on religious considerations, refuse to perform abortion services (some have entered the corresponding provision in their bylaws). Managers of several clinics explained their refusal to provide induced abortion services on the basis of their own religiosity and principles. Some respondents believe that in recent years this has become a fashionable trend and clinics are proud of it. At the same time, several obstetricians and gynaecologists told the researcher that it does not bring much financial profit to the clinic to provide this type of services, and therefore they refuse to provide them and feel proud of it. This latter statement sounds strange, as the provision of abortion services must be profitable, since the price of the service is several times higher than its prime cost, which raises some doubts.

It should be noted that in one of the healthcare facilities, the evaluator was told the following: "We do not perform planned abortions on church holidays at all. If it is decided to perform an abortion after the ultrasound examination, we postpone the procedure to the next day. We perform abortions only in emergency cases, because we believe that we are already committing a sin, and it would be a greater sin to perform an abortion on such a day."

2.3.2. Price and Affordability of Abortion Services

Part of the problem related to the access to abortion services is its affordability. The study found that prices for abortion services in healthcare facilities range from GEL 140 to GEL 275. Mystery clients participating in the study were quite often told that they cannot be informed about the prices of the service over the phone, and they could get the information on the spot, at the reception desk at the clinic.

It should be noted that in all healthcare facilities where medical and surgical abortions are performed, the price of medical abortion is always (sometimes significantly) higher than the price of surgical abortion.

In response to the evaluator's question on pricing medical abortion services, gynaecologists replied that the cost of treating complications was included in the price of medical abortion, so that in case of complications, it was no longer necessary to ask the client to pay for the service. Some gynaecologists added that otherwise situations risked becoming awkward because patients might get annoyed about the complication and asking for additional payment to treat the complications would create some problems.

Some gynaecologists did not rule out that the high price of medical abortion in healthcare facilities could be one of the reasons for self-induced abortions in some cases (the price for the necessary pills is up to GEL 35).

Regarding the price of medical abortion, the evaluator was given a different opinion as well. According to some respondents, the price of medical abortion in healthcare facilities varies within a logical framework, because the price of medical abortion includes initial and repeated counselling, ultrasound before and after the abortion procedure, the cost of pills (GEL 35), the price for treating possible complications, post-abortion counselling via phone calls (for up to two weeks' period) and the profit of a healthcare facility.

The gynaecologists belonging to this group believe that the main reason for self-induced abortions is not the price of medical abortion, but the low level of awareness and not knowing the risks associated with self-induced abortions. According to them, even if the price of medical abortion was 100 GEL, some patients would still choose to pay GEL 2 and use misoprostol.

Regarding affordability of abortion services, the manager of one of the healthcare facilities told the evaluator that they cooperate with the organization "Real People Real Vision", its partner organizations, "Women's Fund in Georgia" (https://www.womenfundgeorgia.org), which refer patients to them and also finance the cost of abortion and related services. Partner clinics both in Tbilisi and in the regions were involved in this initiative. In addition, in 2021, the organization was referring clients to the organization "Tanatdgoma" to participate in the study conducted by them on a new model of medical abortion in Tbilisi, Batumi and Zestaponi. The model considers lower prices for the service compared to the existing ones. Induced abortion services are not funded by the state. Induced abortion services are not funded by the state.

2.3.3. Infrastructure and Amenities in Healthcare Facilities

One of the topics of the individual interviews was the state of the infrastructure in the healthcare facilities. Studying the infrastructure in the 30 healthcare facilities whose representatives participated in the study (due to the pandemic, the researcher managed to visit only 4 of these healthcare facilities), revealed the following:

In the vast majority of the healthcare facilities capital repairs had either been made recently or are currently underway;

The vast majority of the healthcare facilities are provided with constant electricity supply. Only a few municipal outpatient clinics do not have their own generator;

According to the representatives of all thirty healthcare facilities participating in the study, the healthcare facilities are provided with constant water supply. However, about half of them do not have independent, large water reservoirs;

According to the study participants, the running water in the clinic is of high quality. However, none of them confirm that the facility is filtering/treating water;

Proper temperature control - heating/cooling - is provided in various forms in all healthcare facilities, both in wards and doctors' offices, as well as in rooms for administrators and corridors;

In all inpatient facilities, an automatic or hand-flush toilet is available for outpatients;

2.3.4. Pre-abortion Counselling

The subject of the study was pre-abortion counselling. The interviews conducted as part of the study made it clear that only gynaecologists provide pre-abortion counselling, and the conversation is mainly about the reasons for a woman's decision to have an abortion, and they try to convince women to change their mind about having an abortion.

The abortion protocol pays special attention to informing and counselling clients about the expected complications of abortion, the choice of abortion and family planning methods. This requirement of the protocol is, at best, only partially fulfilled, as clients do not have a large choice of healthcare facilities. And within each healthcare facility, there

is not much choice either in terms of medical personnel or the methods of abortion. Clients are provided with the information only about the methods available at the healthcare facility. Therefore, in many cases, clients are not properly informed about the various methods of abortion and possible complications.

According to international practice, a healthcare facility is obliged to provide clients with information about whom to contact in case of violation of their rights. The study failed to identify a single healthcare facility fulfilling this requirement.

No printed, audio-visual or video information materials about methods of abortion and possible complications, post-abortion contraception, as well as the rights of clients are provided to clients in any healthcare facility. Exceptions are only a few healthcare facilities that are partners of Association HERA XXI and receive relevant materials from the Association.

In all healthcare facilities studied clients are required to sign a so-called informed consent, confirming that they have become familiar with the risks and possible complications of the abortion to be performed.

Ultrasound examination is among mandatory pre-abortion procedures. And, in the presence of signs of anaemia, haemoglobin or haematocrit level is determined.

All healthcare facilities confirm that abortion services are not provided without ultrasound examination. If, for example, at an early stage of pregnancy ultrasound fails to confirm the presence of the foetus, clients are offered to pay a repeated visit after one or two weeks to undergo a ultrasound examination.

It should be noted that in the absence of an abortion service, according to the protocol for induced termination of pregnancy, the healthcare facility has the obligation to refer clients to a relevant healthcare facility, which most of the healthcare facilities do not perform or perform improperly. This was proven through the mystery client component of the study, when out of hundreds of facilities that did not confirm the availability of abortion services in their facilities, only seven referred mystery clients to relevant facilities.

2.3.5. 5-day Waiting Period

Among the study questions, special attention was paid to the 5-day waiting period, which was approved by the amendment to the Law of Georgia “On Health Care” on August 8, 2014. In particular, subparagraph "b" of paragraph 2 of Article 139 of the Law was formulated as follows:

„b) if the pregnant woman has been interviewed in the healthcare facility and a five-day term for making a decision has passed from the interview to performing medical intervention for induced abortion. During the interview, the priority shall be given to the protection of the life of the foetus. Making a decision about the abortion shall be the prerogative of the woman. The procedure for the pre-abortion counselling by/preliminary interview with the physician shall be determined by an order of the Minister for Labour, Health and Social Affairs of Georgia.”

Regarding this issue, the evaluator received some contradictory answers. It should be noted that most of the healthcare facilities do not comply with this requirement and have different explanations for this. For example, some directly state that, according to their observations, women change their mind about abortion on the same day of the pre-abortion consultation or, at the most, on the next day. Therefore, waiting for 5 days does not change anything, it only decreases the possibility of women receiving medical abortion and, in general, a safe abortion service, and thus increases the risks associated with abortion. In particular, the earlier the induced abortion is performed, the more likely it is to be completely safe. And the waiting period causes a delay in the procedure.

Frequently voiced opinion was that if the 5-day period considered for abortion is strictly observed, women living far away from the healthcare facility may not come to scheduled visit and resort to a self-induced termination of a pregnancy.

If a client is in the 12th week of pregnancy, most facilities provide abortion services immediately.

Regarding the 5-day waiting period and pre-abortion counselling, the researcher was told in one of the healthcare facilities that when a client expresses a desire for a medical abortion, one of the employees is instructed to bring the needed pill from the adjacent

building, and during this period the gynaecologist tries to convince the client to her mind regarding having the abortion. If the client does not change her mind during this period, medical abortion service is provided.

One of the respondents, who changed her mind to have an abortion 7 years ago, told the evaluator that a few years ago (when a 3-day waiting period was in place) doctors would change the registration date to an earlier date (forms filled out by patients had earlier date instead of the actual date) to enable health care facilities to provide abortion services to clients on the same day they paid their first visit to a healthcare facility.

At one of the facilities the evaluator was told that when the pandemic started they called the Regulatory Agency and received a recommendation from them that in case the patient insisted on having an abortion and in case they themselves were convinced that the patient was firmly determined to have an abortion, they should provide the service the same day, i.e. immediately. Later, they verified the information received from the Regulatory Agency with a representative of the Registry of Births, who confirmed this oral recommendation after having verified the information with the Ministry of Health.

According to the protocol for abortion, psychological assistance should be available to women both before and after receiving an abortion service. According to some respondents, the protocol does not clearly state when a psychologist's assistance is required or necessary. However, research has shown that in practice this requirement of the protocol is hardly ever met. Health care facility personnel say that involving a psychologist in the delivery of abortion services will increase the cost of the service. Some gynaecologists claim that they take on the functions of a psychologist, despite the fact that they are neither appropriately trained nor licensed.

It should be noted that according to international recommendations, women should have the right to choose a gynaecologist when receiving an abortion service. However, the patients have no opportunity to choose a medical staff member in almost all the healthcare facilities participating in the study, because in most health care facilities abortion is performed by only one gynaecologist, while others refuse to perform the procedure due to religious and/or other reasons.

None of the health care facilities has a separate abortion department. Abortion services are mainly provided in gynaecological departments, where all types of gynaecological services are provided, and rarely in the surgical departments.

Family planning and abortion-related services are provided by gynaecologists in all health care facilities (family planning services, pre- and post-abortion counselling, general examination, gynaecological examination, abortion procedure, post-abortion contraceptive counselling). The only exception is laboratory tests performed by a full-time or part-time laboratory technician.

2.3.6. Distribution and Practice of Different Methods of Abortion

One of the objectives of the study was to find out which method of abortion is preferred by the medical staff, on the one hand, and by clients, on the other hand.

