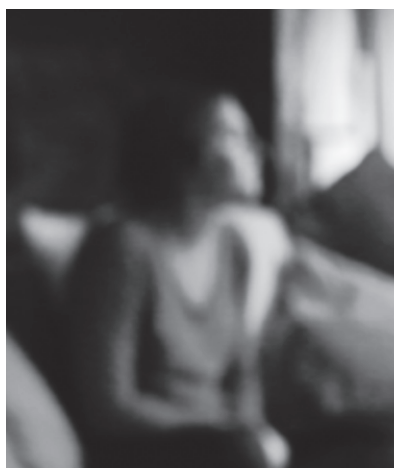


# BARRIERS TO ACCESSING SAFE ABORTION SERVICES FOR WOMEN OF REPRODUCTIVE AGE

Analytical Report

2019





# **Barriers to Accessing Safe Abortion Services for Women of Reproductive Age**



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The opinions expressed in this publication are those of the authors. They do not purport to reflect the opinions or views of the Swedish Association for Sexuality Education (RFSU) or the official policy or position of the Government of Sweden.

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## INTRODUCTION

According to the World Health Organization (WHO), the global annual rate of induced abortion for all women of reproductive age is 22 million. In spite of the fact that over the last five years, the trend of decrease in the number of induced abortions has been observed in Georgia, and the rate of induced abortions in the country stood at 24.9 thousand in 2017, the absolute majority of the abortion service recipients were women aged 20-44 years; and for the majority of these women induced abortion remains the primary method of birth control. Access to abortion service is one of the major factors ensuring women's rights. Barriers to the availability and provision of abortion services violate women's right to health, inviolability of private life, as well as their right not to be subjected to discrimination. As a result of studies conducted around the world various barriers to the availability and provision of safe abortion have been identified, such as system barriers, lack of awareness, long distance from a medical facility and limited clinic options, the problems of geographical availability and affordability (including non-availability of medical insurance), waiting period, etc. In case a combination of the abovementioned barriers, a cumulative effect may arise; for example, a lack of awareness may result in incorrect decisions with regard to artificial termination of a pregnancy, which, in its turn, may further deepen the problem of the lack of awareness and make access to abortion services worse.<sup>1</sup> The World Health Organization (WHO) recommends elimination of barriers to the availability and provision of abortion services unless they are medically required, which impede women's access to health services; they include the barriers such as compulsory waiting period, biased counselling, requirement for the permissions from third parties before performing abortion, a refusal to perform abortions based on religious beliefs.<sup>2</sup> International organizations call on states for adoption of measures to eliminate social and cultural factors that result in gender-biased selective abortion, and to provide abortion services while giving proper consideration to the needs and perspectives of women and girls, guaranteeing confidentiality and respecting their personal dignity, which should be part of broader efforts to protect the right of women to have access to legitimate sexual and reproductive health technologies and services.<sup>3</sup> The Public Defender of Georgia recommends elimination of barriers to the availability and provision of abortion services, together with introduction of the mechanisms monitoring pre-abortion counselling services and providing post-abortion contraception to women and girls of reproductive age.<sup>4</sup>

The barriers to accessibility to induced abortion necessitates due attention to be paid by the state. Besides, the existence of the above mentioned barriers and adverse consequences related to these barriers have significant negative effects on the reproductive health of the population, which is one of the key factors of the well-being of any society.

Therefore, within the frames of the qualitative survey carried out by the Association "Hera XXI", opinions and empirical experiences of women of reproductive age were analysed not only in the normative context, but also in the social, cultural and economic contexts.

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1 Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States. By Jenna Jerman Lori Frohwirth Megan L. Kavanaugh Nakeisha Blades. 10 April 2017

2 WHO, Safe abortion: technical and policy guidance for health systems Second edition, pp. 96-97, 2012

3 The UN interagency statement on Preventing gender-biased sex selection 2011; CEDAW GR 24

4 The Public Defender of Georgia, "Human rights in the context of sexual and reproductive health and well-being: Country Assessment, pp. 69, 2017

## SUMMARY

The survey was conducted by the Association “Hera XXI” within the frames of the programme “Civil Society Advocacy for Sexual and Reproductive Health and Rights” with the support of the Swedish Association for Sexuality Education (RFSU) and the Swedish International Development and Cooperation Agency.

The purpose of the survey was to identify barriers to accessing induced abortion services for women of reproductive age in Georgia. Based on the objectives of the survey, a qualitative survey method has been chosen. Using the technique of in-depth interviewing, real-life experiences, in the context of barriers to accessing safe induced abortion services, of women living in 7 regions of Georgia were studied and analysed. The regions covered by the survey are: Tbilisi, Kakheti, Guria, Samtskhe-Javakheti, Imereti, Samegrelo and Shida Kartli (in total 91 interviews were conducted), in July and August of 2018. The survey covers the experiences of the respondents in the context of induced abortions over the past decade.

**Reasons for abortion and decision-making.** During the survey the respondents identified general as well as personal reasons for abortion. According to the survey findings, both types of reasons are quite common, these reasons overlap one another and consist of interconnected and interrelated factors; the most influential of these factors are financial factors and factors related to the lack of awareness and information. The remaining factors, such as cultural, social, medical or psychological factors, are associated and closely connected with these key factors (for example: family conflicts, domestic violence, the desire for better career or better education, maternal and foetal health, the desire for a male child, etc.).

The type of abortion predominating among the women interviewed was the machine vacuum aspiration procedure (so called “mini abortion”), as the women participating in the survey had received their abortion services at early gestational ages. According to the results of the survey, the rate of receiving abortion service varies and in general exceeds one abortion per woman. Some of the respondents reported having had more than 7 abortions.

The women find it extremely difficult to decide to have an abortion performed and besides, they find it emotionally difficult to bear. No positive attitude regarding the decision was recorded (only a few of the respondents admitted to having been indifferent towards the decision). The more effort one makes to decide, the firmer the decision is (it should be noted that the level of awareness of the abortion procedures among the women interviewed was low). The women had taken the decision independently or together with their husbands. The respondents showed high level of awareness of the necessity for spouses’ joint decisions on the issues of family planning, though their empirical experiences cover some opposite facts (for example, the facts of psychological pressure), which raise the risk of using or serve as a motivation to use unsafe methods for termination of a pregnancy.

**Access to safe abortion services.** The results of the survey confirm that some factors, such as the problems of geographical availability and affordability can prove to become barriers to accessing a safe abortion service. Remoteness from a healthcare facility, in some cases has an adverse effect on receiving a safe abortion service, especially for women living in rural areas far from a regional centre. Identification of the problem of affordability as a barrier is relative (the same cost of an abortion service can be regarded as “too expensive” or “not so expensive” by different respondents, depending on their financial situation); though, in combination with some other descriptors used in the survey, financial factor proved to be one of the most significant of all factors.

The expectations and emotional state of the respondents associated with the initial (pre-abortion) visit to a healthcare facility do not much differ from the negative expectations and emotional state they experienced while making decisions on abortion. This is the time when a support from a psychologist becomes necessary (in spite of the fact that some of the respondents regard the above



mentioned service as redundant (presumably under the influence of the past, when it was considered that only persons with mental disorders needed a psychologist's assistance). Psychologic preventive actions support woman's future mental health, as well as post-abortion psycho-rehabilitation.

As a result of the survey some cases of medical personnel providing biased counselling and trying to convince their patients to continue their pregnancies have been revealed.

Among the arguments used by the doctors to convince their patients to continue their pregnancies were the following:

- religious (reminding a patient that abortion is a sin; a doctor even took her patient to a priest and after that the patient decided not to have the abortion);
- predicting sex of the foetus (gender-biased sex selection - male child preference);
- Age discrimination (stressing that a patient is very young, or over 30 years old) and "intimidating" patients by warning them against possible health problems.

A single case of a doctor coercing a patient into **having an abortion** should be mentioned (It was a case of a pregnancy outside of marriage).

### **Pre-abortion counselling service & examinations to be performed before an abortion procedure.**

Pre-abortion counselling and delivering the service appropriately, following legal procedures, is of high importance for physical and psychological health of patients. Besides, violations of the procedures while providing a pre-abortion service may serve as a factor for preventing provision of a safe abortion service and may result in adverse consequences for patients. The study revealed several shortcomings in this direction:

- Pre-abortion counselling service (generally performed by a gynaecologist) was not provided to some of the respondents at all or it was only partially provided to them (especially to women living in the rural areas), for example: some doctors "didn't bother talking to their patients" or "did so simply because they thought it was their duty";
- Patients are not provided with due support to help them make an informed choice; and patient's guides are very rarely distributed among patients;
- Medical personnel tend to display indifferent attitude towards patients and even treat them in a disrespectful manner;
- Some cases of violating patients' confidentiality rights were reported (for example, in several cases, **a pre-abortion counselling service** was not provided at an isolated place, sometimes it was provided outside the doctor's office – right in the hall);
- Patients are not informed about who should they address their complaints to in case their rights have been violated;
- Patients are not properly informed about post-abortion complications and side effects (the only information they receive is about possible post-abortion bleeding);
- Some of the respondents had not even heard of the possibility to delay or cancel abortion if desired by the patient and that the provision of information about antenatal surveillance is envisaged by the law;
- The majority of respondents did not receive a written informed consent form (envisaged by the law);
- The majority of patients did not undergo appropriate examinations before an abortion procedure, and the patients who underwent pre-abortion examination service, only named ultrasound examinations and blood tests (irrespective of severity of health problems faced by the pregnant women);<sup>5</sup>

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5 Note: The name of the medical test used in the paragraph belongs to the respondents and stands for a hemoglobin or hematocrit test. See p. 11. the Protocol for "Safe Abortion", approved by the order # 01-182/of 28 July 2014 of the Minister of Labor, Health and Social Welfare of Georgia



- Not all the medical facilities practice collecting complete information of the patients' health status.;<sup>6</sup>

During the survey some cases of doctors refusing to provide abortion service to patients based on religious beliefs were reported, though the patients were referred to other doctors and other medical facilities.

**A five-day waiting period and its impacts & termination of a pregnancy.** The respondents' opinion regarding the effectiveness of the five-day waiting period is of high significance as it enables us to answer the question of whether it facilitates or impedes provision of a safe abortion service to women and whether or not it results in the reduction in abortion rates. According to the results of the survey, the majority of the respondents who had received abortion services before 2014 had never heard of the five-day waiting period (the majority of these respondents point to a possible effectiveness of the five-day waiting period). As for the respondents who had received at least one abortion service after 2014: 1. Only a few of them (approximately 20 respondents) either have never been informed about the waiting period, or despite having been informed, had had an abortion procedure performed after the initial counselling session, without having been obliged to wait five more days. 2. Some respondents could not assess the effectiveness of the five-day waiting period; though the majority of them admitted that making decision on abortion is anything but easy (psychologically, morally and emotionally), therefore these decisions are almost always based on pragmatic considerations and are very rarely changed. On the other hand, the five-day waiting period is expected to have a counter effect - putting a strain on the psychological state of women and create some territorial, time-related and financial barriers (as stated by the majority of respondents, regardless whether or not they had been informed about the five-day waiting period before the interview), which may increase the risk of resorting to an illegal abortion service or serve as a motivation for self-induced abortions. The risk is proved to be higher due to the fact that, according to the data collected as part of the survey, an absolute majority of the women interviewed reported to have information about different methods of self-induced abortion (although most deny applying any of the methods in practice). (The methods include the following: jumping from a high place, lifting heavy things, taking drugs other than contraceptives, taking home-brewed herbal remedies (which, in the case of one of the respondents, for example, had caused some complications which had required surgical interference), etc.). In addition, the five-day waiting period, according to the respondents, can help create a territorial barrier for women living far from regional centres.

**Post abortion care and contraception.** Women's health requires monitoring after having an abortion (they should pay a visit to a health facility, 12-14 days after receiving an abortion service) – and appropriate measures need to be taken to ensure a safe post-abortion period, without any complications. Though, the results of the survey show that the procedures are not implemented properly; in particular, there are reported cases of patients having received not a single component of post-abortion care, or cases of patients having received only irrelevant counselling services or prescription (mainly some pills); the majority of respondents were not informed about any forms of contraception, including emergency contraceptives (this can be presumed as a reason for the low level of awareness of issues associated with family planning among the respondents as well as a reason for their mistrust towards emergency contraception); printed material and booklets about abortion are not easily available anywhere; women do not receive any psychological support, which is essential for women, as majority of them face post-abortion syndrome. (it should be mention herein that the distress experienced by the women while taking decision about abortions do not change much after they have received the abortion service. Only a few of the respondents mentioned that they felt relief after receiving an abortion service).

