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Abortion Service Availability and Readiness Assessment (Analytical Report)

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Introduction

Abortion is one of the means of birth control that is an important part of reproductive health. Sexual and reproductive health, in turn, is an important determining factor of the public welfare. Because of the attitudes that used to be present in the Soviet Union, the processes of development and improvement of legal safe abortion services in Georgia started late, compared to other countries. Though further many changes have taken place in the reproductive health and abortion practices, a variety of surveys shows that there are still many problems related to the safe pregnancy termination services, in particular: refusal by physicians or health facilities to deliver the abortion service, the noncompliance of the 5-day time of reflection with women's needs, lack of local access, negative impact of religious values on safe pregnancy termination and other[1]. The low women's awareness of reproductive issues also creates a significant barrier. These and other factors affect the abortion service quality and availability for women.

According to the World Health Organization recommendations, these problems can be solved in several areas: promotion of competition in the health care providers market by increasing the number of service providers; reduction of geographical barriers to the delivery of services and growth of customer's awareness, which will allow them to refer to health facilities that will provide an abortion method desirable for a woman; the medical price regulation by increasing the competition among the service providers and improvement of quality of their service.

It should be noted that regulation and introduction of these issues, first of all, requires the in-depth study and analysis of the current situation in health facilities operating in Georgia. For this reason, the non-governmental organization HERA XXI has undertaken the initiative to assess, through sociological survey methods ,the availability of abortion in Georgia, women's reproductive health, safe abortion service quality in Georgia and common family planning services and practices and to identify problematic aspects of these issues. Based on the complexity of the issue and survey objectives the first phase of studies has embodied the opinions and attitudes of service providers.

1

Summary Report

The survey project of the abortion service availability and readiness assessment was conducted by the Institute of Social Studies and Analysis, on behalf of the nongovernmental organization "HERA XXI". The purpose of research was to study the availability of abortion services for women in different regions of Georgia and to reveal current shortcomings. Subject to the objectives of the study, the synthesis of qualitative and quantitative components took place. The quantitative survey was conducted in all those clinics existing in Georgia where the abortion is performed (with the exception of clinics which refused to participate in the study), using the similar survey questionnaire of the World Health Organization, adapted on the basis of the focus group survey results. Focus groups were held across the country with the women of fertile age and covered a range of issues related to the abortion service. In the frames of the quantitative study, using face to face interviews there were interviewed the clinic staff, who had the competence and information in regard of the abortion service delivery issues at a health facility. The field work was conducted between April and November 2015. The study involved 100 health facilities over Georgia[2].

The survey findings have shown that the condition of amenities and protection of sanitary norms in health facilities providing abortion services is diverse. In recent years, relatively better conditions have been fixed in rehabilitation clinics. However, there are clinics with such problems as poor quality of water, electricity and water supply interruption, inappropriate rooms and so on. Also, there have been revealed service-related problems, such as lines, medical staff neglect, lack of information and incomplete service delivery, insufficient communication between the client and medical personnel and other.

At the clinics women are offered abortion services at different departments, including gynecology, abortion, outpatient, maternity, surgery departments and at specialized rooms. Although, in general, it is desirable to have available a separate department for abortion, however, institutions are not limited to allocate the abortion treatment rooms in gynecological department or other department, where mostly gynecologists and nurses are engaged, that is consistent with the requirements of the protocol. Also, the majority of clinics employ such medical personnel, as a generalist, pediatrician, STD and skin specialist, endocrinologist, urologist, nurse, sexopathologist, laboratory doctor, sexologist, embryologist, mammalogist and other. The type and quantity of the medical personnel is not uniform in different clinics.

[2] See the list of institutions in the Annexes (Annex 1).

According to representatives of health facilities, the majority of clinics within the abortion services provide the pre- and post-abortion consultations in addition to the abortion procedure. However, the focus group results indicate that these services are rarely provided to clients adequately. During pre-abortion counseling doctors provide to clients mostly superficial information of the abortion procedure, methods, and other important issues. In this case, the patient's rights are being violated, because she is to make the final decision lacking sufficient information. Also, there is a risk that the doctor, independently of the patient's will, will arbitrarily select the method that is convenient for him/her and will not take into account the patient's needs. Typically, during a pre-abortion consultation the doctor shall inform the patient of all proven methods of abortion and if the clinic does not use the method preferred by a woman, the doctor shall refer the patient to the health facilities where this method of abortion is available. Though the referral service is available in some clinics, in practice the clinics rarely use it, basically, only in emergency cases. The referral services are not mandatory for clinics, but their existence and .practical application indicates high quality of service.

In addition, the focus group findings indicate that during the pre-abortion consultation the comprehensive medical examination is almost never carried out, though physical and gynecological examination and the minimum standard laboratory tests are recommended before the abortion procedure.

As for post-abortion counseling, mostly, it is held as needed, but some women are not even aware of the existence of such a service, that hinders the woman's general health care and the prevention of unwanted pregnancy, which is confirmed by the results of the focus group: women note that they have had often complications after the abortion. This may be caused by various factors, which are associated with abortion method and its relevance to the patient, the doctor's professionalism, individual patient characteristics and other. Contraindications may be avoided or the risk reduced by selecting the right method, so it is recommended to a doctor to take into account all indications/contraindications associated with each method, which are set out in the protocol and to select a more relevant method for each patient.

As for the abortion procedure, the service providers are offering both the first trimester and second trimester abortion. Clinics have available one or several methods of abortion - dilatation and curettage, vacuum aspiration (electric and manual), medication-induced abortion. The focus group, as well as the survey results indicate that women most often prefer the medical abortion and manual vacuum aspiration.

The focus group results indicate that women's awareness of family planning services is very low, which sometimes becomes a reason of introduction of abortion as a common practice. Also, sometimes in order to terminate pregnancy the women use medically unacceptable means that are often accompanied by a variety

of health problems and complications. The majority of health facilities, after abortion, offer the family planning services to clients, including IUDs, condoms, oral methods of contraception and more. The main source of information about family planning services for women is a health facility, however, before the start of sexual life (basically, before marriage) women, in fact, never go to a gynecologist. It is important to increase the women's awareness of family planning services before the unwanted pregnancy.

The cost of abortion is mostly affordable for women. Clinics have established benefits for certain groups, however, payment of the cost of an abortion is sometimes a problem for women, because the abortion services, in addition to the abortion procedure, include pre-abortion examination and transportation costs. Given the fact that abortion services are not available in all the villages and towns, the transportation costs are sometimes quite high.

A small number of clinics has established internal regulations that restrict providing abortion services to such groups as persons under 16, 16-18 year olds, women with STD history and other infectious diseases, vulnerable people, and sex workers. The biggest restrictions are set on the delivery of abortion services to 16-18-year-olds, which could be described as a violation of the law, because under the Georgian law, a capable teenager over 14 can make a decision on abortion. It should be noted also that a small part of clinics violates the clinic's regulations and provides abortion services to certain groups. At the same time, some clinics do not provide services to particular groups, despite the fact that the certain internal regulations in the clinic do not exist. Although, according to the representatives of the clinics, they provide different information to the women about where to go in case of violation of their rights, women use only one way in such a case – they express their dissatisfaction with the doctor. This action is not always followed by the desired result.

It should be noted that some institutions offer abortion to clients only in case of emergency/based on medical necessity. This creates a problem in populated areas where there is no other institution that provides abortion based on a woman's desire/decision, but not for a medical necessity.

A small number of clinics when providing abortion service do not use protocols and guidelines that not only adversely affects the quality of service, but also is an offense, because under the legislation of Georgia, the service must be provided to the client taking into account the recommendations of the guidelines and protocols. Also, in a small number of clinics there is no training on the guidelines and protocols, despite the fact that they are implemented in practice. Obviously, this negatively affects the quality of service. A significant number of clinics (40%) are lacking the personnel evaluation system that is the need for continuing education in the abortion and family planning issues. Given the fact that the protocols shall be

reviewed and updated every 2-3 years, it is necessary to ensure the continuing education and to conduct appropriate educational activities. Clinics are also lacking a perfect system of training courses: most of them have not elaborated training plans on the abortion issues, are lacking material-technical base and trainers. The number of clinics, which have established a mechanism for continuing education is small. In most cases, the medical staff independently searches educational programs and involves in them on the self-financing basis, because the state does not support financially such activities for the medical staff.

Therefore, the educational activities of medical staff are not systematic. As the representatives of clinics state, in the majority of clinics the staff have access to academic articles and publications.

In the majority of clinics the statistical information of abortion services is collected, but the service quality control mechanism is rather incomplete. A half of the clinics do not study the customer satisfaction. And at those facilities where the quality of service is studied, the method of oral survey of customers prevails, while the safe pregnancy termination protocol provides the audit questions, which enable to check the quality of the delivery of abortion services. Moreover, even when there is adequate statistical information, in a small number of clinics the service improvement is not based on available information. Although the collection and processing of information is not mandatory for them, without such information development of the effective ways of quality improvement is not possible.

Therefore, we can identify different types of problems related to the abortion services, such as, inadequate amenities in health facilities, the problem of implementing the protocol requirements in the practice, lack of medical staff quality control mechanism, incomplete delivery of abortion services, violation of customer rights, problem of territorial accessibility and financial affordability of abortion services, women's low awareness of family planning services, and other.

These problems hinder the quality of service and access to health care, resulting in violation of the patient's rights. In addition, the delayed and/or poor quality services result in the decrease in the indicators of the Quality Adjusted Life Years (QALY) and increase in the indicators of the Disease Adjusted Life Years (DALY)[3], which reflect the country's overall level of health care.

Solution of abortion services quality and accessibility is the prerogative of the Ministry of Health. The work shall be carried out in line with the promotion of competition in the medical service providers. Increase in the number of service providers will make abortion services more accessible. Also, it is

[3]The indicators used in the health assessment indicators on the country's level by the World Health Organization. For more information see.http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

important to raise the client's awareness and to reduce the geographic barriers of delivery of services through the improvement of the referral service.

1. Survey Methodology

1.1 Survey Aims and Objectives

Survey aims: to assess the abortion service accessibility and readiness of relevant clinics for providing services to women in Georgia.

Survey objectives:

- To assess the accessibility of safe abortion methods and women's reproductive health care in Georgia;
- To assess the safe abortion service quality and family planning services and practices in Georgia.

1.2 Methods used

Based on the objectives of the study, a triangulation approach has been used, within which the study quantitative and qualitative components have been combined. In the frames of the qualitative survey, the focus groups were held in the regions and the results were used in the quantitative study instrument development and creation of the final report. The quantitative study was conducted by a survey method and the method of face to face interviews was used. Based on the quantitative and qualitative study data the comprehensive report has been prepared.

1.2.1 Qualitative Study Methodology Description

- **Aims of study:** identification of the attitude of the women of fertility age living in Georgia to the safe abortion.
- **Objectives of study:**
  - to identify the women's attitudes toward the family planning practices and to assess the availability of the relevant information;
  - to determine the reasons of pregnancy termination;
  - to assess the safe abortion availability;
  - to identify the women's attitudes towards abortion services
- **Study Method:** Focus group (group discussion). Discussions duration of 1.5-2 hours.

- **Study tool**: the semi-structured guidelines[4], which have been developed by the analysts of the Institute for Social Survey and Analysis. The guidelines cover 20-30 key issues, such as access to information on family planning, awareness and access to contraceptives, main reasons of abortion, abortion service availability and its quality and more. The focus group guidelines were prepared with the intense participation of the experts.

- **Target group**: women of fertility age of five regions (Tbilisi, Adjara, Imereti, Mtskheta-Mtianeti, Kvemo Kartli), which currently have experienced an abortion at least once. Focus groups were held on July 3-9, 2015, in main cities of each regions *(see Table 1)*

Table 1: Place of focus groups, the target group and number

Region	Target group	Focus group date	N
Tbilisi	Women of fertility age	09.07.2015	1
Imereti (Kutaisi)	Women of fertility age	05.07.2015	1
Ajara (Batumi)	Women of fertility age	07.07.2015	1
Kvemo Kartli (Marneuli)	Ethnic minority representatives, women of fertility age	02.07.2015	1
Mtskheta-Mtianeti (Tianeti)	Women of fertility age	03.07.2015	1
Total			**5**

- **Selection method:** snowball

- **Selective integrity:** the selective integrity covered 40 women of 23-60 years from five cities of Georgia *(see Table 2).*

Table 2: Socio-demographic characteristics of selective integrity

Region	Number of participants	Age	Number of abortions	Abortion trimester
Tbilisi	7	23-41	1-13	First
Imereti (Kutaisi)	8	25-48	1-5	7 participants - first 1 participant – second
Ajara (Batumi)	8	24-60	1-8	First
Kvemo Kartli (Marneuli)	10	25-48	1-8	9 participants – first 1 participant – second
Mtskheta-Mtianeti (Tianeti)	7	23-43	1-20	First

[4] See Annex 2

- **Data analysis**: group discussions are recorded in video and audio format. After decoding each record transcripts of discussions have been made. The data were processed in several stages:
  - ✓ formal analysis of the text (differentiation of factual and evaluation parts);
  - ✓ structural analysis of factual material (data systematization based on different criteria);
  - ✓ evaluation data analysis and identification of the most common schemes;
  - ✓ Identification of the generalized types of interpretative parts.

Based on the analysis result there was prepared the qualitative survey report on the basis of which the questionnaire was modified. The qualitative survey data were used also for creation of the final report of the research.

1.2.2 Quantitative survey methodology description

- **Aim of study:** assessment of abortion service availability and readiness
- **Objectives of study:**
  - ✓ to assess the access to safe abortion methods and women's reproductive health in Georgia;
  - ✓ to assess the safe abortion service quality and family planning services and practices in Georgia.
- **Method of study:** face-to-face interview

Study tool: Semi-structured questionnaire[5], which includes closed, semi-closed and open questions. To prepare the questionnaire we have used the abortion availability and readiness assessment questionnaire[6] developed by the World Health Organization[7] that was modified based on the focus group data results. The questionnaire includes the following blocks:

I. General information about the clinic;
II. Clinic infrastructure;
III. General information about abortion services;
IV. Financial affordability of abortion;
V. Abortion service safety and access;
VI. Post-abortion period;
VII. Customer awareness and satisfaction degree; confidentiality of services;
VIII. Clinic staff;
IX. Statistical data on abortion services;

[5] See Annex 3
[6]Questionnaire of Service Availability and Readiness assessment (SARA)", World Health Organization (WHO), website visit date 24.11.2015 http://www.who.int/healthinfo/systems/SARA_Reference_Manual_Chapter2.pdf?ua=1
[7]World Health Organization (WHO)official website, website visit date 24.11.2015http://www.who.int/en/

- **Selection**

  - ✓ target group: clinics throughout Georgia, that are offering abortion services to clients
  - ✓ selection amount: 100 health facilities throughout Georgia[8]
  - ✓ selection design: target selection

In the frames of the given study, the general integrity and selection integrity match each other, because the study was conducted in all of the health facilities where the abortion is carried out, except for those facilities which refused to participate. The selection was based on health facilities of the Ministry of Labor, Health and Social Affairs of Georgia.

- **Data analysis:** The survey data was processed by the statistical package for social sciences - SPSS. In the first stage, the answers provided by the respondents to the open-ended questions included in the questionnaire were grouped and formalized, by assigning codes (quantitative indicators) to them. The coded responses were included in the computer grid of description of variables created for each specific survey. Then the data were cleaned, weighed and cleansed. For processing and analysis we have used univariate and bivariate analysis methods such as frequency (one-dimensional) distribution, central tendency indicators, correlation analysis, cross tabulation. The final report was prepared summarizing the results of qualitative and quantitative study. The data analysis was made using the protocol[9] and guidelines[10] and legislation of Georgia.

- **Fieldwork:** The fieldwork was conducted by the Institute for Social Survey and Analysis interviewers, who were trained in the fieldwork. During the training, interviewers discussed in detail the content of the questionnaire and its completion instructions, selection instructions and other. The fieldwork was conducted from September 10 through October 20, 2015.

- **Analytical report:** analytical report was prepared in active collaboration of ISSA analysts and experts in November 2015. The analytical report has synthesized the data obtained as a result of the quantitative and qualitative survey.

[8]See the list of participating clinics attached (Annex 3)

[9] The state standard of clinical management (protocol) – the clearly defined stages and sequences of actions of the clinical management developed on the basis of national recommendations (guidelines) of clinical practice

[10]The national clinical practice recommendations (guidelines) - the recommendations for management of clinical condition (diseases / syndrome) developed on the basis of evidence-based medicine, which represents the state policy document and is approved by the Ministry of Labor, Health and Social Affairs of Georgia.

2. Study Findings

2.1 General information about the clinics participating in the study

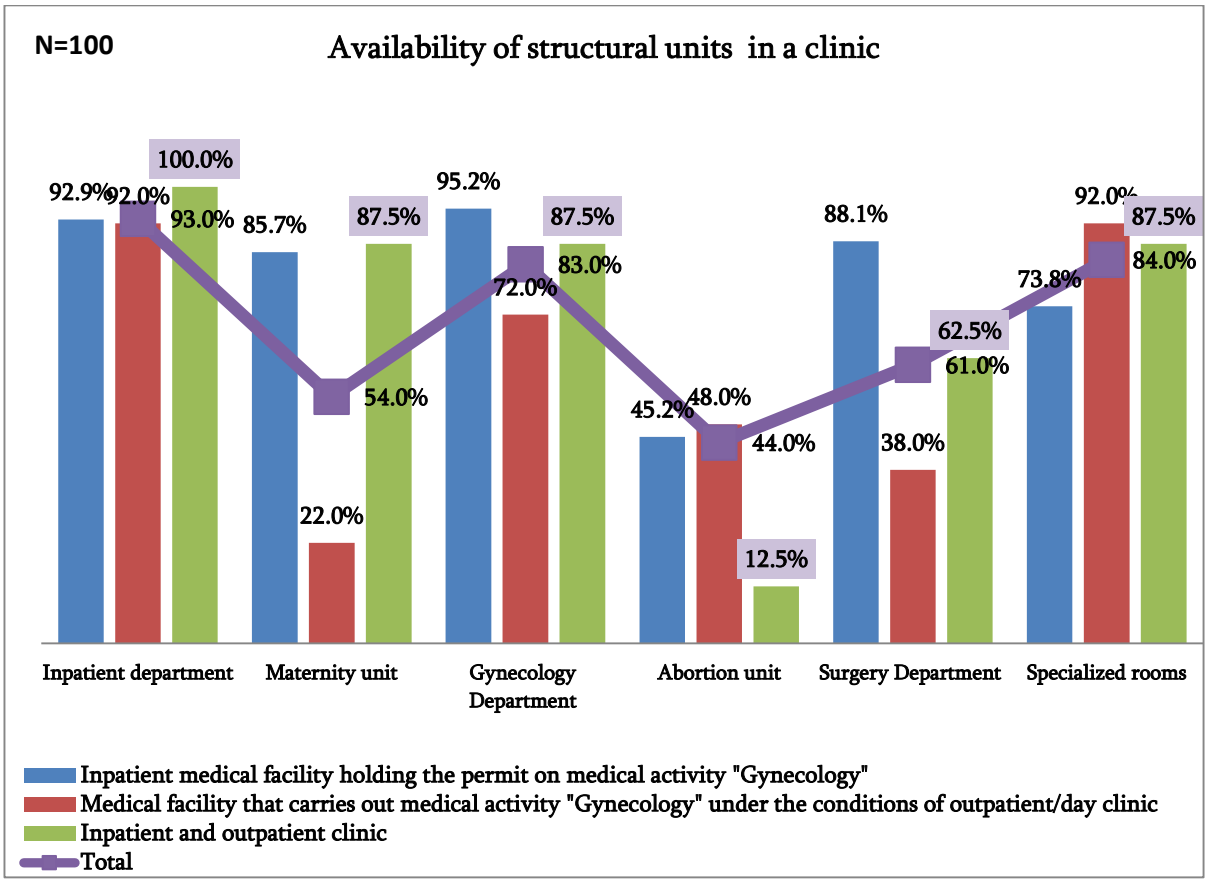
The study was involved 100 medical institutions, of which half (50% - 50 clinics) are implementing the medical activity "Gynecology" in the conditions of an out-patient/day hospital, less than half (42% - 42 clinics) are inpatient facilities, which holds a permit on medical activity "Gynecology" while the rest of the institutions (8% - 8 clinic) are of mixed type - outpatient and inpatient.

Clinics participating in the study have the following structural units:

- ✓ outpatient department (93% of clinics)
- ✓ maternity unit (46% of clinics)
- ✓ gynecological department (83% of clinics)
- ✓ abortion unit (44% of clinics)
- ✓ surgery department (61% of clinics)
- ✓ specialized rooms (84% of clinics)

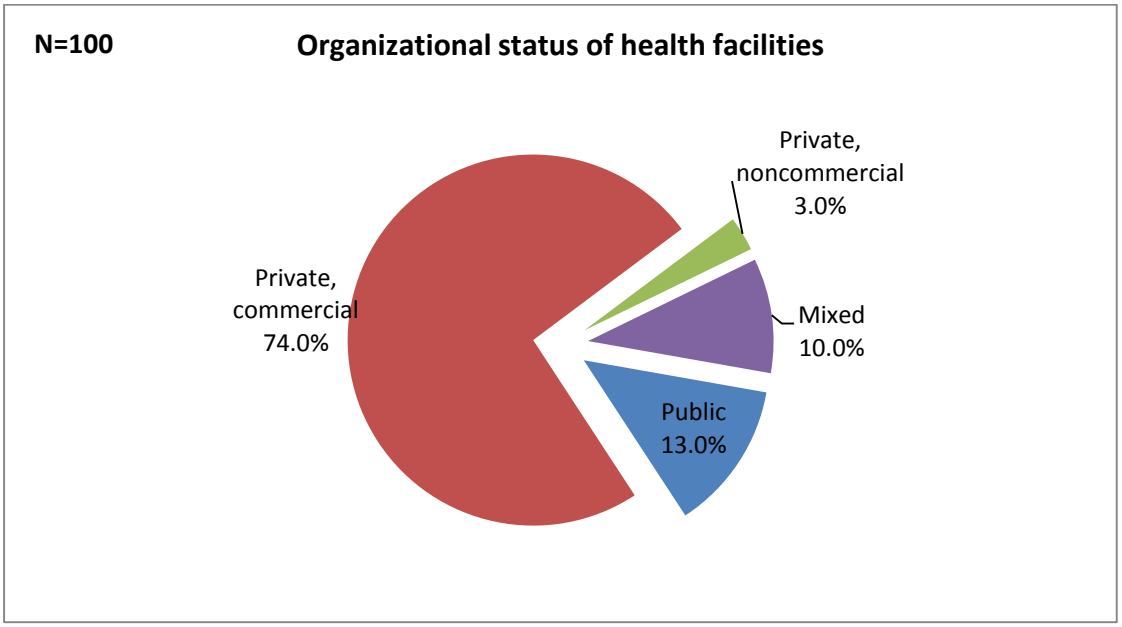
The departments are divided as follows according to facilities:

Chart N1



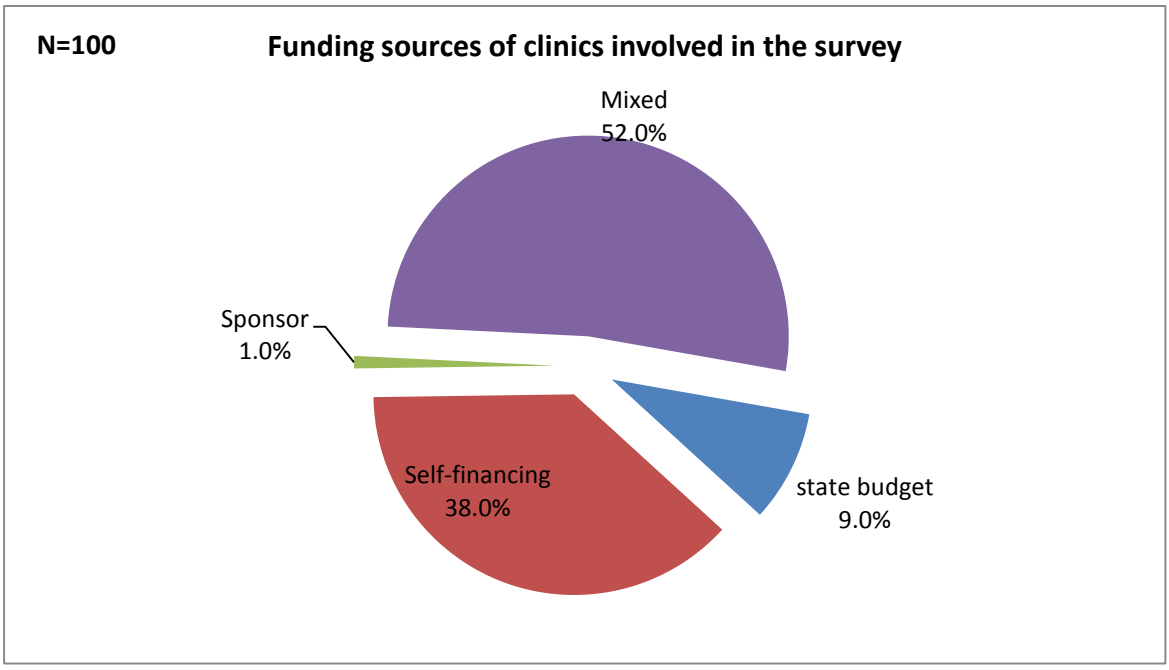
The study involved both private and public health facilities (see Table N2).

Chart N2



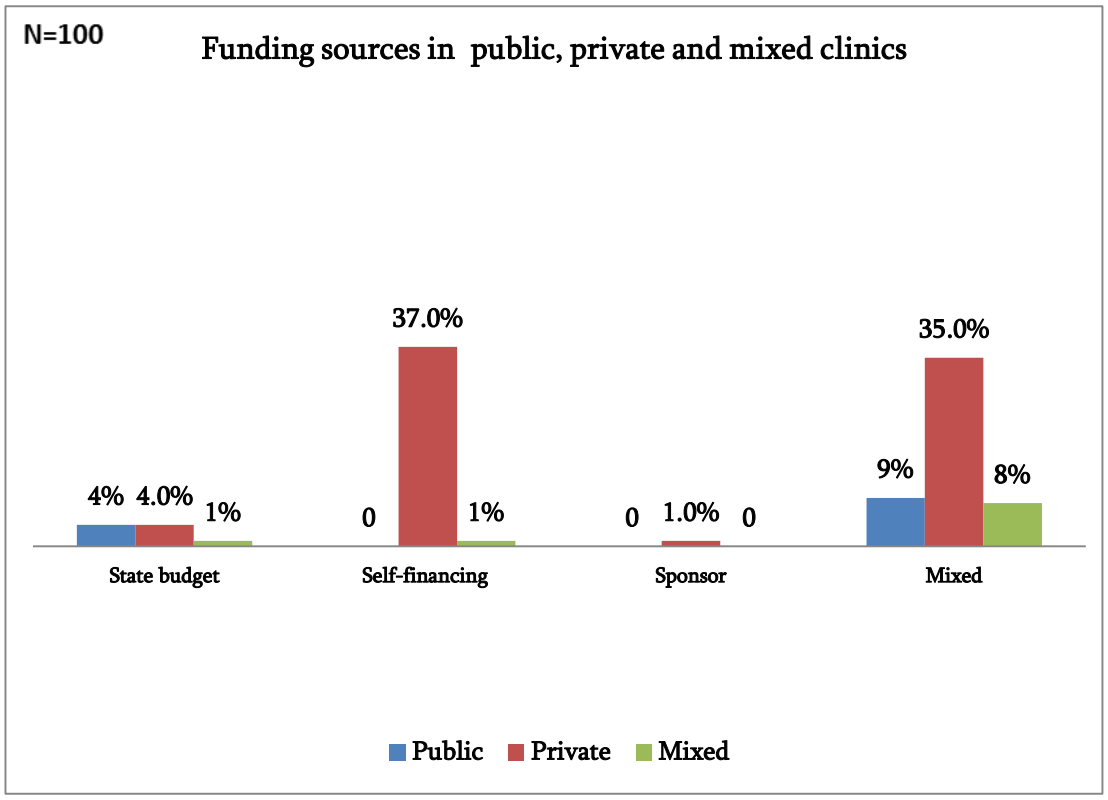
Health facilities are different by funding sources (see Table N3). A small part of clinics (9% - 9 clinics) are funded from the state budget. The majority uses mixed funding (52% - 52 clinics) or self-financing (38% - 38 clinics). Only one such clinic operates on the basis of the sponsor funding only.

Chart N3



Public clinics, mainly use the mixed funding, however, some of them use only state funding. Private commercial and nonprofit clinics, mainly use self-financing (37 clinics, which amounts to 50% of the private clinics) or mixed funding (33 clinics, which amounts to 45% of the private clinics). As for the mixed type clinics, they mostly have mixed funding (see Chart N4). It should be noted that the state finances all of these types of institutions, but the number of state funded institutions is quite small (9% of the participated clinics - 9 clinics).

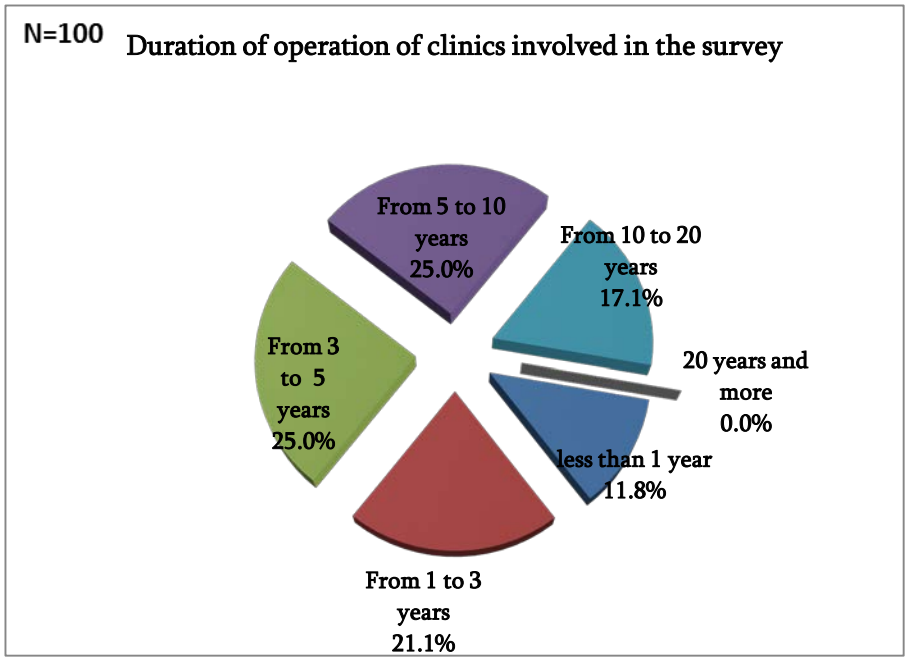
Chart N4



The majority of clinics (61%) have never cooperated with donors, a significant portion (29%) - are still cooperating, while a small portion (10%) - have cooperated in the past.