As part of the study, public information was requested from the National Centre for Disease Control and Public Health regarding the number of induced abortions performed during the last three years, distributed by methods of abortion and age groups. Table #3 presents the relevant statistics.

Table #3 - Number of induced abortions, by methods and age groups

	Women aged 18-24			Women aged 25-40		
	Curettage	Medical Abortion	Vacuum aspiration	Curettage	Medical Abortion	Vacuum aspiration
2021[10]	71	808	361	334	4191	2706
2020	104	1047	533	435	5120	3436
2019	147	1200	667	617	5496	4131

One of the objectives of the study was to find out which method of induced abortion is preferred in different types of healthcare facilities and why.

[10]The data for 2021 are given including the month of November.

In all hospitals where the method of surgical intervention is used (with clients up to 12 weeks of pregnancy), emergency care is available on site in case of post-abortion complications. In the same healthcare facilities, it was reported that they had never had a case of referring a client to other clinics due to post-abortion complications.

Out of 18 outpatient clinics that confirmed providing abortion services during interviews with the researcher, 11 provide only medical abortion services. However, several outpatient clinics participating in the study confirmed providing a surgical abortion service as well. Most of the gynaecological outpatient clinics have a license to perform abortions using the method of vacuum aspiration only with clients who are up to 7 weeks pregnant, because they do not use anaesthesia.

It was found that a large number of out-patient clinics, especially in places far from the municipal centre, refuse to perform medical abortion because they are afraid of complications (bleeding) and fear that they may not be able to transfer clients to another facility in time. In addition, some of the inpatient facilities refuse to perform medical abortion and prefer surgical abortion, because in this case clients remain under their supervision, and in the case of medical abortion, they “cannot control the situation.”

The medical personnel of the old generation use old method (Curettage, among them) because they are good at practicing them. Some of them told the evaluator that they are afraid of medical abortion, because they consider it less safe due to potential complications;

This is probably the reason why, according to official statistics, the percentage of procedures performed using the Curettage method is significantly higher in Georgia than in any of Western European countries. In European countries, induced abortions are mainly performed using medical methods at an early phase of pregnancy, because it has been proven that using the so-called metal rods can lead to infertility in the long run.

According to public information[11] provided to the researcher by the NCDC, , the number of induced abortions among women aged 18 to 40, in the past three years, by types of healthcare facility and methods of abortion is as follows:

Table 4 - The number of induced abortions among women aged 18-40, by types of healthcare facilities and methods of abortion

	Obstetric			Antenatal		
	Curettage	Medical Abortion	Vacuum aspiration	Curettage	Medical Abortion	Vacuum aspiration
2021[12]	362	1992	1924	357	1928	1695
2020	465	2406	2634	435	5443	3051
2019	610	2505	3139	554	2291	2535

The data given in the two tables, according to some indicators, do not match. The evaluator presented the data provided by NCDC unchanged. Despite the mismatch of data, several trends are clearly identifiable. In particular:

Every year, the total number of officially registered abortions decreases;

The percentage of abortions performed using the method of curettage in 2019 (41,22%) increased significantly in 2020 (54,38%), but slightly decreased in 2021 to 47,47%.

One of the objectives of the study was to find out whether abortion methods are used correctly according to the gestational period.

Based on international guidelines for medical abortion and taking into account local specificities, it is recommended to use the following scheme in the first trimester.[13]

[11] See Appendix #5 for statistics related to abortion services provided by NCDC.
[12]The data for 2021 are given including the month of November.
[13] The table is taken from the National Protocol for Induced Termination of Pregnancy.

Amenorrhoea	Mifepristone (orally)	Misoprostol (doses and routes) 24-48 hours after Mifepristone
Last menstrual period ≤ 49 days	200 mg	400 microg *Orally **Buccally ***Sublingually
Last menstrual period ≤ 63 days	200 mg	400 microg Buccally Sublingually
Last menstrual period ≤ 63 days	200 mg	800 microg Buccally Sublingually Vaginally
64-70 days	200 mg	800 microg Buccally

Medical abortion can be performed in all outpatient and inpatient medical institutions licenced to practice obstetrics and gynaecology, by an obstetrician-gynaecologist, provided there is an adequate and timely referral plan for emergencies (agreement with the hospital practicing obstetrics and gynaecology, with proper scheme/plan for referral).

As a result of the study, it was revealed that the healthcare facilities generally do not follow these deadlines and the majority of them refuse to perform a medical abortion 6 weeks after last menstrual period - surgical abortion is offered by those healthcare facilities where it is possible. And, the facilities providing only medical abortion refuse to perform the procedure.

2.3.7. Pharmaceutical Market of Medical Abortion – Management and Practice

Interviews conducted within the frames of the study focused on the pharmaceutical market for medical abortion pills. For example, the extent to which medical personnel monitor the use of appropriate pills and the extent to which they are available to patients in case of self-induced abortion.

The majority of gynaecologists unanimously declare that the cases of self-induced medical abortions have increased significantly, and the cases of clients with complicated conditions, including bleeding, has become more frequent in recent years. The majority of gynaecologists are convinced that the first medication necessary for induced termination of pregnancy is not available to women to get self-induced abortion, and they use the pill for expelling the foetus - misoprostol, which is much more easily available.

Gynaecologists have even heard of some cases when women take misoprostol pills (one pill costs GEL 2-3) if their period is late for a few days, without even taking a pregnancy test.

It should be noted that during the study, an experiment was conducted, as a result of which it was found that pills containing mifepristone (the so-called first pill) are sold without a prescription, for example, in Aversi online sales network, as well as on-site in network pharmacies and small private pharmacies in Tbilisi and Kutaisi.

2.3.8. Quality of Abortion Services, Regulations and Statistics

The measures taken by facilities to ensure the safety of abortion services were also the subject of the study.

According to healthcare facilities participating in the study, all of them know and follow the requirements of the protocol for abortion. However, study has shown that several requirements of the protocol are ignored by the vast majority in the healthcare facilities, for example, the 5-day waiting period, availability of a psychologist, adherence to gestational periods during medical abortion.

According to them, there is a referral plan from clinics to hospitals, in case of emergency, in all healthcare facilities.

Although services are not provided to patients with HIV/AIDS, written referral instructions for such cases are not available in most of the healthcare facilities.

In addition, almost all healthcare facilities confirmed that they do not receive information about patients referred to other clinics, nor do they have any written procedures related to such follow-up.

The study showed that there is an unfavourable situation in most of the healthcare facilities in terms of processing and analysing statistical information about abortion services. Despite the researcher's request, statistics clearly disaggregated by methods of abortion were not or could not be provided by any healthcare facility. Some said they did not keep such statistics, and some promised to send it later, but did not.

The NCDC representative told the evaluator that information on abortions was integrated into the Electronic Registry for Maternal and New-born Health (hereinafter referred to as the Birth Registry). Accordingly, the same requirements apply to the provision of statistics from healthcare facilities on abortions, as for example on childbirth, that is, they must be provided within 24 hours. This system is designed so that each doctor has personal access to the portal and must personally enter the data (date, indication, method, etc.) within 24 hours of service delivery. In reality, sometimes they enter the data themselves, sometimes they have their assistants perform this task, but in most cases it is sent within 24 hours, because the fulfilment of this requirement is strictly controlled by the NCDC.

The evaluator found that some of the healthcare facilities do not have summary statistics (e.g., annual statistics) on abortion methods. The reason for that is that doctors submit data to the NCDC individually and data is not summarized within the healthcare facility. However, in some of the healthcare facilities, it is not the gynaecologists who submit abortion-related data to the NCDC, but instead they report to the person responsible for producing statistics at the facility, who sends data to the NCDC.

In most cases, the same person enters the information about the cases that are financed by the state (for certain groups) based on the Resolution 218 (only spontaneous abortion, not induced) in the Case Registration Module.

However, the Birth Registry does not report about incomplete abortions or post-abortion complications. The NCDC attempts to obtain this information from individual healthcare facilities. However, it is clear to them that information about all such cases is often not

available, as the majority of healthcare facilities do not have the appropriate data management system in place.

The evaluator was not able to compare the data in the NCDC portal with the data in the EHR database managed by the Ministry of Health because the data in the EHR is not accessible to external parties.

It is worth noting that in order to elaborate the data related to the Covid-19 pandemic, the NCDC requested access to the EHR, but the Ministry of Health refused.

The NCDC representative also noted that at the initial stage, data on the 5-day abortion period had been integrated in the Birth Register, but practice showed that, in reality, this requirement was not fulfilled and turned into a formality.

2.3.9. Post-abortion Care

Although post-abortion follow-up is mandatory according to the protocol for abortion, the gynaecologists participating in the study unanimously confirmed that the situation in terms of providing appropriate services for the post-abortion period is not satisfactory. Clients living far away from the relevant healthcare facilities hardly use these services or at best receive only telephone consultations.

This problem also includes post-abortion counselling on contraception.

2.3.10. Patient Feedback on Service Quality

None of the healthcare facilities participating in the study conduct an assessment of patient satisfaction with regard to the quality of abortion services provided to them. In the majority of facilities, the evaluator was told that considering the fact that a large proportion of patients did not pay repeated visit to the facility even for post-abortion follow-up, studying their satisfaction seemed unrealistic.

2.3.11. Confidential Information

One of the topics of the study was the confidentiality of the information about the clients.

The majority of respondents stated that the registration system for abortion services was confidential and functioned effectively. However, some respondents believed that sensitive information about women is not adequately protected, because a gynaecologist who has access to the Birth Registry portal can see information about any woman on this portal, if he/she knows the woman's personal number and ID card number. After entering the personal number on the portal, all the person needs to access the woman's personal page is to enter an additional code sent to the woman's telephone number or log in with the ID number. Because of this, there are cases when the interested person gains access to the full information about the woman without the woman's consent.

In fact, there have been cases when women's interests were harmed by the disclosure of such information. Therefore, some of the respondents are in favour of changing the system in such a way that it is impossible to view the data about the patient on the portal without the patient's permission.