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6 Order # 01-74 / N, October 7, 2014 of the Ministry of Labor, Health and Social Affairs of Georgia.

**Barriers being revealed as a result of the survey:** pressure from family members, indifference and lack of professionalism revealed by doctors, the problem of affordability of contraceptives (in the majority of cases affordability of contraceptives was considered as an alternative to abortion by respondents), a lack of information or knowing nothing of emergency contraception, as well as psychological factors: fear, stress, etc.

The solutions to the problem offered by the respondents include: raising public awareness, fight against relevant cultural stereotypes; availability of effective psychological care; measures taken at the level of health-care service provision, in particular, medical insurance packages and free counselling services.

## SURVEY METHODOLOGY

**The purpose of the survey was** to identify barriers to accessing induced abortion services for women of reproductive age in Georgia.

In view of the above mentioned purpose, **the objectives of the survey** included: assessment of abortion services by women of reproductive age, determining women's attitudes towards abortion, identifying the reasons for referrals to an abortion service, obtaining information on initial counselling sessions and the five-day waiting period and their impact, identifying the barriers which impede or deny access to safe abortion services in Georgia.

**Survey method:** In-depth interviews.

**Average time for an interview:** 1 - 1.5 hour.

**Instruments used in the survey:** Semi-structured interview guidelines, covering some groups of key issues, such as general attitude toward family and marriage, reasons for abortions (general and personal), prevailing types of abortion, the availability (geographical and financial) of an abortion service, initial counselling sessions, emotional state of patients before and after receiving an abortion service, provision of patients with information about the types of abortion, possible complications, etc. by doctors, assessment of the five-day waiting period, self-induced abortion, contraception (including emergency contraception), etc.

**Target group:** women of reproductive age living in 7 regions of Georgia: Tbilisi, Kakheti, Guria, Samtskhe-Javakheti, Imereti, Samegrelo, Shida Kartli.

**Sampling method:** snowball sampling

**Table #1**

The distribution of the in-depth interviews among the regions		
#	Region	Number of in-depth interviews
1	Tbilisi	18
2	Kakheti	19
3	Guria	5
4	Samtskhe-Javakheti	12
5	Imereti	4
6	Samegrelo	19
7	Shida Kartli	14
	<b>Total</b>	<b>91</b>

**Table #2**

Social-demographic profile of respondents		Number
<b>Age</b>		
1	20-24	5
2	25-29	11
3	30-34	29
4	35-39	24
5	40-44	12
6	45-46	7
<b>Marital status</b>		
1	Married	76
2	Divorced	11
3	Single	1
<b>Place of residence</b>		
1	Tbilisi	18
2	Kakheti	16
3	Guria	5
4	Samtskhe-Javakheti	12
5	Imereti	4
6	Samegrelo	19
7	Shida Kartli	14
<b>Attained level of education</b>		
1	Complete secondary education	30
2	Complete higher education	40
3	Incomplete higher education	3
4	Incomplete secondary education	6
5	Professional based on secondary	6
6	No education	1
<b>Careers and Occupations</b>		
1	Unemployed / housewife	40
2	Service worker (accountant, baker, stylist, pharmacist, cashier, nanny, call centre coordinator)	16
3	Teacher, resource officer at a school/manager (at nursery school)	8
4	Lawyer	4
5	Private business owner / individual entrepreneur / self-employed	7
6	Other (economist, PR manager, pianist)	4

**Note:** Some respondents did not name one of the components or more than one component of their demographic profiles. Therefore, total numbers may not coincide with the total number of participants in the survey

**Data analysis:** Audio records of each interview and later transcripts of the records were made.

**Data processing:**

- formal analysis of texts (differentiation between factual and evaluative parts);
- structural analysis of factual material (systematization of the data based on various criteria);
- analysis of evaluative data and identification of the most common schemes;
- identification of generalized types of interpretative and factor components.

As a result of the analysis a qualitative survey report was prepared.

**Limitation of the survey:** The results of the qualitative survey are not subject to generalization to the entire population.

## THEORETICAL FRAMEWORK

Key components ensuring women's rights include family planning means and affordability of safe induced abortion services for women. There are various factors associated with the above mentioned issues, which may become a huge impediment to the availability and provision of abortion services to women; these factors include: system factors (qualification/attitudes of medical personnel, induced abortion services), economic factors (lack of financial means), which is interrelated with factors such as geographical factors (spatial-temporal remoteness), individual factors (for example, psychological, related to the decision-making processes regarding abortions).

The objective of the survey was to identify existing barriers which impede provision of induced abortion service, to study women's attitude towards family planning and induced abortion and to identify problems related to the issues, at the individual, societal and system levels. At the initial stage of the survey there was no analytical framework (considering the specificities of qualitative survey and the method of conducting in-depth interviews). Semi-structured interview guidelines focus on the issues such as general attitude towards family planning and marriage, reasons for abortion (general and personal), the most common type of abortion, availability of abortion services (geographic, financial), initial counselling service, emotional state of patients before and after receiving an abortion service, provision of patients with information about the types of abortion, possible complications, etc. by doctors, assessment of the five-day waiting period, self-induced abortion, contraception (including emergency contraception), etc. The qualitative data acquired as a result of the survey were processed and categorized considering the above mentioned issues.

## KEY FINDINGS

### 1. General Attitude toward Family and Marriage

The lengths of marriage of the respondents participating in the survey varied a lot; for example, 6 - 22 years among the respondents living in Kakheti, 4 - 25 years among the respondents living in Senaki; 1 - 24 years among the respondents living in Tbilisi; 5-22 years among the respondents living in Guria; 10 - 26 years among the respondents living in Imereti; 1 - 27 years among the respondents living in Samtskhe-Javakheti; 11-25 years among the respondents living in Kartli.

As to the number of children, the majority of the women interviewed have two children, and there are a few who have only one child (fewer women have three children and even fewer have four children).

In general, the attitude towards large families and having many children was positive among the women interviewed. Only a few of the women participating in the survey admitted that they would not like to have many children and having many children was not acceptable for them: *“I don’t understand women who give birth to a lot of children and then they find out that they do not have the means to support or raise them properly”* – says one of the respondents. According to respondents, the main problem associated with having a large family and many children is a lack of finances. *“My attitude towards having a large family is positive, but considering the fact that there are a lot of social problems in our country, I think each family should have the number of children they can afford. No one else is obliged to care about raising your children. More children living in destitution is bad for a state”* (a woman of 42, from the village of Gamarjveba);

*“It depends on the situation in the families, their financial situation and their spiritual state as well. I am against the view of giving birth to children being enough and that they will grow up anyway. It is not acceptable for me. So I think a large family and having many children is good if you can afford it”;*

*“It depends on a family. For example, when the families of priests have many children, I understand why they do that, but when poor families have many children, because they say the abortion service is too expensive and that they cannot afford it, it is quite another thing, I think. When families decide to have their third child in the hope that Catalikos-Patriarch will be their god-father, I think, is one thing and when a family, who can afford having many children have many children because they want to have many children, is quite another. I do not understand the mothers who give birth to their children in the hope that God will take care of their children. It is a disaster when you give birth to a child who is doomed to be malnourished and have nowhere to live or no summerhouse, etc., all mothers have to arrange for their children their future, for them not to suffer from inferiority complex when they grow up... That is why we have so many bad things happening around, so many inadequate people around”* (a woman of 44, from Tskaltubo);

*“Three of my classmates have four children and I have very positive attitude towards having many children as I see that they are happy; they are the families where spouses get on very well with each-other and decided to have many children as a proof of their love. At least, this is what I think”* (a woman of 36, from Akhmeta);

As to the attitude of the women who participated in the survey towards the marriage and the family, it is generally associated with their **children and obligations**: *“The happiness is when you have a family and children, of course. Our children make us happy”*; *“There is no greater happiness than having a family of yours”*; *“Children are the ones who make our life worth living”*; *“Marriage is obligatory; the purpose of getting married is to have children”* (a woman of 45, from Tbilisi); *“The thing which matters most for any woman is her children – and then come other things”*;

In spite of this predominant attitude, there were some exceptions: *“If you have a good husband your attitude towards the marriage and family is positive; as is the case with me”*; *“Happiness means a lot of responsibilities; my family for me is happiness and the sense of life”*; *“Marriage is an import-*

*ant stage in every human being's life, which determines their whole life, so everything needs to be properly decided and well thought out. There is no greater happiness than your family. Children are the ones who make our life worth living"; "There is no longer "me" but only "us" and I am now more dependent on my family than on my own self"; "Warmth, comfort, peace, happiness"; "Comfort"; "Marriage is happiness created by a couple; a family founded upon great love is a real happiness..."; „Marriage means a lot for me - understanding and loving your husband, everything which can be associated with your family... children are the ones who make me happy, after my husband.“*

## **Conclusions:**

**In conclusion, the analysis of attitudes towards the institution of family and marriage and having many children, conducted within the frames of the survey, revealed a so called “double” approach - On the one hand, positive characteristics (such as “love”, “warmth”, “happiness”, “comfort”, etc.), on the other hand – only obligations and responsibilities (“Marriage is obligatory”, the purpose of getting married is to have children”, etc.). The latter serves as a reason for making decisions on abortions.**

## **2. About Abortion (General and Personal Reasons for Abortion, Gestational Age, Responsibilities and Decision-Making)**

According to the results of the survey it can be concluded that there are multiple reasons for abortion, with financial and material factors being predominant and having the direct or indirect influence on the decisions made by the women. It should be noted that the women interviewed very rarely named a sex-selective abortion as a reason for their decisions to have an abortion. The reasons for abortion include:

- Financial problems – when women do not have means to feed their children, one more child is perceived as a burden, as they know in advance that they cannot take proper care of them;
- A woman can belong to the group other than the people living below the poverty line but she might consider that her obligation is to give good education to all of her children and create proper environment for their development, provide them with all the means to satisfy their essential needs and this becomes impossible in case they have another child to take care of;
- Women's health – when they have to take medicines which interfere with the development of a foetus;
- The health of the foetus - when the foetal development is hindered or there is little chance of its survival;
- Drug addicted parent or parents;
- unhealthy or bad relationship between spouses or partners – when women have already decided to break up with or divorce their partners;
- Family conflicts and psychologically unbearable conditions in the family;
- The desire to continue studies or advance your career, which can be interfered by a pregnancy or the obligations associated with taking care of a new-born babies;
- Pressure from family members to dissuade a woman from having another baby;
- Having had a Caesarean delivery (C-section) in the near past;
- Having small children and a lot of work (for example, having to cope with a job and house-work), when the woman does not have time to take due and equal care of all her children;
- Pregnancy as a result of rape or sexual assault;



- Psychological condition of the parents – when a parent or parents are not psychologically ready to have children; an experience of a stress or a stressful situation in the family;
- Low level of awareness – when women consider that abortion is safer than contraception for their health *“I have had so many abortions (laughing) if I had given birth to all of them, I would have to run away from my family. Pills preventing pregnancy cause some complications” (a woman of 45, from Tbilisi);*
- Sex of a foetus (a trend to favour boys over girls).

According to the results of the survey, the trend of resorting to abortion service varies and in general exceeds one abortion per woman. Some of the respondents reported having had more than seven abortions (there was a case when a woman had had more than 15 abortions, and another respondent did not remember the number of abortions she had had, as she had multiple of them). Abortion services among the respondents start in the 1990s and the last abortion was performed in 2018. The age of respondents at the time of having received abortion services varies from 18 to 43.

As to the gestational age at the time of abortion, the general trend among the women interviewed is as follows: in general, the respondents name 1-8 weeks of pregnancy as the gestational age at the time of abortion; there were very rare cases of 12 weeks or more of pregnancy at the time of abortion. In addition it was revealed that the women had not been given the five-day waiting period.