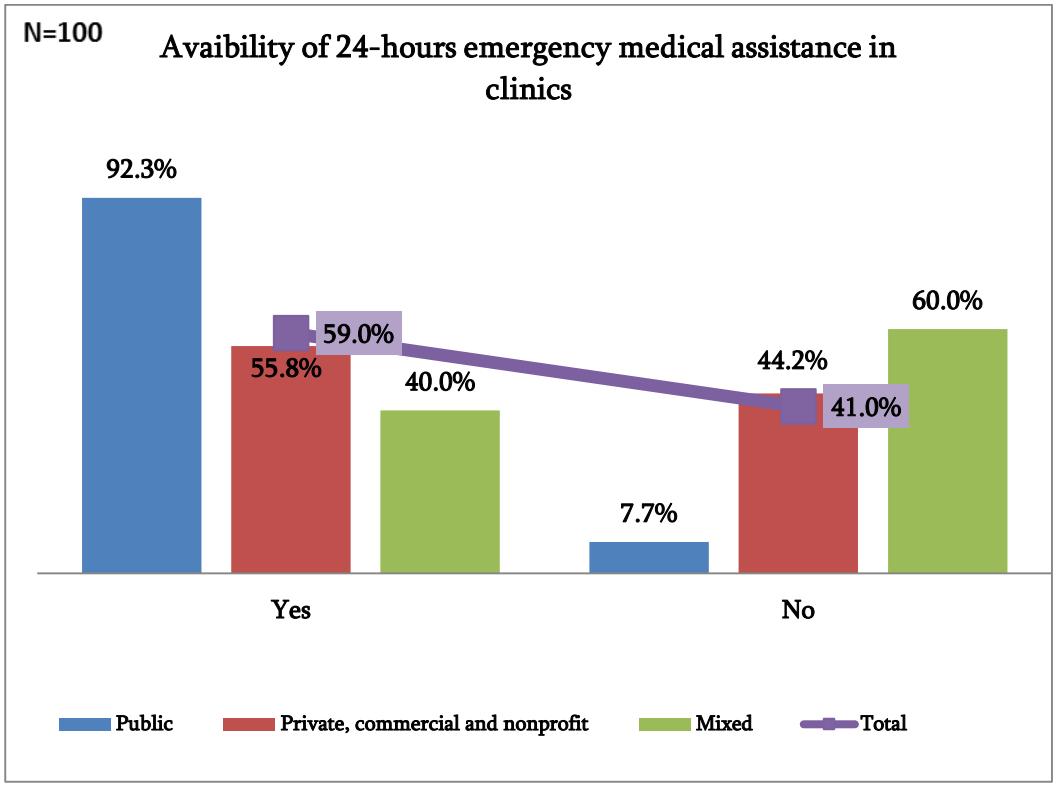
Institutions participating in the survey vary according to the duration of operation (see Figure N 5)..

Chart N5



The majority of public health facilities (92%, which amounts to 12 public clinics) provide 24-hour emergency medical assistance to the patients. Among private and mixed clinics a smaller part operates 24 hours a day (56% of the private clinics and 60% of the mixed clinics). In total, the 24-hour emergency assistance is available in the majority of facilities providing abortion service (59%) (See Chart N6).

Chart N6

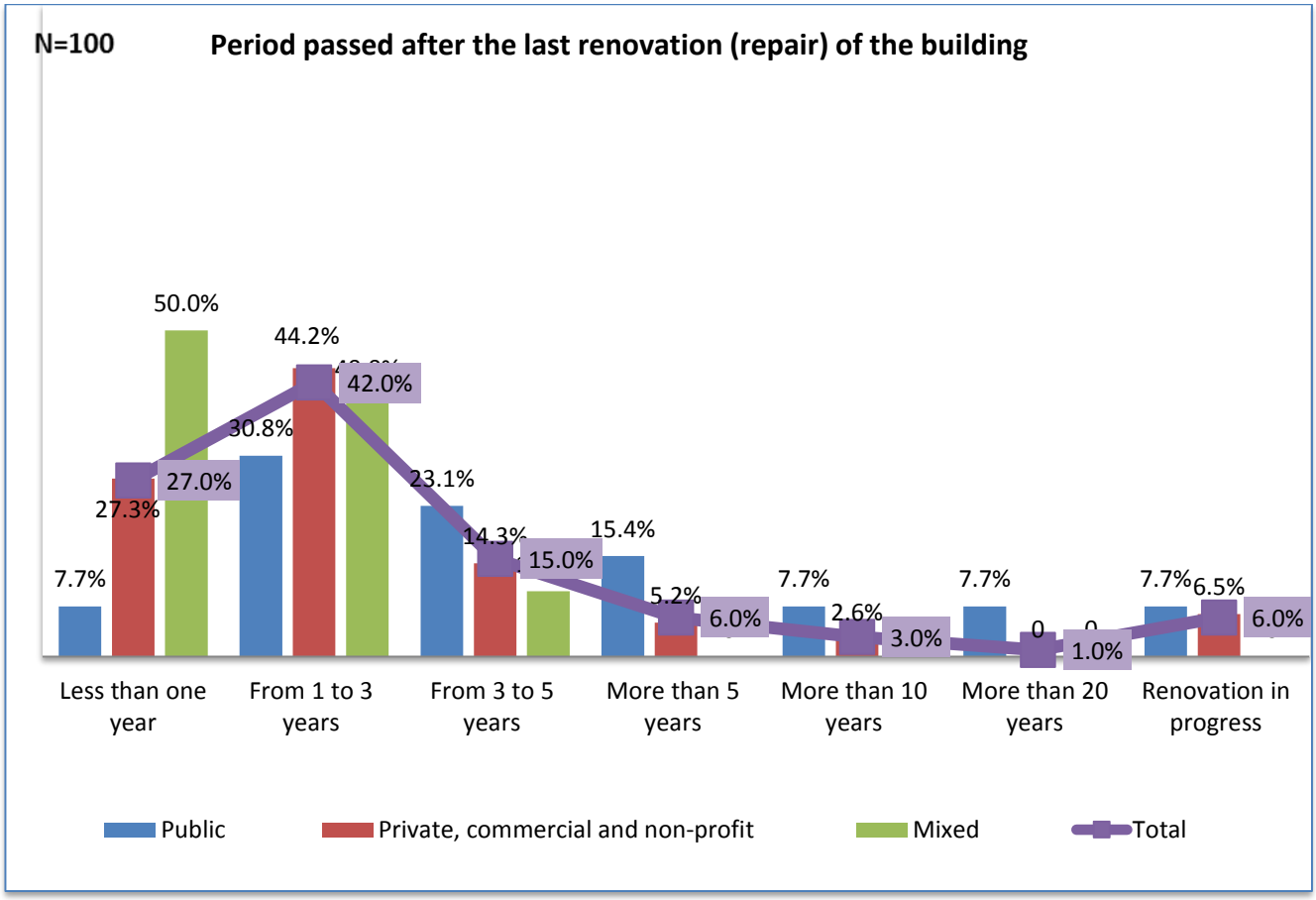


2.2 Amenities

The abortion service quality is significantly determined by the amenities, infrastructure and sanitation of the health facilities that means the proper water and power supply, well maintained toilets, good order of heating/cooling system etc.

The study results show that, in this respect, the situation in medical institutions is different. In many clinics (42%) the last renovation took place 1-3-years ago. The relatively small number of facilities were renovated less than 1 year (27%). The number of facilities the buildings of which were renovated: more than 5 years (6% - 6 clinics), 10 years (3% - 3 clinics) or 20 years (1% - 1 clinic) (see Chart N7). In this regard, there are no significant differences in Tbilisi and regional clinics. Survey results also show that the renovation in private and mixed clinics is more recent than in public clinics.

Chart N7



Electricity is mostly always available for health facilities and is supplied from the main source, however, significant portion (39%) of clinics additionally use backup sources. In a half or more of the clinics of Mtskheta, Javakheti, Svaneti and Guria (50% -100% of clinics in each region participating in the survey), had power interruption once or twice in the last month. In one of the clinics in Imereti last month the electricity interruption took place about once a week. More frequent cases of power supply interruptions have not been reported. Electricity was supplied smoothly for the majority (68%) of the clinics.

Most of the health facilities are well supplied with water. The absolute majority of clinics are supplied with water (90% of clinics) from the main source or the main and backup sources simultaneously (20% of the clinics). A small part of clinics (9% - 9 clinics) use only backup source. The supply is permanent in majority of clinics (91% of the clinics), the water quality is almost always good (96% of clinics). Complaints about the quality of the water were expressed by only a few clinics in regions: in Adjara (1 of 6 Ajara clinics) and Kvemo Kartli (2 clinics of 8 Kvemo Kartli clinics.

Most of the clinics are provided with heating and cooling in wards, doctor's offices, administration offices and corridors. Facilities mostly consume one type of heat. For central heating there is mainly used gas (81% of clinics), the individual heaters (21% of clinics) and central electric heating (11% of clinics).

All facilities have functioning toilets for general outpatients. Toilets are mostly (93% of clinics) with automatic or manual flush, more rarely – ventilated latrines (4% - 4 in clinics), latrines with slab (3% of clinics - 3 clinics) and compost latrine (1% - 1 clinic).

The results agree with the results of focus groups, however, during the discussions more obvious problems the customers face at health facilities have been identified. In modern or renovated facilities, as a rule, amenities and sanitary norms are preserved. However, the situation in clinics is not homogenous and sometimes there are noted the problems such as lack of water, poor sanitation, underdeveloped offices, lines and other. The group discussion participants in Tbilisi, Kutaisi and Tianeti assessed the overall state of modern health facilities as normal: the clinics observe sanitary norms (instrument sterilization, disinfection); doctors have adequate tools (gloves, face masks, medical uniforms, protective goggles, boot covers); there is appropriate equipment and more.

> *"I think there is no more such problem [of sanitation, amenities, etc.] anywhere"*

The problem of amenities is acute in several facilities of Batumi and Marneuli clinics:

> *"The Mother and Child Center was terrible. There was no water and anything else. I should foresee everything and find this in advance. This happened the year before last".*

> *"I also gave birth in Mother and Child Center. I had a personal acquaintance there and because of this I was not in such a bad condition, but the doctors were fond of gifts and things. If I gave something to them they treated me and my child better."*

> *"I gave birth in 1996, that time the Mother and Child Center was not open and I went to the maternity hospital. The conditions were terrible. Rats were running around and children were always with us, so we were afraid of rats. After 2001, the Mother and Child Center was wonderful compared with the old maternity hospital."*

In terms of amenities, the most critical situation is in Marneuli. Focus group participants identified the following problems: unsanitary conditions in toilets, one hospital integrates a children's clinic, adult's clinic and a maternity hospital leaving total chaos; doctors receive several patients simultaneously in one office.

Also, during the discussion it was revealed that the safe sanitation standards are not complied with during the procedures. Two of the participants noted that after the abortion procedure they've got infections. In this case there is a violation of the protocol, as it sets out in detail the infection prevention and control methods, which are necessary for the abortion procedure in order to avoid such consequences[11].

Thus, the survey results show the homogeneous situation with amenities at health facilities. Newly renovated facilities have almost no problems with amenities, which leads to customer satisfaction, however, the facilities where the buildings have not been renovated in recent years, face the problems such as poor sanitation, inadequate doctor's offices. From this aspect the particularly difficult situation is in Batumi and Marneuli clinics. In addition, most hospitals do not have a backup electricity and water supply. In some cases, the facilities use only backup water. Sometimes there is the problem of poor quality of water. Thus, we can say that the majority of clinics are in the normal condition in terms of the amenities, but there are clinics with severe problems in this respect.

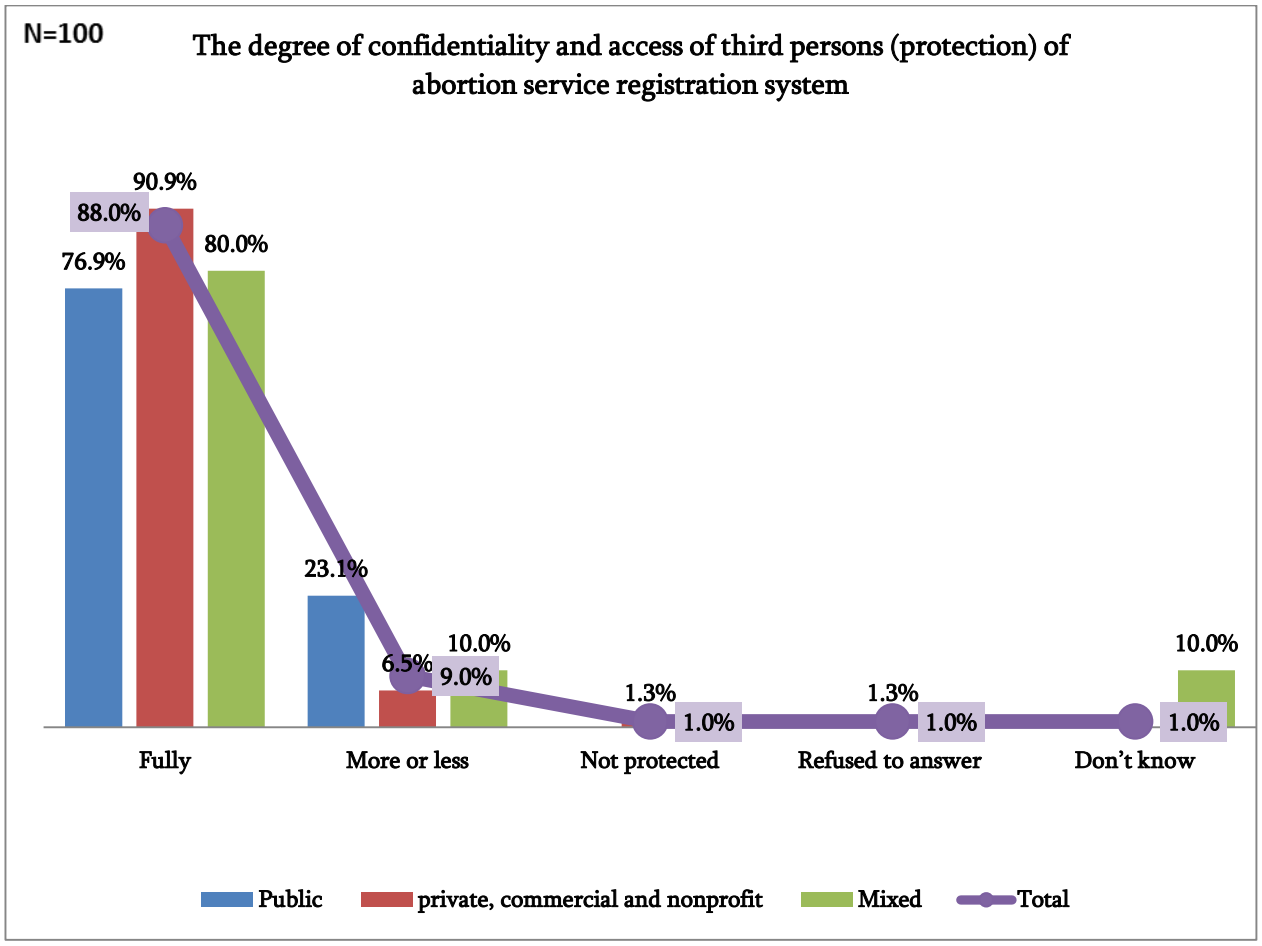
[11]Ministry of Labour, Health and Social Affairs of Georgia, "Safe Pregnancy Termination" (Protocol) (Order N 01-182/o, 2014), Infection Prevention and Control, p. 25, the website visit date 07.11.2015 http://www.moh.gov.ge/files/01_GEO/jann_sistema/gaidlaini/gaidlain-protokol/139-1.pdf

2.3 Abortion Service

2.3.1 Statistical data on abortion service in clinics

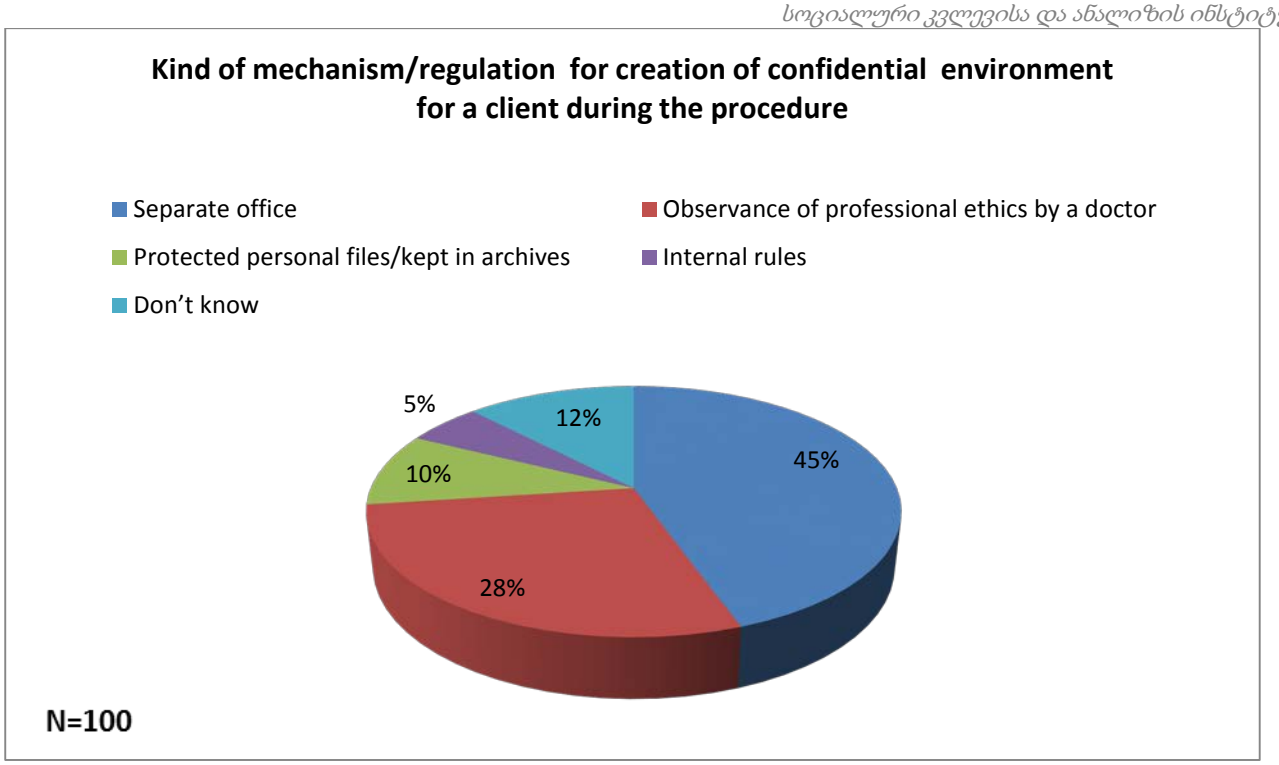
The absolute majority of clinics (93% - 93 clinics) have the abortion service registration system. The vast majority of the clinics (88% - 88 clinics) fully protect the confidentiality of the information, the more or less the confidentiality is protected in 9% of the clinics. Only in one of the clinics confidentiality of the information is not protected (see Chart N7).

Chart N7



73% of the clinics have developed the means by which they create confidential environment for clients. This means an isolated, separate protected room for the procedure (45.2%), strict observance of professional ethics by the service staff (28.8%), strictly protection of personal files archive confidentiality (9.6%) and others. (See Chart N8).).

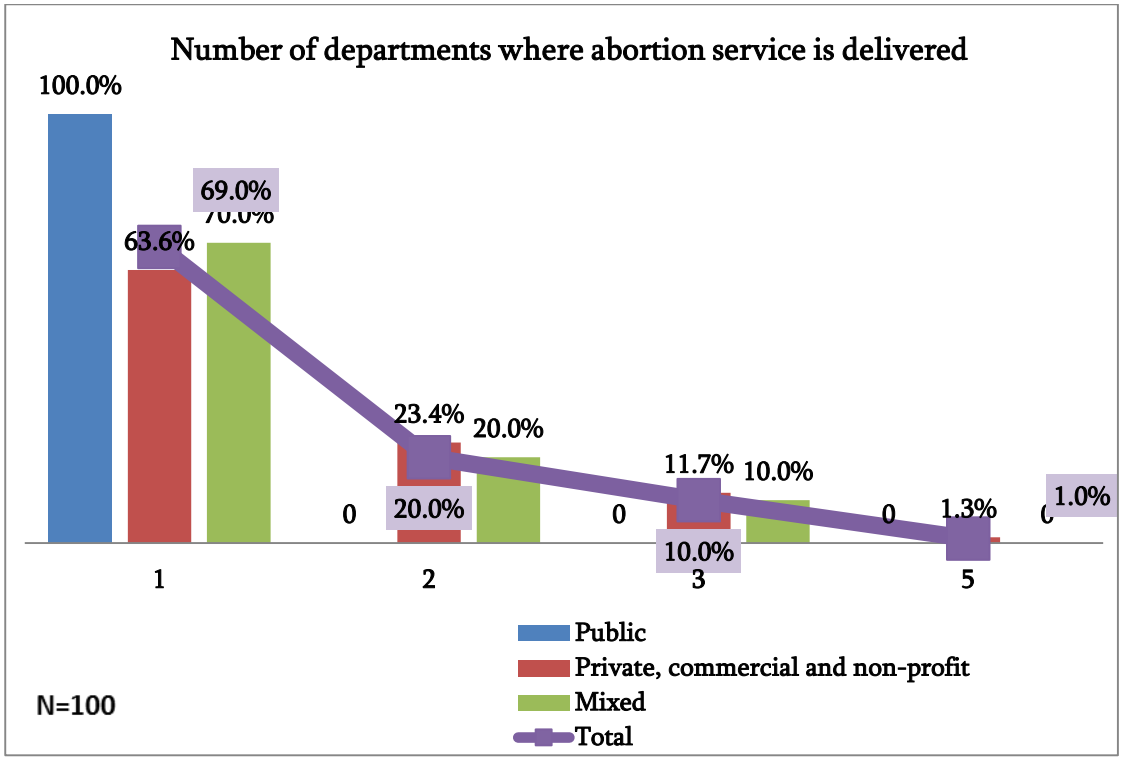
Chart N8



2.3.2 Departments where abortion service is delivered

The facilities offer client abortion services, mostly, in one department (69% of clinics), while in other cases –in two departments (20% of clinics - 20 clinics), in three departments (10% of clinics - 10 clinics) or five departments (1% of clinics - 1 clinic) (see Chart N9).

Chart N9

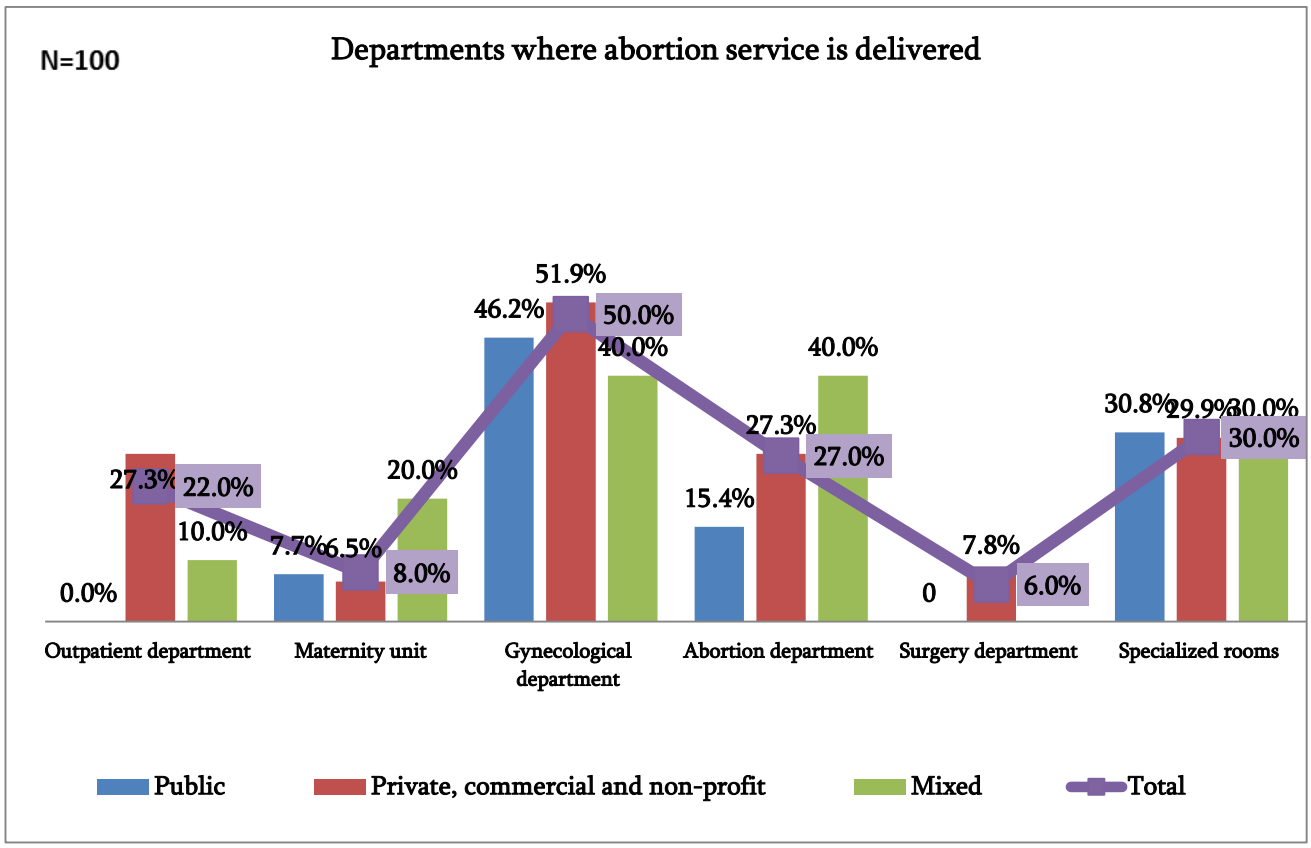


In clinics involved in the survey, customers are delivered abortion service mainly in the gynecological department (50% of clinics - 50 clinics), as well as the following departments:

- ✓ specialized rooms (30% of clinics - 30 clinics);
- ✓ abortion unit (27% of clinics - 27 clinics);
- ✓ outpatient department (22% of clinics - 22 clinics);
- ✓ maternity unit (8% of clinics- 8 clinics);
- ✓ surgery department (6% of clinics - 6 clinics).

In this regard, the situation is different in private and public clinics (see Chart 10).

Chart N10



Each public clinic delivers abortion service to the customers only in one department. This is, in most cases (46% of the clinics - 6 clinics) the gynecological department. In other cases, the abortion service is provided to clients in one of the following sections:

- ✓ specialized rooms (30.8% of public clinics – 4 clinics);
- ✓ abortion unit (15.4% of public clinics - 2 clinics);
- ✓ maternity unit (7.7% of public clinics - 1 clinic).

In each private clinic the number of departments where the client is delivered the abortion service ranges from 1 to 5, mostly - one (63.6% of private clinics - 49 clinics), in other cases - two (23.4% of private clinics - 18 clinics), three (11.7% of private clinics –9 clinics) or five (1 private clinic). The majority of private

clinics deliver abortion services in the gynecological department (51% of private clinics), and also in the following departments:

- ✓ specialized rooms (30% of private clinics);
- ✓ abortion unit (27% of private clinics);
- ✓ surgery department (8% of the private clinics);
- ✓ maternity unit (6.5% in private clinics).

As for the mixed hospitals, like private clinics, in each of them a client may be delivered the abortion service in several departments (1 to 3), more often – in one department (70% of mixed clinics - 7 clinics). These are:

- ✓ gynecology department (40% of mixed clinics - 4 clinics);
- ✓ abortion unit (40% of mixed clinics - 4 clinics);
- ✓ specialized rooms (30% of mixed clinics - 3 clinics);
- ✓ maternity unit (20% of mixed clinics - 2 clinics);
- ✓ outpatient departments (10% of mixed clinic - 1 clinic).

2.3.3 Medical staff type, number and functions

According to the protocol, the department where the abortion is done, should have the medical staff, such as an obstetrician-gynecologist, a fertility specialist and a nurse[12].

In the absolute majority of clinics participating in the survey there are employed an obstetrician-gynecologist (100% - 100 clinics) and a nurse (nurses are available in 88% of cynics, and midwives –in 47%). However, a fertility specialist is available only in one third of clinics (35% - 35 clinics). In addition, in some clinics, where abortions are made, there are employed the medical staff, such as a generalist, pediatrician, STD and skin specialist, endocrinologist, urologist, doctor, sexopathologist, laboratory doctor, sexologist, embryologist, mammalogist and other. The type and number of medical staff is not uniform in different clinics (see Table N3, Chart N11).).