2.3.12. Evaluation of Medical Personnel and Continuing Professional Development (CPD)

Apart from a few healthcare facilities, the system of evaluation of medical personnel and providing continuous professional education is not functioning (even partially). Only a few healthcare facilities have confirmed that they have a separate budget to finance professional training of employees. In most cases, family planning and abortion providers choose training courses at their own discretion to earn the required credit points.

None of the healthcare facilities participating in the study confirmed the existence of a system or a proper procedure for evaluating the performance of medical personnel providing abortion services. According to representatives of some healthcare facilities, this was also due to the fact that in the vast majority of healthcare facilities only one person performed abortions, others would not interfere in his/her work, that made it difficult to assess the quality of his/her performance. In addition, it is difficult to replace this specialist, because the choice is limited.

2.3.13. Challenges Related to the Pandemic

Among the challenges related to the pandemic, it is worth noting the significantly reduced demand for abortion services. The opinion of gynaecologists is divided on the reasons for this. Some believe that travel restrictions introduced in response to the pandemic have reduced the geographic availability of abortion services. According to some, due to the socio-economic situation aggravated by the pandemic, the financial availability of abortion services in healthcare facilities has decreased. Some of the respondents mentioned the transformation of relevant healthcare facilities into Covid-clinics as one of the reasons. In any case, it is logical to expect an increase in the number of self-induced abortions.

2.3.14. Recommendations from Survey Respondents

According to some respondents, the solution to this situation would be a long-term information campaign by the state, which would help raise the awareness of the population, firstly, to prevent unplanned pregnancies and, secondly, to make them realize that a woman has the right to decide whether to continue her pregnancy or not. This right should be protected. Women should not be pushed to seek self-induced termination of pregnancies, and thereby cause long-term harm to their health, including the risk of infertility.

In order to increase access to safe abortion services and prevent self-induced abortions, according to the head of one of the healthcare facilities, “it would be good if the healthcare facilities that participate in the antenatal care component of the state program for maternal and child healthcare had an obligation to employ at least one gynaecologist providing abortion services."

According to the same respondent, along with the above, the best solution would be if the healthcare facilities were obliged to have a psychologist whose function would be to help women change their decision about having an abortion; and in case women did not change their decision, all specialized clinics should be obliged to provide abortion services.

3. *The Findings of the Study*

As the level of awareness and knowledge of the population about the use of contraceptives is low, many women depend on the doctor advice to use a method of contraception of their choice;

The determinant of the attitude towards family planning practice is not only the level of awareness, but also the woman's experience of taking responsibility for her own life, which means that the reason of the existing problem is related more to attitudes than knowledge;

In Georgia, especially in small municipal settlements and rural areas, a large number of women do not use family planning methods;

Women participating in the focus group confirmed that in many cases contraceptives are not financially available to them;

Most of the healthcare facilities admit that there is a problem of financial access to quality contraception for the majority of their clients. Especially in recent years, when none of the healthcare facilities participating in the study cooperated with international donors and were not supplied with contraceptives as part of donor aid;

Neither formal nor informal education systems function in the country include topics related to family planning;

Public awareness of non-governmental organizations working in the field of sexual and reproductive health is minimal;

In general, the demand for family planning counselling from qualified professionals working in healthcare facilities is low, and the small number of clients who require such counselling go directly to go directly to secondary or tertiary healthcare provides. The main reason for this is that the vast majority of family doctors working in primary care settings do not have the proper knowledge to provide this service;

The vast majority of family doctors employed in primary health care facilities do not have adequate knowledge to provide counselling on family planning issues. Therefore, family

doctors refer clients who come to them to receive counselling service to a gynaecologist working in the same outpatient clinic, whose service is not free of charge;

The fact that several healthcare facilities admitted during the interview with the researcher that they implanted expired IUDs in 2020 and 2021 is an indicator of systemic problems with logistics and utilization in the healthcare system.

Approximately 20% of healthcare facilities, which confirmed providing abortion services during the conversation with a mystery client, denied providing such services in the interview with the researcher;

The contact information provided by some of the healthcare facilities was incorrect;

The representatives of abortion service providers clearly stated that in recent years, the pressure on them from different groups of the society has increased significantly;

The running water in the clinics is not filtered/treated and therefore water quality is not controlled;

The requirement set by the protocol for abortion to inform and counsel clients about methods of abortion and expected complications is only partially fulfilled.

No information material about family planning and abortion services is available to clients in any healthcare facility, except for a few healthcare facilities that are partners of Association HERA XXI and receive relevant materials from the Association;

The majority of healthcare facilities do not comply with the 5-day waiting period requirement;

A large number of outpatient clinics, especially in places far from the municipal centres, refuse to perform medical abortions;

Recommendations regarding gestational periods while providing medical abortions are not followed. In general, throughout Georgia, there are very different practices in this regard;

The situation at the pharmaceutical market of medical abortion pills is not controlled, which is why the pills are easily available to patients who decide to have self-induced abortion;

The number of self-induced abortions and complications resulting from them has increased significantly in the last few years;

Abortion service prices vary significantly by method and healthcare facility;

The price for medical abortion service is always (sometimes significantly) higher than the price for surgical abortion. The reason for this is that the cost of possible complications is included in the price of medical abortion;

A very small number of clients benefit from post-abortion services, including counselling on contraceptives, especially clients living far from healthcare facilities;

The situation caused by the pandemic has greatly reduced the geographic and financial availability of family planning and abortion services. Accordingly, the demand for family planning and abortion services in healthcare facilities has decreased, thereby increasing the number of and the risks related to self-induced abortions;

None of the healthcare facilities fulfils the requirement stipulated by international practice to provide the patient with information in advance about whom to turn to in case of a violation of their rights;

No patient satisfaction study is conducted on the quality of abortion services provided in any healthcare facility;

None of the healthcare facilities participating in the study conduct an assessment of the quality of the abortion services provided or the performance of the medical personnel providing the service;

4. *Recommendations*

1. Based on the findings of the National Survey (MICS) conducted in 2018 regarding the sharp decrease in the rate of induced termination of pregnancy, a national study should be conducted to reveal the reason for the scientifically unsubstantiated decrease in the rate of abortions and the imbalance between the rates of induced abortion, birth rate and the use contraceptives;

2. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Protection of Georgia should ensure the fulfilment of the obligation taken under the National Maternal and New-born Health Strategy and the Action Plan for 2021-2023 in relation to the access of vulnerable groups of the population to contraceptives;

3. It should be mandatory for service providers to fulfil the audit criteria stipulated by the national protocol; including for the purpose of monitoring the quality and accuracy of statistics collection and registration;

4. The protocol for safe termination of pregnancy should be revised and updated in accordance with the terms specified in the same protocol;

5. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Protection of Georgia should carry out an assessment of the registration and relevance of the 5-day waiting period established by Order No. 01-74/N of 2014, analyse its effectiveness and ensure the revision of the regulation using an evidence-based approach;

6. A mechanism should be developed to prevent pharmaceutical companies from selling group II prescription medications online or on-site without a prescription;

7. A data collection mechanism should be developed to enable service providers to register incomplete abortions, induced termination of pregnancy complications in the system, by adding appropriate quality indicators. At the level of the healthcare facilities, the implementation and monitoring of an effective mechanism for the collection of statistical data should be ensured;

8. Differentiated statistics should be collected for self-induced abortions and induced abortions;

9. Access to safe abortion and family planning services in primary health care facilities for women at an early stage of pregnancy should be promoted to prevent post-abortion complications and repeated abortions;

10. Continuous supervision of the patient's reproductive health should be provided by a family/village doctor;

11. The state should ensure the creation of youth-friendly sexual and reproductive health services;

12. Teaching on gender rights and sensitive approaches, principles of effective communication should be integrated into programmes for medical students at the bachelor's and master's and residency levels of higher education;

13. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Protection of Georgia should ensure capacity building of service providers with post-graduate continuous education programmes, including the approval of an accredited post-graduate course on safe methods of induced termination of pregnancy;

14. Managing induced termination of pregnancy only through safe methods should be made mandatory. The Ministry of IDPs from the Occupied Territories, Labour, Health and Social Protection of Georgia should ensure the development of a mechanism for the prevention of curettage;

15. In order to inform clients appropriately and promote the acceptance of services based on the patient's rights, a communication strategy on Sexual and Reproductive Health and Rights should be developed and targeted information campaign should be implemented;

16. In order to prevent self-induced abortions, Article 140 of the Law on Health should be revised and advertising abortion should be clarified. Advertising abortion and providing information about safe abortion should defined and distinguished;

17. Adaptability and accessibility The services should be adapted to the needs of and made available for all vulnerable groups, without stigma and discrimination, including persons with disabilities, persons with HIV-positive status and other at-risk groups;

18. Personal data protection and patient confidentiality should be ensured in accordance with the Organic Law on Protection of Personal Data.

Appendices

Appendix 1 – The Text of a Mystery Patient Interested in an Abortion Service

Hello, I am contacting you at the request of my relative.[14] She is considering having an induced abortion and asked me to help her. Can you tell me if she can come to your clinic[15] for an abortion?

If possible, please can you also tell me what methods do you offer[16]?

Can you tell me how much each method costs?

Thank you very much, I will inform my relative about what I have learned and she will contact you.

Note: The space between the items on the list of healthcare facilities, on a sheet of paper, should allow for the information to be inserted appropriately.

[14] "A relative" can be replaced with "a friend", "an acquintance", "a colleague", "a student" (not "a neighbor"). Each mystery patient chooses one.
[15] In healthcare facilities located in the regions of Georgia, they may ask why you are considering receiving the service from their facility, and your answer should be: it is geographically convenient for her to come to your clinic.
[16] A possible list of methods may include the following:

- Manual Vacuum Aspiration (MVA) (The First Trimester)
- Electric Vacuum Aspiration (EVA) (The First Trimester)
- Medical abortion (The First Trimester)
- Dilation & Curettage (The First Trimester)

Appendix #2 - A Focus Group Guide for Women of Childbearing Age

Hello, I am an interviewer from the Association HERA XXI. The Association is conducting a survey to assess family planning and abortion service availability and readiness. The study consists of two main components. Firstly, it aims to assess the level of awareness of family planning services, prevention of unwanted pregnancies and alternative methods of abortion among women of reproductive age. Accordingly, the study will reveal to what extent women make informed decisions regarding abortion.