Besides general reasons for their decision-making on abortion, the women of reproductive age, who participated in the survey, talked about **personal reasons** which served as the basis for them to make decisions regarding having an abortion; the personal reasons include:

- Having a small child or children, and would have found it difficult to take care of them in case they had had another child;
- Taking medicines because of their health condition;
- Unwanted or unplanned pregnancy;
- A husband suffering from alcohol addiction or being unemployed;
- Being obliged to have a period of bed rest during pregnancy which could have interrupted their routine and they had no one to help them;
- Financial problems: *„In both cases the reason was the same - poor economic conditions, unbearable, I dare say. We were renting a flat, and, when I had my first abortion my mother-in-law was having some severe health problems and she died soon after. I would have found it extremely difficult to take care of a new-born baby under those conditions. I have bad memories of that period; I worried a lot so that I even cried very often... But, in the end, that was what I had decided together with my husband” (a woman of 41);*
- A desire to continue studies, which can be interfered by a pregnancy;
- Having small children or breastfeeding;
- Family conflicts (bad relationships with any of the family members);
- Sex of a foetus (a tend to favour boys over girls);
- Having had a Caesarean delivery (C-section) in the near past – a period when next pregnancy is not recommended;
- Women’s health – when they have to take medicines which interferes with the development of a foetus: *“I didn’t know that I was pregnant; I hadn’t had a missed period; I was taking a lot of medicines and I was scared that the foetus might not have developed properly; so I decided to have an abortion... I was taking medicines to regulate my high blood pressure. If I had known I was pregnant, I would not have taken those medicines and I would have given birth*



*to another child" (a woman of 30, from Tbilisi); "I was told that the foetus would have had some developmental delays. Besides I had had a Caesarean delivery (C-section) four months earlier and there was a high likelihood that I would have additional health problems... I had taken a pregnancy test and it had been positive, but they could not see the foetus. It appeared that the foetus had been near my stomach" (a women of 23, from Tbilisi);*

- Very poor health of the foetus;
- The desire to advance your career or being scared of losing your job: *"I already had a small baby and I was working; so I would have found it extremely difficult to have another baby. Besides I had the experience of some serious complications during my first pregnancy, I needed bed rest during my first pregnancy and if I had had to have the same regime, I would have been obliged to quit my hard-won job" (a woman aged 27, from Senaki);*
- Because of a disabled child they had already have and the fear that the next child might have the same disabilities or other health problems; in addition, the fear that they would not be able to pay appropriate attention to their disabled child who needed special care;
- Divorce;
- Women who had not planned to have abortion, but medical examinations found that they had a miscarriage and had to resort to an abortion service;
- Impact of cultural stereotypes – because of their own age and their children's age (for example, a 43-year-old woman, who had already had two grown-up children of up to 28 years old and one of her children was expecting a baby, had to resort to abortion, when she found out that she was pregnant, as she felt ashamed of having another baby, because (1) of the age difference between her children and a child she was expecting and (2) because of her own age);
- Lack of desire (when women think they are not ready to be a parent or do not want another child.

Below are given some examples of **personal reasons** for abortion reported by the respondents. The cases reveal the problems women have to face not only at the time of their pregnancy i.e. their psychological attitudes, stereotypes, etc.

*"My first pregnancy ended with an abortion. I was 16 and it appeared that my body was not ready for pregnancy. The doctor told me then that my child and I might both die and I was obliged to have an abortion. I had my second abortion at the age of 17 and the reason again was a poor health of the foetus that could have caused some complications to my health as well. I had several more abortions and the reason was the unfavourable financial situation, i.e. poverty" (a woman aged 33 from Senaki – had 5 abortions);*

*"My husband's family made the decision that we couldn't afford having the second baby as we were being financially supported by my parents-in-law. It was because of that dependence that we couldn't act against their will. They used to tell me that it was because of our financial conditions. I had no choice. It was such a difficult decision that I wished I could die. But eventually I decided to have an abortion, I already had a child and he needed me as a mother";*

*"I did not want to have another baby. If I had wanted, I would have had no problem. I have always wanted to have two children. I wanted to have a girl, but it was impossible to have one, as I have rhesus negative blood and every time I had abortion I put my life at risk... I don't remember how many abortions I have had... They were all boys and I did not want to have another boy. If I had known that it was a girl, I would have decided to have the third child" (a woman aged 45, from Tbilisi);*

*"My first child was only four months old, and I hadn't overcome the stress I had experienced during*

*my first delivery; besides, I had no one to help me with my baby... So, I was going through difficult times and I could not decide to have another baby. As I was the only one who had to stay up all night because of my baby. I had no one to spend even an hour with my child, neither a nanny nor anyone. I had to raise my child alone and I was exhausted” (a 36-year-old woman from Akhmeta);*

*“Main reason for my decision was that it had been an unplanned pregnancy; besides, I was not ready either economically or psychologically to have a child and my family would disapprove of me having a child outside of marriage, as it was from a temporary partner and not from my official husband. In addition I had not had any support from my partner either. When I started thinking about my future I guessed that I risked to have very tough times. I was studying and lived alone; I had no income at all. The most important thing for me is to carry my own share of responsibility and not to rely on someone else to do what I am supposed to do. That’s why I decided to have an abortion” (A young woman, from Akhmeta, who has never been married);*

*“I would have found it very difficult. I had graduated from university not long ago. I had my first child in a couple of weeks after graduating from university. This is the period when you are eager to start your career as you have already graduated from university; besides I planned not to dedicate my life to only my family and my children. I wanted to do something else as well. Yes, I wanted to have a child and have a successful career. In case I had decided to have another child, I would not have been able to start my career soon” (a 36-year-old woman from Akhmeta);*

*“It’s anything but easy for me to talk about it. This is something private for me. I had to divorce my husband soon after we got married. There were some reasons... some issues we couldn’t agree on and we had to separate. It was not a civil marriage, we had got married in church and our marriage ended in a year or so. I had my first abortion after my first child as I was already alone and could hardly manage to take care of the child I already had. I was living with my mother and I have been living with her since then. I had no job and could hardly make both ends meet. I had my second abortion after I had my second child. I was going through very difficult times in my personal life and I did not want to have another child; so that’s why I decided to have an abortion” (a woman of 39, from Samtskhe-Javakheti);*

*“The reason I decided to have my first abortion was that my first child was very small when I found out about my second pregnancy; so, I decided to have an abortion. The reason for subsequent abortions was that I had no one to help me with my housework and there were some other reasons as well. It took me quite long to make such decisions, I knew that it was one of the deadly sins. I used to take decisions independently, without any consultations with my husband. He was busy working hard and I didn’t tell him anything. I used to have abortions without him knowing anything” (Women aged 40, from Kartli – has had up to 30 abortions).*

Another issue associated with abortion is the issue of **psychological condition** of the women who decide to have an abortion: what they feel, what they think and what their expectations are. In this regard the most important question is whether they made the decision independently or based on the consent of their spouses or other people, or whether they were victims of any psychological violence or abuse and they had no choice.

As it is evidenced from the analysis of the interviews conducted within the survey, the majority of the women consider the abortion as the best solution to the problem of unwanted pregnancy, on the one hand, but on the other hand, they have a psychological barrier and worry about their decisions. This opinion is based on the verbal expressions used while describing their emotions regarding abortion by the women participating in the survey: “regret”, “fear”, “feeling down and depressed”, “strained” “the worst experience, crying” “feeling guilty”, “stressed”, “feeling ashamed”, “fear of God”. At the same time, it should be noted, that some respondents speak of abortion without showing any emotions: “I was looking forward to getting rid of that foetus”; “I didn’t feel anything special. It was me who decided to have an abortion. I think that women should decide such things”.

The trends which have been identified regarding the decision-making about abortion were as follows: Half of the women made the decision independently; the other half sought the consent of their spouses. There were rare cases of involvement of the whole family or other members of the family or close relatives in the decision-making process. Respondent aged 29, from Senaki, noted that she had made the decision regarding abortion independently (due to her living conditions and economic hardship), without having consulted with her husband, as she was afraid of his reaction. When her husband learned about that abortion, he was furious *“He was not on speaking terms with me for a week”* – she noted. Women aged 40, from Tbilisi, noted that she made the decision to have an abortion independently, because she was sure her husband would not let her have one. Although, there are different cases as well: *“My husband cares more about my health than about anything else, of course. For him I am the number one and then come others”* (a woman of 44, from Tskaltubo).

Some of the respondents noted that they would not have made the decision about having an abortion if they had had some support from anyone: *“If there had been a single person I knew was against it, I wouldn’t have decided to have the abortion”* (a 32-year-old woman, who had not wanted to have an abortion but was obliged to have one because of her family conditions and economic hardship); *“If my husband had told me that he wanted that baby and if he were ready to stand by me, I would not have had that abortion, despite all the conditions I’ve already described... But there seemed to be no one to be ready to stand by me...”* (a 36-year-old woman from Akhmeta).

Below are given some excerpts from the interviews conducted within the survey, which express attitudes and feelings of the respondents to their decisions regarding having an abortion:

*“I felt extremely guilty, but the situation I was in couldn’t have been worse. I knew I was about to do something absolutely wrong. I regret having that abortion even more today. I made that decision together with my husband. All the people around me - my relatives and even doctors - were telling me that I had to have another child, but my husband was worried, because the pregnancy was unplanned and I had not had any medical check-up done”* (a 44-year-old woman from Telavi, with a disabled child);

*“First of all, I felt terrible. I always wanted to have many children... I wanted to have a large family. Besides there was my religion telling me that it was a deadly sin. A simple thought of killing your own unborn child in your womb terrifies me”* (a woman of 21, from Senaki; had only one abortion);

A respondent, who had an experience of being a victim of family violence, was obliged to have an abortion because her relatives (her mother-in-law and her sister-in-law) made her have an abortion: *“I felt no regret or fear when I had my first two abortions as I was very young and my health was concerned. As for the subsequent abortions, I felt terrible, but I had no choice”* (a 33-year-old woman from Senaki, had 5 abortions).

*“My husband and my mother-in-law showed more enthusiasm than I did, when we had to make decision concerning that abortion”* (a woman of from Senaki)

Some of the women, who participated in the survey, stated that only women had to decide to have abortion and they did not need to consult with their husbands: *“There are some issues that are personal and I have to make decisions regarding these issues. If I had discussed them with my husband, I wouldn’t have my family and we wouldn’t have the relationships we have now”* (a 34-year-old woman from Akhmeta).

The results of the survey show a trend that the respondents are well aware **that the decisions regarding family planning** should be jointly made by spouses. Though the reality might prove the opposite: *“I wish we decided everything together, but my husband is not willing. When it is impossible to reach an agreement, you are obliged to take the whole responsibility on your own shoulders and make decisions independently. It’s very hard though.”* (a 32-year-old woman from Telavi).“I was

*the one who made plans for everything. But my husband's plans... he wouldn't either plan together with me and had his own plans or wouldn't have any plans at all... I was overly dependent on him at that time... I used to make decisions together with my husband and my mother... He had his private business then and he didn't have anyone to ask for a leave from work. But I remember he looked angry when I came out of the doctor's office after I had abortion, he told me* "Where have you been so long?!"..." (a woman from Akhmeta). A respondent from Tskaltubo says that in case the husband does not have adequate approach towards the issues related to family planning, then the woman has to make decisions and take measures independently.

**What type of abortion did women plan to have?** The results of the survey show that in the majority of cases the respondents planned to have machine vacuum aspiration procedure (so called "mini abortion"). According to one of the participants of the survey: *"It is psychologically less traumatic; the younger the fetus is, the less traumatic it is for a woman"*. Some respondents stated that they had not been informed or did not want to make decision on abortion independently and therefore they paid a visit to a gynaecologist, some of the respondents said that they had heard of abortion pills. Dilatation and curettage were rarely preferred by the respondents: *"When we lived in the rural area, the vacuum aspiration procedure was not practiced there. Instead, there was like an ordinary slaughterhouse... A real hell"*. While answering the question regarding a person the women had consulted before having their abortions performed, the answers vary: a) none; b) a doctor; c) a family member, a relative, a friend: *"I had asked some friends, neighbours, some other people and they told me that there was nothing to worry about, but in my case it was not like that... I had some very hard times"* (a women aged 40, from Tbilisi). *"My mother had told me about this so called mini abortion, which is used in very early stage of pregnancy and I had it performed. I had never visited a doctor to select a method for abortion. I used to tell them what I wanted to be done and they did"* (a woman of 45, from Samtskhe-Javakheti).