[12]Ministry of Labour, Health and Social Affairs of Georgia, "Safe Pregnancy Termination" (Protocol) (Order N 01-182/o, 2014 Annex N1: Human and Material-Technical Resources – Table N2: Human and Material-technical resources, p. 34, the website visit date 07.11.2015 http://www.moh.gov.ge/files/01_GEO/jann_sistema/gaidlaini/gaidlain-protokol/139-1.pdf

Chart N11

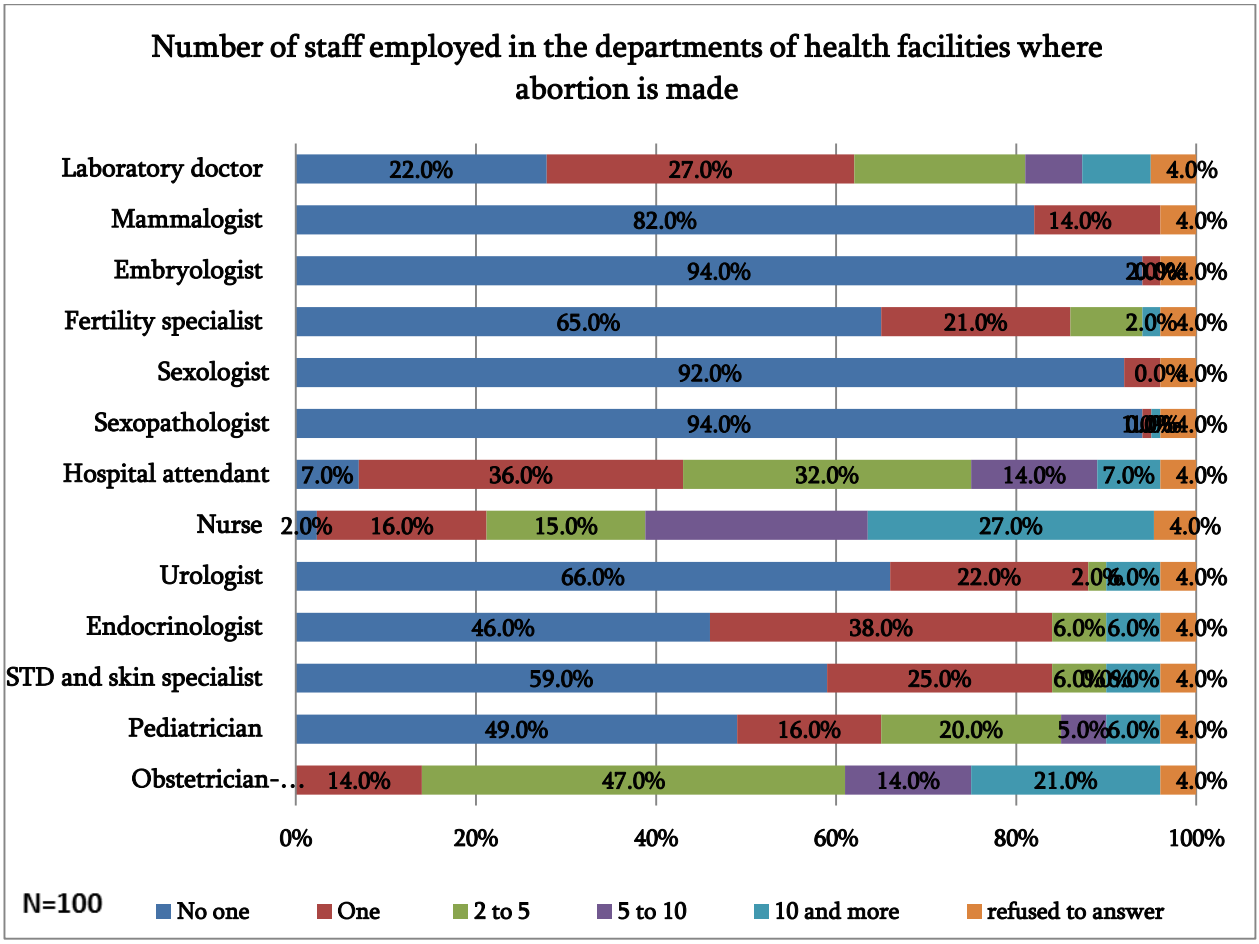

Number of staff employed in the departments of health facilities where abortion is made
Laboratory doctor
Mammalogist
Embryologist
Fertility specialist
Sexologist
Sexopathologist
Hospital attendant
Nurse
Urologist
Endocrinologist
STD and skin specialist
Pediatrician
Obstetrician-...
22.0%
27.0%
4.0%
82.0%
14.0%
4.0%
94.0%
4.0%
65.0%
21.0%
2.0%
4.0%
92.0%
0.0%
4.0%
94.0%
7.0%
36.0%
32.0%
14.0%
7.0%
4.0%
2.0%
16.0%
15.0%
27.0%
4.0%
66.0%
22.0%
2.0%
4.0%
46.0%
38.0%
6.0%
6.0%
4.0%
59.0%
25.0%
4.0%
49.0%
16.0%
20.0%
5.0%
6.0%
4.0%
14.0%
47.0%
14.0%
21.0%
4.0%
0%
20%
40%
60%
80%
100%
N=100
No one
One
2 to 5
5 to 10
10 and more
refused to answer

Table N3 Type and number of medical staff according to the type of clinic

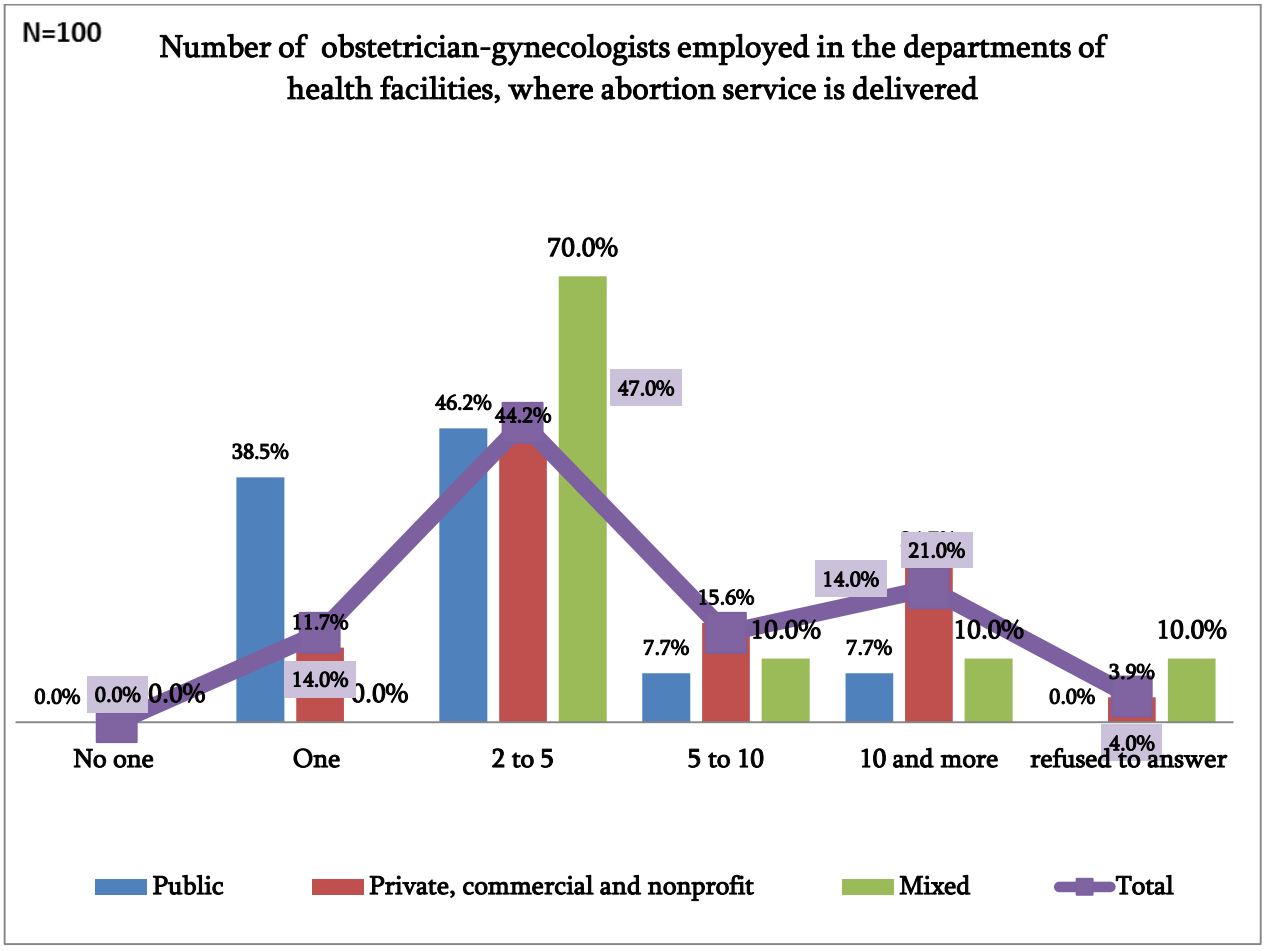
N=100	Public clinics						Private clinics						Mixed clinics					
	No one	One	2 to 5	5 to 10	10 and more	Refused to answer	No one	One	2 to 5	5 to 10	10 and more	Refused to answer	No one	One	2 to 5	5 to 10	10 and more	Refused to answer
Obstetrician-gynecologist	-	38.5%	46.2%	7.7%	7.7%	-	-	11.7%	44.2%	15.6%	24.7%	3.9%	-	-	70%	10%	10%	10%
Pediatrician	30.8%	30.8%	23.1%	7.7%	7.7%	-	53.2%	13.0%	18.2%	5.2%	6.5%	3.9%	40%	20%	30%	-	-	10%
STD and skin specialist	76.9%	7.7%	-	-	15.4%	-	55.8%	27.3%	7.8%	-	5.2%	3.9%	60%	30%	-	-	-	10%
Endocrinologist	53.8%	30.8%	-	-	15.4%	-	44.2%	39.0%	7.8%	-	5.2%	3.9%	50%	40%	-	-	-	10%
Urologist	76.9%	7.7%	-	-	15.4%	-	62.3%	26.0%	2.6%	-	5.2%	3.9%	80%	10%	-	-	-	10%
Nurse	-	30.8%	15.4%	23.1%	30.8%	-	2.6%	13.0%	11.7%	20.8%	28.6%	3.9%	-	20%	40%	20%	10%	10%
Hospital attendant	-	38.5%	46.2%	15.4%	-	-	9.1%	32.5%	31.2%	14.3%	9.1%	3.9%	-	60%	20%	10%	-	10%
Sexopathologist	92.3%	-	-	-	7.7%	-	94.8%	1.3%	-	-	-	3.9%	90%	-	-	-	-	10%
Sexologist	100%	-	-	-	-	-	90.9%	5.2%	-	-	-	3.9%	90%	-	-	-	-	10%
Fertility specialist	92.3%	-	-	-	7.7%	-	59.7%	26%	9.1%	-	1.3%	3.9%	70%	10%	10%	-	-	10%
Embryologist	100%	-	-	-	-	-	94.8%	1.3%	-	-	-	3.9%	80%	10%	-	-	-	10%
Mammalogist	100%	-	-	-	-	-	77.9%	18.2%	-	-	-	3.9%	90%	-	-	-	-	10%
Laboratory doctor	30.8%	38.5%	7.7%	-	15.4%	-	20.8%	20.8%	18.2%	6.5%	5.2%	3.9%	20%	60%	-	-	-	10%

Gynecologist is employed in the department of all health facilities (100% - 100 clinics) which the abortion service is delivered. Number of gynecologists ranges from 1 to 20, however, in each facility, in most cases, there are 1-3 obstetrician-gynecologist (55% of cases), the most often - 2 obstetrician-gynecologists (Mode = 2). Obstetrician-gynecologists deliver to the clients one or several (up to 7) services, including:

- ✓ pre-abortion counseling
- ✓ post-abortion counseling
- ✓ general examination
- ✓ gynecological examination
- ✓ laboratory tests
- ✓ abortion procedure
- ✓ post-abortion contraception counseling

In most of the clinics (68%) the obstetrician-gynecologist delivers the client all the services, except laboratory tests.

Chart N12



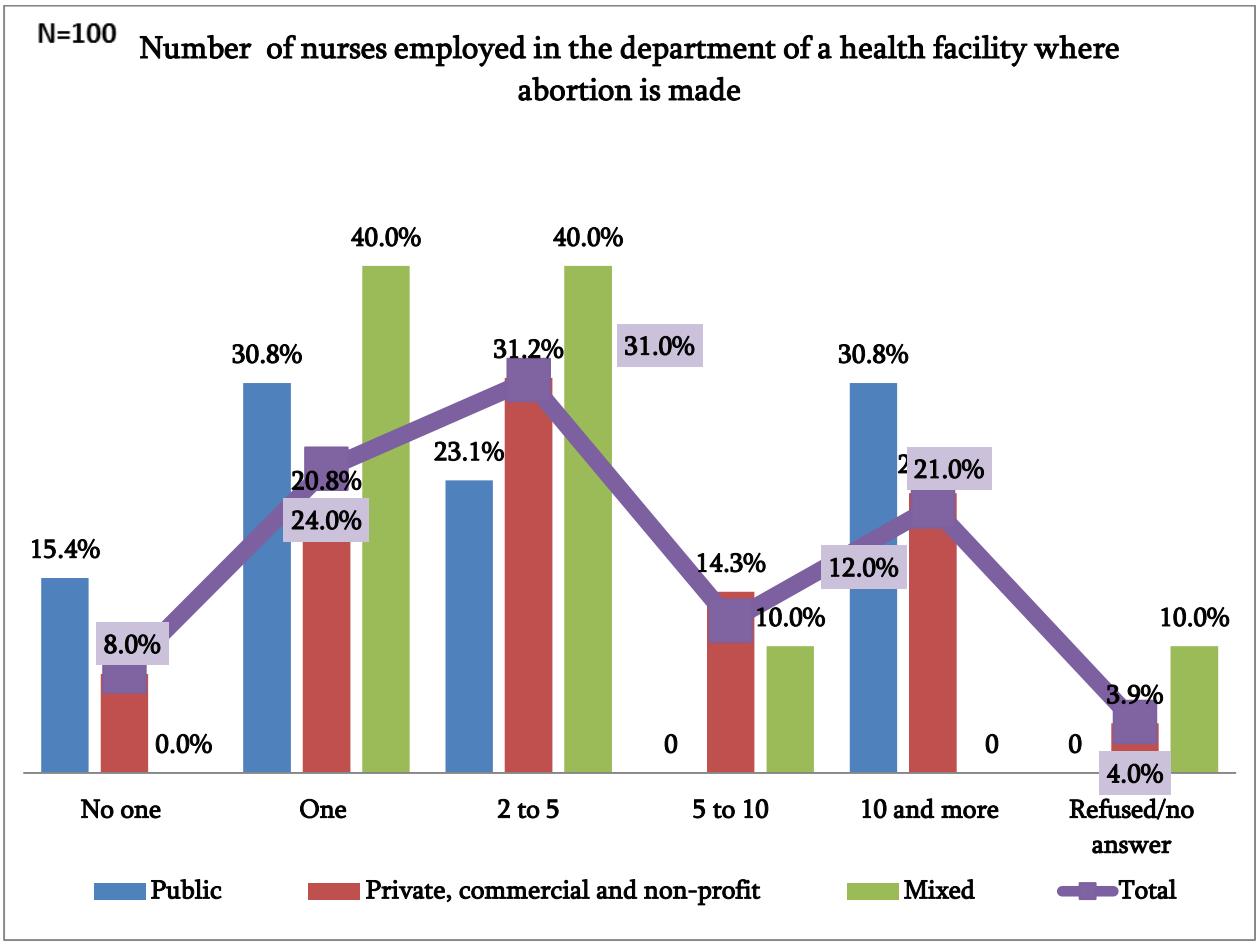
The majority of clinics (65% - 65 clinics) employ generalists, mostly - one (Mode = 1; 34% of clinics). In other cases, the number of generalists employed in one department varies to 20, however, such cases are very rare in private clinics. In public clinics, the number of generalists employed in the department does not exceed 4, and in mixed clinics - 3. Generalists can combine one or two of the following functions:

- ✓ pre-abortion counseling
- ✓ general examination.

Nurses are employed in a vast majority of the clinics (88%). In the department where the abortion is done, mostly 1 nurse is engaged (Mode = 1). In public clinics the number of employed nurses rarely/occasionally ranges up to 20, in private clinics – to 30, and mixed clinics – to 6. (See Chart N13). In the clinics nurses may provide to clients one or more services of the following:

- ✓ pre-abortion counseling
- ✓ post-abortion counseling
- ✓ laboratory tests
- ✓ abortion procedure

Chart N13

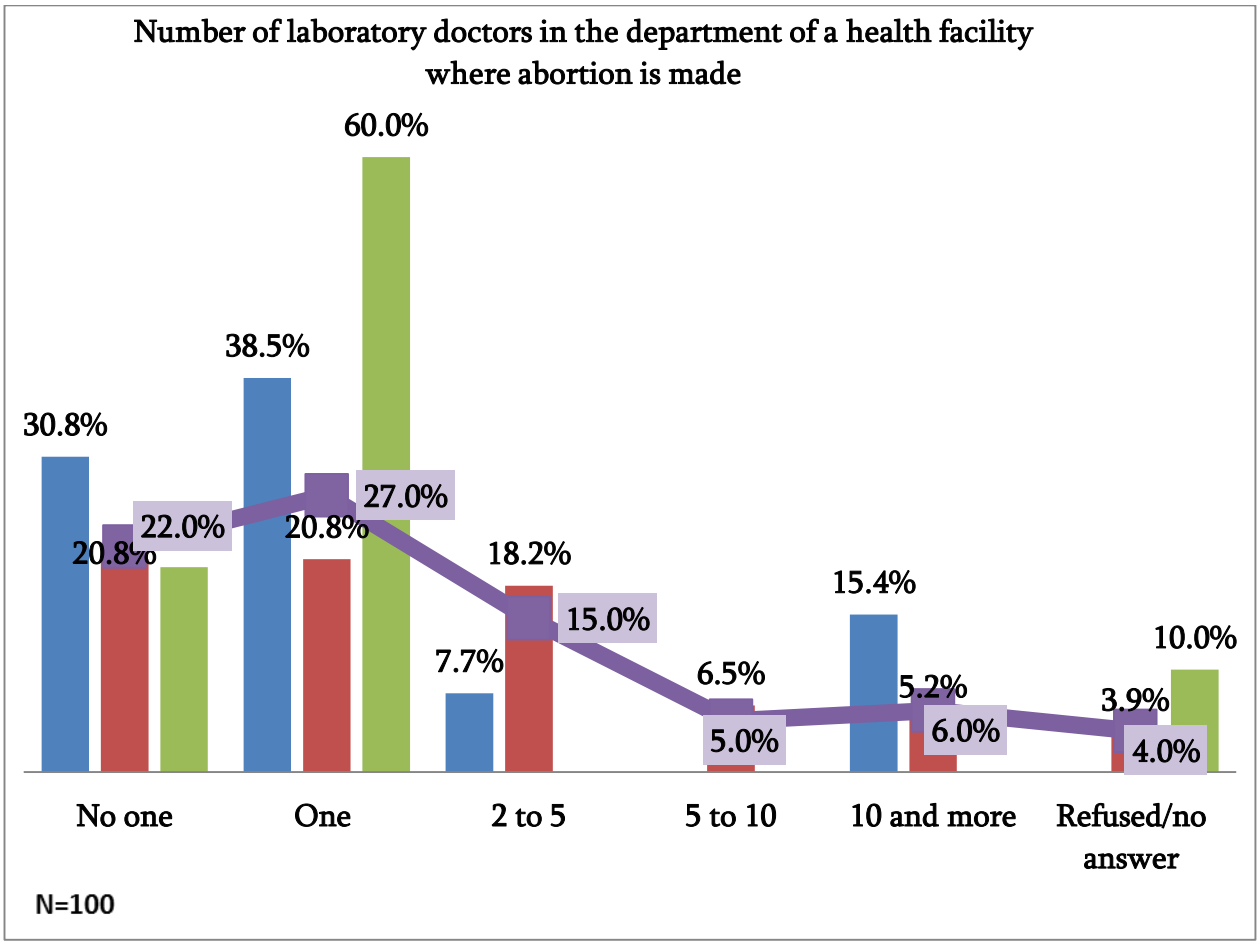


Almost half of the clinics (47% - 47 clinics) employ midwives (nurses). In public clinics, mostly 3 or 4 midwives (53.9% of public clinics), while in private clinics - mostly 1-5 midwifes (39% of private clinics) are employed. Rarely and only in private clinics, the number of midwives employed in the relevant department ranges 6 to 30.

Laboratory doctors are employed in a majority of clinics (62% - 62 clinics). Number of laboratory doctors ranges 1 to 12, in some cases - up to 20 (see Chart N14). Most often there is a laboratory doctor (Mode = 1). A laboratory doctor may provide to a client one or more following services at the same time:

- ✓ gynecological examination
- ✓ laboratory tests
- ✓ abortion procedure

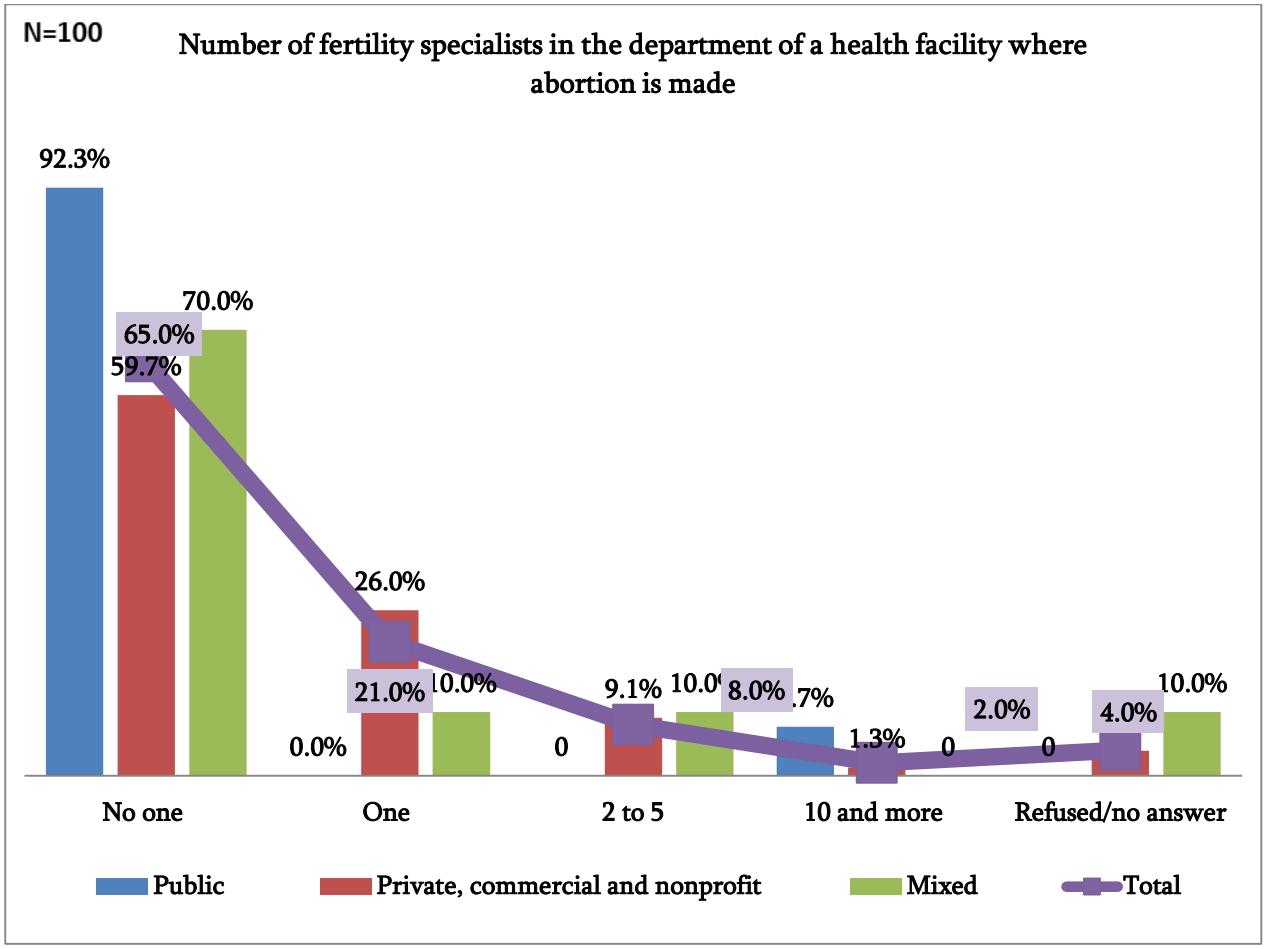
Chart N14



Fertility specialist is employed by only one third (31%) of the clinics. The number of fertility specialists ranges from 1 to 9, in some cases - up to 20. (See Chart N15). A fertility specialist mostly delivers to a client one of the following services:

- ✓ pre-abortion counseling
- ✓ post-abortion counseling
- ✓ general examination
- ✓ gynecological examination
- ✓ post-abortion contraception counseling
- ✓ family planning services

Chart N15



Almost half of all clinics employ **pediatricians** (47% - 47 clinics). The number of pediatricians is mostly 1 to 3, rarer (31% - 31 clinics) ranges up to 20, however, it is mostly found in private clinics.

STD and skin specialists are employed in more than a third of the clinics (37% - 37 clinics). Relatively often they is one STD and skin specialist (25% of cases – 25 clinics). In certain cases, mainly in private clinics, the number of STD and skin specialists reaches 20 (6% - 6 clinics).

A half of clinics (50% - 50 clinics) employ **endocrinologists**, mostly - one (31 clinics). In certain cases, in private (4) and public (2) clinics the number of endocrinologists reaches 20.

Almost a third of the clinics (29% - 29 clinics) have employed urologists, mostly – one in the staff. In certain cases (2 public and 4 private clinics) the number of urologists reaches 20.

Hospital attendants are employed by the vast majority of clinics (89% of clinics). The number of employed hospital attendants ranges from 1 to 28. More often, there is one hospital attendant (Mode = 1).

IN the department where abortions are made, a very small number of clinics have one **sexopathologist** (2% - 2 clinics) and **sexologist** (4% - 4 clinics).

Embryologists are employed in only two clinics (2%) and mammalogist – in 14 clinics (14%). Their number does not exceed 1.

In the department where abortions are made some clinics have employed a dentist, gastroenterologist and the neurologist.

Thus, the majority of clinics in the department, where abortion is made have employed an obstetrician-gynecologist and a nurse, which is consistent with the requirements of the Protocol. In addition, in some clinics in the department, where abortions are made, there are employed the medical staff, such as a generalist, pediatrician, STD and skin specialist, endocrinologist, urologist, hospital attendant, sexopathologist, laboratory doctor, sexologist, embryologist, mammalogist and other. The type and number of medical personnel is not uniform in different clinics.

2.3.4 Abortion services

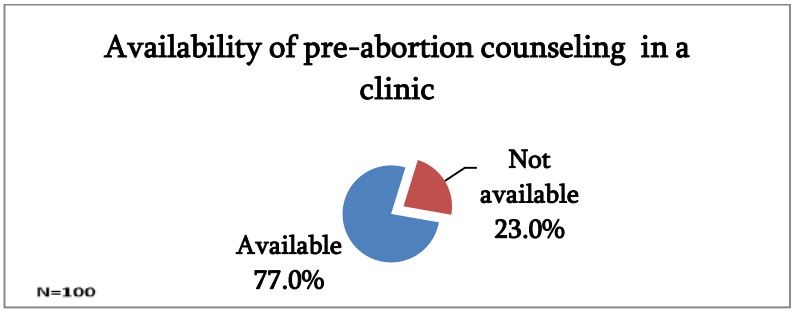
Clinics have available both an abortion procedure and pre-abortion and post-abortion services.

a) Pre-abortion period and service

Pre-abortion counseling and its delivery

The majority of clinics have available the pre-abortion counseling:

Chart N 16



According to the protocol, before the abortion procedure a client shall undergo a pre-abortion counseling, which includes **interviews** on the following issues:

- ✓ forms of abortion and possible complications;
- ✓ counseling of abortion method choice and facilitating a patient in making decision by herself;
- ✓ counseling related to family planning;
- ✓ written informed consent with regard to abortion.

A pre-abortion counseling also means providing the standard physical, gynecological and laboratory studies. But in the case abortion is made at a health facility, a comprehensive health examination shall be provided, which includes the following:

a) physical examination: assessment of the health condition, assessment of the patient's general condition, physical examination, the menstrual period assessment, pregnancy term identification, pelvic examination: bimanual examination and speculum examination;
b) laboratory and other tests: ultrasound diagnosis to confirm pregnancy and identification of the gestational period, hemoglobin or hematocrit determination in case of signs of anemia and other.

The vast majority of facilities allow customers always (80% -84% of the facilities) or sometimes (5% -8% of the facilities) to choose a desirable doctor who will provide the pre-abortion advice, abortion services, post-abortion counseling and post-abortion contraception.

Pre- and post-abortion advice may be provided to a client by several medical staff: gynecologist, fertility specialist, nurse or generalist. Mostly, this function is charged on a gynecologist (92% of cases), which is consistent with the requirement of the Protocol.

Tthe general examination of a client is provided by one or more employees, including a gynecologist, fertility specialist, generalist or echoscopy specialist, mostly –by a gynecologist (93% of cases).

Gynecological examination of the client is always (100% of clinics) conduced by a gynecologist, however, this function can be performed by a fertility specialist, generalist or echoscopy specialist.

Laboratory tests of a client are conducted by one or more employees, including a laboratory assistant, gynecologist, nurse, generalist, endocrinologist or echoscopy specialist, mainly - by a laboratory assistant (87% of cases).

The abortion procedure may be conducted to a client by one or more employees, however, is mostly cases this procedure is carried out by a gynecologist (72% of cases), nurse (16% of cases). Also, in some cases, it is possible to carry out an abortion procedure by a hospital attendant, midwife, surgeon or laboratory assistant.

Post-abortion contraception counseling is mainly conducted by a gynecologist (92%) or fertility expert (7% of cases), in some cases - by both of them.

Family planning services to clients, mostly, are delivered by a gynecologist (85.5% of cases), as well as fertility specialist (14%), in some cases –by endocrinologist. In some clinics this function is performed by several employees.

Thus, mainly (91-100% of cases), a gynecologist delivers to a client such services as pre-abortion counseling, post-abortion counseling, general examination, gynecological examination, abortion procedure, post-abortion counseling about contraception and family planning. Such approach is cost-effective for clinics and sometimes a trained gynecologist may combine all the above listed functions, however, such procedures, as: clinical evaluation, confirmation of pregnancy, decision-making on medical and/or surgical abortion and contraceptive methods shall preferably be delivered with involvement of a fertility specialist, and such services, as the risk profile assessment and counseling the patient about the risk factors, drug-free modalities, prevention and medication side effects, shall be preferably provided by a nurse to a client. Laboratory service to a client is mostly (92.6% of cases) provided by the laboratory staff. It can be said that in the departments of health facilities where abortions are made , the staff functions are not allocated in accordance with the protocol.

The survey results show that in almost one-fifth of the clinics (19% - 19 clinics) a pre-abortion counseling is not provided before abortion procedure. In this case, the patient agrees on what she has not been informed, therefore, her rights are violated. A doctor also violates the law, because in accordance with the

medical practice law, he or she is obliged to ensure the informed consent[13]. In addition, there is a risk that the doctor separately from a patient, arbitrarily will select the abortion method which is convenient to him/her and will not take into account the recommendation described in the Minister's Order N 01-74/n, according to which the duty of the physician is to select for a woman the less invasive method of abortion.