Secondly, the study aims to assess the quality and access to safe abortion services, to prevent possible complications of abortion and to reduce the rates of morbidity and mortality caused by abortion.

The data derived from the interviews is confidential and will be used only in aggregate form for statistical purposes. Please be considerate and answer the questions frankly and openly.

Thank you in advance for your cooperation.

The focus group respondents will be selected based on two main criteria: a. having received at least one abortion service since 2014; b. belong to one of two age groups - 18-24-year-old women or 25-45-year-old women;

1. What family planning methods do you know? How have you learned about them? Which of the methods have you used? Why do you prefer a particular method? Have you changed the method of contraception, if yes, why?

Intrauterine device (IUD);

- Oral Contraceptives, Progestin-only Pills (POPs) (Mini-pills);
- Injectable Contraceptives;
- Spermicides;
- Condoms;
- Emergency Contraception;
- The calendar or rhythm method (also known as the Knaus-Ogino method)
- Coitus Interruptus;
- Other;

2. Who chose a particular method for you? Who did you consult with and who provided you with the service (rural doctor, family doctor, gynaecologist, other)? Was the service affordable and territorially accessible?

3. Do you think the practices of using contraceptives are different in rural and urban areas? Are there any differences with regard of the use of contraceptives among women of different ages? If yes, what is the reason?

4. Have you ever received or are you currently receiving a family planning service from any service provider, programme or project? What services are you currently receiving or what projects are you currently involved in? Tell us about your experience.

5. In case the service involved a face-to-face consultation with a doctor, was any additional person present there without your permission? e.g. a student or a trainee?

6. If you have never received family planning services, what is the reason?

- There is no information about these services;
- The services are not affordable or available to you;
- The number of participants is limited;
- You do not receive proper counselling;
- You think that you do not need these services;

7. What was your main reason for seeking an abortion?

- Financial reasons;
- Pressure from the family;
- Marital status (not being married)
- Other;

8. Was your spouse/partner involved in the decision making?

To what extent was he involved in making the decision about terminating the pregnancy? In general, do you decide things, such as family planning, use of contraceptive methods (self-protection), etc. together?

9. When was the last time you used an abortion service?

10. Who did you first turn to for receiving an abortion service?

- Family doctor who referred you to a gynaecologist (referral chain);
- A gynaecologist;

11. How many weeks pregnant were you when you received the abortion service?

12. During the family planning and abortion counselling, did the doctor use the principle of “understanding”?

- ✓ Met the patient kindly
- ✓ Studied the anamnesis purposefully
- ✓ Provided the patient with information about problems and methods
- ✓ Helped the patient to make an informed choice, including about method selection
- ✓ Explained the choice, clarified it in details
- ✓ Agreed on the next visit with the patient

13. How was the gestational age determined?

- o Using the calendar method
- o Through ultrasonography;

14. Which clinic provided the abortion service? In general, do you know how many clinics are there in the place (town/village) you live, which offer these services to women? Can you list them?

15. Which abortion services do you know about?

- o Pre-abortion counselling;
- o Post-abortion counselling;
- o Manual Vacuum Aspiration (MVA) (The First Trimester);
- o Electric Vacuum Aspiration (EVA) (The First Trimester);
- o Medical abortion (The First Trimester);
- o Dilation & Curettage (The First Trimester);
- o Emergency treatment for complications related to abortion;
- o Referral to other clinics in case of post-abortion complications;
- o Post-abortion counselling on contraception;
- o Providing contraceptives.

16. What topics were you informed about during the pre-abortion consultation?

- o Reasons for a decision to have an abortion;
- o Woman should not have an abortion;
- o Rare complications related to abortion;
- o Different methods of abortion, their pros/cons;
- o Disadvantages of selective abortion; Other (please specify).

17. Did they tell you that in case you wish to, you can postpone or cancel abortion?

18. If you were informed about the above-mentioned, who was the person who informed you about them?

- An obstetrician-gynaecologist;
- A reproductive health specialist;
- A midwife;
- A nurse;
- A sanitation worker;
- Other.

19. How comfortable you think is the 5-day waiting period that was introduced in October 2014? Did your coincide with the 12th week of pregnancy?

20. What advice did you receive and where were you referred to?

21. What other information did the doctor provided you with when you visited the healthcare facility? What kind of informational material did you receive about methods of abortion and post-abortion contraception?

- Printed material on methods of abortion and complications, as well as post-abortion contraception and client rights;
- Audio-visual material on methods of abortion and possible complications, as well as post-abortion contraception and client rights;
- Anatomical model of a female pelvis.

22. Did you receive a thorough medical examination? Did you undergo a general examination? Didi you undergo laboratory tests? Did the medical personnel examined signs of anaemia (haemoglobin or haematocrit) or did you have a blood test? Who performed the listed procedures?

23. How long after the counselling did you go to the clinic for the abortion procedure?

24. Has there ever been a time when you changed your mind about having an abortion? for what reason?

25. Have you ever experienced the situation when a doctor refuses to perform an abortion and refers client to another doctor or another facility? If yes, what was the reason? What happened after that?

26. Have you ever resorted to a self-induced abortion?

27. What were the reasons for you deciding to resort to a self-induced abortion?

- A problem with access the a healthcare provider;
- Financial barriers;
- Refusal to provide the service by the clinic;
- The 5-day waiting period;
- Desire to keep the fact as a secret;
- Other.

28. Have you ever had a medical abortion (termination of pregnancy by taking medicines orally, vaginally, in the form of an injection, etc.)? If yes, please tell us what medications you took and in what form (e.g., orally, vaginally, or sublingually). How much medicine did you take? Where did you take them - at the clinic or at home?

29. Have you ever had a surgical abortion? If yes, were any antibiotics prescribed before or after the procedure? Did you have any side effects or complications? Has there ever been a case of a failure to completely terminate the pregnancy? If so, how did you act in such a case, what did the doctor recommend?

30. During the abortion, were you offered to take some painkillers? What type of painkillers did you use - local anaesthesia, medication (which medication) or general anaesthesia?

31. Which of the methods of abortion could the clinic provide? Which one did they offer you? And which one did you choose?

- Manual Vacuum Aspiration (MVA) (The First Trimester);
- Electric Vacuum Aspiration (EVA) (The First Trimester);
- Medical abortion (The First Trimester);
- Dilation & Curettage (The First Trimester).
- 32. How much did you pay for the abortion procedure? How affordable was it for you? Did you pay in advance (before the procedure) or after the procedure? Was there any scheme to promote financial access to services at the clinic?
- System of discounts on abortion services;
- A flexible payment scheme for abortion services;
- Other financial schemes that facilitate access to abortion services for women who can’t afford them.

33. Did you have any post-abortion complications?

34. Did you have to pay extra money to be treated for post-abortion complications?

35. Due to the challenges caused by the pandemic, what barriers have you faced in accessing abortion-related services?

36. Did you receive counselling about methods of contraception after the abortion? Did you receive counselling about self-care? were you offered to schedule your next visit in 7-14 days?

37. What other inconveniences besides the ones listed above did you face during, before or after the abortion procedure? In your opinion, what are some other shortcomings related to abortion services in Georgia and how should they be eliminated?

Additional questions, if necessary and if the timeframe allows you to discuss the topic further

38. How can you describe the infrastructure and sanitary-hygienic conditions (water, toilets, electricity, heating/air conditioning) in the healthcare facility providing abortion services?

39. Which complications did you get information about during the counselling and which ones have you heard about?

- *Uterine rupture; Bleeding; Cervical injuries; A lethal outcome; Infections.*

40. Did you pay a repeat visit to the clinic? If yes, what procedures did you go through on the repeat visit?

41. In addition to your own experience, can you talk about the experiences of your acquaintances? How do women in your area deal with abortion service-related problems? Where and how they get abortion procedures, what problems they face during the procedure, etc.

42. In your opinion, are attitudes towards and practices related to abortion different in rural and urban areas? Do women of different ages have to face different problems related to abortion service? If yes, what is the reason?

Thank you for the interesting discussion!

Appendix #3 - Questionnaire for Healthcare Facilities

Name of the healthcare facility_____

Address of the healthcare facility

_____

Telephone number of the healthcare facility_____

Respondent's name, surname

_____

Respondent's telephone number

_____

Hello, I am an interviewer representing the Association HERA XXI. The Association is currying out a study with the aim to assess family planning and abortion service availability and readiness. The study consists of two main components. Firstly, it aims to determine the level of awareness among women of reproductive age of family planning services, prevention of unwanted pregnancies and alternative methods of abortion. Accordingly, the study will allow to assess the extent to which women can make an informed decision regarding abortion.

Secondly, the study aims to assess the quality of abortion-related procedures and access to safe abortion services, for the purpose of avoiding possible abortion complications and reduce abortion-related rates of morbidity and mortality.

The interview data is confidential and will be used only in aggregate form for statistical purposes. Please be considerate and answer the questions frankly.

Thank you in advance for your cooperation.

A. General Information about the Healthcare Facility

A1. Type of the Healthcare Facility:

1. An inpatient healthcare facility, licensed to practice gynaecology _____

2. An outpatient healthcare facility/day care health facility, licensed to practice gynaecology _____

A2. Organization Status:

1. Public;
2. Private, commercial;
3. Private, non-profit;
4. Mixed;
5. Other (please specify)

_____

A3. Source of Funding

1. State budget;
2. Self-financing;
3. Sponsor;
4. Mixed;
5. Other (please specify)

_____

A4. Operation Duration:

1. Less than 1 year
2. 1 to 3 years
3. 3 to 5 years
4. 5 to 10 years
5. 10 to 20 years
6. 20+ years
7. Other (please specify)

_____

A5. Is a 24-hour emergency service available at the healthcare facility?

1. Yes
2. No

A6. Does the healthcare facility collaborate with donors and partner organizations?

1. Collaborates currently
2. Collaborated in the past
3. Does not collaborate and has never collaborated

B. Infrastructure

B1. In general, how would you describe the infrastructure of the healthcare facility?