## Conclusions:

*The reasons for abortion (both general reasons as well as personal reasons mentioned by the respondents) can be classified into several main categories: financial (which is a major factor), psychological and physical violence (for example, family conflicts), cultural stereotypes, which are closely interrelated with a low level of awareness (for example, selective abortion, discriminatory attitudes toward single mothers), social (for example, desire to continue studies or advance one's career), medical (maternal and foetal health, etc.).*

*The attitude of women of reproductive age towards the abortion procedure is somehow ambivalent: on the one hand they feel psychological stress, and on the other hand, they (majority of them) make a firm decisions. The survey also showed that, the respondents were willing to decide issues related to family planning together with their spouses, though it is not always practicable and the reluctance displayed by husbands with regard to issues of family planning quite often lead the family to face the necessity of having abortion. How can the abovementioned be associated with availability of safe abortion services? The fact is that financial problem, on the one hand, which has been identified as a key factor of decisions made to have an abortion, and unplanned and unwanted pregnancies, on the other hand, can lead to resorting illegal abortion services, self-induced abortions and a number of other life-threatening actions.*

*As for the predominant form of abortion, according to the survey, referrals of women to have abortion in the majority of cases took place at an early gestational age, therefore, the predominant form of abortion was the machine vacuum aspiration procedure (so called "mini abortion").*



### 3. ACCESS TO ABORTION SERVICES

#### 3.1. Remoteness to a Health Care Facility/Geographical Availability

The results of the survey show that the distance to a health care facility cannot be considered as a factor of deciding whether health-care facilities are available or not. The majority of respondents report that it takes them approximately 10-15 minutes, 20-30 minutes or 40-45 minutes to get to a health-care facility on foot or by transport. The respondents generally travel by their own or family car, by a public transport or, in some cases, by a taxi, to get to a health-care facility. But getting to a health-care facility proves to cause some problems for women living in rural areas or far-away villages, who have to get to a regional centre or to another town to get the service they need (besides, there were some cases of women receiving illegal abortion services (in Kakheti), when the abortion service was received at the patient's house, in a village): "I had an abortion in my own district; there was a woman who provided abortion services; she used to work in a maternity hospital, but now she is retired and aged and has given up the practice (a 36-year-old woman from Alvani)"; *"I lived in the village of Otobaia and the only transport there is a horse-drawn cart. I had to travel in the cart to a place where I could get a taxi and then I had to get to the health-care facility by a taxi"*. (It took the women 45 minutes to get to the health care facility by a taxi and the taxi fare was GEL 6 – which the respondent can hardly afford); The worst thing is that due to insufficient finances, some women have to get back home by a public transport after having received the abortion service. *"It might sound terrible that soon after an abortion procedure one has to travel by a public transport. But this was the case with me. I had to get back home by a public transport"*. The expenses are larger for the women who have to travel by a taxi (a taxi fare is approximately GEL 10-15 or even more; and if they have to travel from a region to Tbilisi their expenses are increased further and are sometimes doubled). The results of the survey show that respondents have a low degree of confidence on the quality of service and qualification of medical personnel in health-care facilities situated in rural areas; so part of the respondents living in such areas had to travel to Tbilisi to get an abortion service there. An opinion expressed during the survey was that the distance to a health-care facility (i.e. remoteness to a health-care facility) can represent a barrier to gaining access to an abortion service.

#### 3.2. Non-attendance at Work or Educational Institution

During the survey, respondents reported on the cases of non-attendance at work or educational institution due to the fact that they had to receive an abortion service. The majority of the women interviewed had no problem receiving an abortion service as they were either unemployed i.e. housewives, or had flexible work schedules (for example, working in shifts), or were employed in the field of agriculture, where strict attendance is not required. In some cases the respondents had to ask for sick leave from work, or take a day off. Considering the results, no loss of pay or leave without pay has been reported in case of the participants in the survey.

Some of the respondents, who were students at the time of their abortion, reported about problems of having missed some important lectures, or having jeopardized their own health by attending make-up lectures (for example, on the day they received an abortion service).

As for the persons accompanying the women – some of the respondents said that they had not been accompanied by anyone while receiving abortion services. The majority of respondents said their spouses had accompanied them; some of them had been accompanied by a friend and/or a family member or a relative. According to the results of the survey, the majority of the persons who had accompanied the women had no work-related problems or loss of pay or a leave without pay owing to the same reasons reported in the case of the respondents themselves.

Mothers appear to have problems leaving their children when having to be away to receive an abortion service. The majority of respondents said they had had to leave their children with their family

members, but some of the respondents had had to leave their children with their relatives, friends, or neighbours, or had had to take their children with them. Under such circumstances, the children had been left with either unemployed persons, housewives or retired persons, but there were cases when the persons who had to stay with children in the absence of their mothers, had to change their plans (for example, take a day off from work).

In the **majority of the cases** reported during the survey women did not have to visit a health care facility twice (first to receive a pre-abortion counselling service and later to have the abortion procedure performed). None of the participants in the survey had to find a place to spend a night there, while being away from their homes.

### 3.3. Affordability of Abortion Services

The women who participated in the survey name different costs of the abortion service. The cost of abortion proves to have changed overtime (i.e. there were different costs of abortion in different periods and years) and there is a variation in the cost of abortion in different regions; the cost of abortion depends on the procedures involved (for example, whether it is accompanied by narcotic pain medications or not), and whether the patient has medical insurance or not. The cost of abortion varies between GEL 30-50 and GEL 180-200. As for the affordability of the service, it depends on the financial situation of the patients. For example, the same cost i.e. GEL 80, 100, 130 and 180 of an abortion service can be regarded as “too expensive” by some (those who had to borrow to cover the cost, or for those who already had a bank loan, or had to resort to the pawnshops), whereas some consider that the same cost is “not so expensive” and is absolutely reasonable.

No case of any patient being offered an alternative service, in case the cost of abortion was unaffordable for them, has been reported within the frames of the survey.

**Can the cost of abortion create a barrier, which can lead women to resort to illegal abortion service?** Some cases of women resorting to illegal abortion services (in particular, in Alvani and Akhmeta) were reported during the survey.

#### Conclusions:

*Problems with geographical availability - remoteness to a health-care facility can turn into a barrier to receiving an abortion service (as it was admitted by respondents), though, according to the given survey, the respondents who participated in the survey had travelled a long distance to receive an abortion service at health-care facilities situated far from the place they lived. Some women, who had financial problems, had to travel by a public transport after having received an abortion service at a health-care facility situated far from the place they lived. A few respondents reported about having resorted to illegal abortion services; and there were fewer cases of women resorting to self-induced abortion.*

*As for the issue of having to take a day off from work or missing lectures at educational institutions, it is not considered as a barrier to receiving an abortion service in Georgia, as the majority of women are unemployed and do not face the problem of having to take a day off, and those who work or study manage to solve the problem of a missed day without any material loss.*

*The most significant barrier to receiving an abortion service is the cost of the abortion service (as evidenced from the answers of respondents when discussing problems associated with abortion). When women have material problems, they sometimes have to borrow from a bank to cover the cost of an abortion service provided to them; and besides, in some cases it is the cost of the abortion service which makes some women to resort to illegal abortion services or self-induced abortions.*

## 4. PRE-ABORTION COUNSELLING SERVICE

### 4.1 Expectations and Emotional State Associated with the Initial Visit to a Health-care Facility

The emotional state before the initial visit to a health-care facility for receiving an abortion service is generally described by the respondents using negative verbal expressions, which are much the same as the verbal expressions used by the respondents to describe their psychological state after having arrived at the decision to have an abortion (and is actually a continuation of the latter): “fear”, “being nervous”, “being in a bad mood”, “regret”, “great and long-lasting pain”, “confusion”, “deadly sin”, “stress”, “psychological strain”, “feeling depressed”, etc.: *“I had some strong negative emotions, but I knew I couldn’t afford it, I wouldn’t be able to give them (my children) what they needed and I couldn’t stand watching them being hungry, so I made that decision, but it was anything but easy to make such a decision” (a woman of 33);*

*“I’ll tell you what it feels like. In general, when a woman learns that she is pregnant – expecting a baby, what she feels is a delight; but there are cases when the fact doesn’t cause any positive feeling, for example when the woman doesn’t feel any support from her spouse – from her husband. So this is one of the key factors, of course. Another factor is knowing and being aware that you intend to kill a living being inside your body. In my case, all these factors had great influence on my emotional state. As for being sure, I was pretty sure that if I had not stopped that pregnancy in a week or two, I wouldn’t have been able to do it later; and I hadn’t had any material or economic means of my own, any kind of support from the people around me, from my husband. I had nothing and no one around that would help me change my decision” (a woman of 35, from Tbilisi);*

*„I used to have to go through very hard times before getting to a clinic. Every time it was the same and it was very hard. I had never thought that I was doing the right thing. I knew that it was bad for my health as well, besides, it means killing a living being and I felt depressed. I used to feel spiritual emptiness after having abortions as well. I had to go through extremely hard times every time I had an abortion” (a woman of 38).*

The majority of the participants of the survey had made firm decisions concerning abortions, but a few of them reported being hesitant: *“I was not sure, because I knew that it was a deadly sin, but every time I considered my own situation, I arrived at the decision that I was doing the right thing” (a woman of 35).*

In addition, the majority of the women, who participated in the survey, noted that they had been in need of a psychologist’s support: *“I think that every woman, who has an abortion, needs this kind of support, because the decision has to be well-informed and well thought out”; “It would be better if women had an opportunity to receive several sessions of psychological counselling after having an abortion procedure”; „A counselling session with a psychiatrist is necessary for women in this condition... I used to visit a psychologist in Tbilisi when I was expecting my first child, because I had a high-risk pregnancy, I suffered from insomnia. It is very important to consult a neuropathologist and a psychologist; women need to be confident and to think out everything” (a woman of 28, from Samtskhe-Javakheti).*

Although, there were a number of respondents who think that a psychological support is redundant and not needed at all; it is likely that they have a kind of stereotypical attitude towards a psychological support and think that only the people suffering from either an extreme stress or a psychological disorder are in need of such a support: *„No, no. I am absolutely balanced and I think I am far from the condition when people need a support from a psychologist. In general, when I have to face a problem, I am well mobilized” (a 34-year-old woman from Akhmeta): “I think I don’t need things like this; I always make decisions independently” (a 49 –year-old woman from Akhmeta).*



## 4.2. Did the doctor try to convince you to continue the pregnancy?

The majority of the women of reproductive age, who participated in the survey, noted that their doctors had not attempted to dissuade them from having an abortion, or simply had asked them whether they would change their decision or not. With regard to the reasons for the reluctance displayed by doctors to fulfil their obligation of trying to convince their patients to continue the pregnancy, one of the respondents says: „Doctors don't care. The most important for them is making money. They think that their primary obligation is making money rather than taking care of patients" (a woman of 33, from Senaki)

The attempt to dissuade the patient from having an abortion in case of the illegal abortion service was not expected, but similar cases have been reported with regard of the patients receiving legal abortion services. Among the reasons of the attempts to dissuade patients from having an abortion some factors stood out, such as a religious factor and gender-biased selective factors. For example: *"The doctor kept repeating that it was a deadly sin and that she as well would have fallen into sin if she had performed that procedure. She talked for a long time and told me a lot about it. But I have to reiterate that I always felt terrible whenever I was pregnant and I had never changed my decision"* (a woman of 44, from Tbilisi). Religious reasons had been brought up with some other respondents as well.

Another predominant reasons used by doctors was gender of the foetus (gender-biased sex selection - male child preference): „The doctor had a lot of arguments, one of them was that it might have been a boy" (a 30-year-old woman from Akhmeta); *"My doctor tried to dissuade me from having an abortion, telling me to wait until the foetus was 12 weeks old when it would be possible to identify the gender of the foetus and if it were a girl again then I could have an abortion. She told me "You have two daughters, don't you want to have a son as well? If it is a boy you shouldn't have this abortion". But my decision was firm and besides, the sex of the foetus wouldn't make me change my decision"* (a woman of 30, from Tbilisi)

In addition, it seems that doctors tend to use a patients age in an attempt to dissuade them from having an abortion (stressing that a patient is very young, or over 30 years old) "intimidating" patients by warning them against possible health problems: „My doctor kept telling me that it would be better for my health if I gave birth to that child; that the abortion was not recommended as I might have some complications and bleeding. I felt terrible, but I couldn't change my decision" (a woman of 26, from Samtskhe-Javakheti).