In the rest of the clinics (81% - 81 clinics) during the pre-abortion counseling the interview takes place on the following issues:

- ✓ the reasons of woman's abortion decision (is held in 79% of the clinics - 79 clinics);
- ✓ that the woman shall not undergo an abortion (is held in 80% of the clinics - 80 clinics);
- ✓ rare complications during abortion (is held in 81% of the clinics - 81 clinics);
- ✓ various methods of abortion, their advantages/disadvantages (is held in 81% of the clinics - 81 clinics);
- ✓ the consequences of the abortion (is held in 81% of the clinics - 81 clinics);
- ✓ the disadvantages of selective abortion (is held in 71% of the clinics - 71 clinics).

Also, during the pre-abortion counseling a woman shall sign the informed consent form while the doctor then fills out a patient's medical history.

The focus group results also confirm that the pre-abortion counseling does not always take place and, as a rule, neither the control of whether the doctor provides this service to a patient, takes place. In fact, it depends on the doctor and his /her good will, whether the patient is provided with this service. The only thing that all the doctors do during the pre-abortion advice, is that he/she tries to dissuade the patient from the abortion that is the protocol appropriate action. There are cases where such dissuasion takes effect and women refuse to perform an abortion, but in most cases, dissuading efforts fail.

The discussion has shown that those patients who have passed the pre-abortion interview, as a rule, are provided the information on effectiveness of different methods, abortion complications, abortion procedure and post-abortion rehabilitation. Patients are provided the information in written form – by leaflets. Some doctors deliver comprehensive information about abortion to a patient, garner attention, evaluate the patient's physiological state and readiness, interview her history; the majority provide a comparatively superficial, general information:

"No patient asks for detailed information, she generally speaks to you (the doctor)"

There are cases where patients have not been provided the initial counseling service – neither interviews nor health examination, which violates the requirements of the Protocol.

"They examine nothing in case of abortion. If I was pregnant, then they examined my state of health - checking blood pressure, blood test, everything. In case of abortion I was sent to the procedure immediately as if I was a toy. So it was before, now – not".

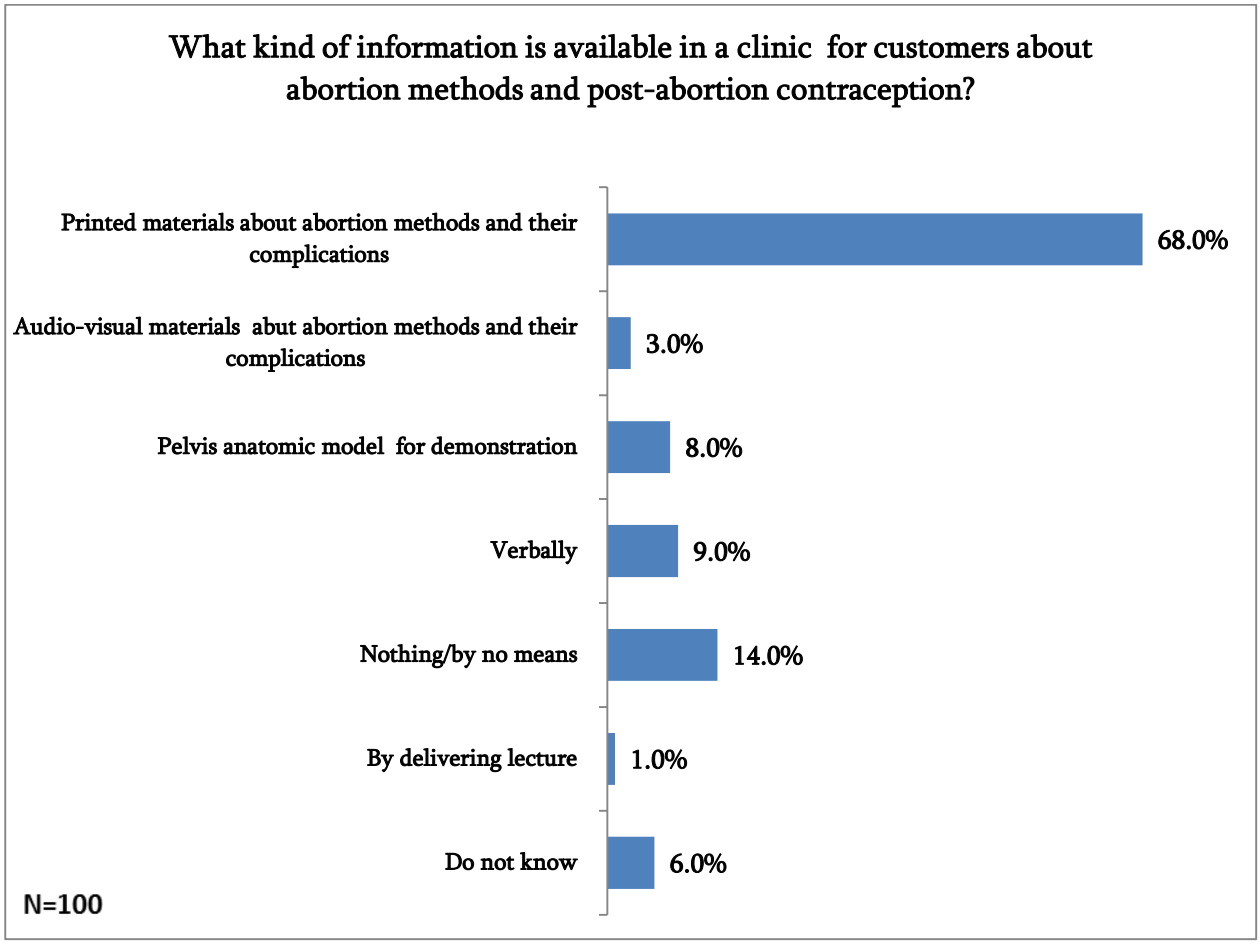
As for health examination, the focus group results show that examination takes place mostly partially, sometimes – comprehensively, more often - does not take place at all. To determine pregnancy, doctors mostly use ultrasound, however, they often use such methods, as the calendar method, manual

[13]The Law of Georgia On Medical Practice, Chapter 5, Article 44, paragraph 1.

examination, gynecological examination, X-ray. Sometimes patients are asked to pass the common blood count. Noteworthy is that using these methods for determining pregnancy the diagnostic error probability is quite high, because, according to the protocol, the establishment of pregnancy requires gynecological examination and pelvic ultrasound examination.

According to the protocol, the clients shall be provided with information materials on abortion and contraception after abortion. Only a small part of clinics (12% - 12 clinics) does not offer customers any type of informational materials about abortion methods and the post-abortion contraception, other clinics offer one or several means, including, most of all (68% - 68 clinics) print material on the methods of abortion and its complications, post-abortion contraception and customer rights. A relatively small part of clinics (1% -8%) offers audio-visual material about abortion methods and its complications, as well as provides information on the post-abortion contraception and the rights of customers, using anatomical pelvic models for demonstration during the informing process, offers a verbal method. (See Chart N17)

Chart N17



The analysis shows that, basically, it depends on the doctor, whether or not the client will be provided this service and there is no mechanism to control whether or not this service is provided to the client by a doctor. And in those cases where the pre-abortion advice is provided, doctors mostly deliver superficial information about the abortion types and the possible complications of abortion. The scope and comprehensiveness of information to be provided by the doctor to the patient is not defined or controlled by a clinic and it depends only on the doctor and his or her good will. In addition, the standard physical and gynecological examination before an abortion procedure recommended by protocol is not always conducted. Moreover, the focus group results show that such a study is conducted fairly rare and usually limited to establishing pregnancy. In other cases - examination takes place partly or does not take place at all.

Decision-making on abortion

According to the protocol, the final decision on an abortion shall be made by a woman. According to the legislation of Georgia, before the abortion procedure, the doctor shall receive a written and verbal informed consent from the client[14].

The question of whether a woman makes an informed decision with regard to abortion was answered by the representatives of the majority of the clinics (81%) saying that women make completely informed decision. Much smaller and almost equal is the percentage of the clinics, which representatives consider that:

- ✓ A woman makes more informed decision, rather than uninformed (6% - 6 clinics);
- ✓ A woman makes more uninformed decision, rather than informed (5% - 5 clinics);
- ✓ A woman makes a uniformed decision (4% -4 clinics).

Representatives of 4 clinics (4%) found it difficult to express their position on this issue.

The focus group results indicate that women make the final decision independently, however, the majority of women always agree this issue with their husbands. However, some women completely independently make the decision because their husbands did not want interfere with this issue:

"They do not want to take it upon them; they say that it is your choice".

Although none of the participants in the discussion mentioned any kind of violence or resistance from the side of the husband during the decision-making, several respondents talked about abortions made secretly from their husbands:

"I, personally, have often gone to abortion procedure secretly, because, (the husband) might have been opposed. A man wants to have many children".

"Once I had done this (abortion) before. My husband wanted (a child) very much, but I had to remain silent"

[14] Law of Georgia On Patient's Rights, Chapter IV, Article 2, paragraph 1, paragraph 2, paragraph 3; Law of Georgia On Medical Practice, Chapter V, Article 44, paragraph 1

Thus, the reality is more in line with the requirements of the Protocol – that the women shall make a decision on abortion independently, however, in many cases, women agree their final decision with their husbands. It is important to note, that some women believe that decision-making on abortion is their prerogative but not of their spouses.

Abortion reasons

During the focus groups we have identified reasons why women have abortions. These reasons reported by respondents are quite diverse. Most often women refer to economic problems as the reason of abortion:

"If my husband wants and reregister the house on him, I will leave alone with my children. In such a situation, of course, I will not bear a child. This is the most important, but if a woman wants to give birth, she will bear".

"I wanted to have a third child, but this is not depend me but on the economic situation"

In addition, women often have abortions for family planning in three main cases:

- ✓ abortion in case of a new pregnancy soon after giving birth, as it will be difficult to bring up two infants: *"My second child was too small and I did not want to give birth in such a small period after"*
- ✓ they have big aged children and have abortions in order to avoid big differences of the age of children: *"The first [abortion] I have had, when I had a small child, now my children are all grown up, and the difference will be too much".*
- ✓ they do not want more children, which, in many cases, is related to psychological readiness or family planning: *"Psychologically, I was not ready to give birth to one more child, I did not want the third one", "The thing is not only to bear a child but to grow him or her up, the child needs many things ", "It is better to have two children and care for them that to have more without care".*

Among other reasons of abortion named are: woman's old age, health problems, diseases (genetic, viral, caused by childbirth or unsafe abortion, etc.). In certain cases, the participants named the reason for the abortion also the motive of job maintenance, sex selection, non-availability of contraceptives and other.

In the Tbilisi focus group an interesting fact has been revealed: some women assess abortions from the religious aspect and view it as a sin:

"This is a sin of a doctor as well as of yours"

"My doctor does not make abortions; she has banned them because of faith. She does not want to have her hands in blood".

As the discussion has showed, abortion reasons are quite diverse and could be related both to personal motives, and the problems caused by external factors, such as, for example, the family's economic situation.

It is important to note that from April 2014, the amendments to the Health Protection Law of Georgia have entered into force, according to which the time for reflection in the artificial pregnancy termination before the medical intervention was increased from 3 days to 5 days[15]. Some of the respondents had an abortion after these changes took place and in all cases the 5-day time of reflection was observed. Focus group participants in the discussion process expressed their attitude to this change, as a result there was revealed differences of opinion on this issue. Most of the respondents believe that the 5-day time of reflection is ineffective, because a woman hardly changes the decision on abortion:

"It was once such period (5-day period of reflection), but when you decide to have abortion, then it does not matter how long will you think, nothing will change".

"A woman knows in advance before she becomes pregnant, will her or will not give birth".

However, respondents identified some cases, when after the 5-day time of reflection a woman changed her mind to have an abortion.

Marneuli focus group participants believe that appointment of the 5-day time of reflection, at this stage, is not relevant, because they see more serious problems with regard to abortion services to:

"Let's look at this problem from another aspect: the government should not give us 5 days to think about abortion, but should give women normal jobs and conditions to bear children. If my husband wants and reregister the house on him, I will leave alone with my children. In such a situation, of course, I will not bear a child. This is the most important, but if a woman want to give birth, she will bear".

Tianeti focus group participants more positively assessed the 5-day time of reflection and consider that it will be effective:

"It's good, I like [5-day time of reflection]. In such a way more children will be born".

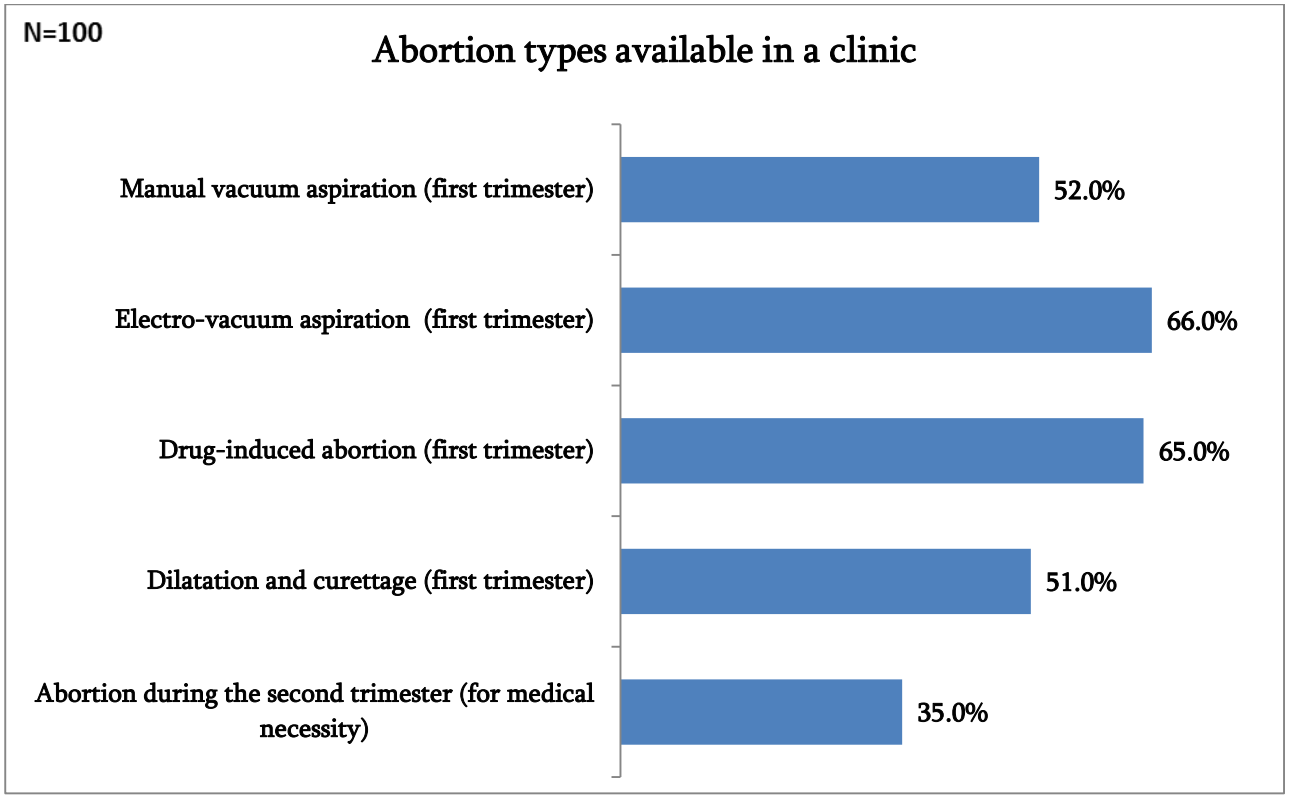
Therefore, a woman's abortion causes are quite diverse. Women mostly independently make their decision, and rarely change this decision, so it is important to check the 5-day time of reflection efficiency, due to the fact that this often becomes a source of additional problems for women.

b) Abortion procedure and types

Clinics participating in the survey are offering both the first and second trimester abortion using a variety of methods (see Chart 18).

[15] The Law of Georgia On Health Care", Chapter 23, Article 139, paragraph b, 2014

Chart N18



First trimester abortion

First trimester abortion means the termination of pregnancy of less than 12 weeks term. Usually it is made both by medical indications and by a patient's wish. First trimester abortions are made in all health facilities involved in the survey. Participating clinics are offering one or more types of abortion method to the women in the first trimester (two, three or four at a time):

- **Medication -induced abortion**

Medication-induced abortion is the artificial termination of pregnancy using drugs. The recommended method of medical abortion is to use Misoprostol after Mifepristone. This is the most common method in the clinics participating in the survey. The abortion by this method is made in 65% of clinics (65 clinics).

- **Surgical abortion**

✓ *Vacuum aspiration*

Vacuum aspiration is a method of surgical abortion in which evacuation of the contents of the uterine cavity is made with a plastic or metal aspiration cannula, which is connected to a vacuum source. There are two types of vacuum aspiration and, both are available in the clinics participating in the survey.

During electric vacuum aspiration (EVA) there is used an electric vacuum pump/electric suction, which is designed for various sizes of plastic cannula with the 12-16 mm diameter range. By this method abortion is made in 66% of clinics (66 clinics).

During manual vacuum aspiration (MVA) the vacuum is created by manually started plastic aspirator or the syringe with a volume of 60 ml. The aspirators are designed for using the cannula of different sizes (4-12 mm in diameter). By this method the abortion is made in 52% of clinics (52 clinics).

- ✓ *Dilatation and curettage*

Dilatation and curettage (D&C) is a procedure of cervix dilatation with mechanical expanders or pharmacological means and curettage of uterus walls, using a sharp metal curette. By this method the abortion is made in half of the clinics - 51% (51 clinics).

The pregnancy termination method is to be chosen by a woman and she must have all the information on the method of abortion. In cases where only one of the methods is available in the clinic, the clinic is obliged to refer the patient to other relevant institutions. In many cases, the service providers do not provide complete information to the client and the woman does not make the right choice, therefore, this limits the patient's freedom of choice. However, the confirmation of this is virtually impossible because by signing the "informed consent" form the woman declares her consent.

Second-trimester abortion

Artificial termination of the second trimester pregnancy means abortion in over 12 weeks pregnancy period. It can be made only on the basis of medical and social indications, which are defined by the legislation of Georgia[16]. In the case of medical indication, the issue of artificial termination of more than 12 weeks term pregnancy will be discussed by the commission, with an individual approach to a patient. The commission is formed by the head of the health facility and is composed of the chief physician of the same facility (clinical director or manager), the lawyer and 2 obstetrician-gynecologists and doctor in charge (whose competence covers the pregnant woman's illness). The commission meeting is executed under the minutes. The second-trimester abortions are made in a relatively small amount of clinics (35%) (35 clinics). Such clinics exist in the regions, except for Samtskhe-Javakheti, however, they are not available in all villages and towns. A second-trimester abortion is made both by surgical and medical methods.

It should be noted that some of the health facilities (7% -7 clinics) offer only urgent/spontaneous abortion, which is done only on the basis of medical necessity and not at woman's will/decision. Such a situation is, for example, in Tianeti, for which reason women have to go to another city to get abortion services that is related to additional problems and costs for them.

According to the representatives of clinics, women most often use the following methods:

- ✓ medical abortion in the first trimester (named by representative of 60 clinics - 60%)
- ✓ electric vacuum aspiration in the first trimester (named by representative of 52 clinics - 52%)
- ✓ manual vacuum aspiration (named by representatives of 33 clinics - 33%)
- ✓ dilatation and curettage (named by representatives of 31 clinics - 31%)

The focus group participants have experienced both spontaneous (natural) abortion, which is referred to as a "misbirth" or "miscarriage" and artificial abortion. They have experienced almost all methods of abortion:

[16]The Law of Georgia On Health Care, Chapter 23, Article 140, paragraph 2, 2014.

To refer to the vacuum aspiration method the respondents used the term "mini-abortion". The respondents do not talk about the significant discomfort during the vacuum aspiration procedure. The respondents described both types of vacuum aspiration - manual vacuum aspiration and electric vacuum aspiration as unpleasant, but, almost painless procedure.

The discussion participants refer to the dilatation and curettage as "scraping". They describe this method of abortion as a strong painful: "*I've cried, it was very painful, disheartening*"". It should be noted that some of the clinics use only this type of abortion (for example, the Tianeti clinic).

Some respondents have also made a medical abortion according to the doctor's prescription. However, in the group discussions it was revealed that women often take pills arbitrarily, without a doctor's prescription. The following pills have been named: Pituitrin, Saitotek, No-Spa, stomach medications (by oral and vaginal way), calcium (intravenously) and others. In medical terms, these drugs are not considered. Numerous studies have shown that in order to increase the clinical effect of the medical abortion and to accelerate the expulsion of impregnated ovum, for safe abortion it is recommended to use the combination of Mifepristone and prostaglandins that excludes the above-mentioned drugs in terms of efficiency. Some respondents mentioned that the abortion developed in light of the drugs taken arbitrarily was often accompanied by various complications (especially bleeding), which, subsequently, required serious medical treatment.

In addition, members of the group named such non-medical mean causing abortion as mint juice, nut infusion and other. However, it is not an established practice for them due to frequent complications. In medical terms, the use of these infusions for the termination of pregnancy is not subject to consideration.

Respondents unanimously noted that none of them have made abortion with an illegal facility and have not heard of similar cases. Only a participant of the Marneuli focus group noted that in Marneuli villages illegal abortions still have place, because there are no clinics, which offer the range of services to women.

During the group discussion it was revealed that in case of second-trimester abortion the Protocol requirements of 1 overnight stay of a patient in the hospital after the procedure is not always followed.

During the artificial pregnancy termination procedure an important issue is also anesthesia. Focus group participants noted that they always have had a choice of local or general anesthesia in an abortion. In addition to the patient's demand, the choice of the type of anesthesia depends on the type of abortion. The discussion participants noted that in case of their needs and wishes they have been always provided with extra painkillers. We can assume that the protocol requirements in almost all cases have been observed.

Thus, clinics are offering to patients both the first trimester and the second trimester abortions. Out of first trimester abortion methods there are available medical and surgical (electric and manual vacuum aspiration, dilatation and curettage) methods. In clinics there are available one or several (two, three, four) methods. The most unwanted and painful method for women is dilatation and curettage, however, in some cases they have to experience this method, because the clinic does not offer another method. In such a case, it is important that women be informed about the methods. If a facility is lacking the method desirable for a woman, it is required to refer the woman to the facility where this method is available. However, as a rule, in practice it does not happen, because in case of referral the health facility loses income, or faces a

problem with access to services (especially in the regions) or the patient faces financial problems. It should be noted that only a small number of clinics offer the service to a client by medical indication only in case of a spontaneous abortion. In some inhabited areas, for example, in Tianeti only this type of abortion is available, which, according to the protocol, does not constitute a violation; however, it restricts the access of abortion services for women and creates the extra time and financial problems. In addition, the abortion in the second trimester is only available in a third of clinics which covers all regions, but not all villages/towns.

c) Post-abortion period

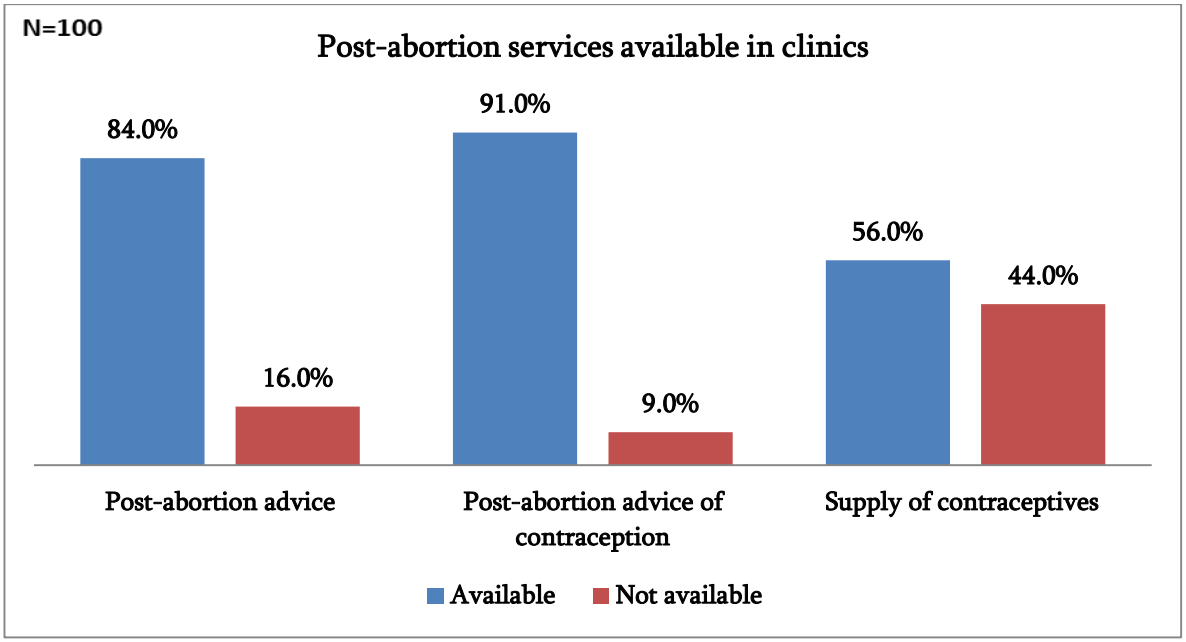
Post-abortion services

According to the Protocol, after uncomplicated surgical abortion and medical abortion routine visits to a health facility are not required, but women should be informed about the availability of additional services, depending on the needs and wishes. An important component of abortion services is the follow-up, which means counseling a patient before the discharge from a health facility, and the provision of information on contraceptives, including the selection of the appropriate contraception method. Post-abortion counseling is aimed at the prevention of unwanted pregnancy. Also, it aims at the patient's psycho-emotional health assessment to ensure the woman's general health.

In connection with follow-up, the situation in health facilities is different from one another.

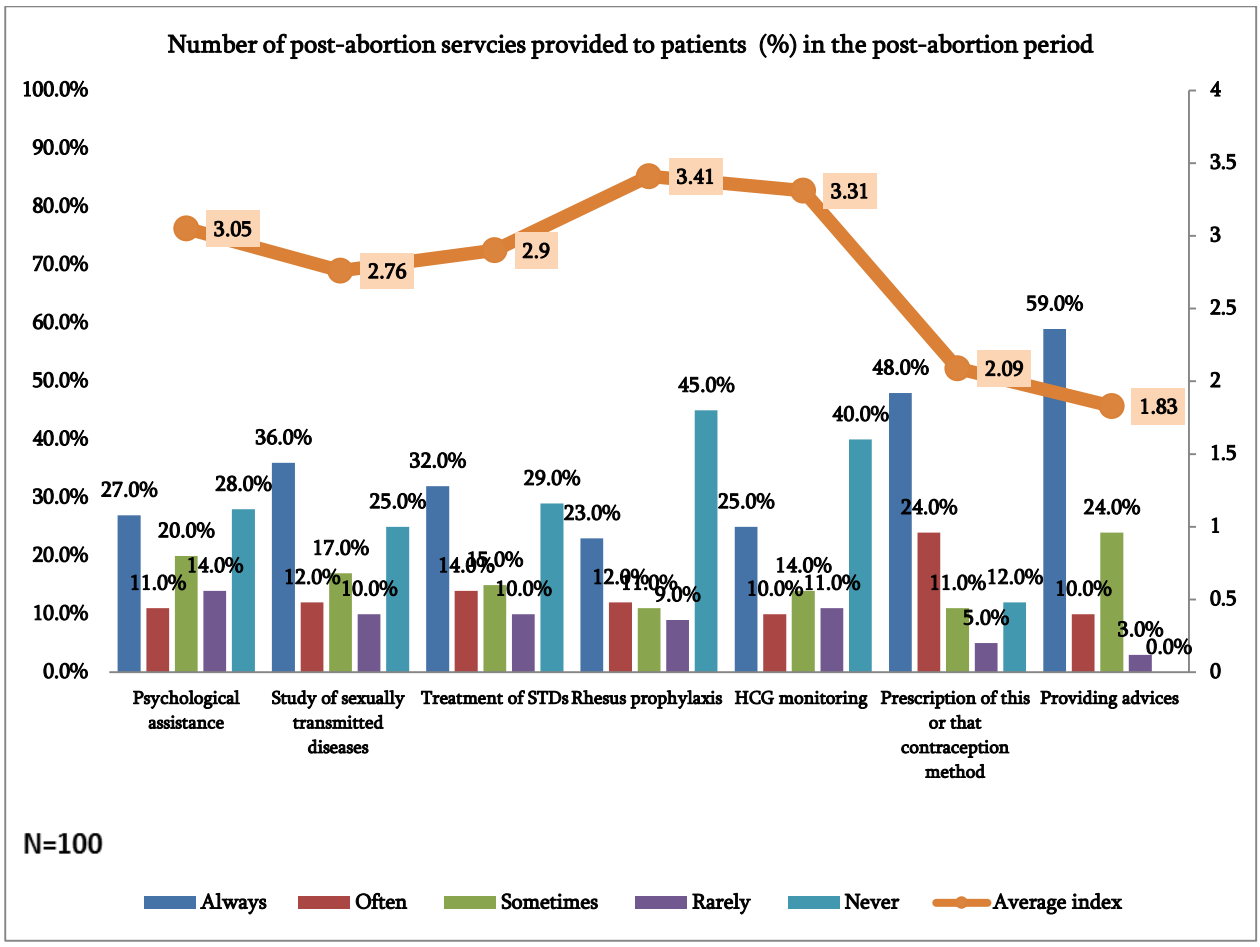
Only in a small part of the clinics (16%) the post-abortion counseling is not held, that gives rise to the risk of unwanted pregnancy and, therefore, may be the cause of the repeated artificial pregnancy termination. Also, small is the number of clinics (9% - 9 clinics), which, after the abortion, do not offer clients advice on contraception, as recommended according to the protocol. In addition, in case of medical abortion such a consultation is mandatory. More than half clinics (56% - 56 clinics) provide also contraceptives to clients, after the abortion (see Chart N19).

Chart N19



Health facilities provide a variety of services to post-abortion patients:

Chart N20



The average rate is calculated based on the 5-point scale, where 1 means – "Always", 5 –"Never"

As the chart shows, in the post-abortion period less than one-third of facilities (28% - 28 clinics) never provide the client with psychological assistance, almost the same number always provide psychological assistance, in other cases, the facilities providing psychological support services to women(11%), sometimes (20%) or rarely (14%). It should be noted that psychological assistance is necessary in such cases, when there is an arbitrary abortion, abortion as a result of pregnancy resulting from rape, during depression and so on. In other cases, psychological assistance is desirable.