1. When was the last time the facility was renovated and does it currently need to be renovated?
2. Is uninterrupted power supply ensured? _____
3. Is uninterrupted water supply ensured?_____
4. what is the quality of running water in the facility?

_____

5. Is the facility provided with proper temperature control - heating/cooling?_____

In wards
In doctor's offices
The space for administrators
In corridors

B2. Does the facility have a restroom/toilet for outpatients?

1. Yes
2. No

B3. If yes, what type of restroom/toilet is it? (Please ,ark all types of restroom/toilet available in the facility)

1. manual-flush or automatic-flush toilets
2. A ventilated improved pit latrine (VIP)
3. Pit latrines with footrests

4. Pit latrines without footrests

5. Composting toilets

6. Other (please specify)

_____

C. General information about abortion services

C1. Structural units available in the healthcare facility?		**1. Yes**	**2. No**
C1. 1.	An outpatient department		
C1. 2.	A maternity unit		
C1. 3.	A gynaecological department		
C1. 4.	An abortion unit		
C1. 5.	A surgery		
C1. 6.	specialty offices (e.g. gynaecological)		
Other (please specify)			

C2. Which of the listed below departments provide abortion services? (Multiple answers allowed)

1. An outpatient department

2. A maternity unit

3. A gynaecological department

4. An abortion unit

5. A surgery

6. specialty offices (e.g. gynaecological)

7. Other (please specify)

_____

C3. The type and number of stuff employed in the department providing abortion services		**Number**
C3.1.	Obstetrician-Gynaecologist	
C3.2.	Therapist	
C3.3.	Paediatrician	
C3.4.	Dermatologist & Venereologist	
C3.5.	Endocrinologist	
C3.6.	Urologist	
C3.7.	Midwife	
C3.8.	Nurse	
C3.9.	sanitation worker	
C3.10.	Sexopathologist	
C3.11.	Laboratory doctor	
C3.12.	Sexologist	
C3.13.	Reproductive Health specialist	
C3.14.	Embryologist	
C3.15.	Mastologist	
Other (please specify)		

C4. Who of the medical personnel listed above provide the following services?		
C4.1.	Pre-abortion counselling	
C4.2.	Post-abortion counselling	
C4.3.	General examination	
C4.4.	Gynaecological examination	
C4.5.	Laboratory tests	
C4.6.	Abortion procedure	
C4.7.	Post-abortion counselling on contraceptives	
C4.8.	Family planning services	

C5. Does the healthcare facility provide abortion services and post-abortion counselling on contraceptives to following persons:		**1. Yes**	**2. No**	**3. No case registered**
C5.1.	Persons under 16 (in the presence of their mothers)			
C5.2.	Persons aged16-18			
C5.3.	Women infected with STIs (e.g., HIV/AIDS)			
C5.4.	Women infected with infectious diseases (e.g., tuberculosis)			
C5.5.	Women living in other regions (within Georgia)			
C5.6.	Women belonging to socially vulnerable groups			
C5.7.	Sex-workers			

C6. Is there an order in the healthcare facility restricting provision of the service to women belonging to any of the groups listed above?

1. Yes
2. No

C7. Which abortion services are available at the healthcare facility?		**1. Available**	**2. Not available**
C7.1.	Pre-abortion counselling		
C7.2.	Post-abortion counselling		
C7.3.	Manual Vacuum Aspiration (MVA) (The First Trimester)		
C7.4.	Electric Vacuum Aspiration (EVA) (The First Trimester)		
C7.5.	Medical abortion (The First Trimester)		
C7.6.	Dilation & Curettage (The First Trimester)		
C7.7.	Abortion during the second trimester (Medically-indicated termination of pregnancy)		
C7.8.	Emergency care in case of post-abortion complications		
C7.9.	Referral to other clinics in case of post-abortion complications		
C7.10.	Post-abortion counselling on contraception		
C7.11.	Provision of contraceptives		

C8. Which of the following methods of abortion are mainly used by women in this clinic? (Name no more than 3 of the most frequently used methods)

C8.1. Manual Vacuum Aspiration (MVA) (The First Trimester)

C8.2. Electric Vacuum Aspiration (EVA) (The First Trimester)

C8.3. Medical abortion (The First Trimester)

C8.4. Dilation & Curettage (The First Trimester)

C8.5. Other (please specify)

_____

C9. Can a client (patient) choose a doctor or other medical staff in the clinic to provide the following services:		1. Yes, always	2. Yes, sometimes	3. Never
C9.1.	Abortion service			
C9.2.	Post-abortion counselling			
C9.3.	Post-abortion contraception			

C10. What topics are covered during pre-abortion counselling?		1. Yes	2. No
C10.1.	Reasons for the decision to terminate pregnancy		
C10.2.	Women should not resort to induced abortion		
C10.3.	Rear complications of abortion		
C10.4.	Different methods of abortion, their advantages/disadvantages		
C10.5.	Possible complications in the post-abortion period		
C10.6.	Disadvantages of selective abortion		
C10.7.	Other (please specify)		

C11. From the issues listed in C10, which ones are provided to clients in a written form?

(please indicate numbers corresponding to the items listed in the Table C10.)

_____

C12. Is the 5-day waiting period that was introduced in October 2014 strictly followed in your clinic? What decision do you make if your client's visit after the 5-day waiting period cioncides with the 12th week of pregnancy?

D. Affordability of Abortion Service

D1. In order to facilitate access to abortion services, does the clinic provide:		1. Yes	2. No
D1. 1.	System of discounts on abortion services		
D1. 2.	Flexible payment scheme for abortion services		
D1. 3.	Other financial schemes that facilitate access to abortion services for women who can't afford them		
D1. 4.	Other (please specify)		

D2. Does the clinic assume the responsibility for appropriate pricing and performance of payment procedures by abortion service providers (medical staff)?

1. Yes
2. No

Other (please specify)

_____

E. Abortion Service Safety and Availability

E1. Are there abortion service delivery guidelines and protocols in the clinic? (Multiple answers allowed)

1. There are guidelines
2. There are protocols
3. There are neither guidelines nor protocols

E.2. Does the clinic have the following:		1. Yes	2. No
E.2.1	A plan for referral of patients from the clinic to a hospital, in case of emergency		
E.2.2.	Written instructions on referral of clients infected with sexually transmitted infections (STIs)/HIV/AIDS to a different healthcare facility		
E.2.3.	Written instruction on the purpose of post-abortion visit and how it should be conducted		

E3. Does the clinic receive the information about patients referred to other healthcare facilities?

1. Yes, always
2. Yes, but not always
3. No
4. Other (please specify)

_____

F. Post-abortion Care

F.1. Do women receive the following post-abortion services:		1. Yes	2. No	Number & percentage of women having received the service in the period from 2018 to 2021
F.1.1.	Psychological support			
F.1..2.	Testing for Sexually Transmitted Infections (STIs)			
F.1.3.	Treatment for Sexually Transmitted Infections (STIs)			
F.1.4.	Rhesus prophylaxis			
F.1.5.	HCG monitoring			
F.1.6.	A method of contraception			
F.1.7.	counselling			

G. Clients' Awareness and satisfaction; Confidentiality

G.1. What kind of information material are available about methods of abortion and post-abortion contraception for the clients in the clinic? (Multiple answers allowed)

G.1.1. Printed material about methods of abortion and possible complications, as well as about post-abortion contraception and clients' rights

G.1.2. Audio-visual material about methods of abortion and possible complications, as well as about post-abortion contraception and clients' rights

G.1.3. Anatomical model of a female pelvis

G.1.4. Other (please
specify)_____

G.2. Is there a system of registration of abortion services delivered to clients in the clinic?

1. Yes
2. No

G3. Is the abortion service registration system confidential and protected from unauthorized access?

1. Fully
2. More or less
3. Is not confidential

G4. Does the clinic have any mechanisms or regulations to ensure a confidential environment for the client during the procedure?

1. Yes
2. No (go to the question G6)

G5. What types of mechanisms and regulations are in place?

_____

G6. Do you provide clients with the information about the authorities they can address in case their rights are violated?

1. Yes
2. No (go to question G8)

G7. How and in what form do you provide the information?

_____
_____
_____

G8. Does the clinic study the customer satisfaction with the quality of the abortion services provided by the clinic?

1. Yes
2. No (go to question G11)

G9. How is the customer satisfaction studied?

_____

_____

_____

G10. Does the clinic try to improve abortion services based on information collected as part of studying customer satisfaction?

1. Yes, adequately (please specify)_____
2. Yes, but not adequately (please specify)_____
3. No
4. Other (please specify)_____

G11. In your opinion, do women make informed decision on abortion?

1. Fully informed decision
2. More informed decision
3. Less informed decision
4. Uninformed decision

H. Medical Staff

H1. Is there a medical staff evaluation system identifying the staff's need for continuing medical education (CME) on abortion and family planning issues?

1. Yes
2. No (go to question H4)

H2. Does the evaluation system consider the following information?		1. Yes	2. No
H2.1.	Evaluation of staff performance in respect of abortion services and family planning		
H2.2.	Medical staff needs for additional training courses on abortion and family planning		
H2.3.	Introduction of new clinical guidelines and protocols		
H2.4.	Introduction of new technologies in abortion and family planning		

H3. Does the clinic have a plan to conduct annual training courses on abortion and family planning?

1. Yes
2. No

H4. How is the education of the medical staff financed?

1. Through clinic's budget
2. Through donors
3. Through personnel's own budget
4. Other (please specify)

_____

H5. Are there training courses organized by clinic?

1. Yes
2. No (go to question H8)

H6. Which training courses are conducted by experienced trainers representing the clinic? (Multiple answers allowed)

1. Reproductive health and family planning
2. Manual Vacuum Aspiration (MVA)

3. Electric Vacuum Aspiration (EVA)

4. Curettage

5. Medical abortion

6. Performing an abortion during the second trimester

7. providing emergency care in case of post-abortion complications

8. Counselling

9. Quality service provision

10. Prevention of sexually transmitted infections (STIs), HIV and other infections

11. Other (please specify

_____

I. Family Planning Services

I.1. What family planning methods are available in the clinic?		**1. Yes**	**2. No**
I.1.1.	Intrauterine device (IUD)		
I.1.2.	Oral Contraceptives		
I.1.3.	Injectable Contraceptives		
I.1.4.	Spermicides		
I.1.5.	Condoms		
I.1.6.	Emergency Contraception		
I.1.7. Other (Indicate)			

I2. Do you generally provide counselling for family planning services? What approaches are in place in your clinic in this regard?