Besides, it was reported that some doctors tried to dissuade their patients from having an abortion when patients had some doubts about the health condition of the foetus (because the parents having taken medicines, genetic problems, etc.). The doctors' arguments imply possible treatments and giving a chance. Though, in general, women do not share these arguments and do not tend to change their decisions. One of the respondents reported about the case when she had changed her decision, highlighting that religious reasons and the factor of different people involved can have an influence on the decision made by a woman: *"When I wanted to have another abortion, my doctor advised me not to have it. She even took me to a priest, who asked me why I had decided to have an abortion. I told him that I was ill and I was not sure that I could give birth to a healthy child. He tried to dissuade me from having an abortion for which I am thankful. In the end, my husband and also other people talked to me and I decided to have another child"* (a woman of 30, from Samtskhe-Javakheti).

There were cases when a doctor advised a patient to have an abortion, because she was going to have a child outside of marriage. In this case the influence of some cultural stereotypes can be identified: *"Her first question was about whether I was married or not. I told her about my situation, that it was a pregnancy outside of marriage, but what I was worried about the most was that at the moment of conceiving the child I had been under the influence of alcohol and my partner had been*

*under the influence of some narcotics, and I wanted to find out whether there was a chance for the foetus to be healthy. As soon as I told my doctor about that, she immediately advised me to have an abortion. She told me that I was not in need of that child, especially if I was not going to marry that man. She sounded convincing. When I entered the room to have an ultrasound examination, another doctor tried to dissuade me from having an abortion so that she hadn't even asked me about the details. Those are the pieces of advice I had received" (a woman from Akhmeta).*

## Conclusions:

***The emotional state of the respondents before the initial visit to a health-care facility for receiving an abortion service is generally much the same as that the respondents had at the time of arriving at the decision to have an abortion, and in the majority of cases the emotional state is extremely negative. It comes as no surprise that the respondents talk about the need and necessity for a psychological support and a psychological counselling service. On the other hand, women who participated in the survey had made firm decisions concerning having an abortion and in the majority of cases the arguments used by the doctors to dissuade them from having abortions proved not to be sufficient or convincing (though it should be noted that the outcome was influenced by reluctance displayed by doctors in some of the cases).***

### 4.3. Pre-abortion Counselling Service

The Order of the Minister of Labour, Health and Social Affairs of Georgia on Approval of Rules for Induced Abortion – Termination of Pregnancy stipulates, that: **the aim and purpose of pre-abortion counselling is to:**

- a) Provide women with complete, accurate and easy-to-understand information in a language that is understandable to them, in order to ensure that they make an informed and pressure-free decisions;
- b) Confirm a pregnancy, determine the foetal lie and determine gestational age;
- c) identify the possible and/or existing diseases women suffer from and which may require management or may have an influence on the selection of abortion methods;
- d) Inform women on post-abortion contraception.

**The pre-abortion counselling consists of the following parts:**

- a) Counselling with a doctor and obtaining information;
- b) Collecting anamnesis and physical examination;
- c) Laboratory and other types of testing (in case of necessity);
- d) Family planning.

**Counselling with a doctor covers the following: providing patients with information about the methods of abortion and possible complications; helping patients to select an appropriate method of abortion and helping them to arrive at the decision independently; consulting patients on issues concerning family planning in details; obtaining an informed consent for abortion in writing.**

The survey has shown that some of the respondents haven't received a pre-abortion counselling service at all (in particular the respondents living in the regions) or have received a partial pre-abortion counselling service. One of the respondents (from Kartli region), expressed her dissatisfaction over the failure to receive the service and declared that her rights were violated: *„I had decided to have a so called "mini abortion", therefore I visited a doctor at the earliest gestational age. They are interested in making money and that's why they recommend abortion pills, which are quite expensive (the respondent considers that abortion pills are more expensive than other methods of abortion)*

(a woman of 40, from Khashuri). Some of the respondents had close relations with doctors and, for example, had made an appointment on the phone and paid their visit to a doctor directly to receive an abortion service, or paid a visit to a doctor to inform them about their decisions to have an abortion to receive their doctor's consent. *"I hadn't had much time and hadn't cared about counselling service at all. They told me that they would perform a machine vacuum aspiration procedure... As the foetus was very small, they decided to do vacuum aspiration procedure and they told me that after the procedure they would let me go. They hadn't informed me about any different methods of abortion"* (a 32-year-old woman from Telavi).

The respondents report that some doctors *"didn't bother talking to their patients"* or *"did so simply because they thought it was their duty"*, or asked some simple questions to obtain information about the patients' health status. Some cases of reluctance displayed by doctors are worth mentioning. For example: *"She explained to me that she would do nothing for free and that I had to pay for the abortion service. She told me directly 'I'll do that' and that was all"; "No, nothing of this kind; she simply told me how much I had to pay, she named the cost of the service and told me that I had to pay. That was it, the aim of the initial counselling service was to find out whether I could afford it or not, and that was it. I don't remember exactly, but I think it was a nurse who talked to me about it"* (a 40-year-old woman from Senaki).

As for helping patients to make an **informed decision**, judging from the general trend, it can be concluded that the procedure is more or less practiced. Although, the same is not the case with patient's guide which is either not distributed at all or is very rarely distributed among patients. Some of the respondents report that they had been given "a sheet of paper", but they didn't read it. Some respondents report that a **patient's guide** was on the wall.

In case of the respondents, who had received a pre-abortion counselling service, the service had been provided by a gynaecologist (in some cases the session was attended by a nurse or an assistant).

The attitude of medical personnel to the respondents was positive in general (friendly, attentive, caring). The majority of respondents said that they had been treated adequately or well enough: *"The attitude was quite good. The doctor seemed to be worried to see me being so nervous. Everyone there had daughters and wanted to have sons"* (a 30-year-old woman from Akhmeta).

Though, there were cases of reluctance or an inappropriate attitude displayed by some doctors (or other medical personnel), as well as the cases of medical personnel trying to avoid responsibility, being arrogant or showing indifference: *"unfortunately, during my last visit to a health-care facility to have an abortion, I experienced something I had to protest against and express my dissatisfaction... It was an example of irresponsible treatment... I had developed an allergic reaction to the medicine they had given and the doctor tried to avoid responsibility, saying that she had nothing to do with it as she had not even touched me; that I had taken the pill myself and that she was not to be responsible for the side effects and complications that followed"* (a woman aged 35, from Senaki). In spite of the fact that the majority of the women, who participated in the survey, said that the environment was free from **discrimination**, some cases of abusive treatment have been revealed.

*"Doctors were very cold and indifferent. I think that the reason for them being so indifferent and inattentive was the fact that I was from a village and they thought I did not know much. The doctor didn't even try to look at me, she ignored me. She was extremely inattentive and showed indifference."*

*"I understand that they consider it as a normal procedure. It is something common that they practice on a daily basis. That is why they lack empathy. But I think I don't have to complain about the way I was treated there. I was treated like a normal ordinary patient"* (a woman aged 34, from Senaki).

*"I was led to a room where there were some women expecting their deliveries. Can you imagine what it might mean for a woman who has decided to have an abortion, to watch somebody about*

*to deliver? The environment was not at all friendly and comfortable. Besides I had to wait for half an hour in a place where women are expecting their deliveries... They seemed to be in a hurry doing everything so quickly. But when I was led to the room where I had to have the procedure, I had to complain, because the door was open and I told them that it was something intimate and I needed some privacy, but they replied that it was OK and there were a lot of women in my condition there, and nobody would be able to see anything they hadn't seen before" (a woman from Akhmeta)*

*"I have very bad memories. The gynaecologist was a man and I remember his cold attitude towards me. Nurses there were more attentive and they treated me warmly. I can't say that I have noticed anything there to be qualified as discriminatory, but I think the man didn't enjoy what he was doing and I felt even worse" (a woman aged 30, from Samtskhe-Javakheti).*

**Initial visits to a doctor** generally took place in doctors' offices. The persons attending the pre-abortion counselling sessions were: a gynaecologist and nurses and sometimes people accompanying a patient; in rare cases the presence of a reproductive health specialist has been reported. Only some of the respondents had been informed about **alternative methods of abortion**. Some respondents said that they had selected the method of abortion in advance or that they had been told by a doctor which method would be used in their cases and had not been informed about alternative methods of abortion. One of the respondents reports about the consequences of inappropriate counselling: *"I hadn't been informed about anything of this kind [about alternative methods of abortion]. The reason I had to have my uterus removed [hysterectomy] most likely was that the abortion had not been performed appropriately. I had to have an emergency surgery and, presumably, one of the reasons for that had been that abortion, which was performed inappropriately and without any pre-abortion examinations" (a 40-year-old woman from Senaki).*

Despite everything, the majority of respondents said that the attitudes displayed by the doctors were **positive** (The respondents might think that not "wasting" patients' time on providing them with information and performing abortion procedure immediately can be considered as a positive attitude, because it proved to be time-saving). But some of the respondents have reported about negative attitudes displayed by doctors: *"It was far from being open and sincere, it was much more money-oriented" (a women aged 32, from Senaki).* A respondent from Samtskhe-Javakheti pointed out that the doctor had not been friendly at all, vice versa, she couldn't wait to get rid of another patient. Some of the respondents said that their doctors had asked them **detailed questions** to correctly collect their complete information of the patients' health status, whereas some talk about nonexistence of such facts and about a superficial approach used by the doctors they visited.

With regard to **pre-abortion examinations**, it can be concluded that either patients are not offered to have pre-abortion examination, or the patients who undergo pre-abortion examination service, only have general blood tests done.

The issue of **guaranteeing confidentiality** is of high importance. The majority of the women, who participated in the survey, consider that there were no facts proving that their right to confidentiality has been violated. Though there are some cases, which prove that the confidentiality has been violated: for example, in several cases, a pre-abortion counselling service was not provided at an isolated place, sometimes it was provided outside the doctor's office – right in the hall and was attended by many different people; or when it was provided at the doctor's office, the door was open and a lot of people could walk in and out:

*"My name written there was absolutely exposed, the door was open and some nurses kept walking in and out. Anyone could read my name. Then another doctor entered the room and took the form filled by me somewhere. Everyone knew that I was there to have an abortion";*

*"The doctor's behaviour was far from that required from a professional. As I've already mentioned we hadn't had any face-to-face conversation. The decision was made right in the hall, where there were dozens of people. Then someone advised her to have additional medical examinations done*



*before abortion and it was then when she finally took me into a separate room, though we were not alone there either, as nurses were coming in and out that room. I found myself way more stressed because of the doctors' behaviour there.... The decision was made only on the basis of the results of the ultrasound examination, no additional examinations had been performed" (a woman aged 23, from Tbilisi – She was told that the development of the foetus was hindered and the abortion was inevitable, though, according to her, she had not been appropriately examined before having the abortion);*

*Nobody attended my initial counselling session with a doctor, some people would walk into the doctor's office either to tell her something or to borrow something and then they would walk out of the office; there was no such thing as anonymity there. There were a lot of people in the waiting room as well. A woman who had entered the doctor's office before me was having her abortion carried out directly in the office, so that I could see the surgical instruments being rinsed off blood. It was totally depressing... (a woman from Akhmeta);*

*My first experience of being shocked is associated with environment in the room for medical procedures, where I was being examined and nurses were having coffee and some sweets in a kind of adjacent room, in fact it was one big room and only curtains served as room dividers .. " (A woman from Kartli).*

Patients **are not informed** about who they should address their complaints to in case their **rights have been violated** during their initial pre-abortion counselling session (not a single case of patients being informed about the above mentioned has been reported during the survey).