Study of sexually transmitted diseases in women is conducted comparably often (always - 36%, often - 12%, sometimes - 17%, rarely - 10%). A quarter of these clinics do not offer this service to clients. 29% of clinics have never conducted treatment of sexually transmitted diseases in women, and 32% always offers this service to women in the post-abortion period. According to the Protocol, smear analysis is not mandatory, and it is prescribed only in case of certain clinical signs, however, septic complication, prevention after abortion is essential.

Almost half of the clinics (45%) never conduct Rh prophylaxis in women, while 23% - always, in other cases Rh prophylaxis is offered: often (14%), sometimes (15%) or rarely (10%).

In the post-abortion period women are provided advices, prescribed one or another method of contraception, study and treatment of sexually transmitted infections. Rh prophylaxis and HCG monitoring is rarely provided.

In the last two years the clinics have been provided the post-abortion consultation, on average, only to a third of clients(35%). Psychological services to clients have not been provided by 37% clinics and 19% of the clinics have provided psychological services to all patients.

In the last two years the study of sexually transmitted infections in the clinics were offered on average, only to a third of the clients (36% of clients). 39% of health facilities have not provided these services to any patients, while 19% provided this service to all clients.

As for the sexually transmitted infection treatment, in the last two years this service has been provided, on average, to less than one third (29%) patients. Less than half of clinics (41%) have not provided this service to clients at all, and a small number (11% of clinics) have provided it to all of the clients.

Rh prophylaxis, in last two years, on average, was conducted to a quarter of customers (24%). More than half of clinics (52%) have not provided this service to any client, while about a sixth of the clinics (14%) provided it to all the patients,

HCG monitoring in the last two years, on average, was conducted to a quarter of customers (24%). More than half (54%) of facilities have not provided this service at all, while less than a fifth (17%) provided it to all patients. Noteworthy is that HCG monitoring should be administered under certain indications and is not mandatory in the absence of such indications.

Post-abortion consultation, in the last two years, was provided on average, to 85% of clients. A very small number of clinics (8%) have not provided this service to any client, and the majority of the clinics (67%) – to all customers.

In two last years, the contraception method in the post-abortion period was prescribed to more than half of the patients (53%). Clinics for almost one-fifth (19%) None of the patients will be appointed for contraception, and clinics-thirds (31%) This service is offered to all patients.

Thus, the mandatory post-abortion services, such as post-abortion counseling, psychological assistance, studies (on sexually transmitted infections, Rh prevention, HCG monitoring) and the treatment to the clients, are provided mostly inadequately. Small is the number of clinics that provide all the necessary services to all patients.

At the same time, the necessary studies are conducted more often in public clinics than in private or mixed clinics (See Table N4)

Table N4

How often women are provided the following services in the post-abortion period?		Public health facilities	Private, commercial and nonprofit health facilities	Mixed health facilities
Psychological assistance	Always	23.1%	29.9%	10.0%
	Often	15.4%	6.5%	40.0%
	Sometimes	23.1%	16.9%	40.0%
	Rarely	7.7%	16.9%	
	Never	30.8%	29.9%	10.0%
Study of sexually transmitted infections	Always	23.1%	41.6%	10.0%
	Often	7.7%	13.0%	10.0%
	Sometimes	30.8%	10.4%	50.0%
	Rarely	15.4%	9.1%	10.0%
	Never	23.1%	26.0%	20.0%
Treatment of sexually transmitted infections	Always	15.4%	36.4%	20.0%
	Often	7.7%	14.3%	20.0%
	Sometimes	23.1%	10.4%	40.0%
	Rarely	15.4%	9.1%	10.0%
	Never	38.5%	29.9%	10.0%
Rh prophylaxis	Always	23.1%	24.7%	10.0%
	Often	15.4%	9.1%	30.0%
	Sometimes		11.7%	20.0%
	Rarely	7.7%	10.4%	
	Never	53.8%	44.2%	40.0%
HCG monitoring	Always	7.7%	29.9%	10.0%
	Often	15.4%	6.5%	30.0%
	Sometimes	15.4%	13.0%	20.0%
	Rarely	7.7%	10.4%	20.0%
	Never	53.8%	40.3%	20.0%
This or that contraception method is prescribed	Always	38.5%	49.4%	50.0%
	Often	23.1%	23.4%	30.0%
	Sometimes		11.7%	20.0%
	Rarely	7.7%	5.2%	
	Never	30.8%	10.4%	
Counseling	Always	61.5%	59.7%	50.0%
	Often	7.7%	9.1%	20.0%
	Sometimes	15.4%	24.7%	30.0%
	Rarely	7.7%	2.6%	
	Never	7.7%	3.9%	

The focus group results in the above data have revealed more problems. Post-abortion services are not always provided to client adequately. Doctors sometimes offer post-abortion counseling and prescribe contraceptives, but, more often, women face problems such as lack of communication, indifferent attitude from doctors and others. Doctors sometimes even of not provide to patient the information about the availability of the repeated visit.

"Communication is zero. We are to ask the doctor by ourselves to snatch the word. They do not talk with us and create such an environment that excludes asking a lot of questions"(Batumi)

"They simply asked me if I feel good. I said, yes. That it is, then get up" (Marneuli)

Like pre-abortion counseling, nobody provides the control of the abortion follow-up. Doctors do not always offer post-abortion advices to patients. Most likely, post-abortion counseling is appointed only when necessary and not for prophylaxis.

Post-abortion complications and referral

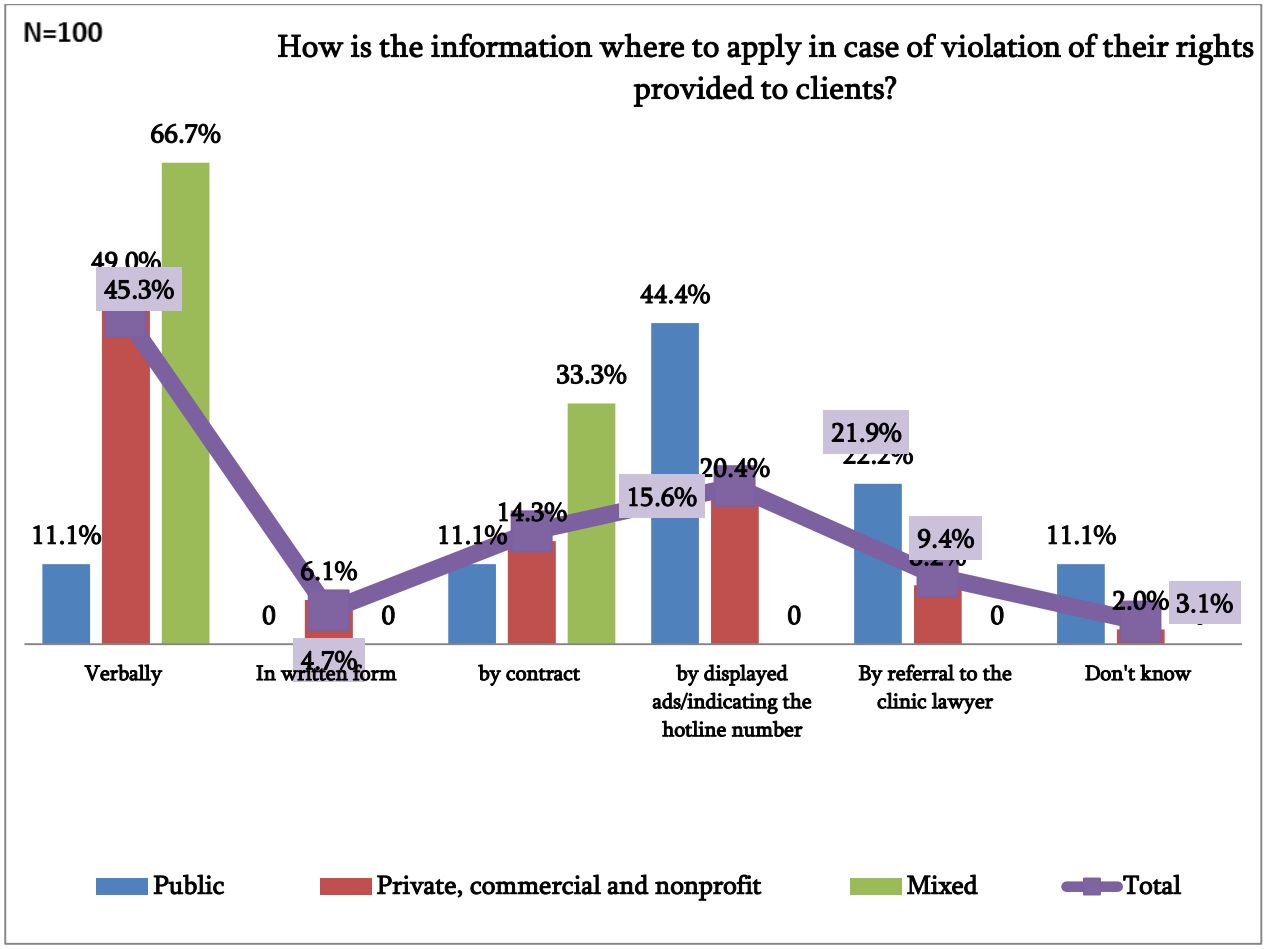
Focus group results show that post-abortion complications are quite frequent. Abortion complications such as uterine perforation, bleeding, toxic shock, sepsis, loss of fertility are to some extent depending on the abortion term and method (medical and vacuum aspiration, scraping, however, may be due to the low quality of abortion services.

"I've had [complication] after the first abortion. Apparently, they did not scrapped me well, and a month after the bleeding began which I could not stop. Then I went to the doctor in Tbilisi, who prescribe me something but this made me even worse. Something remained inside and I was to agree on the repeated scrapping".

"I had infection after a miscarriage. I go to Tbilisi in such cases, but one they advised me a doctor here after the visit to which I've got infections. So, it was not a sterile procedure made".

As the representatives of a majority of health facilities (64%) state, they provide to the client the information about where to go in case of violation of their rights. This information is provided by one or more methods, including, mainly – verbally (45% of cases), by posted ads where the appropriate hotline number is given (22% of cases), through the contract (16% of cases). A small number of clinics (9%) have their own lawyer. Different types of clinics use a different method for the client to provide information, for example, private and mixed clinics, mostly use verbal means (49% of private clinics - 24 private clinics; 66.7% of mixed clinics - 4 mixed clinics), the public clinics mainly use ads where the hot line numbers are indicated (44% - 4 public clinics) (see Chart N21).

Chart N21



However, the focus group results indicate that in the case of the violation of women's rights, they do not use the ways, other than to express their dissatisfaction with the doctor and to claim response from the doctor:

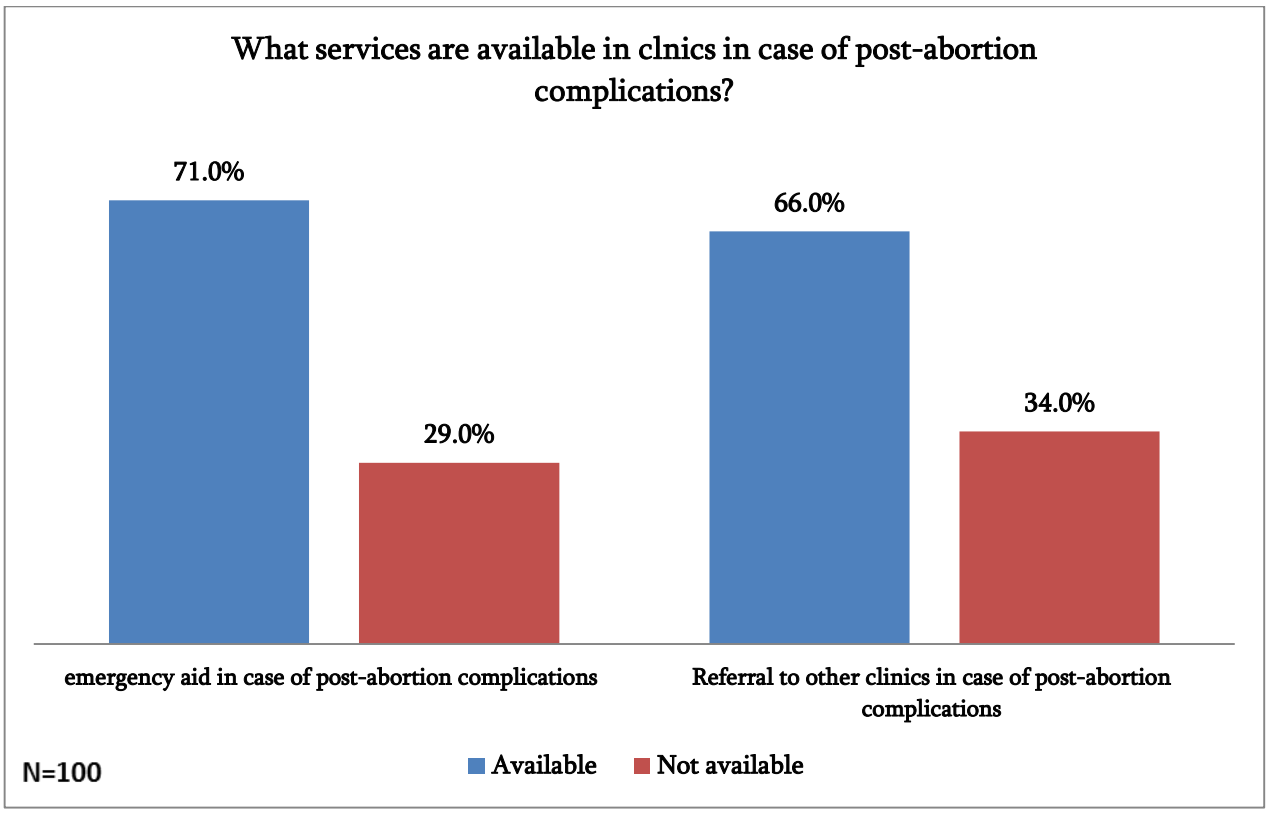
"I've had [complication] after the first abortion. Apparently, they did not scrap me well, and a month after the bleeding began which I could not stop. Then I went to the doctor who prescribed me something but this made me even worse. Then I went to Tbilisi. As it became obvious something remained inside and I was to agree on the repeated scrapping".

"I slammed the doctor. I told her that she had done the procedure in a non-sterile way and something happened to me, so she was to cure me. I took the money paid by me back".

Thus, according to the survey results, despite the fact that the representatives of the clinics state that they provide information to clients on how to behave in the case when their rights are violated, in fact, women use only one method - to express their dissatisfaction with the doctor. This action is not always followed by the desired result.

Most clinics offer emergency assistance in case of post-abortion complications, and refer to other clinics in case of post-abortion complications (see Chart 22).

Chart N22



These clinics cover all regions.

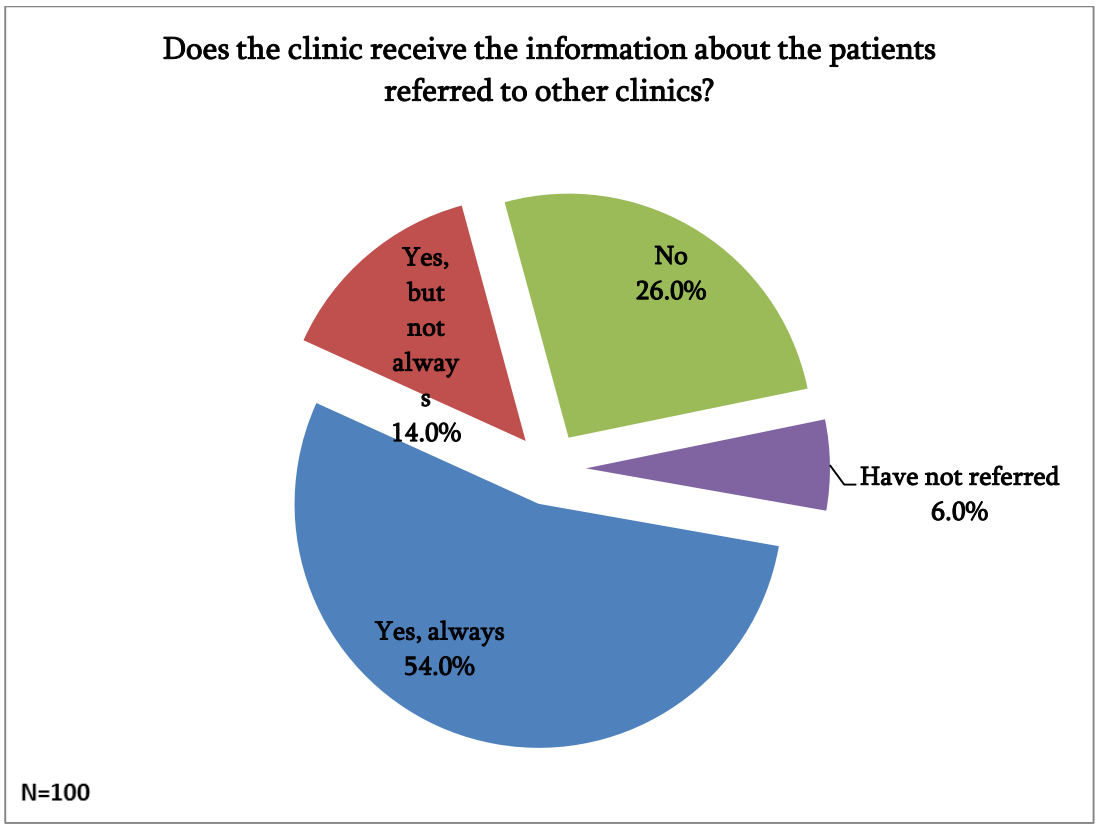
Most of the clinics have the following referral services:

- ✓ the scheme of referral to the hospital in case of emergency (79% of clinics);
- ✓ the written instructions on referral to other hospital of those clients who are infected with sexually transmitted diseases and HIV/AIDS (63% of clinics);
- ✓ the written instructions on post-abortion visit appointment and conduct (63% of clinic). s

The availability of these schemes is not binding upon the health facilities, though their presence ensure delivery of services to patients without delay, which, in turn, demonstrates the high quality of service. Primary health facilities are required to have a signed contract with the hospitals which will provide a referral service to women in case of abortion complications.

Only 6% of surveyed clinics (6 clinics) have never referred patients. Out of those clinics which have referred the clients, most of them (57% of clinics - 54 clinics) always get information about patients, a small part of clinics (15% of clinics - 14 clinics) sometimes receives information and almost a third of clinics (28% of clinics - 26 clinics) - never receives the information (see Chart N 23).

Chart N23



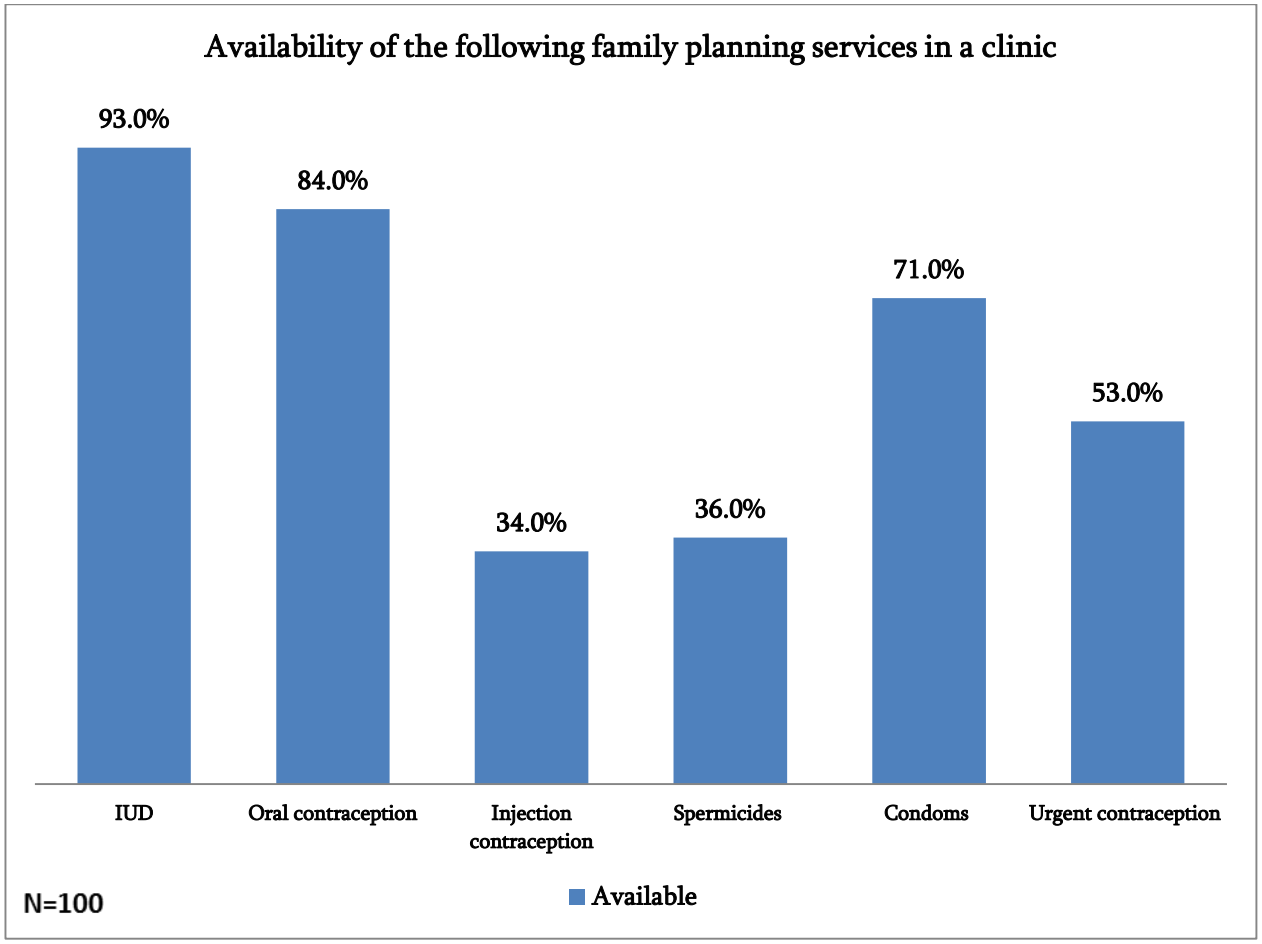
2.3.5 Family planning

The post-abortion counseling includes family planning service, where the doctor informs the patient about the unwanted pregnancy prevention methods, their effectiveness, side effects and helps in the selection of the appropriate method.

Family planning methods available

Clinics offer to the client one or more (2 to 6) family planning methods.

Chart N23



✓ **Intrauterine contraceptive device**

An intrauterine contraceptive device (IUD)[17] is a flexible, multiple-shaped device that is placed in the uterine cavity. There are medical (copper-bearing or hormonal) and nonmedical IUDs. IUD does not cause abortion (termination of pregnancy), but directly affects the fertilization process. It reduces the sperm mobility and ovum maturity process. the contraceptive effect develops upon introduction. The IUD is inserted once for a long time. may be required due to bleeding and pain.

IUD is available in the absolute majority of clinics (93% - 93 clinics).

The focus group results show that an IUD is most popular means of family planning for women. As a rule, women use the IUD on the doctor's advice. There is a difference of opinions with regard to efficiency and desirability of the IUD. A part of women are satisfied with the effectiveness of the IUD.

"I like most the IUD. But I think it should not be introduced for a long time, only for 1-2 years and then should be removed and a new one should be set. One and the same [IUD] is not good. It is more practical: one may forget to buy pills and cannot buy a condom suddenly".

[17] Ministry of Labor, Health and Social Affair's of Georgia, Family Planning Guidelines (Order N366/o), website visit date 17.11.2015 http://www.moh.gov.ge/files/gaidline/protokoli/25.1.pdf

"I had IUD made. When it was removed, everything was so clean".

However, a majority of women, who have used the IUD talk about the complications caused by this kind of contraception:

"I had the IUD for 2 years. After IUD I should cure and now use nothing".

"I had had the IUD for two times but then my body did not accept it".

"I had had the IUD two times, but did not tolerate it, it torn totally and the doctor was to remove it by parts as it had ingrown. I felt so bad!"

"The IUD has many bad properties, if an organism is not healthy, the IUD is risky. Many cannot tolerate it".

"I know the fact when a woman had made the IUD, then she was pregnant and the baby was born accompanied with the IUD".

The existence of these contraindications may be attributed to various reasons, including wrong selection of the method. The doctor is required based on the proper diagnosis and assessment to prescribe to the patient this method of contraception in accordance with the Protocol and with assessment of the risk of contraindications.

- ✓ **Oral contraceptive (combined oral contraceptives - COC)**

Combined oral contraceptive pills[18]represent a highly effective, synthetic estrogen-progestin drugs that protect women from unwanted pregnancy. There are mono and multi-phase COCs. COC mechanism of action may affect the reproductive system at different levels: the hypothalamus, pituitary, ovaries, uterus, and uterine tubes. Today, there are available a variety of COCs as by their hormonal composition and by the intake form, which has its limitations and their selection depends on the woman's different characteristics: age, smoking, hereditary disposition, human psycho (forgetful, very busy, hypersensitive). Also, special attention is paid to the woman's state of health: cardiovascular disorders (thrombophlebitis, thrombophilia, mitral valve prolapse, and heart failure), diabetes mellitus, and systemic disease, amenorrhea of unknown origin, depression, body mass index, cervical and uterine cancer, liver disease and other. Because of this, the issue of selection of a COC shall be solved after consulting with a doctor.

Oral contraceptives available in most clinics (84% - 84 clinics).

The focus group results show that oral contraceptives for prevention of unwanted pregnancy is the second most commonly used method. However, in most cases, women are taking the pill arbitrarily - without a doctor's prescription. In some cases, the drugs are effective, but more often women quit to take them because of the weight problem. Respondents talked about other problems caused by the pills, such as skin disease, edema, bone cancer and other. From the medical aspect, administration of contraceptive pills arbitrarily is unjustified, because its selection is subject to the patient's individual characteristics.

[18]Ministry of Labour, Health and Social Affairs of Georgia, "Family Planning" (Guidelines) (Order N 366/n), Combined Oral and Injectable Contraceptives, the website visit date 17.11.2015
http://www.moh.gov.ge/files/gaidline/protokoli/25.12.pdf

✓ **Condoms**

Condoms[19] are attributable to one of the most popular and safe barrier methods to avoid unwanted pregnancy. During a sexual intercourse, a condom creates a barrier to spermatozoids preventing them to get into the vagina or cervical canal. Condoms are available in the majority of clinics (71% - 71 clinics).

The focus group results show that for women condoms are less likely popular method of protection. The majority of women say the reason of this the unwillingness of men to use it:

"Most men do not like condoms. My husband used it one or two times and then stated that it did not fit him", "The men are adverse to the use of condoms", "They are against to use it".

There should be noted one more reason of non-use of condoms, which is related to the values: *"In our generation the use of condoms between the legal wife and husband was excluded".*

✓ **Emergency Contraception**

Emergency contraception[20]is used after an unprotected sex to prevent pregnancy. It cannot be used often. The studies show that the use of emergency contraception pills inhibits or postpone ovulation. The use of Levonorgestrel (LNG) in the pre-ovulation period leads to the delay of ovulation process. The emergency contraception is available in more than half clinics (53% - 51 clinics).

✓ **Spermicides**

Spermicide[21] is a chemical substance that causes death or immobilization of sperm in the vagina until it ingrains in the inner genitals. Spermicides can be in a form of aerosols (foams), vaginal tablets, compressed or soluble suppositories, cream and gel. Modern spermicides usually consists of 2 components: a chemical agent harmful for sperm (active ingredient), and a carrier. Spermicides are safe and quite popular contraceptives, because they do not have any health-related risk and any somatic side effects. Spermicides are available in 36% clinics - 36 clinics.

Among the focus group participants spermicides is not accepted/popular method of contraception. Women believe that this method is inconvenient.

✓ **Injectable contraception**

Progestin-only injectable contraceptive (POIC)[22] consists of synthetic steroid, which is similar to a woman's progesterone. The injection drug is slowly released from the place of injection into the bloodstream and carries a high contraceptive effect of 2 or 3 months. There are different types of POICs: Depo-Provera -a microcrystalline aqueous suspension, which is done once every 3 months in muscle and NET-EN oily

[19]Ministry of Labour, Health and Social Affairs of Georgia, "Family Planning" (Guidelines) (Order N 366/n), Barrier Methods and Spermicides, the website visit date on 17.11.2015http://www.moh.gov.ge/files/gaidline/protokoli/25.1.pdf
[20]Ministry of Labour, Health and Social Affairs of Georgia, "Family Planning" (Guidelines) (Order N 366/n), Emergency Contraception, the website visit date on 17.11.2015http://www.moh.gov.ge/files/gaidline/protokoli/25.3.pdf
[21]Ministry of Labour, Health and Social Affairs of Georgia, "Family Planning" (Guidelines) (Order N 366/n), Barrier Methods and Spermicides, the website visit date on 17.11.2015http://www.moh.gov.ge/files/gaidline/protokoli/25.1.pdf
[22]Ministry of Labour, Health and Social Affairs of Georgia, "Family Planning" (Guidelines) (Order N 366/n), Barrier Methods and Spermicides, the website visit date on 17.11.2015http://www.moh.gov.ge/files/gaidline/protokoli/25.12.pdf

suspension, which is done in 2 months. POIC causes the following changes: gonadotrophic pituitary function impairment and anovulation; the cervical mucus thickening, resulting in inability of the sperm to penetrate the mucus; endometrium hypo and/or atrophic changes, resulting in a complicated implantation; peristaltic of the fallopian tubes, and reducing spermatozoids motility in them. The injection method of contraception is available in a third of clinics (34% - 34 clinics). Among the focus group participants no one has used this method.

- ✓ **Other methods of contraception used by women**

In addition to these methods, women use other methods of contraception- including the **rhythm method**. The rhythm method among the natural contraception methods is the most widely used method and is based on the establishment of the fertile days of the menstrual period and it has a rather large failure index. This method of contraception is based on the establishment of fertile days of a woman's menstrual cycle. The essence of this method is to refrain form the sexual contact during the fertile phase. From the medical aspect the rhythm method is the most ineffective method. The women participating in the focus group note, it is the safest method, however, is not reliable and often ends in an unwanted pregnancy.

The participants of the discussion have mentioned other methods of contraception: syringe, using vitamin vaginally, contraception by using soap. From the medical aspect, these methods are not allowed because of the risk of damage to the cervix, which, in turn, is a prerequisite for cervical cancer. These methods cause vaginal and cervical trauma, solution of epithelial continuity, which facilitates the penetration of infection and initiation of various hyperplastic processes locally. As for the contraceptive effectiveness of those methods, none of them is described in the medical literature. Thus, these methods of contraception are not considered for use as contraception.