_____

_____

_____

J. Statistical Data on Abortion Services

J1. Does the clinic have the practice of processing/analysing the statistical information compiled in the clinic?

1. Yes, on a monthly basis

2. Yes, annually

3. No

J2. To what extent is the clinic's service improvement policy based on statistical information compiled in the clinic?

1. Completely (please specify)_____

2. To a certain extent (please specify)_____

3. To a lesser extent (please specify)_____

4. Not in any degree_____

J**3. Due to the challenges caused by the pandemic, what barriers have you faced in providing abortion-related services?**

_____

_____

Thank you for your time and effort.

Appendix #4 – The List of Documents and Public Information Processed as part of the Study

- Electronic Registry for Maternal and New-born Health (Birth Registry); Three year report 2018-2020;
- 2017 – 2021 Statistics on Abortions Compiled and Developed by the NCDC through the Birth Registry;
- Sexual and Reproductive Health in Georgia (MICS 2018) - the Study Supported by the United Nations Population Fund (UNFPA);
- Sexual and Reproductive Health and Rights - National Assessment by Public Defender of Georgia;
- Abortion Service Availability and Readiness Assessment (2016) - The Institute of Social Studies and Analysis (ISSA)
- Safe Abortion (Protocol) (approved by the Order N 01-182/o, 2014 of the Ministry for Labour, Health and Social Affairs of Georgia).

Appendix #5 - Clinics and Individuals Participating in the Study

1. Medguide LLC – an outpatient clinic - Ms Tamar Katsarava - Obstetrician-Gynaecologist - Tbilisi;
2. Clinic Intermed - an outpatient clinic - Ms Henrietta Kutalia - Obstetrician-Gynaecologist;
3. Batumi Multi-Profile Maternity Hospital LLC – Ms Rusiko Chabua - Obstetrician-Gynaecologist;
4. Reproductive Medicine Centre Universe LLC – Ms Lana Machavariani - Obstetrician-Gynaecologist;
5. Tamar Settlement Family Medicine Centre LLC- an outpatient clinic – Ms Maia Kavtaradze-Metreveli - Obstetrician-Gynaecologist;
6. Batumi #1 Polyclinics, LLC – Ms Guliko Gogitidze - Obstetrician-Gynaecologist;
7. Medalpha LLC (Ozurgeti) - Mr Davit Mdinaradze - Manager;
8. Obstetrics and Gynaecology Department for Maternal Care “Nino” – Ms Nino Kakulia – Head of the Department (participated in a face-to-face interview);
9. Aversi Clinic – Ms Marina Machaidze - Clinical Director (participated in a face-to-face interview);
10. Bolnisi Central Clinic, LLC – Ms Darejan Chkhetiani – Director (participated in a face-to-face interview);
11. Bolnisi Central Clinic, LLC – Ms Eka Giorbelidze – Statistician;
12. Ginemedi - an outpatient clinic Ms Nino Chkhaidze - Obstetrician-Gynaecologist; Ms Maia Aroshidze - Manager (participated in a face-to-face interview);
13. Clinic in Vake – Ms Zinaida Vashakidze – Head of the Clinic;
14. Rustavi Maternity Hospital – Ms Khatuna Tsutskiridze - Gynaecologist;
15. Zhordania-Chikovani Clinic - Ms Maka Chikovani – Head of the Clinic;
16. JSC Lazika-Media – Ms Sophio Tatarishvili - Obstetrician-Gynaecologist;
17. Khobi Polyclinics for IDPs from Abkhazia, LLC - Manager;
18. Life 2012 - an outpatient clinic – Ms Ia Kvitikashvili - Obstetrician-Gynaecologist;
19. Imedi and Mariami – Mr Zura Abalaki - Manager;
20. Kutaisi No. 2 Polyclinics, LLC – Ms Iza Kochadze - Obstetrician-Gynaecologist;

21. Medical Clinic Baiebi – Ms Nato Shengelia - Reproductive Health Specialist;
22. 23. Poti Maternity Hospital – Ms Marina Khoferia - Obstetrician-Gynaecologist;
23. Poti Maternity Hospital – Ms Sofi Kukhianidze - Statistician;
24. Women's Clinic LLC - an outpatient clinic – Ms Maia Bodokia - Clinical Supervisor;
25. Imedi LLC – Ms Iza Bajelidze - Obstetrician-Gynaecologist;
26. Diagnostic Center LLC - an outpatient clinic - Administrator;
27. HERA XXI, LLC – Administrator;
28. MeZone, LLC - Ms Rusudan Arveladze – Manager
29. Mothers' and Children's Medical Centre Iavnana – Mr Vasil Simonia - Head of Gynaecology Department;
30. I. Zhordania clinic - Nana Janelidze - Manager;
31. American Medical Centres Tbilisi - Manager;
32. National Center for Disease Control and Public Health (NCDC) – Mr Levan Kandelaki - Head of the Department of Statistics.

Appendix #6 - Abortion Service Statistics Provided by the NCDC

2021

Distribution of Abortions by Methods of Abortion and Age Groups			
Method of Abortion	Age Groups		
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Curettage	35	3345	305
Medical Abortion	27	7699	722
Vacuum aspiration	31	5939	592
Other		165	15
Information Not Available		154	8

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 18-40)			
	Antenatal	Obstetric-antenatal	Other
Adjara	262	1814	7
Guria		87	
Tbilisi	3475	3984	50
Imereti	37	1621	9
Kakheti	N/A	709	N/A
Mtskheta-Mtianeti	N/A	N/A	N/A
Racha-Lechkhumi & Kvemo Svaneti		N/A	
Samegrelo-Zemo Svaneti	371	522	
Samtskhe-Javakheti	26	412	
Kvemo Kartli	264	1206	15
Shida Kartli	225	978	N/A
Information Not Available		N/A	

Distribution of Abortions by Age Groups and Types of Healthcare Facilities			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Antenatal	9	4664	542
Obstetric-antenatal	54	11340	1066
Other	N/A	87	8

Distribution of Abortions by Regions and Age Groups			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Adjara	7	2083	199
Guria		87	N/A
Tbilisi	23	7509	790
Imereti	8	1667	149
Kakheti	8	711	60
Mtskheta-Mtianeti		7	
Racha-Lechkhumi & Kvemo Svaneti		N/A	N/A
Samegrelo-Zemo Svaneti	N/A	893	91
Samtskhe-Javakheti	N/A	438	45
Kvemo Kartli	17	1485	139
Shida Kartli		1207	137
Information Not Available		N/A	

Distribution of Abortions by Methods of Abortion and Types of Healthcare Facilities			
	Antenatal	Obstetric	Other
Curettage	21	3262	N/A
medical abortion	3869	4405	
Vacuum aspiration	1240	4613	
Other	80	140	
Information Not Available	5	40	98

Distribution of Abortions by Types and Location of Healthcare Facilities			
	Obstetric-antenatal	Antenatal	Other
Adjara	301	1980	8
Guria		92	
Tbilisi	3899	4367	56
Imereti	39	1776	9
Kakheti	N/A	775	N/A
Mtskheta-Mtianeti	N/A	N/A	N/A
Racha-Lechkhumi & Kvemo Svaneti		N/A	
Samegrelo-Zemo Svaneti	403	584	
Samtskhe-Javakheti	29	455	
Kvemo Kartli	285	1338	18
Shida Kartli	255	1085	N/A
Information Not Available		N/A	

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged < 18)			
	Antenatal	Obstetric-antenatal	Other
Adjara	N/A	6	
Guria			
Tbilisi	7	15	N/A
Imereti		8	
Kakheti		7	N/A
Mtskheta-Mtianeti			
Racha-Lechkhumi & Kvemo Svaneti			
Samegrelo-Zemo Svaneti		N/A	
Samtskhe-Javakheti		N/A	
Kvemo Kartli	N/A	14	N/A
Shida Kartli			

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 40+)			
	Antenatal	Obstetric-antenatal	Other
Adjara	38	160	N/A
Guria		N/A	
Tbilisi	417	368	N/A
Imereti	N/A	147	
Kakheti		59	N/A
Mtskheta-Mtianeti			
Racha-Lechkhumi & Kvemo Svaneti		N/A	
Samegrelo-Zemo Svaneti	32	59	
Samtskhe-Javakheti	N/A	42	
Kvemo Kartli	20	118	N/A
Shida Kartli	30	107	

Distribution of Abortions by Methods of Abortion and Regions (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	N/A	N/A	N/A		
Guria					
Tbilisi	N/A	13	N/A		N/A
Imereti		N/A	N/A		
Kakheti	N/A	N/A	N/A	N/A	N/A
Mtskheta-Mtianeti					
Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti		N/A	N/A	N/A	
Samtskhe-Javakheti	N/A				
Kvemo Kartli	6	N/A	8		N/A
Shida Kartli					

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	6	N/A		
Obstetric-antenatal	15	16	20	N/A	
Other					N/A

Distribution of Abortions by Methods of Abortion and Regions (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	612	564	867	31	9
Guria	63	19		N/A	
Tbilisi	952	4676	1710	102	69
Imereti	132	642	866	15	12
Kakheti	216	190	276	22	7
Mtskheta-Mtianeti	N/A			N/A	N/A
Racha-Lechkhumi & Kvemo Svaneti	N/A				
Samegrelo-Zemo Svaneti	44	425	412	7	N/A
Samtskhe-Javakheti	9	132	293	2	N/A
Kvemo Kartli	673	295	494	5	18
Shida Kartli	245	592	364	N/A	N/A
Information Not Available				N/A	

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	17	3484	1091	67	N/A
Obstetric-antenatal	2936	4051	4192	125	36
Other	N/A				86