According to the majority of the women who participated in the survey, they had been properly informed about **post-abortion complications** and side effects (such as uterine rupture, bleeding, cervical tears, death, infectious complications) and doctors had discussed the issues concerned with their patients: *„The doctor informed me about pills, contraceptive coils; she told me that I had to stay in bed and avoid doing things which require great physical activities, in order to prevent possible complications. All these were quite well-organized" (a woman aged 31, from Gomi).* But in the course of the analysis of the survey results, it turned out that the respondents didn't have complete information about possible post-abortion complications and the only information they had received was about possible post-abortion bleeding (There were rare cases when the patients were informed about other types of complications such as erosion, pain in the lumbar area and infections). Some of the respondents reported about the cases when the procedure of a doctor providing a patient with information about possible post-abortion complications was limited to doctors telling their patients that in case of any kind of complications they had to visit them or call them. *"She talked to me about complications but the information provided by her was too superficial. She might have given much more complete information. She seemed to be simply performing her duty and nothing more. What mattered to her most was that she got paid" (a woman aged 34, from Senaki);*

*"I asked them a question or two, but they replied in a manner that I felt reluctant to ask some further questions; regarding some possible complications, one of the doctors told me to stay in bed and not to do too much housework. She was very unfriendly. I think people like her should not work as doctors" (a woman aged 33, from Senaki).*

The majority of the women interviewed within the survey admitted that the final decision on the **method of abortion** had been the prerogative of doctors and that their doctors were **objective** in their judgment (i.e. there had been no psychological pressure or an attempt on the part of a doctor to influence their patients' decisions for or against having an abortion<sup>7</sup>); *"my doctor used to explain*

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7 The only exception was a case of a young woman, who had got pregnant outside of marriage from her temporary partner, who was under the influence of some drugs at the moment of conception. The gynaecologist tried to influence the patient's decision and persuade her to have an abortion, without any prior ultrasound or other types of examinations.

*to me in details that so called “mini abortion” is performed only at the very early stage of pregnancy and later, when I paid visits to her and she found that it was an advanced stage of pregnancy, she seemed to be very cautious and careful, as “mini abortion” is not recommended at this stage of pregnancy. Every time I paid a visit to her, she would ask questions regarding my health and everything. But as I was her patient she already knew everything about me and, in the end, she would rebuke me for coming to her again” (a woman aged 38, from Borjomi).*

The majority of respondents say that the language used by doctors was quite **understandable** for them; though, there were some cases when women complained about the language used by doctors: *“I always ask doctors to use the language I can understand, because I am not a doctor. Otherwise they start explaining something using the vocabulary I know nothing of. This is a mistake. As, in fact, too many patients leave a doctor’s office without any information at all” (a 42-year-old woman from Gamarjveba).*

Some of the respondents had not even heard of the possibility to **delay or cancel abortion** if desired by the patient. But some of them said that the information about the possibility to delay or cancel abortion had been provided to them by their doctors during their initial pre-abortion visits to a doctor.

The majority of respondents had not received **written information about abortion** (i.e. patient’s guide and a written informed consent form, with complete information about abortion). Very few respondents have reported about the fact of receiving such documents. And one of the women interviewed said that she had seen such information on the wall in a health-care facility (presumably, she meant a poster with different information from what should be included in a patient’s guide).

Doctors **refusing** to perform abortions **on religious grounds** were very rare among the cases analysed as part of the survey and in case of such a refusal the patients were referred to other doctors or health-care facilities; one of the respondents, who was from Samtskhe-Javakheti, reported that the day she had planned to have an abortion coincided with an Orthodox religious holiday and her doctor did not want to perform the abortion procedure and even tried to dissuade the patient from having that abortion; though, in the end, the doctor did what the patient wanted: *„When the doctor saw me crying and guessed that I was very nervous, she told me: - my child, don’t worry; I see you believe in God. Go to a church and light a candle, ask God for forgiveness. It’s not a sin, it isn’t you fault” (a woman aged 30, from Tbilisi);*

*„The doctor who attended my deliveries told me that she was not specialized in performing abortions and referred me to another doctor, who performed abortions. So I had an abortion there. I don’t have any negative feelings towards the doctor who had refused to perform the abortion based on her religious beliefs, and neither have I negative feelings towards the one who had performed it, as I insisted on having an abortion, It was me who wanted to have an abortion and nobody else. There was no pressure and no one had obliged me to have that abortion” (a woman aged 38, from Tbilisi)*

It should be mentioned that the emotional state/states of the women of reproductive age, who received **initial pre-abortion counselling service** remained much the same it had been before receiving the pre-abortion counselling service and in general it was described by the participant of the survey as negative: “being in a bad mood”, “fear”, “being nervous”, “feeling hesitant”, “big discomfort”, “time appeared to be going slowly”, “anxious and strained”, “on the verge of tears”, “regret”, “feeling ashamed”, “feeling depressed”, etc. Despite the fact that the majority of the women noted that they had not changed their decisions and had received an abortion service, some of the respondents pointed out that the pre-abortion counselling services they received were very helpful and useful.

## Conclusions:

*In general, pre-abortion counselling service cannot be regarded as absolutely satisfactory, due to some shortcoming and gaps reported by the women who participated in the survey; in conclusion:*

- *The majority of patients did not undergo appropriate examinations before an abortion procedure, and the patients who underwent pre-abortion examination service, only named ultrasound examinations and general blood tests (irrespective of severity of health problems faced by the pregnant women); In addition, women were made to have some medical tests performed, which were not in accordance with Protocol (for example: general blood test);*
- *Not all the medical facilities practice collecting complete information of the patients' health status;*
- *Some cases of violating patients' confidentiality rights were reported (for example, a crowded doctor's office, in several cases, a pre-abortion counselling service was not provided at an isolated place, sometimes it was provided outside the doctor's office – right in the hall, etc.);*
- *Patients reported being informed about post-abortion complications and side effects , though, in fact the only information they had received was about possible post-abortion bleeding;*
- *Almost none of the respondents had receive a written informed consent form or the information about the possibility to delay or cancel abortion if desired by the patient;*
- *Only some of the respondents had been informed about different alternative methods of abortion. Some of the respondents said that they had arranged the details with their doctors in advance, whereas some of them admit that their doctors talked only about the methods they considered appropriate with particular patients.*

*It is obvious that the facts listed above serve as impediments to availability of safe abortion services.*

*It also should be noted that according to the women who participated in the survey, in general, doctors display objective attitude towards patients and try to explain to them abortion-related issues using a language that is understandable for their patients. A few cases of doctors refusing to perform abortions on religious grounds have been revealed and in case of such a refusal the patients were referred to other doctors or health-care facilities.*



## 5. A FIVE-DAY WAITING PERIOD AND ITS IMPACTS

It should be noted that the majority of the respondents who had received abortion services before 2014 had never heard of the five-day waiting period (**a period between the pre-abortion counseling and the abortion procedure, envisaged by the law**). Some of the respondents learned about the five-day waiting period from the interviewers and tried to assess a possible effectiveness of the five-day waiting period, in particular, whether it can work to reduce the number of abortions or have an influence on women's decisions to have an abortion, what effect it might have on the emotional state of women with regard to feeling remorse etc.

The majority of the women of reproductive age, who have received abortion services since October 2014, noted that their doctors had informed them about the five-day waiting period, and the period between the pre-abortion counselling and the abortion procedure in their cases was approximately 7 - 10 days.

Approximately 20 respondents, who have received abortion services since October 2014 reported that their doctors either had not informed them about the five-day waiting period, or they were informed but did not use this period (either because of the reluctance displayed by doctors, or as a result of patients' insistence):

*"Yes, my doctor informed me about that five-day waiting period, but I was sure I had to have that procedure as soon as possible. Because I was sure it would have become more and more difficult for me to take that step and I might even have changed my mind if I had had to wait, because the foetus would have grown by that time. Even now I think that if I had felt its heart beating, I would have changed my mind. Therefore I did not want to wait and I had that abortion the very day I paid my first visit to a doctor" (a woman aged 35, from Tbilisi).*

*"I received a pre-abortion counselling service but I was not informed about the five-day waiting period. The fact was that my doctor refused to perform that abortion the day I visited the clinic; she might have been busy or might not feel like performing that procedure" (a woman aged 30, from Akhaltsikhe).*

*"No, I have never been informed about the five-day waiting period. My doctor was always busy; she always had too many patients and as I have already mentioned, she used to give me no more than 20-30 minutes to think over my decision" (a woman aged 41, from Khashuri).*

*"In short, my doctor had told me to go and think over my decision and come back in several days, but I insisted that I didn't want to think it over as I had already decided to have that abortion. After that they performed that abortion. I didn't want and I couldn't wait for several days, as I would have had to go and then come back to Tbilisi and I didn't have time for that" (a woman aged 27, from Borjomi).*

Alternative services offered to patients to avoid the five-day waiting period as exception has been reported (for example, replacing the entry with "induced abortion" with "spontaneous abortion". Only one of the respondents had received an abortion service while lying about a miscarriage; Some of the respondents, who had received abortion services since 2014, had never heard of the compulsory five-day waiting period and they reported in their interviews that they had received abortion service the same day the paid their first visit to a doctor "without any problem".

First of all it should be noted that the majority of respondents either could not or would not assess the effectiveness of the five-day waiting period.

The respondents' assessments were divided regarding the effectiveness of the five-day waiting period. Some considered that the five-day waiting period was necessary, that it can influence women's decision, can cause a sense of regret and can help them change their mind regarding a planned abortion. A woman aged 45, from Samtskhe-Javakheti admitted that it was because of the five-day

waiting period that helped her daughter change her mind and decide not to have an abortion and now she is very thankful for that. Furthermore, some of the respondents consider that the five-day waiting period should be extended.

But some of the respondents - quite a lot of them - base their opinion on an argument that if a woman is a 100% sure and has already made the decision to have an abortion, nothing can influence her decision and can make her change her mind; though it can have a counter effect – cause irritation (some exceptions may include so called “hesitant” patients). Besides, the waiting period can help create additional geographical, time-related and financial barriers for women, who live far from regional centres (i.e. two visits to a health-care facility can prove to be associated with problems such as doubled transport costs and twice as much time). It should be noted that additional problem is associated with advanced stages of pregnancies and, in particular for women who are at 12<sup>th</sup> week of pregnancy. Below are given some counter-arguments regarding the five-day waiting period:

*“Under such circumstances a woman may decide to resort to a self-induced abortion or an illegal abortion service and the consequences might be disastrous. But in my case it meets all the requirements”.*

*“Financial conditions can create some barriers, if a woman learns that she can have her abortion performed at a lower cost which is more affordable for her, somewhere else, she will go and have her abortion at that place. She won’t change her mind in five days, instead she will go and search for simpler and cheaper ways to have her abortion” (a woman aged 32, from Senaki);*

*I had already decided to have that abortion and was not in need of additional five days to wait to have it. Presumably, it can reduce the number of abortions by 1% or 2%, not more. Because when a woman has already decided to have an abortion, she might search for and resort to other ways. Some might feel angry and irritated because of the delay, but those, who are not quite sure what they have already decided to do, will have more time to think it over” (a woman aged 27, from Senaki);*

*„For the women who have decided firmly to have abortion, delays in the provision of the service will add to their stress... I think it is needed, though it seems to me to be a mere formality”.*

*“I was sure I had to have that procedure as soon as possible. Because I was sure it would have become more and more difficult for me to take that step and I might even have changed my mind if I had had to wait, because the foetus would have grown by that time. Even now I think that if I had felt its heart beating, I would have changed my mind. Therefore I did not want to wait and I had that abortion the very day I paid my first visit with a doctor”. **Will it decrease the number of abortions?** “I find it difficult to answer this question; because I am not quite sure. If we consider my case, when a woman worries about the stage of the pregnancy, this five-day waiting period won’t help reduce the number of abortions. But if psychologists were involved and women had the support of social agencies and some guarantees that they would have no problems in the future, regarding adequate conditions for bringing up these children and ensuring normal life for them, and if some social benefits and support from a lawyer were guaranteed, then it would reduce the number of abortions” (a woman aged 44, from Tbilisi);*

*“Reduction of the number of abortions is possible, but not a significant reduction of course. Because when deciding such a thing, it is not without struggle with yourself. There might be very few women who find it easy to make such a decision. When taking such a decision... Those who have a simple reason for an abortion (for example, think that taking care of another child will be tiring or a burden) can feel remorse and might even change their mind, as in the process of making such kind of decisions a woman already has to face an inner struggle... I think I would not like to be given a five-day waiting period, because it might have worsened my psychological state and those five days would feel like a century” (a woman aged 43, from Tbilisi);*

*“If a woman decides to have an abortion, the five-day waiting period will fail to influence her deci-*

sion, because the decision is already made based on unfavourable life conditions or unfavourable conditions in her family, and everything and everyone around her urges her to make such a decision... This period will be the most stressful period for the woman, she will feel despair and will worry a lot... Whenever I paid a visit with a doctor to have an abortion, I had already decided to have one and I wouldn't have listened to anything they might have told me" (a woman aged 41, from Khashuri); / the patient used to be given 20-25 minutes before receiving abortion service/.