Access to information of family planning

In the frames of qualitative survey, a significant part of women participated in the discussion noted that during a sexual contact they do not use the means of contraception. The name the reason of it the fact that there are very rarely pregnant and do not need to protect themselves, while some of them have had a negative experience with a variety of contraceptives and now reject them. However, the biggest problem in this regard, is the low awareness that is a very sensitive factor for the women:

"Lack of information about contraception is a distress for women. All of us share the common experiences".

The survey results show that the majority of women connect the start of sexual life with marriage. At the start of the sexual life they do not have enough information about family planning and contraceptives, which, in some cases, is the reason of abortion as an acceptable practice:

"Before marriage, of course, I had not visited a gynecologist. I did not want to have a child just after marriage but I was pregnant very quickly. I did not know how to avoid the unwanted pregnancy".

Also, there is a very low awareness of abortion. In this regard, the main source of information for women is a health facility, to which they do not always have access for some reasons. In addition, there is no established practice, which would enhance the women's awareness in this regard. The group discussion

members unanimously perceive this as a serious problem and they wished trainings to be held on these issues, consulting services be available or the problem be taught in school.

"It would be good if this (information) was of academic character".

""There is information available but it is optional. As such, systematical access to this information or understand of its importance does not exist. It depends on personal interest more. If you are interested, you will get it".

"A sexopathologist shall also be a psychologist. We have a country, where a woman will not visit a doctor with this problem and will not ask advice from a doctor"; "It should be provided in such a manner that women will visit a doctor with such a problem".

Women, in most, but not in all cases, complain of the lack of information about abortion and contraception from the doctors:

"Communication is zero. Weare to ask the doctor by ourselves to snatch the word. They do not talk with us and create such an environment that excludes asking a lot of questions"

"The doctors think that I should master the terminology. They claim they know everything and do not talk to use. The fact is that all people are s not obliged to know the medicine. Do not avoid providing explanation. This is as mandatory for a doctor, as a practice".

"Basically, it is the communication problem and, therefore, women sometimes are reluctant to visit a doctor".

Respondents, in some cases, name the Internet as the information source, such as, youtube.com, mkurnali.ge and others.

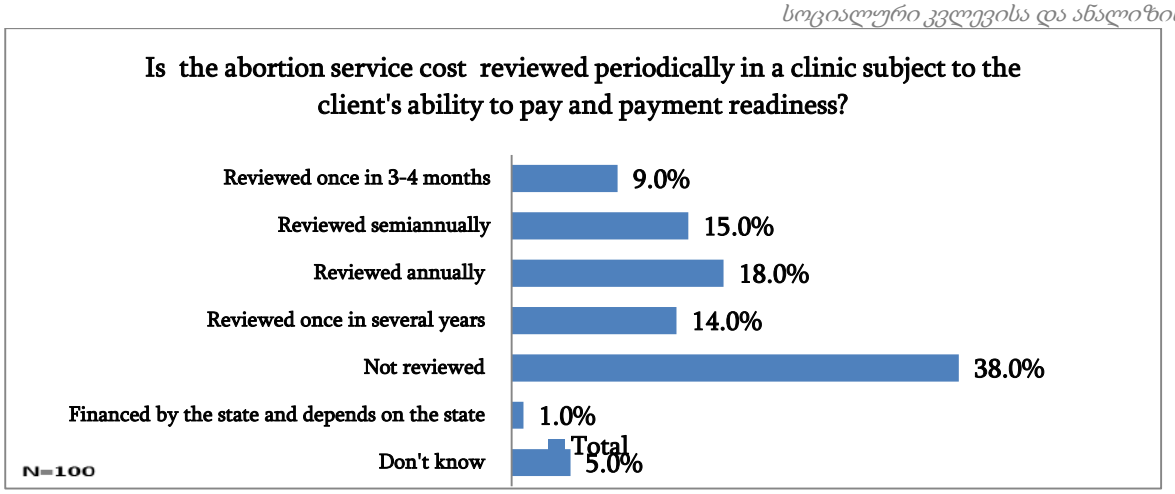
Thus, the access to information on family planning issues, is a serious problem for women and causes their apparent dissatisfaction.

2.3.6 Abortion affordability

Abortion prices in various medical institutions or in various regions are different. Abortion prices differ by abortion type and form of anesthesia: an abortion with general anesthesia is more expensive than with topical anesthesia.

A majority of health facilities (57% - 57 clinics) periodically review the abortion service cost subject to the client's ability to pay and payment readiness. This happens most often once a year (18% - 18 clinics), semi-annually (15% - 15 clinics), or once in a few years (14% - 14 clinics), more rarely (9% - 9 clinics), once in 3 -4 months (see Chart N24). In 38% of cases the cost has not been reviewed. In this regard, the situation is almost similar in private and public facilities and significant differences are not observed..

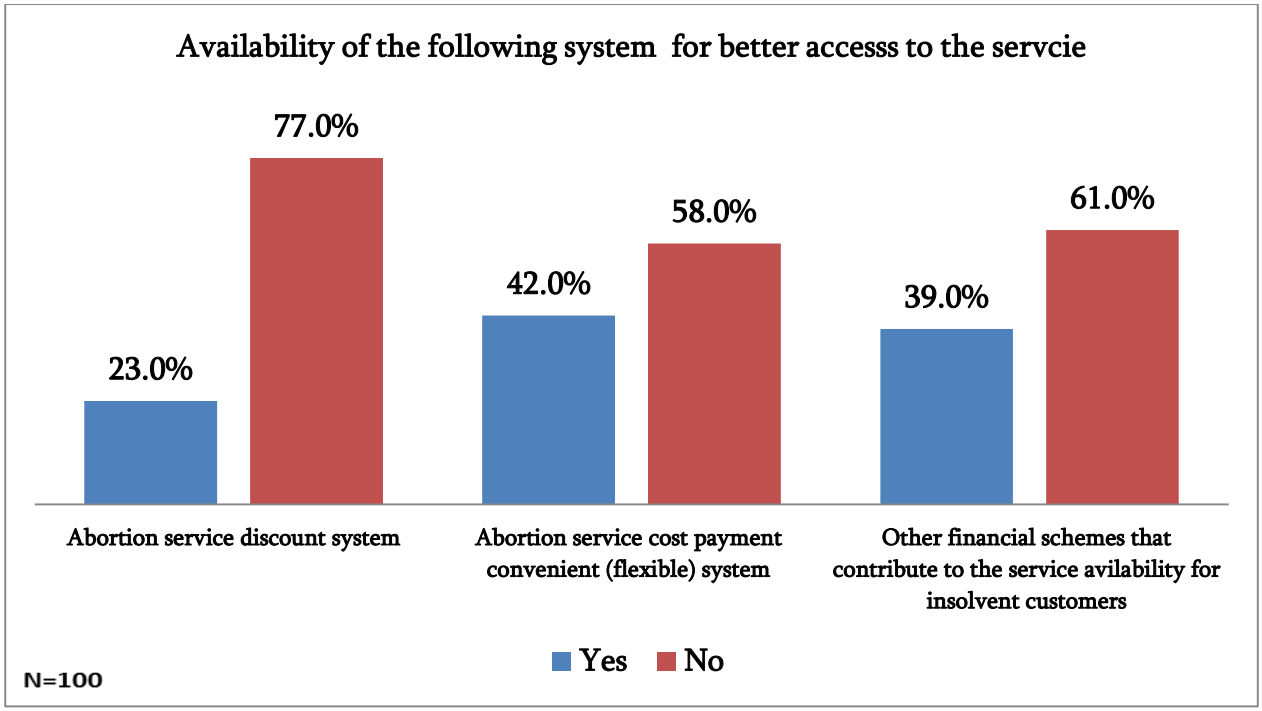
Chart N24



Most of the clinics (85%) take responsibility for implementation of justification of the pricing and payment procedures established in the clinic, by abortion service providers (doctors).

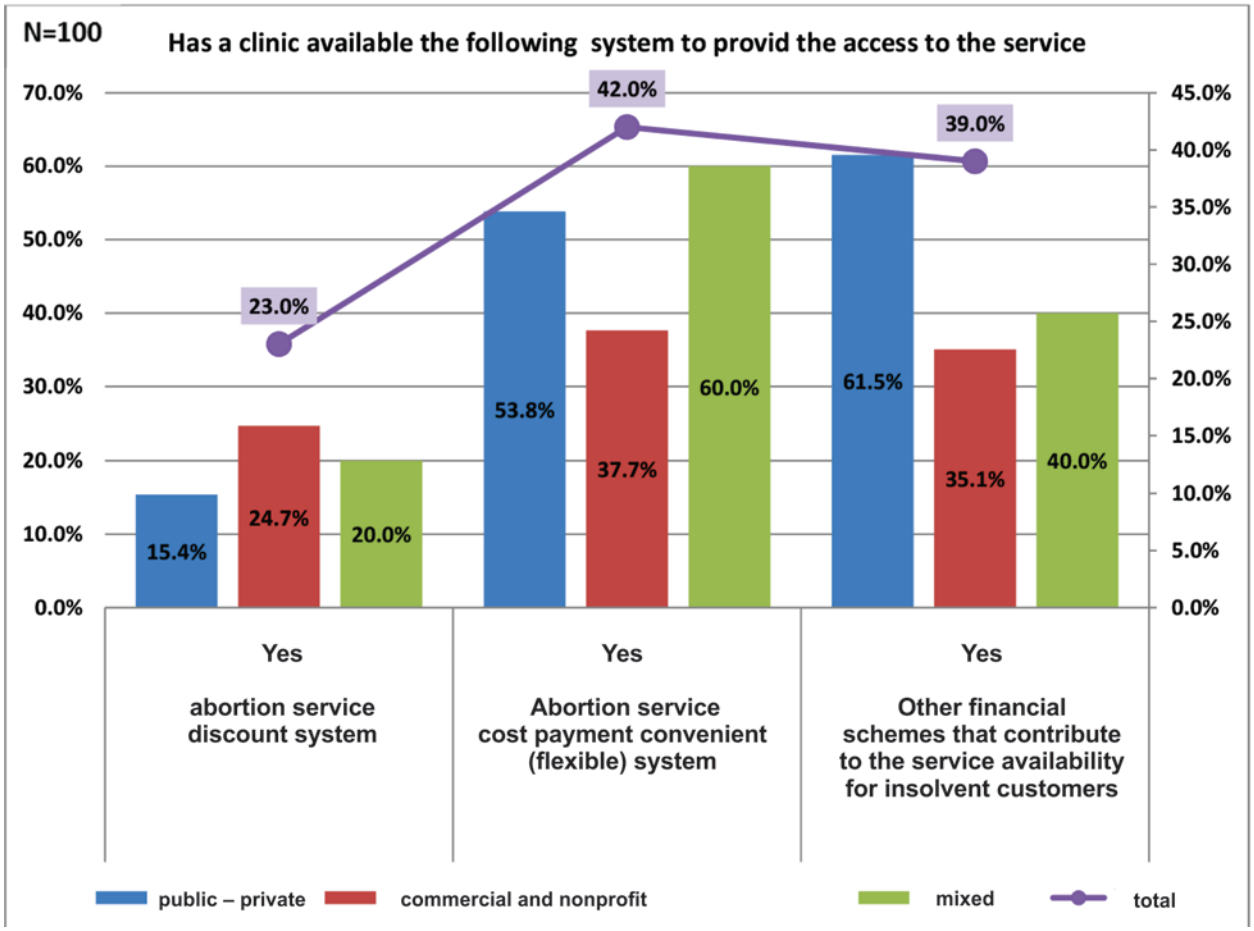
For better access to abortion services a variety of services are introduced in health facilities, including the discount system on abortion services (77% of cases), convenient (flexible) payment for abortion service (42% of cases) and various financial schemes, which contributes to service availability for insolvent customers (39% of cases) (see Chart N25).

Chart N25



In this regard, there are minor differences between the private, mixed and public health facilities (see Chart N24).

Chart N 24



- ✓ Almost a quarter of private facilities (24.7% - 19 clinics) have a discount system, while this figure for mixed clinics makes one fifth (20% - 23 clinics), and for public clinics - one sixth (15.4% - 2 clinics);
- ✓ More than half of the mixed clinics (60% - 6 clinics) and public clinics (53.8% - 7 clinics) have the abortion service payment convenient (flexible) system, while the share of private clinics is significantly lower (37.7% - 29 clinics) ;
- ✓ Other financial schemes, which contributes to service availability insolvent consumers have the clinics, more than half (61.5% - 8 He also brought), when such schemes have a third less than in private clinics (35.1% - 35.1% - 27 clinics) and mixed clinics (40% - 4 clinic).

The focus group results show that the abortion cost is mostly acceptable for women: “An affordable price for an average life”. However, due to the fact that abortion service, in addition to the cost of the abortion procedure, includes a variety of expenses, sometimes its cost is not available to everyone. For example, the Marneuli focus group participants noted that abortion services are not available in rural areas and they need to move long distance that requires additional transportation costs. The costs grow more due to the adoption of the law on the 5-day time of reflection. In addition, before the abortion, in almost all cases, a patient undergoes a variety of research, therefore, the cost of abortion services for women, in the end, rises to a rather high price:

"Should it be a bit cheaper, it would be better. Some women have eight children, because they have no money for abortion".

Thus, women are mostly valuate the abortion cost as affordable. However, despite the fact that clinics have imposed abortion service benefits for certain groups, in some cases to pay the cost is still a problem for women.

2.3.7 Restrictions for certain groups in connection with the provision of abortion services

A certain part of clinics have imposed a restriction on the provision of abortion services for one or more of the following groups:

- ✓ persons under 16
- ✓ 16-18 year olds
- ✓ venereal disease infected women
- ✓ infectious diseases infected women
- ✓ vulnerable persons
- ✓ sex workers

A half of clinics (52% - 52 clinics) have never had an occasion when a person under 16 years has referred for abortion services and further contraception. Out of those clinics (48% - 48 clinics), where such persons have applied, the majority (65% - 31 clinics) have provided abortion services. Most of the clinics (63% - 63 clinics) have no prescription on restrictions on abortion service delivery to persons under 16 years, however, 11 of them are not delivering the abortion services to this group of clients. At the same time, a small part of clinics (6% - 6 clinics) violates the internal rules and provides abortion services to persons under 16 years of age, although those clinics have the prescription on the service delivery restriction for this group.

A quarter of clinics (25% - 25 clinics) have never had an occasion when a person under 16 years has referred for abortion services and further contraception. Most of the remaining clinics (77% - 58 clinics) have provided such service to 16-18-year-olds. Restriction on the delivery of abortion services for 16-18-year-olds is established only in about a fifth of the clinics (21% - 21 clinics), which might be regarded as a violation of the law, because according to the law, a capable teenager over 14 has the right to make decision on abortion without parents. At the same time, a quarter of the clinics (5 clinics) violate the internal rules of the clinic and are still providing abortion services to persons under 16. In addition, 18 clinics have no restrictions with regard to 16-18 years, but they still do not provide abortion services.

Delivery of abortion services to persons aged 14-16 is governed by the Georgian law as well. In the case where a minor is considered to be capable or when she, in option of a medical service provider, correctly assessed her health condition, the doctor does not have the right to inform her legal guardian or parent about the state of her health[23].

[23] The Law of Georgia On the Rights of Patients, Chapter 8, Article 40, paragraph 2, subparagraph "a", subparagraph "b".

A third of clinics (34%) have never had an occasion when STD infected women referred for abortion services and further contraception, while the majority of the remaining clinics (62% - 41 clinics) has provided abortion services to this group. Only one-fifth of the clinics (20% - 20 clinics) have established restriction on abortion services delivery for STD infected women, however a half of them (9 clinics) violates the clinic's internal rules and still delivers the abortion services to this group. In addition, there are 15 clinics (15%) which have no such restrictions; however, they still do not provide abortion services to this group.

More than a third of clinics (37%) have never had an occasion when women with infectious diseases have referred for abortion services and further contraception, while the majority of the remaining clinics (60% - 38 clinics) have provided abortion services to this group. Only less than one-fifth of the clinics (17% - 17 clinics), have established restrictions on abortion services delivery to women with infectious diseases and a small part of them (3% - 3 clinics) violates the internal rules and still provide abortion services to this group. In addition, there are 19 clinics (19%) which have no such restrictions, but still do not provide abortion services to this group.

A small number of clinics (12%) have never had an occasion when vulnerable persons have referred for abortion services and further contraception, while the vast majority of the remaining clinics (88% - 78 clinics) have provided abortion services.

More than a third of clinics (38% - 38 clinics) have never had an occasion when sex-workers have referred for abortion services and further contraception while the majority of the remaining clinics (62% - 39 clinics) have provided abortion services to this group. Restrictions on the delivery of abortion services for sex workers are established only in a small part of clinics (9% - 9 clinics), however, more than half of these clinics (5 clinics) still have provided abortion services for the group, despite the restrictions. In addition, there are 22 clinics (22%) which have no such restrictions, however, still do not provide abortion services to this group.

Thus, most clinics have imposed restrictions on the provision of abortion services for persons under 16. Fewer restrictions are established for o vulnerable persons and sex workers. A small number of clinics violate the clinic's internal regulations and still provide abortion services to certain groups. At the same time, some clinics do not provide the service to particular groups, despite the fact that their internal regulations do not restrict this. Identification of reasons of such situation is subject of separate survey.

2.4 Medical personnel qualification and continuing education

A half of health facilities (52%) have both the protocols and the guidelines. Only guidelines are available in 18% of the clinics, while, only the protocols – in 14% of the clinics. 14% of health facilities have neither guidelines nor protocol, of which in half (7 clinics) the have not undergone training required by the Protocol.

In an absolute majority of facilities (95%), the staff have access to the description of their rights and obligations. In a great part of the clinics (85%) the staff has access to academic articles and publications about abortion and family planning.

40% of health facilities are lacking the mechanism of evaluation of the abortion and family planning knowledge of the medical staff, and in general, of the assessment of the continuing education, which is important in terms of quality assurance. Due to the fact that the medical practice should be based on the protocols and, at the same time, the protocols are subject to review after a certain period, the clinics are required to conduct continuing education activities. In the conditions where the state has no systematic strategy of staff evaluation and postgraduate education, some health facilities and corporations are conducting the training of the medical staff in different directions by themselves. However, such a practice is rarely systematic. At the same time, all facilities do not have the possibility of local conduct of trainings.

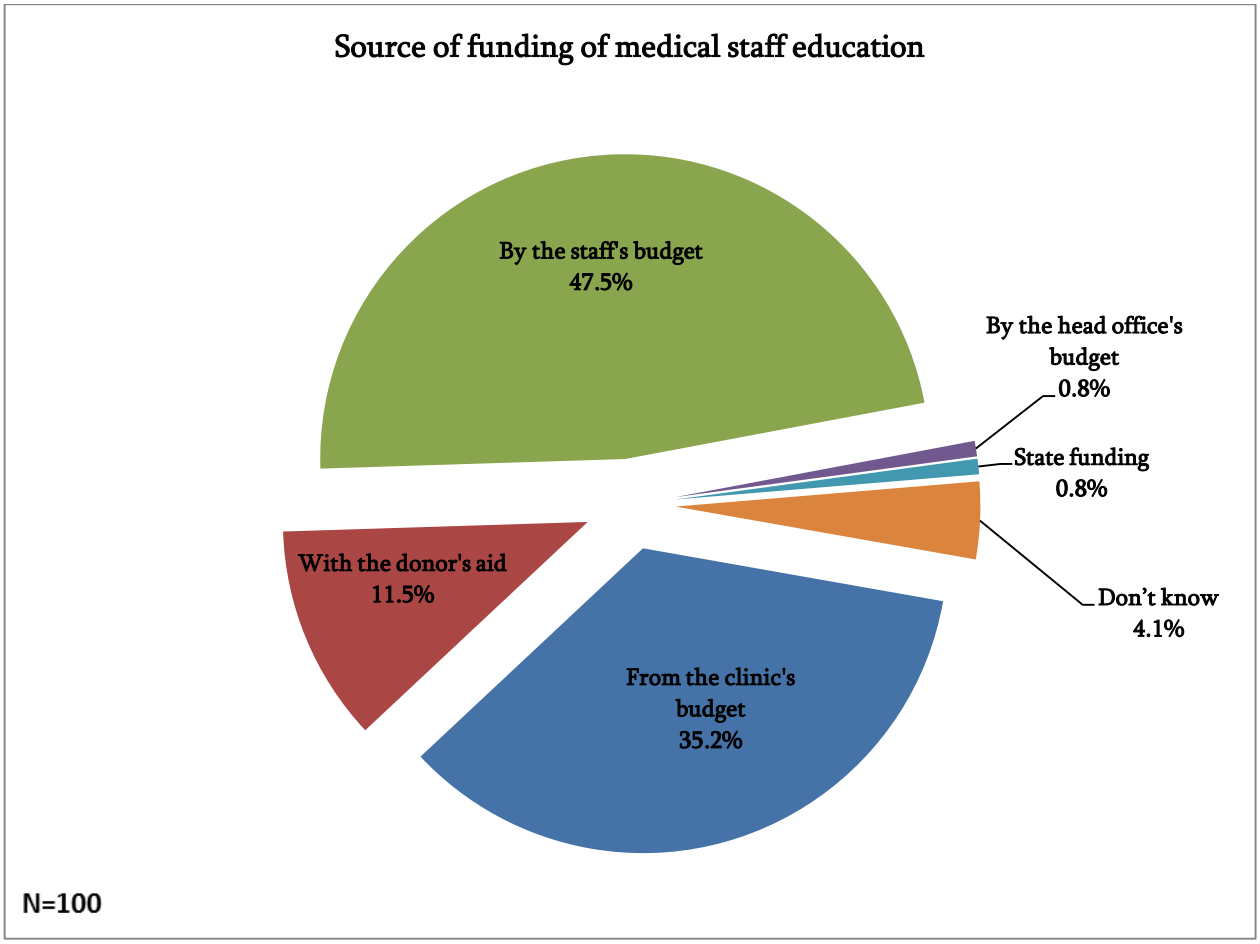
In the clinics, where this practice exists , the assessment includes the following information:

- ✓ personnel performance appraisal, in abortion services and family planning (52 clinics, that is 87.7% of clinics);
- ✓ identification of medical personnel requirements for additional training courses in the abortion and family planning issues (49 clinics, that is 81.7% of clinics);
- ✓ the introduction of new clinical guidelines and protocols (54 clinics, that us 90% of health facilities);
- ✓ introduction of new technologies in abortion and family planning (49 clinics, that 81.7% of clinics).

Most of the clinics (58% - 58 clinics) have no annual training courses plans in the abortion and family planning issues. In this regard, there is a significant difference between the private, public and mixed clinics.

Clinics use various sources for funding if the staff education (see Chart N25)

Chart N25

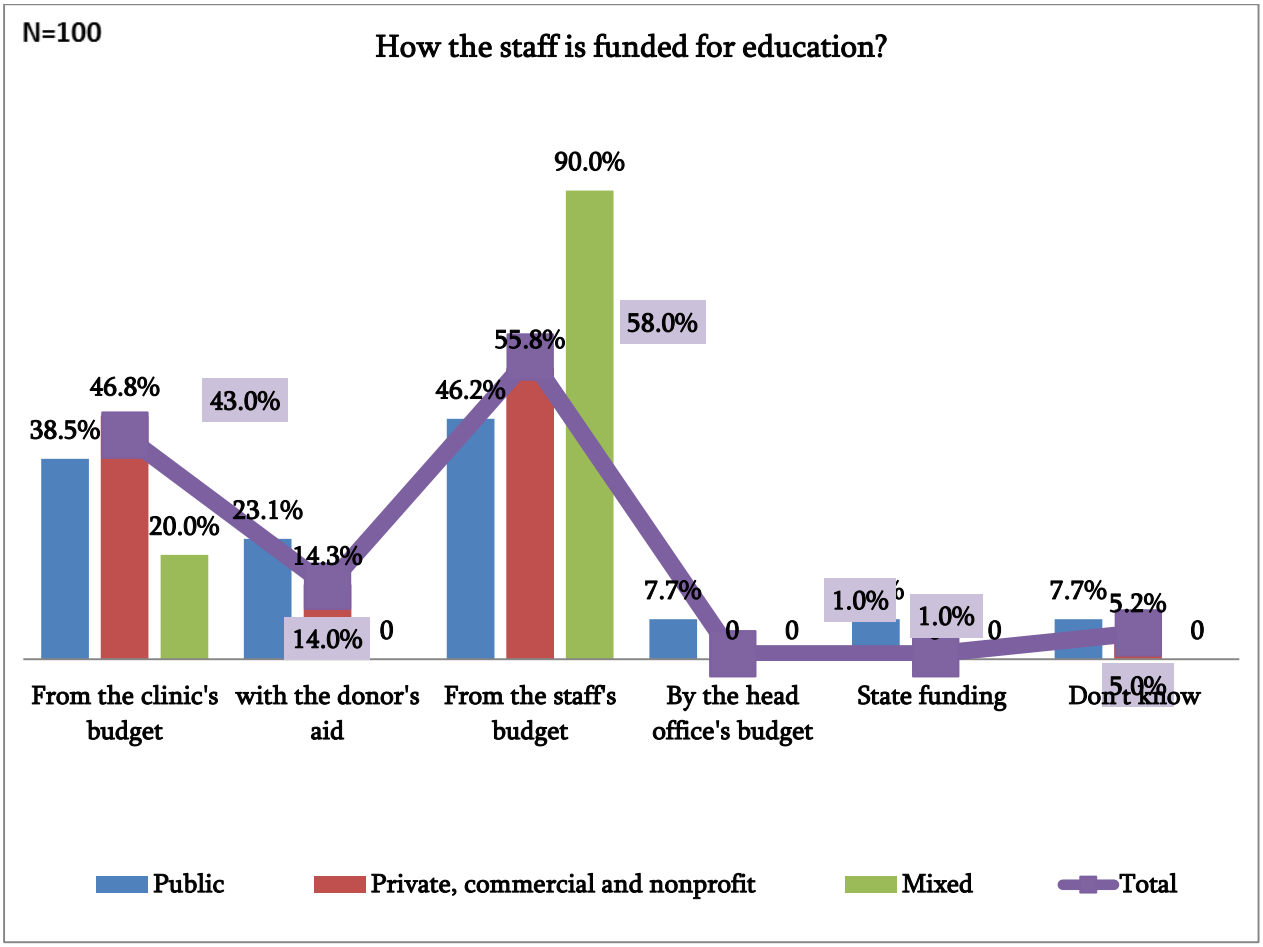


Among the private clinics, relatively more clinics are funding the staff education than among the public clinics, however, in all cases, mostly the staff participate in educational programs at the expense of their own budget (58% - 58 clinics) (see Chart N26). As a rule, the doctors have two choices in such a case:

1. To involve in the trainings conducted by pharmaceutical companies;
2. To involve in the trainings provided by donors and/or non-governmental organization to the clinics free of charge (in the case of the clinic collaborates with such institutions).

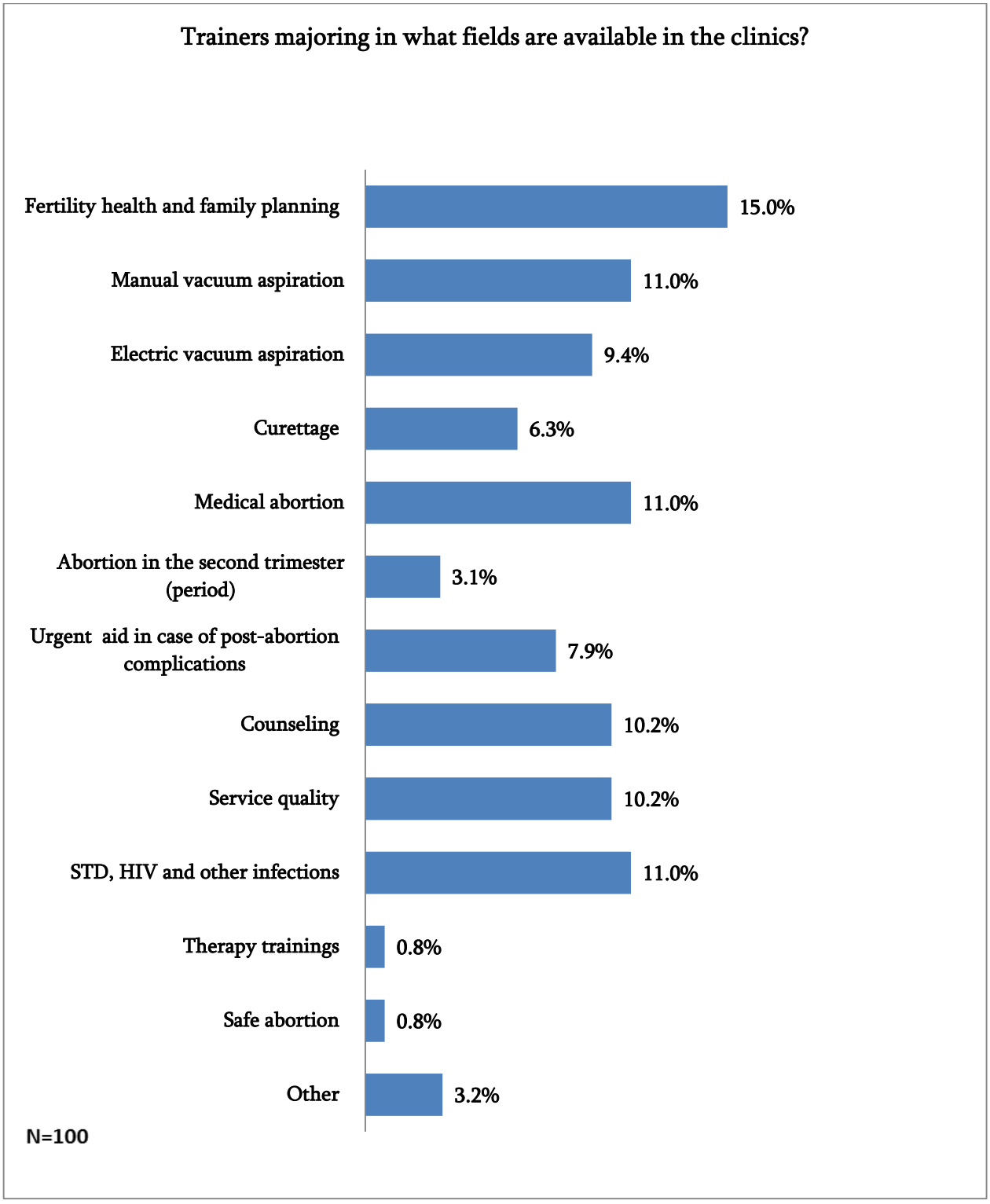
Thus, the training system does not have a systematic character and the doctors are seeking qualification courses by themselves. Moreover, participation in this courses/training is not supported by the state financially or otherwise.