Distribution of Abortions by Methods of Abortion and Regions (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	50	42	103	N/A	N/A
Guria	3	N/A		N/A	
Tbilisi	115	480	171	17	7
Imereti	11	51	86	N/A	
Kakheti	19	15	24	N/A	N/A
Mtskheta-Mtianeti					
Racha-Lechkhumi & Kvemo Svaneti					N/A
Samegrelo-Zemo Svaneti	8	36	47		
Samtskhe-Javakheti	N/A	16	28		
Kvemo Kartli	71	22	44		N/A
Shida Kartli	36	54	45	N/A	

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	379	147	13	
Obstetric-antenatal	311	338	401	12	N/A
Other					8

2020

Distribution of Abortions by Methods of Abortion and Age Groups

Method of Abortion	Age Groups		
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Curettage	35	3345	305
medical abortion	27	7699	722
Vacuum aspiration	31	5939	592
Other		165	15
Information Not Available		154	8

Distribution of Abortions by Age Groups and Types of Healthcare Facilities

	< 18-year-olds	18-40-year-olds	> 40-year-olds
Antenatal	15	5372	605
Obstetric-antenatal	78	11779	1026
Other		151	11

Distribution of Abortions by Regions and Age Groups

	< 18-year-olds	18-40-year-olds	> 40-year-olds
Adjara	11	2700	226
Guria		120	10
Tbilisi	27	7448	782
Imereti	9	1700	134
Kakheti	10	840	70
Mtskheta-Mtianeti		9	
Racha-Lechkhumi & Kvemo Svaneti		10	
Samegrelo-Zemo Svaneti	N/A	896	95
Samtskhe-Javakheti	N/A	476	38
Kvemo Kartli	23	1669	117

Shida Kartli	7	1413	166
Information Not Available		21	N/A

Distribution of Abortions by Methods of Abortion and Types of Healthcare Facilities			
	Antenatal	Obstetric-antenatal	Other
Curettage	104	3580	N/A
medical abortion	4213	4215	20
Vacuum aspiration	1609	4949	N/A
Other	61	118	N/A
Information Not Available	N/A	21	136

Distribution of Abortions by Types and Location of Healthcare Facilities			
	Obstetric-antenatal	Antenatal	Other
Adjara	735	2191	11
Guria		130	
Tbilisi	3980	4196	81
Imereti	44	1790	9
Kakheti	N/A	910	8
Mtskheta-Mtianeti	N/A	N/A	
Racha-Lechkhumi & Kvemo Svaneti		10	
Samegrelo-Zemo Svaneti	433	559	N/A
Samtskhe-Javakheti	31	478	8
Kvemo Kartli	407	1387	15
Shida Kartli	355	1228	N/A
Information Not Available			25

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged < 18)			
	Antenatal	Obstetric-antenatal	Other
Adjara	N/A	10	
Guria			
Tbilisi	10	17	
Imereti		9	
Kakheti		10	
Mtskheta-Mtianeti			
Racha-Lechkhumi & Kvemo Svaneti			
Samegrelo-Zemo Svaneti	N/A	N/A	
Samtskhe-Javakheti		N/A	
Kvemo Kartli	N/A	21	
Shida Kartli		7	

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 18-40)			
	Antenatal	Obstetric-antenatal	Other
Adjara	654	2035	11
Guria		120	
Tbilisi	3583	3789	76
Imereti	39	1653	8
Kakheti	N/A	831	8
Mtskheta-Mtianeti	N/A	N/A	
Racha-Lechkhumi & Kvemo Svaneti		10	
Samegrelo-Zemo Svaneti	391	503	N/A
Samtskhe-Javakheti	27	441	8
Kvemo Kartli	367	1287	15
Shida Kartli	305	1106	N/A
Information Not Available			21

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 40+)			
	Antenatal	Obstetric-antenatal	Other
Adjara	80	146	
Guria		10	
Tbilisi	387	390	N/A
Imereti	N/A	128	N/A
Kakheti	N/A	69	
Mtskheta-Mtianeti			
Racha-Lechkhumi & Kvemo Svaneti			
Samegrelo-Zemo Svaneti	40	55	
Samtskhe-Javakheti	N/A	34	
Kvemo Kartli	38	79	
Shida Kartli	50	115	N/A
Information Not Available			N/A

Distribution of Abortions by Methods of Abortion and Regions (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	6	N/A	N/A		
Guria					
Tbilisi	N/A	13	9		
Imereti	N/A	3	N/A		
Kakheti	N/A	N/A	N/A		
Mtskheta-Mtianeti					
Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti	N/A	N/A			
Samtskhe-Javakheti	N/A		N/A		
Kvemo Kartli	14	N/A	8		
Shida Kartli	N/A	N/A	N/A		

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	10	N/A		
Obstetric-antenatal	34	17	27		
Other					

Distribution of Abortions by Methods of Abortions and Regions (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	6	N/A	N/A		
Guria					
Tbilisi	N/A	13	9		
Imereti	N/A	3	N/A		
Kakheti	N/A	N/A	N/A		
Mtskheta-Mtianeti					

Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti	N/A	N/A			
Samtskhe-Javakheti	N/A		N/A		
Kvemo Kartli	14	N/A	8		
Shida Kartli	N/A	N/A	N/A		

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	10	N/A		
Obstetric-antenatal	34	17	27		
Other					

Distribution of Abortions by Methods of Abortion and Regions (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	646	709	1300	22	23
Guria	104	11		N/A	
Tbilisi	1102	4486	1695	82	83
Imereti	189	625	864	15	7
Kakheti	242	234	333	20	11
Mtskheta-Mtianeti	9				
Racha-Lechkhumi & Kvemo Svaneti	8		N/A	N/A	
Samegrelo-Zemo Svaneti	92	422	371	6	N/A
Samtskhe-Javakheti	45	106	316	N/A	8
Kvemo Kartli	606	405	636	7	15
Shida Kartli	301	684	420	6	N/A
Information Not Available	N/A	17	N/A		

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	95	3813	1403	56	N/A
Obstetric-antenatal	3249	3869	4533	108	20
Other	N/A	17	N/A	N/A	129

Distribution of Abortions by Methods of Abortion and Regions (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	52	47	126		N/A
Guria	8	N/A			
Tbilisi	122	446	201	8	N/A
Imereti	15	40	77	N/A	N/A
Kakheti	16	24	26	N/A	
Mtskheta-Mtianeti					
Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti	11	42	41	N/A	
Samtskhe-Javakheti	7	11	20		
Kvemo Kartli	40	42	35		
Shida Kartli	34	65	65	N/A	N/A
Information Not Available		N/A	N/A		

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	8	390	202	N/A	
Obstetric-antenatal	297	329	389	10	N/A
Other		N/A	N/A		7

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 18-40)			
	Antenatal	Obstetric-antenatal	Other
Adjara	654	2035	11
Guria		120	
Tbilisi	3583	3789	76
Imereti	39	1653	8
Kakheti	N/A	831	8
Mtskheta-Mtianeti	N/A	N/A	
Racha-Lechkhumi & Kvemo Svaneti		10	
Samegrelo-Zemo Svaneti	391	503	N/A
Samtskhe-Javakheti	27	441	8
Kvemo Kartli	367	1287	15
Shida Kartli	305	1106	N/A
Information Not Available			21

2019 Distribution of Abortions by Methods of Abortion and Age Groups			
Method of Abortion	Age Groups		
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Curettage	41	4059	380
medical abortion	38	8306	627
Vacuum aspiration	30	6977	675
Other	N/A	206	14
Information Not Available	N/A	229	14

Distribution of Abortions by Age Groups and Types of Healthcare Facilities			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Antenatal	19	6181	584
Obstetric-antenatal	93	13475	1121
Other		121	N/A

Distribution of Abortions by Regions and Age Groups			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Adjara	12	3343	273
Guria	N/A	110	14
Tbilisi	48	8712	829
Imereti	12	1819	149
Kakheti	7	958	70
Mtskheta-Mtianeti		20	N/A
Racha-Lechkhumi & Kvemo Svaneti		7	N/A
Samegrelo-Zemo Svaneti	N/A	813	71
Samtskhe-Javakheti	N/A	544	36
Kvemo Kartli	24	1914	112
Shida Kartli	N/A	1537	152

Distribution of Abortions by Methods of Abortion and Types of Healthcare Facilities			
	Antenatal	Obstetric	Other
Curettage	47	4432	N/A
medical abortion	4579	4392	
Vacuum aspiration	2064	5618	
Other	58	164	
Information Not Available	36	83	125

Distribution of Abortions by Types and Location of Healthcare Facilities			
	Obstetric-antenatal	Antenatal	Other
Adjara	2649	971	8
Guria	124		N/A
Tbilisi	5030	4479	80
Imereti	1937	34	9
Kakheti	1032	N/A	N/A
Mtskheta-Mtianeti	11	11	N/A
Racha-Lechkhumi & Kvemo Svaneti	8		
Samegrelo-Zemo Svaneti	497	385	N/A
Samtskhe-Javakheti	550	23	8
Kvemo Kartli	1609	428	13
Shida Kartli	1242	451	N/A

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged < 18)			
	Antenatal	Obstetric-antenatal	Other
Adjara	N/A	11	
Guria		N/A	
Tbilisi	15	33	
Imereti		12	
Kakheti		7	
Mtskheta-Mtianeti			
Racha-Lechkhumi & Kvemo Svaneti			
Samegrelo-Zemo Svaneti	N/A	N/A	
Samtskhe-Javakheti		N/A	
Kvemo Kartli	N/A	23	
Shida Kartli	N/A	N/A	

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 18-40)			
	Antenatal	Obstetric-antenatal	Other
Adjara	875	2460	8
Guria		109	N/A
Tbilisi	4097	4540	75
Imereti	33	1777	9
Kakheti	N/A	955	N/A
Mtskheta-Mtianeti	9	10	N/A
Racha-Lechkhumi & Kvemo Svaneti		7	
Samegrelo-Zemo Svaneti	348	461	N/A
Samtskhe-Javakheti	21	515	8
Kvemo Kartli	397	1504	13
Shida Kartli	399	1137	N/A