"It took me a week to decide to have an abortion and to visit a doctor and I had gone through difficult times; I felt terrible: if I had been instructed to wait for additional five days, it would have made my situation even worse" (a woman aged 36, from Tskaltubo);

Besides, the majority of respondents (irrespective of having heard or not about the five-day waiting period and whether or not they consider it effective) pointed out that the five-day waiting period **can create territorial barriers**: „When you pay a visit with a doctor and they send you back telling you that you will have to pay a repeated visit in a few days' time, it puts a great strain on your emotions. First time you might have managed to come to a healthcare facility from a region where you live, but for the second time the anonymity of women (and their families) can be compromised!" (a woman aged 36, from Tbilisi).

It was suggested that psychologists' support during the five-day waiting period can increase efficiency of the waiting period.

Inefficiency of the five-day waiting period is indirectly confirmed by the fact that very few of the respondents admitted to **having changed their decision regarding an abortion** – one of the respondents from Kartli admitted that learning about the sex of the foetus, i.e. that she was going to have a boy – made her change her decision. The majority of respondents had made firm decisions and they had not changed their decisions. There were cases when husbands' involvement proved to be decisive. One of the respondents was very happy to have "quite accidentally" changed her mind: "I want to tell you about my case – I was in the third month of pregnancy and I felt terrible. I went to visit my mother, who lives in a village. I wanted to borrow some money to pay for an abortion, but my mother refused to give me any money. I went to Tbilisi and paid a visit to a doctor. The doctor told me that she wouldn't perform an abortion because I was already in the third month of pregnancy and she wasn't going to kill that baby, who was alive. So I had to give birth to my daughter and I am very grateful to my doctor for that" (a woman aged 44, from Tbilisi);

„When I decided to have an abortion, I went to a health-care facility, after having talked to my priest. It was an advanced stage of pregnancy and my doctor warned me about possible complications, telling me that it was too risky to have an abortion; besides I had not been fully recovered from pneumonia and she was afraid that I would have some serious complications or bleeding, so she refused to perform that abortion. Then I talked to my husband and he was also afraid that something bad could happen to me. In the end we decided to have that child. I went to Tbilisi and I was registered in a clinic there and had all the examinations I needed" (a woman aged 30).

## Conclusions:

*The main purpose of the five-day waiting period – i.e. the period women are given from their pre-abortion visit till the day they receive an abortion procedure, envisaged by the law, is to reduce the number of abortions, based on the presumption that the women who find it difficult to arrive at the decision of having an abortion, might change their mind and decide not to have abortion, in case they are given a few days' time to think the matter over. Though, the results of the survey showed that the introduced measure is not an easy solution to the existing problem. In spite of the fact that many of the respondents admit to having gone through very hard times, having suffered emotional distress and pain while making decision to have an abortion, thus revealing that they needed a psychologist's support, the five-day waiting period has not proved to be effective:*

- 1. The five-day waiting period had no influence on the decisions made by the respondents, who had resorted to abortion services after October 2014, and they received the abortion services;*
- 2. Only a few of the respondents who received abortion services after October 2014 (approximately 20 respondents) either have never been informed about the waiting period, or despite having been informed, had had an abortion procedure performed on the day they had their initial counselling session, thus the procedure related to the terms of receiving an abortion service was not properly performed;*
- 3. A part of the respondents who consider the five-day waiting period as positive and needed, had had no information about the abovementioned procedure and learned about the procedure from the interviewers during the interviews (so they had no time to properly analyse the information provided to them);*
- 4. The majority of respondents admitted that when women make a decision to have an abortion, nothing can make them change their decisions as these decisions are almost always based on pragmatic considerations, taking into consideration their material situation, social conditions, situation in their families, their small children, who require their care and attention, and many other factors, which were mentioned by respondents when they were discussing the topics related to the family and marriage or when they were listing the reasons for abortion. Delayed abortion has a counter effect - putting a strain on the psychological state of women, which may increase the risk of receiving an illegal abortion service or serve as a motivation for self-induced abortions (which is a real threat to women's health);*
- 5. It should be also noted that, according to some of the women interviewed, the five-day waiting period creates territorial, time-related and financial barriers for women having problems with geographical accessibility to health-care facilities.*

## 6. EXAMINATIONS TO BE PERFORMED BEFORE AN ABORTION PROCEDURE AND INDUCED ABORTION

The respondents had to answer a question about whether they had undergone pre-abortion examinations, such as ultrasound scanning and laboratory tests, what effect had the results of ultrasound scanning had on them and whether they helped them to change their decisions regarding abortions.<sup>8</sup>

**The results of the survey showed that:**

- Some of the respondents have never been examined before having an abortion procedure performed. According to one of the respondents: *„I had never had an ultrasound examination before an abortion. But I think pre-abortion examinations and blood tests are necessary, though I had never had one. I think that my rights were violated” (a woman aged 41, from Khashuri);*
- Some of the respondents had only had a pre-abortion ultrasound examination, and some had had a pre-abortion ultrasound and laboratory examinations; It should be noted, that women either had not received any pre-abortion examinations envisaged in the Protocol, or had received only a pre-abortion ultrasound examination. In addition, there were some cases of patients being made to have some laboratory examinations performed, which are not envisaged in the Protocol (for example: general blood test);
- The majority of respondents either could not hear the foetal heart beat and could not see the foetus on the screen or had asked the doctor to turn off the monitor so as to avoid seeing the foetus or hear its heart beating which might have had an effect on their emotions and might have made them change their decisions to have an abortion: *“As far as I am concerned, when a woman has already decided to have an abortion she tries to have as little information about the foetus as possible. I did not want to know anything about it, because it would have been very hard for me. I tried to save my conscience, in order to feel less guilty” (a woman aged 35);*
- Very few of the respondents admitted to having selective abortions, instead they consider such attitude as unacceptable and immoral. Therefore, they had not even tried to learn the sex of the foetus during the pre-abortion ultrasound examination.

Some of the respondents, who had their pre-abortion ultrasound examination performed, reported that there had been attempts to dissuade women from having an abortion, generally, through the experience of hearing the foetal heart beat. From these cases there were some when the women refused to change their decision regarding having an abortion, though they reported of extremely negative psychological pressure.

*“foetal heart beat can hardly be heard, so I never listen to it... Then they would tell you: ‘here is your baby, don’t you want to look at it?’ but what you can see is a shapeless black spot, but still it hurts. The strongest feeling then is the feeling of regret. But if a woman has made a firm decision to have an abortion, nothing will make her change her decision” (a 38-year-old woman from Khashuri);*

*„[Being made to listen to the foetal heart beat] had a very strong influence. frankly speaking, I even had thought of changing my mind, but it lasted only for several seconds. I am pretty sure that there is no woman who will not be moved by the experience. I don’t know, may be unless one is a stony-hearted. I felt terrible, but I tried my best to hide my emotions, as I did not want the doctor to notice how I felt. Finally, I did not change my decision to have an abortion, but me state of depression lasted for a long time” (a 30-year-old woman from Tbilisi);*

8 See p. 11. the Protocol for “Safe Abortion”, approved by the order # 01-182/of 28 July 2014 of the Minister of Labor, Health and Social Welfare of Georgia.



The majority of respondents reported having information about **self-induced abortions**, although very few of them admitted to having applied it in practice. In general, they pointed out that they had heard about these methods from their relatives/friends/neighbours. The respondents named various methods of self-induced abortion, which included:

- Taking drugs (for example, “Cytotec”: *“reduces the risk of stomach ulcers... It’s not dangerous... simply it should not be taken by pregnant women”*);
- Lifting heavy things;
- Injections (for example: Dexamethasone - *„I had a Dexamethasone injected and nearly died. I will never ever have it again and do not recommend it to anyone”* (a woman aged 32, from Samtskhe-Javakheti);
- Jumping from a high place;
- Taking home-brewed herbal remedies;
- Having hot baths;
- Taking iodine.

One of the reasons for some of the respondents resorting to a method of self-induced abortion was that they could not afford the abortion service: *„The gynaecologist scolded me for doing these things and asked me why I had not visited a doctor. But I couldn’t because I would have had to pay to the doctor and I had no money so I used those means”* (a woman aged 41, from Khashuri).

Some of the respondents recall their attempts of terminating pregnancies which could have had very bad or even fatal consequences:

*“I did not know that I had been pregnant with twins, I was sure it was a girl and I intentionally lifted very heavy buckets and had a miscarriage of one twin. I did not have any severe complications. I had already had two girls and I was afraid it could be a girl again. And someone calculated the gender and told me that it was a girl. But the other twin survived and he is one of my sons”* (a woman aged 38);

*“I took pills twice. I had some complications. Bleeding, in the first place, which lasted for several days; it was very intense bleeding and wouldn’t stop, so I was obliged to see a doctor and they gave me some injections to stop bleeding”* (a woman aged 31, from Senaki);

*“My co-worker took some pills and she had a partial miscarriage. She felt extremely bad. Then she was taken to a hospital and had an abortion procedure there.”*

## Conclusions:

***Pre-abortion examinations are not performed appropriately. Part of the respondents had not had any pre-abortion examinations and those who had had pre-abortion examinations had only had either ultrasound examinations or laboratory examinations (in general blood tests). As the results of the survey showed, a pre-abortion ultrasound examination can have an influence on a woman’s decision regarding having an abortion; in particular, after having seeing a foetus or after having listened to its heartbeat, it becomes extremely difficult to control emotions and to stick to the decision.***

***With regard to using different methods of self-induced abortion, the survey revealed that (a) an absolute majority of the women interviewed had information about these different methods of self-induced abortion (b) a few of them admitted to applying any of the methods in practice; (c) One of the major reasons for women applying a method of self-induced abortion was high cost of abortion.***

## 7. PSYCHOLOGICAL ASPECTS OF ABORTION, POST-ABORTION SYNDROME (PAS), SPECIFICS OF PSYCHO-EMOTIONAL SUPPORT

Psychological aspects of abortion are multifaceted and what should be taken into consideration is a psychological factor of the decision regarding having an abortion and psychological state of the women who make such a decision, on the one hand, and the psychological problems associated with the procedure of abortion as well as psychological problems emerging in the post-abortion period, on the other hand.

As it is evidenced from the analysis of the interviews conducted within the survey, the majority of the women consider the abortion as the best solution to the problem (due to their specific conditions), on the one hand, but on the other hand, they have a psychological barrier and worry about their decisions. This opinion is based on the verbal expressions used while describing their emotions regarding abortion by the women participating in the survey: “regret”, “fear”, “feeling down and depressed”, “strained” “the worst experience, crying” “feeling guilty”, “stressed”, “feeling ashamed”, “fear of God”. At the same time, it should be noted, that some respondents speak of abortion without showing any emotions: “I was looking forward to getting rid of that foetus”; “I didn’t feel anything special. It was me who decided to have an abortion. I think that women should decide such things and other’s participation in the decision-making process is redundant”.

A conscious decision, refusing from an unwanted pregnancy or future motherhood, often causes mental, moral and social trauma, which often serves as a basis for the development of Post-Abortion Syndrome (PAS)<sup>9</sup>. Post-Abortion Syndrome (PAS) requires treatment performed by psychologists, psychotherapists and psychiatrists. Immediate surroundings and close people play a big role in the treatment of Post-Abortion Syndrome (PAS) as well as the patient herself. It should be noted, that the majority of the women interviewed within the survey had one or more symptoms of Post-Abortion Syndrome (PAS), though none of them had tried to receive a psychological assistance, either because of lack of information about the existence of such a service, or because of non-existence of such a service, or because of some social and material barriers.

Some respondents report of suffering from intense feelings of grief, regret, emptiness, perception of loss and self-stigma, after having an abortion. Self-stigma was further intensified due to the fear of religious punishment.