Chart N26



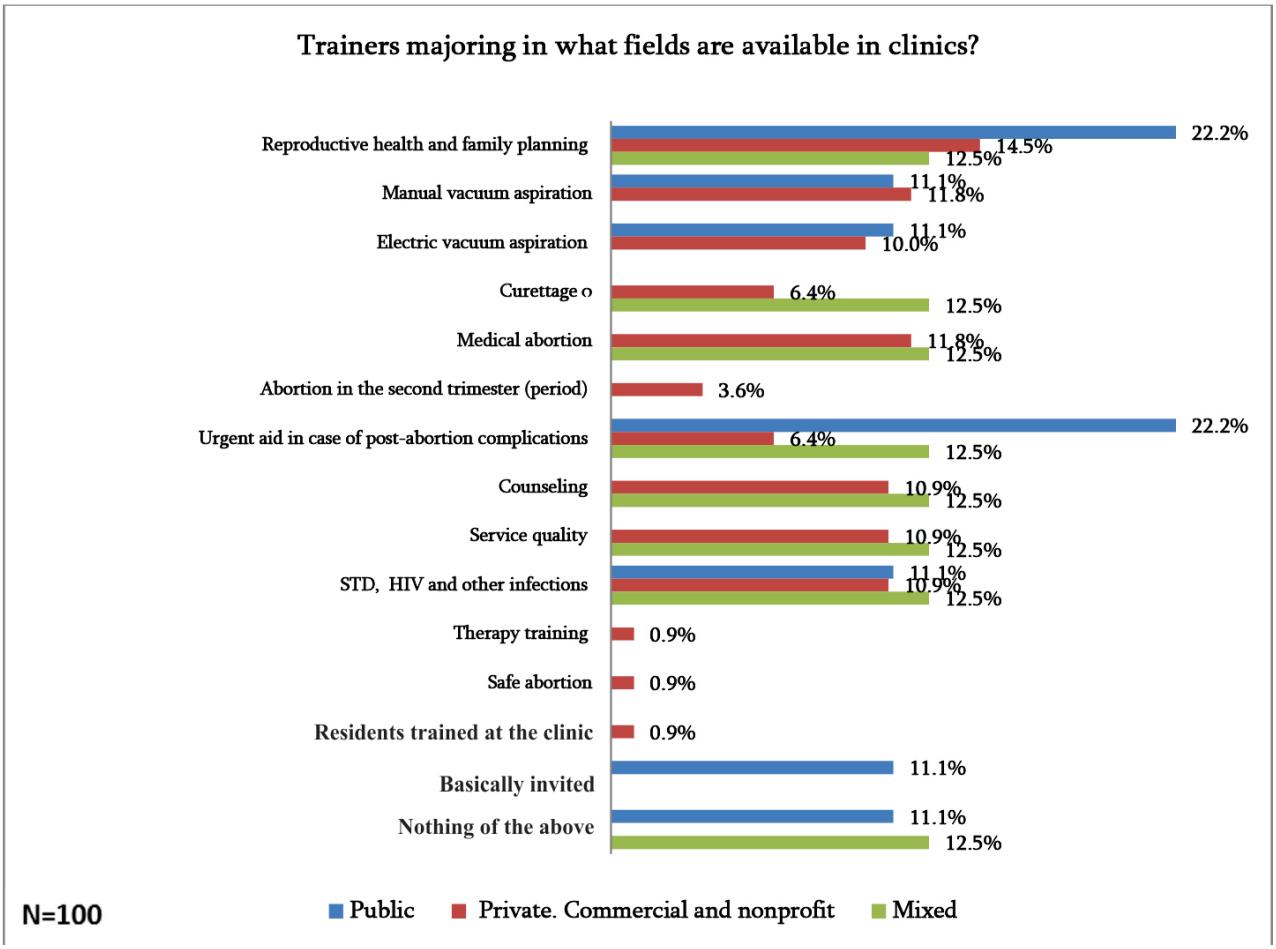
In the vast majority of the clinics (69%) training courses are not conducted on the clinic's basis, while the rest of the clinics have one or more (up to 10) different trainers (see Chart N27).

Chart N27



It should be noted that private clinics have all the above listed specialization trainers, the trainers specialized in relatively fewer fields are available in mixed clinics, while the smallest number of fields–the public clinics:

Chart N28



The facilities participated in the survey more or less have the necessary technical equipment for training:

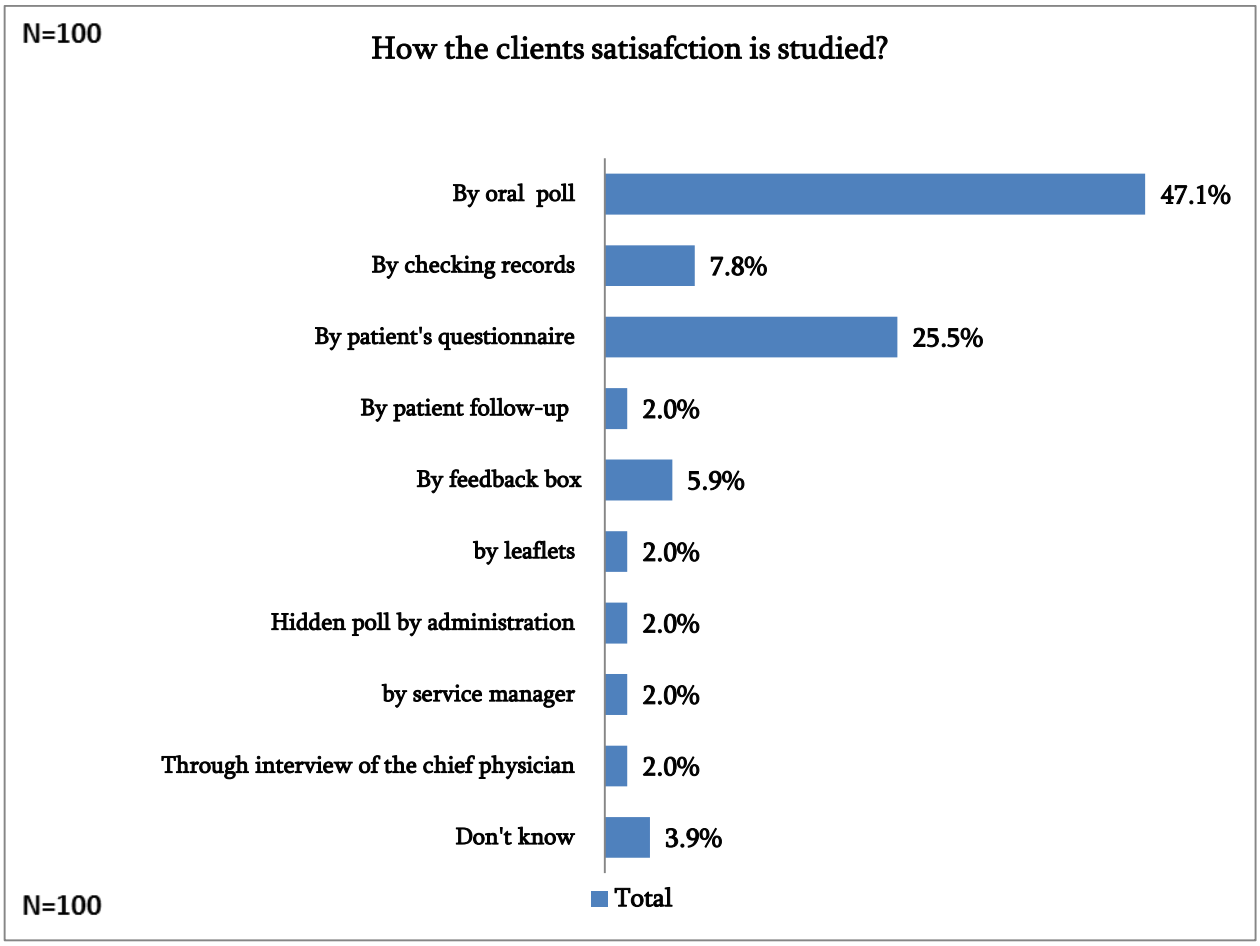
- training room (50% of the clinics)
- the computer and printer (86% of the clinics)
- projector (41% of the clinics)
- overhead (graphic) projector (25% of the clinics)
- Internet (85% of the clinics)
- copier (Xerox) (79% of the clinics)

Thus, a small part of clinics do not use any protocols and guidelines for abortion service delivery. An absolute majority of the medical staff do have access to academic articles and publications, however, a significant part of the clinics have not introduced the evaluation system, which will reveal the need for continuous education in abortion and family planning issues. There is no a sophisticated system of conducting training courses: most clinics do not have a written training plan on the topic of abortion, do not have trainers and do not have the appropriate facilities and equipment. The number of clinics where the continuing education mechanism is introduced is small.

2.5 Service Quality Control

The customer satisfaction is studied in the half of the clinics (51% of cases), by using the following means:

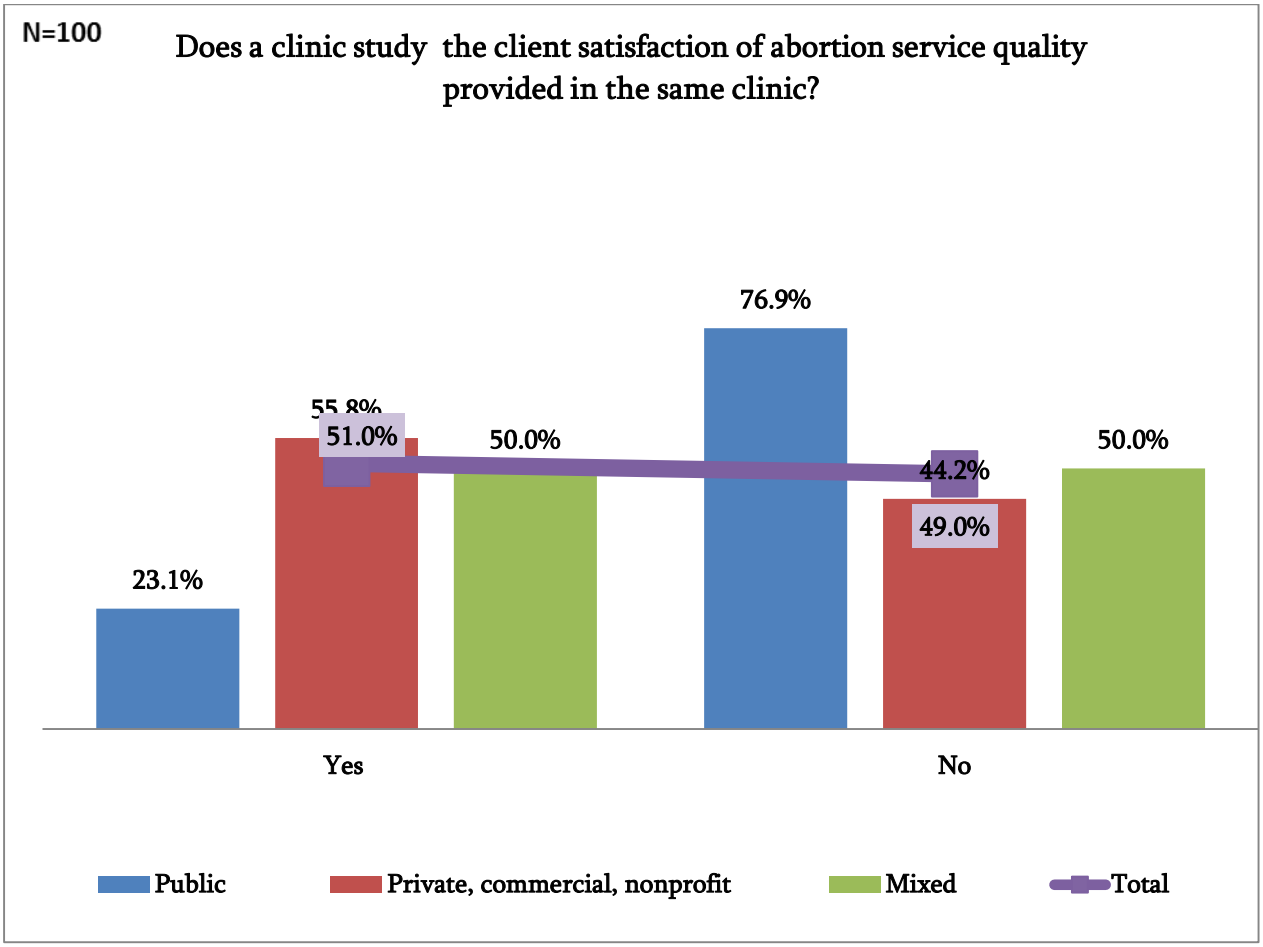
Chart N29



Thus, the results show that customer satisfaction is most commonly studied by oral poll, while the safe pregnancy termination protocol provides for the audit questions, which makes it possible to check the provider and the quality of service.

Noteworthy is that among the private clinics a number of clinics which are studying customer satisfaction is more than among the public clinics (see Chart N30).

Chart N30

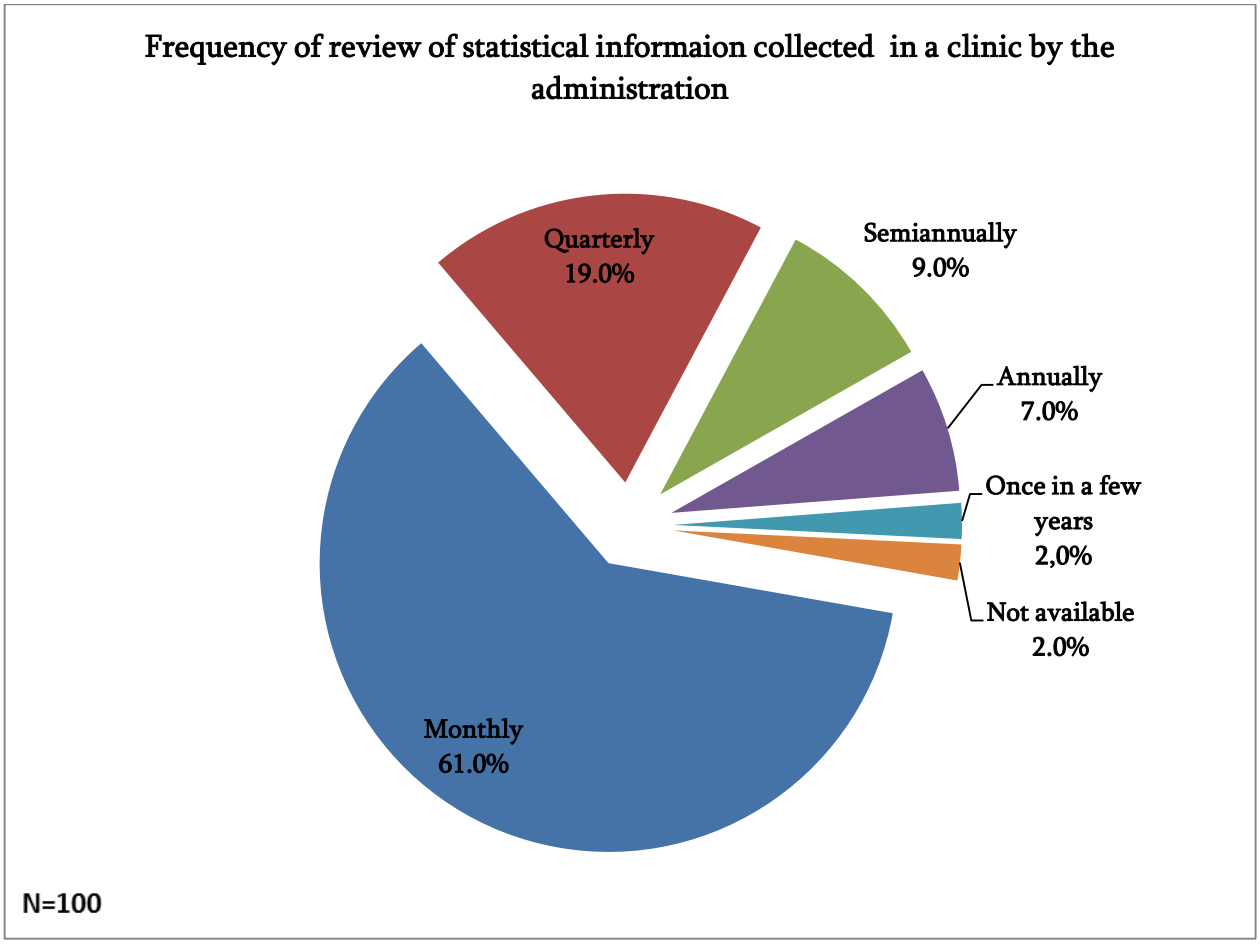


In the majority of the health facilities (88.2%), where the customer satisfaction is studied, it is sufficiently to improve the service based on the information collected, and in a small part (2 clinics) the service improvement becomes insufficient. Only in four clinics, which are 7.4% of the total clinics which are studying customer satisfaction, the service improvement does not take place based on the data obtained.

In the vast majority of the clinics (81%) the collected statistical information is processed monthly, while in 16% - annually. In a small part of private clinics (3% - 3 clinics) the statistical information is not processed. In case such information is absent, it is impossible to develop the effective ways of service improvement. However, statistical information collection/processing are not mandatory for clinics.

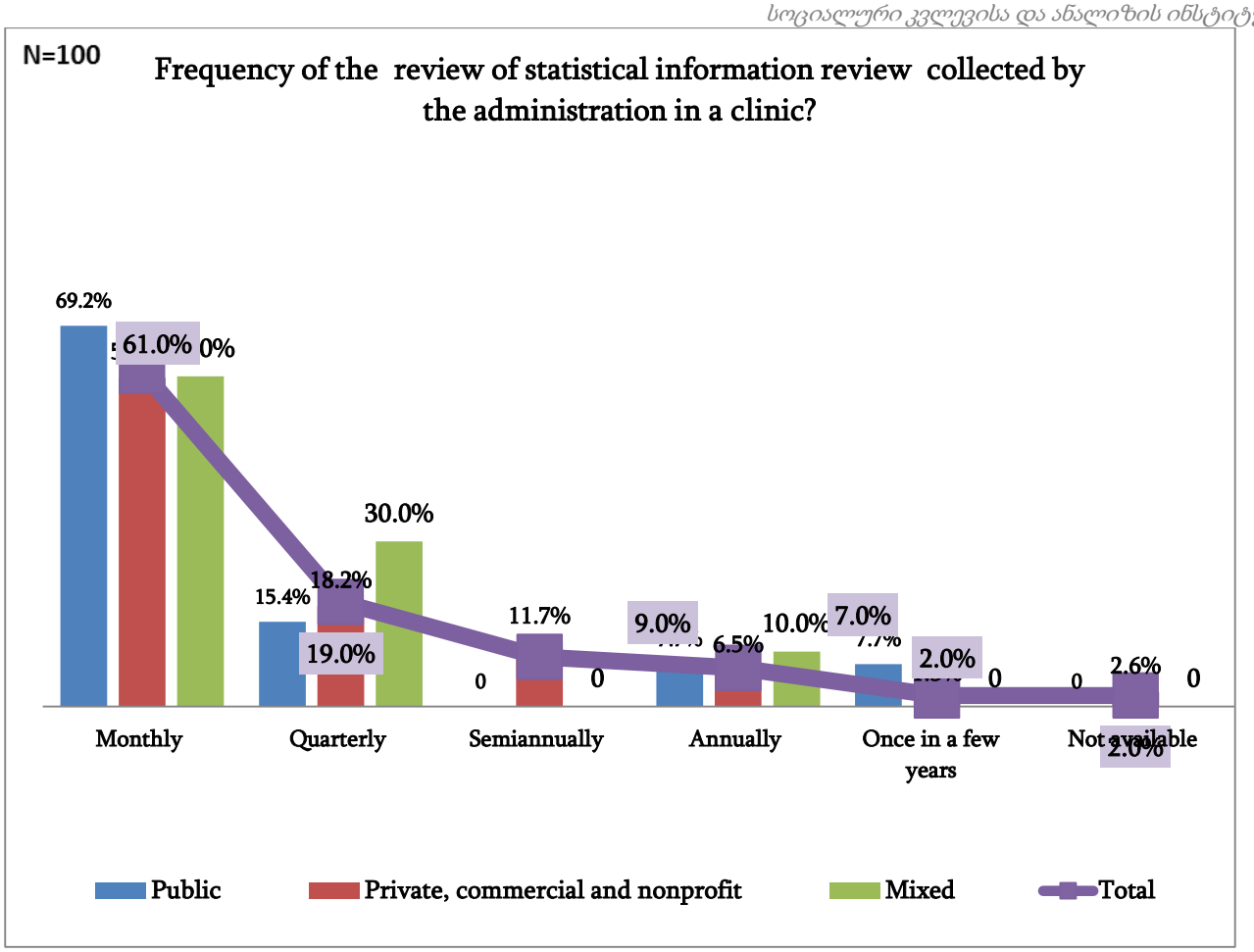
In 98% of clinics the administration reviews the collected statistical information. This practice does not exist only in two private clinics (2%). Most of the clinics (61% - 61 clinics) which review the collected statistical information on a monthly basis, a fifth of clinics (19% - 19 clinics) – on a quarterly basis. A small part of the clinics review this information twice a year (9% -9 clinics), each year (7% - 7 clinics) or once in a few years (2% - 2 clinics) (see Chart N 31).

Chart N31



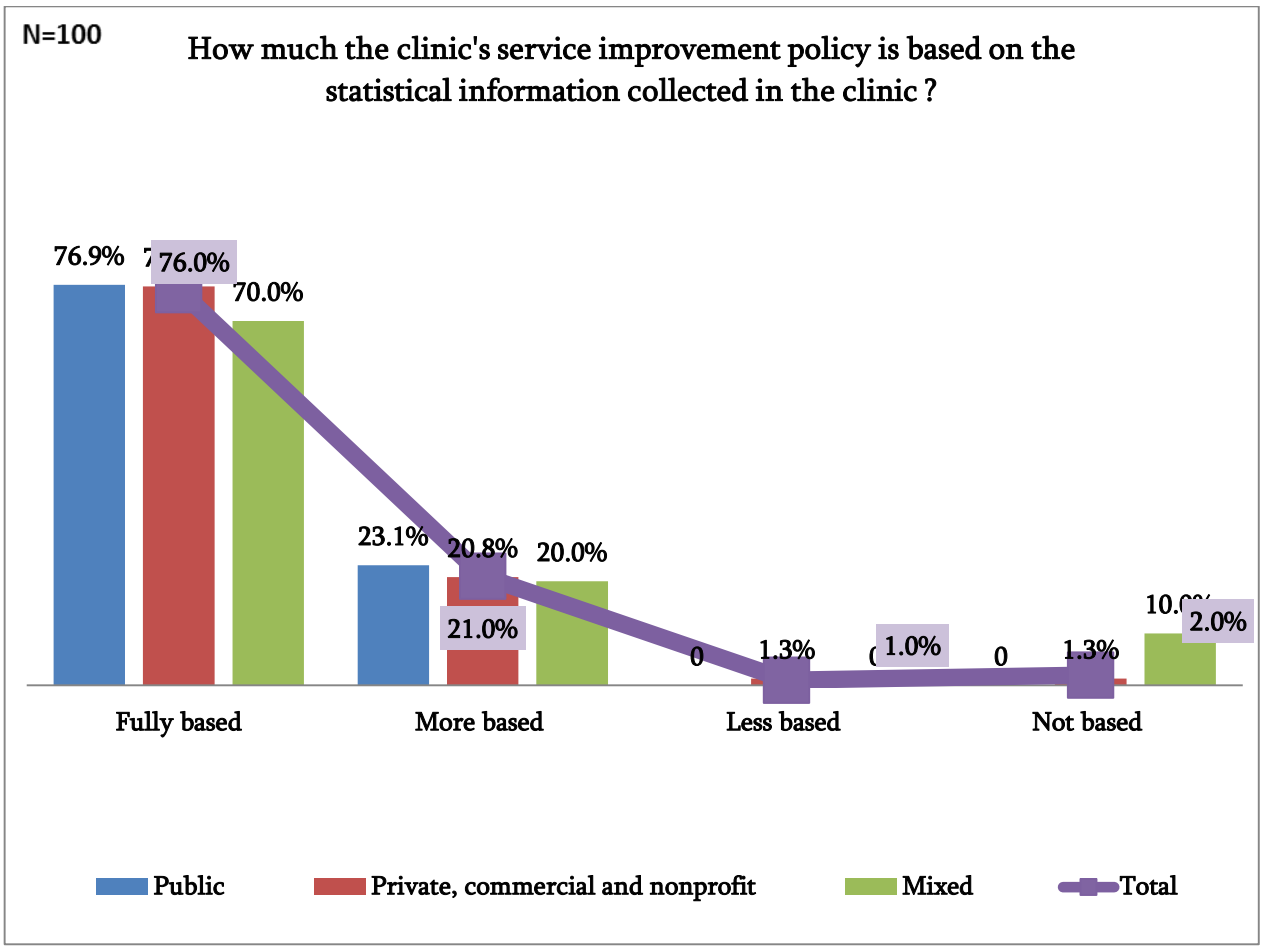
It is important that in public clinics the review of statistical information by the administration is more frequent , rather than in mixed or private clinics (see Chart N32).

Chart N32



In the vast majority of the clinics (76% - 76 clinics) the clinic's service improvement policy is based on the collected statistical information, in a fifth (21% - 21 clinics) is more based, than not. Only in 2% of the clinics (2 clinics) the collected statistical information is not used for service improvement (see Chart N33).

Chart N33



Thus, in the majority of clinics the statistical information is collected, but the service control mechanism is rather incomplete. In a half of the clinics the customer satisfaction is not studied at all, while in the rest of the clinics the oral customer survey method prevails. Even when the relevant information is available, in a small part of the clinics the service improvement is not based on the available statistical information. .

ANNEXES

Annex 1

List of clinics involved in the survey

Region	City	Health facility	Actual address	Type of facility
Tbilisi	Tbilisi	LEPL Tbilisi State University Alexandre Aladashvili University Clinic	4 Gudamakari Street	Inpatient
Tbilisi	Tbilisi	Embryo Ltd.	N2/6 Ljubljana street	Inpatient
Tbilisi	Tbilisi	Academician O. Gudushauri National Medical Center Ltd.	8/20 Ljubljana street	Inpatient
Tbilisi	Tbilisi	Reproductive Medicine Center Universe" Ltd.	2/6 Ljubljana street (plot 009/013),	Inpatient
Tbilisi	Tbilisi	Davit Gagua Clinic Ltd.	2/6 Ljubljana street	Inpatient
Tbilisi	Tbilisi	Academician Vakhtang Bochorishvili Clinic "Sepsis" Ltd.	16 Al. Kazbegi Street	Inpatient
Tbilisi	Tbilisi	Medical Center "Neoclinic" Ltd.	10a Bakhtrioni street (57 Ikalto street)	Outpatient
Tbilisi	Tbilisi	JSC Chachava Clinic	38 Kostava street	Inpatient
Tbilisi	Tbilisi	Medicore Ltd.	16 Kavtaradze street	Outpatient
Tbilisi	Tbilisi	VarketiliMedicalCenter Ltd.	Varketili–3, 1 m/d, Bldg. 33	Outpatient
Tbilisi	Tbilisi	Maternity Welfare Clinic N11 Ltd.	10Saburtalo street	Outpatient
Tbilisi	Tbilisi	Medical-Prophylactic Center N 4 Ltd.	Varketili3, 1 m/d, Bldg. 16a	Outpatient
Tbilisi	Tbilisi	Jamrteloba 2015 Ltd.	Varketili 3, 4 m/d, in the vicinity of building 419	Outpatient
Tbilisi	Tbilisi	Tamila Sekhiashvili Medical-Prophylactic Center "Dada"	Mukhiani, I m/d, Bldg. 2	Outpatient
Tbilisi	Tbilisi	Reproductive Medicine Center "Universe" Ltd.	Vazha Pshavela Avenue, Block 6, Bldg. 1b	Outpatient
Tbilisi	Tbilisi	Medical and Recreational Center Anatropous Ltd.	9 Navtlugi Dead Alley	Outpatient
Tbilisi	Tbilisi	Maternity Welfare Clinic N6 Ltd.	93 Khizanishvili street, Gldani	Outpatient
Tbilisi	Tbilisi	Medelana Ltd.	8/12 Sevan street	Outpatient
Tbilisi	Tbilisi	Imedi Clinic Ltd.	10a Mirian King Street	Inpatient
Tbilisi	Tbilisi	Hera 2011 Ltd.	5 Ljubljana street	Inpatient
Tbilisi	Tbilisi	Maternity Welfare Clinic "Momavali" Ltd.	11Tevdore Mgvdeli street	Outpatient
Tbilisi	Tbilisi	Medical Center "Ester" Ltd.	10 Pushkin street	Outpatient
Tbilisi	Tbilisi	Mkurnali 2002 Ltd.	87 Tsotne Dadiani street	Outpatient
Tbilisi	Tbilisi	Medservice Ltd.	2 Buachidze street	Outpatient
Tbilisi	Tbilisi	Maternity Welfare Clinic N1 Ltd.	3 Tornike Eristavi street	Outpatient