Distribution of Abortions by Types and Location of Healthcare Facilities (women aged 40+)			
	Antenatal	Obstetric-antenatal	Other
Adjara	95	178	
Guria		14	
Tbilisi	367	457	N/A
Imereti	N/A	148	
Kakheti		70	
Mtskheta-Mtianeti	N/A	N/A	
Racha-Lechkhumi & Kvemo Svaneti		N/A	
Samegrelo-Zemo Svaneti	36	35	
Samtskhe-Javakheti	N/A	34	
Kvemo Kartli	30	82	
Shida Kartli	51	101	

Distribution of Abortions by Method of Abortion and Regions (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	N/A	N/A	6		
Guria				N/A	
Tbilisi	15	23	8	N/A	N/A
Imereti	N/A	N/A	6		
Kakheti	6		N/A		
Mtskheta-Mtianeti					
Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti	N/A		N/A		
Samtskhe-Javakheti		N/A			
Kvemo Kartli	13	N/A	8		
Shida Kartli	N/A	N/A			

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged < 18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	13	N/A	N/A	
Obstetric-antenatal	40	25	26	N/A	N/A
Other					

Distribution of Abortions by Method of Abortion and Regions (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	663	820	1780	43	37
Guria	74	11	17	N/A	N/A
Tbilisi	1511	5044	1952	99	106
Imereti	217	599	980	10	13
Kakheti	267	245	416	18	12
Mtskheta-Mtianeti	16		N/A	N/A	N/A
Racha-Lechkhumi & Kvemo Svaneti	7				
Samegrelo-Zemo Svaneti	99	370	329	N/A	11
Samtskhe-Javakheti	96	113	310	7	18
Kvemo Kartli	792	445	649	6	22
Shida Kartli	317	659	542	14	N/A

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	40	4235	1819	53	34
Obstetric-antenatal	4018	4071	5158	153	75
Other	N/A				120

Distribution of Abortions by Method of Abortion and Regions (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	58	48	158	N/A	N/A
Guria	9	N/A	N/A		N/A
Tbilisi	179	416	221	7	6
Imereti	14	37	97		N/A
Kakheti	12	17	40	N/A	
Mtskheta-Mtianeti	N/A				
Racha-Lechkhumi & Kvemo Svaneti	N/A				
Samegrelo-Zemo Svaneti	14	36	21		
Samtskhe-Javakheti	9	N/A	23		
Kvemo Kartli	46	33	31	N/A	N/A
Shida Kartli	35	34	82	N/A	

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	6	331	241	N/A	N/A
Obstetric-antenatal	374	296	434	10	7
Other					N/A

2018 Distribution of Abortions by Methods of Abortion and Age Groups			
Method of Abortion	Age Groups		
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Curettage	44	4438	417
medical abortion	37	8193	627
Vacuum aspiration	37	7578	682
Other	N/A	104	8
Information Not Available	7	533	27

Distribution of Abortions by Age Groups and Types of Healthcare Facilities			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Antenatal	16	6578	596
Obstetric	106	12988	1025
Other	N/A	1280	140

Distribution of Abortions by Regions and Age Groups			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Adjara	11	3321	260
Guria		135	12
Tbilisi	40	9246	820
Imereti	20	1710	152
Kakheti	8	1069	69
Mtskheta-Mtianeti	N/A	38	N/A
Racha-Lechkhumi & Kvemo Svaneti		N/A	N/A
Samegrelo-Zemo Svaneti	6	836	85
Samtskhe-Javakheti	N/A	585	41
Kvemo Kartli	32	2061	147
Shida Kartli	6	1844	173

Distribution of Abortions by Methods of Abortion and Types of Healthcare Facilities			
	Antenatal	Obstetric	Other
Curettage	61	4510	328
medical abortion	4395	3771	691
Vacuum aspiration	2534	5380	383
Other	22	89	N/A
Information Not Available	178	369	20

Distribution of Abortions by Types and location of Healthcare Facilities			
	Obstetric-antenatal	Antenatal	Other
Adjara	2353	1165	74

Guria	146	N/A	
Tbilisi	5450	4439	217
Imereti	1828	6	48
Kakheti	1144	N/A	
Mtskheta-Mtianeti	18	22	
Racha-Lechkhumi & Kvemo Svaneti	N/A		
Samegrelo-Zemo Svaneti	489	438	
Samtskhe-Javakheti	592	36	
Kvemo Kartli	1713	516	11
Shida Kartli	384	565	1074

Distribution of Abortions by Types and location of Healthcare Facilities (women aged <18)			
	Obstetric-antenatal	Antenatal	Other
Adjara	11		
Tbilisi	35	N/A	
Imereti	19	N/A	
Kakheti	8		
Mtskheta-Mtianeti		N/A	
Samegrelo-Zemo Svaneti	N/A	N/A	
Samtskhe-Javakheti	N/A		
Kvemo Kartli	27	N/A	
Shida Kartli	N/A		N/A

Distribution of Abortions by Types and location of Healthcare Facilities (women aged 18-40)			
	Obstetric-antenatal	Antenatal	Other
Adjara	2177	1081	63
Guria	134	N/A	
Tbilisi	4999	4056	191
Imereti	1662	N/A	43
Kakheti	1067	N/A	
Mtskheta-Mtianeti	18	20	
Racha-Lechkhumi & Kvemo Svaneti	N/A		
Samegrelo-Zemo Svaneti	446	390	
Samtskhe-Javakheti	550	35	
Kvemo Kartli	1583	469	9
Shida Kartli	351	519	974

Distribution of Abortions by Types and location of Healthcare Facilities (women aged 40+)			
	Obstetric-antenatal	Antenatal	Other
Adjara	165	84	11
Guria	12		
Tbilisi	416	378	26
Imereti	147		N/A
Kakheti	69		
Mtskheta-Mtianeti		N/A	
Racha-Lechkhumi & Kvemo Svaneti	N/A		
Samegrelo-Zemo Svaneti	41	44	
Samtskhe-Javakheti	40	N/A	
Kvemo Kartli	103	42	N/A
Shida Kartli	31	46	96

Distribution of Abortions by Methods of Abortion and Regions (women aged <18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	N/A	N/A	6		
Guria					
Tbilisi	16	17	N/A		N/A
Imereti	N/A	N/A	13		N/A
Kakheti	N/A	N/A	N/A		
Mtskheta-Mtianeti			N/A		
Racha-Lechkhumi & Kvemo Svaneti					
Samegrelo-Zemo Svaneti	N/A	N/A			
Samtskhe-Javakheti			N/A		
Kvemo Kartli	14	N/A	8	N/A	N/A
Shida Kartli	N/A	N/A			

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged <18)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal		9	N/A		N/A
Obstetric	44	24	35	N/A	N/A
Other		N/A			

Distribution of Abortions by Methods of Abortion and Regions (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	499	826	1935	28	33
Guria	103	12	13	N/A	N/A
Tbilisi	1986	4864	2149	44	203
Imereti	199	508	982	8	13
Kakheti	235	297	506	9	22
Mtskheta-Mtianeti	38				
Racha-Lechkhumi & Kvemo Svaneti	N/A				
Samegrelo-Zemo Svaneti	107	386	332	N/A	10
Samtskhe-Javakheti	97	97	372	N/A	18
Kvemo Kartli	830	481	534	7	209
Shida Kartli	343	722	755	N/A	21

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 18-40)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	56	4041	2299	20	162
Obstetric	4091	3520	4943	82	352
Other	291	632	336	N/A	19

Distribution of Abortions by Methods of Abortion and Regions (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Adjara	47	42	171		
Guria	10		N/A		N/A
Tbilisi	211	378	213	N/A	15
Imereti	13	56	80	N/A	N/A
Kakheti	18	12	39		
Mtskheta-Mtianeti	N/A				
Racha-Lechkhumi & Kvemo Svaneti	N/A				
Samegrelo-Zemo Svaneti	13	39	32	N/A	
Samtskhe-Javakheti	6	N/A	30		N/A
Kvemo Kartli	63	40	34	N/A	9
Shida Kartli	34	56	82	N/A	

Distribution of Abortions by Types of Healthcare Facilities and Methods of Abortion (women aged 40+)					
	Curettage	medical abortion	Vacuum aspiration	Other	Information Not Available
Antenatal	N/A	345	233	N/A	11
Obstetric	375	227	402	6	15
Other	37	55	47		N/A

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Distribution of Abortions by Methods of Abortion and Age groups

Method of Abortion	Age Groups		
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Curettage	70	4964	418
medical abortion	39	8188	560
Vacuum aspiration	46	8930	683
Other			
Information Not Available	6	976	59

Distribution of Abortions by Age groups and Types of Healthcare Facilities

	< 18-year-olds	18-40-year-olds	> 40-year-olds
Antenatal	N/A	252	26
Obstetric-antenatal	155	22679	1679
Other	N/A	127	15

Distribution of Abortions by Regions and Age groups			
	< 18-year-olds	18-40-year-olds	> 40-year-olds
Adjara	13	3181	209
Guria	N/A	150	12
Tbilisi	52	10119	841
Imereti	17	1971	124
Kakheti	12	1188	102
Mtskheta-Mtianeti		35	N/A
Racha-Lechkhumi & Kvemo Svaneti		N/A	N/A
Samegrelo-Zemo Svaneti	6	919	66
Samtskhe-Javakheti	N/A	596	36
Kvemo Kartli	47	2689	158
Shida Kartli	11	2205	169

Distribution of Abortions by Types and Location of Healthcare Facilities									
	< 18-year-olds			18-40-year-olds			> 40-year-olds		
	Antenatal	Obstetric-antenatal	Other	Antenatal	Obstetric-antenatal	Other	Antenatal	Obstetric-antenatal	Other
Adjara		13			3179	N/A		209	
Guria		N/A			146	N/A		12	
Tbilisi		51	N/A	105	9933	81	18	810	13
Imereti	N/A	16		61	1903	7	N/A	119	
Kakheti		12			1182	6		102	
Mtskheta-Mtianeti					35			N/A	
Racha-Lechkhumi & Kvemo Svaneti					N/A			N/A	
Samegrelo-Zemo Svaneti		6		8	907	N/A		66	
Samtskhe-Javakheti		N/A			590	6		36	
Kvemo Kartli	N/A	46		36	2639	14	N/A	154	N/A
Shida Kartli	N/A	8		42	2160	N/A	N/A	168	