Region	City	Health facility	Actual address	Type of facility
Tbilisi	Tbilisi	Tbilisi Medical and Prophylactic Center N 3 Ltd.	7 Z. Chavchavadze street	Outpatient
Tbilisi	Tbilisi	Maternity Welfare Center "Ganymede" Ltd.	10 Khudadov street	Outpatient
Tbilisi	Tbilisi	"Healthy Family" Ltd.	Varketili, 3rd Housing Estate, Block I, bldg. "D"	Outpatient
Tbilisi	Tbilisi	MEDISON Ltd.	83/11 Vazha Pshavela Avenue	Outpatient
Tbilisi	Tbilisi	Aesculapius Ltd.	83 Vazha Pshavela Avenue	Outpatient
Tbilisi	Tbilisi	Medical-Prophylactic Center "Intermed" Ltd.	4 Bakradze street	Outpatient
Tbilisi	Tbilisi	Mother Aid Obstetric and Gynecological Department Ltd.	93 a Khizanishvili street	Outpatient
Tbilisi	Tbilisi	Bayebi Ltd.	10 Kalandadze street, plot 01/044	Inpatient
Tbilisi	Tbilisi	RED Ltd.	84 Guramishvili avenue	Inpatient
Tbilisi	Tbilisi	Clinic Newmed Ltd.	4 Marijani street	Outpatient
Tbilisi	Tbilisi	Medical and Prophylactic Center N 8 Ltd.	13 Shiraki street	Outpatient
Tbilisi	Tbilisi	NELP Association of Georgia and Auvergne Solidarity	6 Bogdan Khmelnitsky street	Outpatient
Tbilisi	Tbilisi	Medcapital Ltd.	18Ilia Vekua Street	Inpatient
Tbilisi	Tbilisi	Lancet Ltd.	12th km DavitAgmashenebeliAlley (plot 14/470)	Inpatient
Ajara	Batumi	Iris Bochorishvili Health Center "Medina" Ltd.	237Fridon Khalvashi Avenue	Inpatient
Ajara	Batumi	Batumi Inpatient Clinic N1	2 Tbel Abuseridze street	Outpatient
Ajara	Batumi	Khelvachauri Medical Center Ltd.	3 7th Fridon Khalvashi avenue	Outpatient
Ajara	Batumi	Company Paracelsus Ltd.	141 Pushkin street	Outpatient
Ajara	Batumi	Batumi Maternity Hospital Ltd.	3-39 26th MAy and Rustaveli street	Inpatient
Ajara	Batumi	Batumi Republican Clinical Hospital Ltd.	2 Tbel Abuseridze street	Inpatient
Guria	Lanchkhuti	Regional Health Center Ltd.	21 Chanturia street	Inpatient
Guria	Ozurgeti	Medalfa Ltd.	3 E. Ninoshvili street	Inpatient
Guria	Chokhatauri	RegionalHealthCenter Ltd.	22 N. Dumbadze street	Inpatient
Imereti	Baghdadi	Imedi Ltd.	6a Tsereteli street	Outpatient
Imereti	Zestafoni	Clinic Elite Ltd.	Aslanikashvili Embankment	Inpatient
Imereti	Samtredia	Ind. entrepreneur Marina Buadze	64 Republic street	Outpatient
Imereti	Samtredia	Ind. Entrepreneur Khatuna Khuchua	1 Pagava street	Outpatient
Imereti	Kutaisi	Kutaisi New Maternity Hospital N2 Ltd.	13 Lortkipanidze street	Outpatient
Imereti	Kutaisi	Academician Z. Tskhakaya Western Georgia Intervention Medicine National CenterLtd.	83a Javakhishvili street	Inpatient
Imereti	Kutaisi	Kutaisi Maternity Hospital N 3 Ltd.	11 Javakhishvili street	Inpatient
Imereti	Kutaisi	Leri Khonelidze Clinic Ltd.	11 Lortkipanidze street	Inpatient

Region	City	Health facility	Actual address	Type of facility
Imereti	Tskaltubo	Medical-Diagnostic Center Ltd.	13/18 G. Tabidze street , new – 26 26th May street	Outpatient
Imereti	Khoni	Ind. entrepreneur Teimuraz Moseshvili	7 Solomon II street	Outpatient
Kakheti	Gurjaani	Geo Hospitals Ltd.	35 Marjanishvili street	Inpatient
Kakheti	Telavi	Sikharuli Ltd.	4 Aladashvili street	Inpatient
Kakheti	Lagodekhi	Archimedes Clinic Ltd.	9th April street	Inpatient
Kakheti	Sagarejo	Geo Hospitals Ltd.	13 Kakheti Highway	Inpatient
Kakheti	Sagarejo	Clinic LIFE Ltd.	3a I. Chavchavadze street	Inpatient
Kakheti	Sighnaghi	Hera_ Ltd.	1st Davit Agmashenebeli lane, village Sakobo	Inpatient
Samegrelo-Zemo Svaneti	Zugdidi	Life Ltd.	69 M. Baramia street, village Chitatskaro	Inpatient
Samegrelo-Zemo Svaneti	Senaki	Senaki Maternity Hospital Ltd.	108 Rustaveli street	Inpatient
Samegrelo-Zemo Svaneti	Senaki	Medical-Diagnostic Center Aesculapius Ltd.	1 Chkondideli street	Outpatient
Samegrelo-Zemo Svaneti	Poti	Medea Tsagareli Obstetrics-Gynecological Center Ltd.	49 Agmashenebeli street	Outpatient
Samegrelo-Zemo Svaneti	Poti	Poti United Maternity Hospital Ltd.	23 Mikaberidze street	Inpatient
Samegrelo-Zemo Svaneti	Tsalenjikha	Jvari Hospital Engurhes Ltd. "	17 Stalin street, village Jvari	Inpatient
Racha-Lechkhumi and Kveda Svaneti	Ambrolauri	RegionalHealthCenter Ltd.	11 Bratislava-Racha street	Inpatient
Racha-Lechkhumi and Kveda Svaneti	Tsageri	Regional Health Center Ltd.	31 Rustaveli street	Inpatient
Samtkhe-Javakheti	Aspindza	Regional Health Center Ltd.	75 Vardzia street	Inpatient
Samtkhe-Javakheti	Akhalkalaki	JSC Medical Corporation Evex	31 Davit Agmashenebeli street	Inpatient
Samtkhe-Javakheti	Ninotsminda	JSC Medical Corporation Evex	48 Freedom street	Inpatient
Kvemo Kartli	Bolnisi	New Medical Center Ltd.	25 Davit Agmashenebeli street	Inpatient
Kvemo Kartli	Bolnisi	Bolnisi Maternity Hospital Ltd.	25 Davit Agmashenebeli street	Inpatient
Kvemo Kartli	Dmanisi	New Medical Center Ltd.	37 St. Nino street	Inpatient
Kvemo Kartli	Marneuli	Geo Hospital Ltd.	112 Rustaveli street	Inpatient
Kvemo Kartli	Marneuli	Aversi Clinic Ltd.	26th May street	Outpatient
Kvemo Kartli	Rustavi	Rustavi Maternity Hospital Ltd.	3 St. Nino street	Inpatient
Kvemo Kartli	Rustavi	Georgian Steel Medical Center Ltd.	12 Gagarin street	Inpatient
Kvemo Kartli	Rustavi	Aversi Clinic Ltd.	3 a Meskhishvili street	Outpatient
Kvemo Kartli	Rustavi	Clinic Rustavi Ltd.	Microdistrict VII	Inpatient
Kvemo Kartli	Tsalka	Regional Health Center Ltd.	4 Ekvtime Takaishvili street	Inpatient
Shida Kartli	Gori	Jumber Gogiashvili Ltd.	14 Tskhinvali highway	Inpatient
Shida Kartli	Gori	Imedi and Mariam Ltd.	17a Shindisi Highway	Inpatient

Region	City	Health facility	Actual address	Type of facility
Shida Kartli	Gori	JSC Iavnana	105 Chavchavadze street	Inpatient
Shida Kartli	Kaspi	Medalfa Ltd.	27b Saakadze street	Outpatient
Shida Kartli	Kaspi	Marimedi Ltd.	10 Saakadze street	Outpatient
Shida Kartli	Kaspi	Ginika + Ltd.	4 Tsulukidze street	Inpatient
Shida Kartli	Kareli	Regional Health Center Ltd.	30 Zaza Panaskerteli street	Inpatient
Shida Kartli	Kareli	Dastakari Ltd.	4 Rustaveli street	Inpatient
Shida Kartli	Khashuri	Life 2012 Ltd.	10a-44 Leselidze street	Outpatient
Shida Kartli	Khashuri	Alliance Med Service Ltd.	40 Shota Rustaveli street	Inpatient
Shida Kartli	Khashuri	Women's Clinic Ltd.	116(108) Saakadze street	Outpatient
Mtskheta-Mtianeti	Dusheti	Geo Hospital Ltd.	71 Stalin street	Inpatient
Mtskheta-Mtianeti	Tianeti	RegionalHealth Center Ltd	75 Rustaveli street	Inpatient
Mtskheta-Mtianeti	Mtskheta	Geo Hospital Ltd.	5 Gvinjilia street	Inpatient
Mtskheta-Mtianeti	Kazbegi	Regional Health Center Ltd	35 Kazbegi street, village Stepantsminda, Kazbegi region	Inpatient

Annex 2

Focus Group Guideline

Institute of Social Studies and Analysis

Abortion Service Availability and Readiness Assessment

Focus Group Guideline for Women of Fertility Age

Hello! I am _____, from the Institute of Social Studies and Analysis. ON behalf of the association "Hera XXI" we are conducting the survey, which aims at assessment of the safe abortion methods and women's access to reproductive health and evaluation and monitoring of the quality and use of the safe abortion and family planning services and practices.

For implementation of the purposes, it is intended to survey the health facilities that perform abortion procedures. Before conducting the survey, to develop an adequate questionnaire, we have planned to organize focus groups, on the basis of we will determine the essential characteristics of the problem to be subsequently provided when making the questionnaire.

A focus group is confidential. The discussion will be recorded on anaudio and video tape only in order to decode our conversation (to remember the information that you have provided). Accordingly these records will be kept only by the Institute of Social Studies and Analysis and by the customer. If your words will be used anywhere, it will be in writing in form of 1-2 sentences and without mentioning the name and other data of the author. If you agree, then let's start the discussion.

I will ask questions to discuss and please answer frankly to each of them.

1. Please introduce yourself –what is your given name (if you like, you can not give your surname), age, Have you ever used the family planning services? How many times have you used abortion services? When have you used it first and when last (year, month)? How old were you during the first abortion?
2. What was your main reason for the abortion decision-making (for example, economic problems, family pressure, the absence of marriage, etc.)?
3. Was your spouse/partner involved in the decision-making process? To what extent was he involved? In general, are you solving together such issues as family planning, contraception methods (self-protection) and so forth?

4. How many weeks pregnant were you when you refer to the abortion service?
5. In which clinic have you used these services? Have you used the services in illegal (*moderator: Explain what you mean as illegal, it is desirable not to mention this word*) clinics? If yes, what were the reasons?
6. In general, do you know, how many clinics there are in your place of residence (city, village), which offer these services to women? If you can, list them.
7. Are you satisfied with the clinic's infrastructure - water supply, electricity, cleanliness, toilet, heating/cooling, which you have used?
8. Are you satisfied with the procedure administration –where there lines, did you need additional documents, were there any other types of obstacles and complications?
9. Was the abortion procedure affordable for you? Was the clinic or the staff available for you?
10. Did you get the first advice service (*moderator: Explain to the participants what does this service mean*)? If you did, where the first advice was provided? How many people attended this conversation? Did you feel safe, anonymously, whether the confidentiality was kept? Was the doctor considerate, supportive? Di he or she inquire in your history? Did he or she talk to you about the abortion, the various methods of abortion? Did he or she tell you which one is best for you? Did the doctor talk to you about complications (*moderator: complications are uterine rupture, bleeding, cervical injury, death, infectious complications*)? Did they tell you that if you wish to, you can postpone or cancel the abortion? If you received the first advice service, did they provide you with written information about abortion?
11. If you discussed these topics, who carried out the consultation - an obstetrician, gynecologist, midwife, nurse, sanitarian, or other? What do you think, was the doctor helpful to make an informed choice?
12. Was your health examined comprehensively (*moderator: pelvic examination bimanual and speculum examination*)? Have you undergone a general examination? Have you undergone the laboratory test? Have they examined the signs of anemia (hemoglobin or hematocrit) or whether they took blood tests? Who carried out the listed above procedures?
13. How was your pregnancy term established –by the calendar method or ultrasound? Has there been ever a case when you considered that the pregnancy term was incorrectly calculated?
14. Have you had an experience when the doctor refused to perform an abortion, and to refer to other doctor or other facility? If yes, what was the reason? What did you do thereafter?
15. How many days after the consultation did you refer to the clinic for the abortion procedure?
16. If you have had an abortion since October 2014, have you passed the mandatory 5-day time of reflection or referred to another clinic before the expiration of this period?

17. Has there ever been a case when you changed your mind to have an abortion? What was the reason?
18. Let's pass to the abortion procedure. Have you had a pre-abortion ultrasound scan (echoscopy)?
19. Have they offered you analgesics or not? What type of analgesic use was used - local anesthesia, drugs (which drugs?) Or general anesthesia?
20. Please tell me who among you have done medical abortion (termination of pregnancy by drug taking (orally, vaginally, injection, etc.)? If you have done medical abortion, please remember what medicines have you taken and in what form (e.g.: oral, vaginal or sublingual). What was the quantity of drugs? Do you remember the exact dose and how many days did you take drugs? Where did you take the drugs - in the clinic or at home? Did you have any kind of side effects and complications (e.g. complications: bleeding, strong bleeding, pain, fever, nausea, diarrhea, headache, weakness, dizziness, infection)? Has there been a case, when the incomplete abortion or progressive pregnancy has occurred after taking drugs? If yes, how have you act in such cases, contacted your doctor or waited for symptoms reduction? If you have contacted your doctor, what has he or she recommended to you?
21. If you have done a surgical abortion, by what method - manual vacuum aspiration, electric vacuum aspiration, dilatation and curettage or dilatation and evacuation *(moderator: Explain the meaning of each of them*)? In case of surgical abortion, whether antibiotics were prescribed before or after the procedure? Have you had any kind of side effect or complication? Have there been ant case cases when you have faced an incomplete abortion or progressing pregnancy? If yes, how did you act in such cases, what did the doctor recommended to you?
22. If you have had a surgical abortion, whether there was adequate disinfection and sterilization in the clinic? If the physician was wearing sterile gloves, veil, medical uniform, protective goggles, shoe wrappers (moderator: sterile overshoes), etc.? Was the procedure carried out with sterile tools? Was a clinic equipped with resuscitation equipment in case of complications?
23. If you have had a second trimester (12 weeks) abortion, have you stayed in the hospital for 24 hours?
24. Whether the analgesic have been available to you anytime you wanted it? Have there been any cases when you asked for analgesic and the clinic has not provided it?
25. After the abortion, did the clinic offer psychological support? If they told you, how to take care of yourself and in what case should you refer to the health facility again? If they offered to plan a next visit in 7-14 days?
26. Whether you have had available in the clinic such the informational material about abortion methods and post-abortion contraception, as printed materials about abortion, audio-visual materials, pelvic anatomical model for a demonstration and other?

27. Have you visited the clinic for the second time? If yes, what the procedures have you undergone through the second visit?
28. What was the method of payment in the clinic? Did you pay in advance (before the procedure) or after the procedure?
29. If they have provided to you the consultation about the methods of contraception in the clinic?
30. What type of contraception do you use now (*moderator: explain the contraception as a means of self-protection*)? What type of contraception did you use before the counseling and/or abortion? Are you satisfied with the method of contraception? If you have changed the method of contraception, for what reason?
31. In addition to the above mentioned problems, what other problems have you encountered during the abortion procedure, before or after the procedure? In your opinion, what defects there are in Georgia with regard to abortion and how they should be eliminated?
32. In addition to your own experience, can you talk about the experiences of your acquaintances? How women solve these kinds of problems in your area of residence? Where and how they undergo an abortion procedure, what problems they encounter within the procedure, etc.
33. Have you passed any training on this issue? Have you ever been at an informative meeting? If yes, what they have discussed at the meeting?

Thank you for the interesting discussion!

Annex 3

Quantities survey questionnaire

Institute of Social Studies and Analysis

Abortion Service Availability Survey

Interviewer N. _____

Point of selection _____

City N. _____

City _____

Region N. _____

Region _____

Facility actual address cadastral code:

_____

Health facility:

_____

Facility address

_____

Facility telephone

_____

Respondent's given name, surname
(in case of her desire)

_____

Respondent's adders and telephone
(in case of her desire)

_____

Questionnaire for health facilities

Welcome, I am _____, the interviewer for the Institute of Social Studies and Analysis. The poll is held on the theme "Abortion Service Availability" on behalf of the Association "Hera XXI". The objectives of the survey are to assess the safe abortion methods and women's access to reproductive health and evaluation and monitoring of the quality and use of the safe abortion and family planning services and practices.

The interview data is confidential and will only be used in the generalized form for statistical purposes. Please be generous and sincerely respond to the questions.

Thank you for your cooperation.

2015

A. General information about a clinic

A1. Type of clinic

1. An inpatient health facility, which holds a permit for medical activity "Gynecology"
2. A health facility that performs medical activities "Gynecology" in the outpatient/day-hospital conditions.

A2. Organizational status:

1. Public
2. Private, commercial
3. Privet, nonprofit
4. Mixed

Other *(please specify)* _____

A3. Source of funding

1. State budget
2. Self-financing
3. Sponsor
4. Mixed

Other *(please specify)* _____

A4. Clinic 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 and more years

Other *(please specify)* _____

99. Don't know

A5. Is there a 24-hours emergency aid in the clinic

1. Yes
2. No

A6. Has the clinic cooperated/cooperate with donors?

1. Currently cooperates
2. Cooperated in the past
3. Neither cooperates nor cooperated

B. Clinic's infrastructure

B1. How much time has passed since the last renovation (repair) of the building?

1. Leas 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 and more years

Other *(please specify)* _____

99. Don't know

B2. Which power source supplies electricity to the facility?

1. Main source
2. Backup source

Other *(please specify)* _____

B3. During 1 last month, how often was the electricity available in the facility's working hours?

1. Always available, the electricity was not interrupted
2. Only 1-2 times interrupted in the last 1 month
3. Almost once a week interrupted in the last 1 month
4. A few times a week interrupted in the last 1 month
5. Almost every day interrupted in the last 1 month (for 2-3 hours daily)
6. Almost every day interrupted in the last 1 month (more than 2-3 hours daily)

Other *(please specify)* _____

B4. Which source supplies water to the facility?

1. Main source
2. Backup source ***(go to question B6)***

Other *(please specify)*_____

B5. What is the quality of the clinic running water?

1. Good quality
2. Poor quality (have an unpleasant odor, color, taste, with particles)

B6. What are water supply intervals in the health facility?

1. Permanently
2. 12-20 hours daily
3. 7-12 hours daily
4. 4-6 hours daily
5. 1-3 hours daily
6. Once in 2 two days
7. Once in 3 days
8. Once a week

Other *(please specify)*_____

B7. Is a proper temperate control – heating provided in a health facility?		**1. Yes**			**2. No**
		1.1. Always	1.2. Sometimes	1.3. Rarely	
B7.1.	In wards	1.1	1.2	1.3	2
B7.2.	In doctor's offices	1.1	1.2	1.3	2
B7.3.	In administrating offices	1.1	1.2	1.3	2
B7.4.	In corridors	1.1	1.2	1.3	2

B8. What kind of heating is there?

1. Central heating (gas)
2. Central heating (electricity)
3. Individual heaters
4. Individual gas heaters
5. Wood/diesel stove

Other *(please specify)*_____

B9 Is a proper temperate control – cooling provided in a health facility?		**1. Yes**			**2. No**
		1.1. Always	1.2. Sometimes	1.3. Rarely	
B9.1.	In wards	1.1	1.2	1.3	2
B9.2.	In doctor's offices	1.1	1.2	1.3	2
B9.3.	In administration offices	1.1	1.2	1.3	2
B9.4.	In corridors	1.1	1.2	1.3	2

B10. Is there a lavatory in the functional condition that is accessible for general outpatients in the facility?

1. Yes
2. No

B11. If yes, what type of lavatory is it?

(please mark all types of toilet available in the facility)

1. Toilet with automatic or manual flush
2. Ventilated pit latrine
3. Pit latrine with slab
4. Pit latrine without slab
5. Composting toilet

Other *(please specify)* _____

C. General information about abort services

C1. What structural units are available in the clinic		1. Yes	2. No
C1.1.	Outpatient department	1	2
C1.2.	Maternity unit	1	2
C1.3.	Gynecological department	1	2
C1.4.	Abortion unit	1	2
C1.5.	Surgery department	1	2
C1.6.	Specialized rooms (e.g. gynecological)	1	2
Other *(please specify)*		1	2

C2. In which of the listed below premises the abortion service is provided to a client? *(Multiple answers allowed)?*

1. Outpatient department
2. Maternity unit
3. Gynecology department
4. Abortion unit
5. Surgery department
6. Specialized rooms (e.g. the gynecology room)

Other *(please specify)* _____

C3. The type and number of staff employed in the department of the clinic, where, as a rule, the abortion is made		**Number**
C3.1	Obstetrician-gynecologist	
C3.2	Generalist	
C3.3	Pediatrician	
C3.4	STD and skin specialist	
C3.5	Endocrinologist	
C3.6	Urologist	
C3.7	Midwife	
C3.8	Nurse	
C3.9	Hospital attendant	
C3.10	Sexopathologist	
C3.11	Laboratory doctor	
C3.12	Sexologist	
C3.13	Fertility specialist	
C3.14	Embryologist	
C3.15	Mammalogist	
Other *(please specify)*		

C4. Who of the listed above medical staff provides the following services? (Insert appropriate number according tom the listed services)		1. gynecologist	2. fertility specialist	3. midwife	4. Nurse	5. endocrinologist	6. Generalist	7. Laboratory assistant	Other (please specify)
C4.1.	Pre-abortion consultation	1	2	3	4	5	6	7	
C4.2.	Post-abortion consultation	1	2	3	4	5	6	7	
C4.3.	General examination	1	2	3	4	5	6	7	
C4.4.	Gynecological examination	1	2	3	4	5	6	7	
C4.5.	Laboratory tests	1	2	3	4	5	6	7	
C4.6.	Abortion procedure	1	2	3	4	5	6	7	
C4.7.	Post-abortion counseling of contraceptives	1	2	3	4	5	6	7	
C4.8.	Family planning service	1	2	3	4	5	6	7	

C5. Does a clinic deliver abortion services and post-abortion contraception:		1. Yes	2. No	88. N/A
C5.1.	To persons under 16 (in presence of the mother)	1	2	88
C5.2.	To persons aged 16-18	1	2	88
C5.3.	To venereal disease-infected women (e.g., HIV / AIDS)	1	2	88
C5.4.	To women infected with infectious diseases (e.g., Tuberculosis)	1	2	88
C5.5.	To women from other regions (within Georgia)	1	2	88
C5.6.	To vulnerable people	1	2	88
C5.8	To sex-workers	1	2	88

C6. Is there the order restricting to supply services to the following groups in the clinic?		1. Yes	2. No
C6.1.	To persons under 16 (in presence of the mother)	1	2

C6.2.	To persons aged 16-18	1	2
C6.3.	To venereal disease-infected women (e.g., HIV / AIDS)	1	2
C6.4.	To women infected with infectious diseases (e.g., Tuberculosis)	1	2
C6.5.	To women from other regions (within Georgia)	1	2
C6.7.	To vulnerables	1	2

C7. Which of abortion services are available at the clinic?		**1. Yes**	**2. No**
C7.1.	Pre-abortion consultation	1	2
C7.2.	Post-abortion consultation	1	2
C7.3.	Manual vacuum aspiration (the first trimester)	1	2
C7.4.	Electric vacuum aspiration (the first trimester)	1	2
C7.5.	Medical abortion (the first trimester)	1	2
C7.6.	Dilatation and curettage (the first trimester)	1	2
C7.7.	Second trimester abortion (in case of medical necessity)	1	2
C7.8.	Emergency aid in case of post-abortion complications	1	2
C7.9.	Referral to other clinics in case of post-abortion complications	1	2
C7.10.	Post-abortion consultation on contraception	1	2
C7.11.	Supply of contraceptives	1	2

C8. What abortion methods form the below listed are mainly used by women in the clinic? (Name no more than three most frequently used method)

1. Manual vacuum aspiration (the first trimester)
2. Electric vacuum aspiration (the first trimester)
3. Medical abortion (the first trimester)
4. Dilatation and curettage (first trimester)

Other (please specify) _____

C9. What family planning methods are available in the clinic		1. Yes	2. No
C9.1.	Intrauterine contraceptive device (IUCD)	1	2
C9.2.	Oral pills	1	2
C9.3.	Injectable contraceptives	1	2
C9.4.	Spermicides	1	2
C9.5.	Condoms	1	2
C9.6.	Emergency contraception	1	2
Other (please specify)		1	2

C10. Can a client (patient) choose a doctor or other medical staff in the clinic who will provide:		**1. Yes, always**	**2. Yes, sometimes**	**3. No**
C10.1.	Abortion service	1	2	3
C10.2.	Pre-abortion consultation	1	2	3
C10.3.	Post-abortion consultation	1	2	3

C11. What topics are covered with the interview during the pre-abortion consultation?		1. Yes	2. No
C11.1.	Women's reasons for abortion solution	1	2
C11.2.	That the woman shall not undergo an abortion	1	2
C11.3.	Rare complications of abortion	1	2
C11.4.	Various abortion methods, their advantages / disadvantages	1	2
C11.5.	Possible complications in the post-abortion period	1	2
C11.6.	Disadvantages of selective abortion	1	2
Other (please specify)		1	2

C12. Of the issues listed in question C11 which ones are provided to the client in writing?

*(write out answer number(s)*_____

D. Abortion affordability

D1. Taking into account the client's ability to pay and willingness to pay the fees, whether the clinic periodically reviews the abortion service fee?

1. Yes, once in 3-4 months
2. Yes, semiannually
3. Yes, annually
4. Once in a few years
5. No

99. Don't know

D2. In order to facilitate access to services, is there available in the clinic:		1. Yes	2. No
D2.1.	Abortion service discount system	1	2
D2.2.	Abortion service payment suitable (flexible) system	1	2
D2.3.	Other financial schemes, facilitating the affordability of service for insolvent clients	1	2

D3. Does the clinic take responsibility for the pricing and appropriate performance of payment procedures in the clinic, by abortion service providers (doctors)?

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

88. No

E2. Have the department doctors passed the training in the protocol practice in terms of implementation?

1. Yes
2. No

E3. Are there in the clinic		1. Yes	2. No
E3.1.	The plan of referral to hospitals from the clinic in case of emergency	1	2
E3.2.	Written instructions on referral to other hospitals of the clients who are infected with sexually transmitted diseases and HIV/AIDS?	1	2
E3.3.	Written instructions on the purpose and conduct of post-abortion visit	1	2

E4. Does the clinic receive the information about the patients referred to other clinics?

1. Yes, always
2. Yes, but not always
3. No

Other (please specify) _____

F. Post-abortion period

F1. How often the women are delivered in the post-abortion period:		Always	Often	Sometimes	Rarely	Never
F1.1.	Psychological support	1	2	3	4	5
F1.2.	STI research	1	2	3	4	5
F1.3.	STI treatment	1	2	3	4	5
F1.4.	Rhesus prophylaxis	1	2	3	4	5
F1.5.	HCG Monitoring	1	2	3	4	5
F1.6.	Prescribed one or another method of contraception	1	2	3	4	5
F1.7.	Delivered advice					

F2. Number of patients (%) who were delivered in the post-abortion period: In 2014-15		Note the approx. percentage
F2.1.	Psychological support	
F2.2.	STI research	
F2.3.	STI treatment	
F2.4.	Rhesus prophylaxis	
F2.5.	HCG Monitoring	
F2.6.	Prescribed one or another method of contraception	
F2.7.	Delivered advice	

G. Customer awareness and satisfaction; Services confidentiality

G1 What kind of information materials are available in the clinic for users about abortion methods and post-abortion contraception? (Multiple answers allowed)

1. Printed material about methods of abortion and its complications, as well as post-abortion contraception and the clients' rights
2. The audio-visual material about methods of abortion and its complications, as well as post-abortion contraception and the clients' rights
3. Pelvis anatomical model for demonstration

Other (please specify)_____

G2. Is there the system of registration of abortion service delivered to clients in the clinic?

1. Yes
2. No

G3. How confidential and not accessible to third persons (protected) is the abortion service registration system?

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

G4. Does the clinic have any mechanism or regulation, which provides for creation of a confidential environment for the abortion procedure to a client ?

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

G5. What kind of mechanism or regulation is it?

_____
_____
_____

G6. Do you providing to a client the information of where she should apply if her rights are violated?

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

G7. How and in what form do you provided this information?

_____

_____

_____

G8. Does the clinic study the customer satisfaction of the abortion services quality provided in the same clinic?

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

G9. In what for the customer satisfaction is studied?

_____

_____

G10. Does the clinic improve the abortion service based on information gathered on the customer satisfaction?

1. Yes, adequately
2. Yes, but not adequately
3. No

Other (please specify) _____

G11. In your opinion, does a woman make an informed decision on abortion?

1. Makes a completely informed decision
2. Makes more informed decision rather than uninformed
3. Makes more uninformed decision than informed
4. Makes uninformed decision

H. Medical staff

H1. Does the medical staff have access to information on:		1. Yes	2. No
H1.1.	Job description of the staff	1	2
H1.2.	Academic articles and publications on abortion and family planning	1	2

H2. Is there available the medical staff evaluation system that detects the staff's need for continuing education in abortion and family planning issues?

1. Yes
2. No *(go to question G4)*

H3. Does the evaluation system consider the following information?		1. Yes	2. No
H3.1.	On the staff performance evaluation, on abortion services and family planning	1	2
H3.2.	On the medical personnel requirements for the need for additional training courses on abortion and family planning	1	2
H3.3.	On the new clinical guidelines and protocols implementation	1	2
H3.4.	Introduction of new technologies in abortion and family planning	1	2

H4. Is there a plan of annual training courses in abortion and family planning issues in a clinic?

1. Yes
2. No

H5. By what financial resources the medical staff is educated?

1. Clinic's budget
2. Donor's aid
3. Staff's budget

Other sources *(please specify)*

_____

H6. Are the training courses held on the basis of the clinic?

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

H7. In what training courses are there experienced trainers in the clinic? (*Multiple answers allowed*)

1. Reproductive Health and Family Planning
2. Manual vacuum aspiration
3. Electric vacuum aspiration
4. Curettage
5. Medical abortion
6. Abortion in the second trimester (period)
7. Delivery of emergency aid in the case of post-abortion complications
8. Counseling
9. The quality of service
10. Sexually transmitted diseases, HIV- prevention and prevention of other infections

Other (Specify) _____

H8. Is there the necessary technical equipment for conducting the training in a clinic (with reference to the following instruments)?		**1. Yes**	**2. No**
H8.1.	Training room o		
H8.2.	Computer and printer		
H8.3.	Projector		
H8.4.	Overhead projector		
H8.5.	Internet		
H8.6.	Copier (Xerox)		

I. Statistical data of abortion service

(the information is filled in by the worker of a relevant department)

I1. Does the clinic process/analyze the collected statistical data?

1. Yes, on the monthly basis
2. Yes, on the annual basis
3. No

I2. How often the statistical information collected in the clinic is reviewed by the administration?

1. Monthly
2. Quarterly
3. Twice a year
4. Annually
5. Every few years

6. Not applicable

I3. How the clinic's service improvement policy rely on the statistical information collected in the clinic?

1. Completely relies
2. More relies than not
3. More doesn't rely than relies
4. Do not rely