*“I feel something resembling emptiness for two or three days. Then my body starts regaining strength and my conscience gets used to the state, and then life goes on as usual. There is nothing that can be done! Not to mention psychological support, sometimes a word might have a huge effect - a word from someone. You feel devastated” (a 38-year-old woman from Tbilisi).*

*„I felt great regret, loss, and heartache. I was ashamed of myself, because I was doing it. The strongest feeling I had was the feeling of guilt. If someone asks me what I am most ashamed of, about the most shameful thing I have ever done in life, I’ll answer that it has been that abortion.” (a 35-year-old woman from Senaki).*

*“I feel awful whenever I have an abortion. Abortion is the deadliest sin of all the deadly sins” (a 32-year-old woman from Senaki).*

*“ There is no one who can stand by you; they don’t think it is a problem and it makes things worse. And when you have to return to your everyday routine the next day... This is the most difficult aspect, I think” (a 36-year-old woman from Tbilisi).*

*“A friend or a family member alone cannot provide the professional psychological support women re-*

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9 Post Abortion Stress Syndrome (PASS) is the psychological aftereffects of abortion, based on Post Traumatic Stress Disorder (PTSD). The term was first used by an American psychologist Vincent Rue, in 1981.



*quire in this situation. They may help you calm down, but it cannot be called “psychological support, certainly. Doctors have no understanding of the importance of psychological support. In the best scenario, quite often, their counselling is limited to administering some drugs, when Post-Abortion Syndrome (PAS) requires intense psycho-emotional support and professional assistance. (a 36 year-old woman from Tbilisi).*

Majority of respondents admitted to the necessity of a psychologist’s support: “I think that every woman, who has an abortion, needs this kind of support, because the decision has to be well-informed and well thought out”; “It would be better if women had an opportunity to receive several sessions of psychological counselling after having an abortion procedure”; “I used to visit a psychologist in Tbilisi when I was expecting my first child, because I had a high-risk pregnancy, I suffered from insomnia. It is very important to consult a neuropathologist and a psychologist; women need to be confident and to think out everything” (a 28-year-old women from Samtskhe-Javakheti).

Although, there were a number of respondents who think that a psychological support is redundant and not needed at all; it is likely that they have a kind of stereotypical attitude towards a psychological support and think that only the people suffering from either an extreme stress or a psychological disorder are in need of such a support: „No, no. I am absolutely balanced and I think I am far from the condition when people need a support from a psychologist. In general, when I have to face a problem, I am well mobilized” (a 34-year-old woman from Akhmeta): “I think I don’t need things like this; I always make decisions independently” (a 49 –year-old woman from Akhmeta).

## **Conclusion:**

***In spite of the fact that the analysis of different components of the survey demonstrate psychological and emotional state of the respondents, their stress and negative feelings associated with abortions, it should be noted that psychological support is the weakest spot of post-abortion services provided to the respondents; psychological counselling is not included in the abortion services, hence the failure to effectively prevent Post-Abortion Syndrome (PAS) and ensuring mental health and well-being of women receiving abortion services.***

## 8. POST ABORTION CARE AND CONTRACEPTION

With regard to post-abortion care, the respondents had to answer a question regarding whether they had been offered the following:

- Psychological support;
- An appointment 7-14 days after an abortion procedure;
- A counselling session on family planning issues and methods of contraception;
- Whether information material – printed material concerning abortion, family planning services, and methods of contraception available in Georgia and concerning the locations where these contraception means can be purchased was available in a healthcare facility they visited.

As a result of general analysis, it can be concluded that the survey revealed a category of respondents, who had never received any of the services listed above (irrespective of their place of residence – rural or urban area). The most common offer received by the respondents was an appointment 7-14 days after an abortion procedure – though, it should be noted herein that part of the respondents had not taken advantage of the offer and they did not pay a visit with a doctor to receive a counselling service. The women had either been provided with incomplete information on the methods of contraception or had not been provided with the information at all. In some cases they had straightaway been administered some medicines. The counselling on contraception is provided by a gynaecologist or, in some rare cases, by a reproductive health specialists.

As for the printed material on abortion, family planning services, modern methods of contraception available in Georgia and the locations where these contraception means can be purchased – the respondents very rarely report about being provided with any of them.

Nearly none of the respondents has ever been offered a psychological support (with a few exceptions, however). Nevertheless, an obvious need for psychological counselling has been identified, as part of the respondents perceive psychological counselling as a way of prevention of post-abortion problems. Some of the respondents are well aware of the importance of such a service: *“I think it would have been very helpful and I wouldn’t have suffered so much. For example, I wish I had had someone to talk to me and comfort me after an abortion. In addition, I think that a psychologist is more able to dissuade women from having an abortion than a doctor is”* (a woman aged 43, from Tbilisi)

*“It is extremely important because, in general, it proves to be very difficult for young women of approximately my age, when they pay their first visit to a health-care facility to have an abortion. For example, one or two of my friends were treated coldly when they visited a health-care facility to have an abortion... because, say, they were pregnant outside of marriage. The medical personnel were ignorant and displayed disrespect towards them and this is not acceptable as it is a personal choice every woman has got to make for herself”* (a woman aged 26, from Tbilisi).

**Do women of reproductive age use any method of contraception?** It should be noted, that while speaking about contraception, what the respondents could think of, **in the first place, were contraceptive pills**. Besides contraceptive pills they also named “contraceptive coils”, “contraceptive candles”, “condoms”, “calendar rhythm method”. The majority of the women who use contraception are satisfied and do not intend to change the method they use. A rather significant part of the women admitted that they do not use any method of contraception, the reasons mainly being side effects (dizziness, vomiting, etc.), as well as being without a partner at the given moment.

Women's attitudes towards **emergency contraception** varied and were expressed in several directions:

- The respondents have never heard of emergency contraception (there were many respondents who declared that), but after being informed about emergency contraception by interviewers they show interest in it and consider that emergency contraception is an alternative to abortion. A part of the respondents belonging to this category said they would resort to emergency contraception in the future and another part said they wouldn't (because they are not sure whether it works and if it does, than how);
- The respondents have never heard of emergency contraception, and even after being informed about emergency contraception by interviewers they do not consider that emergency contraception is an alternative to abortion;
- The respondents have heard of emergency contraception (some of them have even used it) and plan to use it in case of need; or they have heard of emergency contraception but are fiercely against it because of the side effects associated with emergency contraception.

*„I have heard of some pills but I cannot take them, because the first time I tried one I had a terrible reaction. It was a single pill I took but still I felt terrible. They are counter indicated in my case and that was why I gave up taking them. I had bought it at the chemist's and the price was quite reasonable, there were some other pills but they were more expensive and I couldn't afford them. So I bought the one I could afford and it had an undesired harmful effect in my case. I took that pill without consulting a doctor. I can't take these pills. When I did I felt dizziness and had to quit taking them. So I have never taken one since” (a woman aged 32);*

*“If I don't want to have an abortion or take those pills, I will have to protect myself against pregnancy, but not by taking contraceptive pills but by using condoms” (a woman aged 23, from Tbilisi);*

*“I chose to have an abortion, I would at least be sure that everything had been done as it should have been done...” (a woman aged 45, from Tbilisi);*

*“I'm not sure whether I will ever be able to take one, as I can't learn about my pregnancy in 72 hours” (a woman aged 38, from Tbilisi)*

*“It is a sin from religious point of view but at least it is better than abortion”.*

*“I have taken some pills. One doctor used to give them to me. She used to come to our rural clinics. Nobody has ever administered them or advised me to take them; I learned about them and I took them for about three months. I think they do more harm than good. I personally do not like these pills” (a woman aged 31, from Gomi).*

Part of the respondents, who have taken pills used for emergency contraception, had consulted a doctor, and the other part have bought them without having consulted a doctor. As for whether women can afford them or not, like in case of affordability of abortion services, it depends on the financial state of an individual. For example, one and the same medicine can be perceived as affordable for some and not quite affordable for others.

## Conclusions:

*According to the respondents, in the post-abortion care the trends are much similar to those observed, for example, during the initial counselling service. In the given case several drawbacks have been revealed:*

- *Some of the respondents have never received even a single component of post-abortion care;*
- *Not all the respondents have been provided by information about contraception;*
- *Printed material and booklets about abortion are not easily available anywhere;*
- *In spite of the fact that the analysis of different components of the survey demonstrate psychological and emotional state of the respondents, their stress and negative feelings associated with abortions, it should be noted that psychological support is the weakest spot of post-abortion services provided to the respondents.*

*In addition, the survey has revealed low level of awareness of issues of family planning among the women interviewed within the frames of the survey: Part of the respondents have never heard of any means of contraception and the majority of respondents associate contraception with only contraceptive pills (and they also talk about side effects of contraceptive pills). The respondents who use contraceptives also mention contraceptive coils, condoms, a calendar rhythm method and contraceptive candles.*

*The majority of respondents either have never heard of the emergency contraception, or do not have a clear understanding of this method of contraception. Though, after having been informed about the emergency contraception by the interviewers, Part of the respondents (including the respondents who have already had information about the emergency contraception) display their mistrust towards emergency contraception, in general, due to their complicated side effects.*

## 9. THE PROBLEMS WITH ABORTION AND FAMILY PLANNING IN THE COUNTRY (BARRIERS, DISCOMFORT, SOLUTIONS TO THE PROBLEM)

Some of the problems pointed out by the respondents during the survey were combined on the basis of being qualitatively homogenous and were organized into the following categories:

- Lack of finances and unfavourable social status;
- Low level of public awareness;
- Selection abortion;
- Cultural stereotypes and/or a mental or psychological factor;
- Religious Factor;
- Non-existence of family planning culture.

*“The problem is in mentality; for example, pregnant single young women, single mothers – people who are ignored and neglected by the state as the state provides no support for women who fall in this category”. “If a woman is pregnant outside of marriage, the whole society seems to be against her, people display aggression towards them and their private lives frequently become subject of discussion, and people tend to judge them, which is unacceptable in itself, as it is an infringement of the inviolability of private life. As for the medical personnel, in spite of the fact that their duty is to be impartial and unbiased and to offer quality service to all patients, it is not always the case and women have to face the same problems there – at health-care facilities - women become the targets of negative gossips and judgment; there have been many cases when doctors refuse to perform abortion on religious grounds; At least I have heard of such cases and I think it is not acceptable; as religion is my choice and if a doctor refuses to perform this procedure, why he or she needs a gynaecologist’s medical license? Then they shouldn’t be gynaecological surgeons” (a woman aged 26, from Tbilisi).*

As is evidenced from the answers provided by the respondents, the factors are interconnected and interrelated and have a common basis that is low level of awareness and lack of financial means. For example, selective abortion, nonexistence of family planning culture, cultural stereotypes and other psychological aspects are mental peculiarities, which feed on low level of awareness. The attitude of the women participating in the survey towards selective abortion should be mentioned herein: on the one hand, they pointed out that the sex of the foetus had not been important factor when they made decisions to have an abortion, though, on the other hand, selective abortion was named as one of the key factors of abortion or family planning-related problems in the country.

**Barriers to accessing a safe abortion service are as follows:**

- A family conflict on the grounds of abortion;
- Having problem with leaving a child (children) when paying a visit to a doctor;
- Illegal abortion service/ self-induced abortion;
- Being worried about your health when visiting a doctor you do not know;
- Violation of the confidentiality right;
- Lack of professionalism and indifferent attitude displayed by doctors: *„Any doctor’s duty is to explain everything in details to their patients and to inform them about everything they are supposed to know; but doctors tend to be reluctant and not to feel like answering any questions asked by their patients”. “They want to have their patients and would not appreciate it if any of their patient visited other doctors; as this would mean less money for them” (a woman aged 40, from Khashuri);*



- Unawareness and the reluctance to take or the desire to avoid responsibility displayed by partners/husbands: “I would like to highlight a psychological factor... There is no one who can stand by you; they don’t think it is a problem and it makes things worse. And when you have to return to your everyday routine the next day... This is the most difficult aspect, I think”;
- Cost of contraceptives;
- Territorial barrier: *“Women who live in villages can’t readily get into a town; they have to travel a long distance and it is expensive; Then they make decisions to resort to self-induced abortion, which in most cases has negative consequences, some develop bleeding... there are cases when ambulance cannot arrive in time to find them alive and their children become orphans. The main barrier, I think, is that health-care facilities are too far from some places and there is a lack of ambulances. There are only two ambulances in Senaki, can you imagine how many villages they have to serve? No, we are not well informed we need to learn much and be well-equipped with appropriate information in order to make a well-informed decision regarding any sphere” (a 40-year-old woman from Senaki).*

As it was evidenced from the results of the survey, the barriers to the availability and provision of safe abortion include: system barriers (inadequate attitude displayed by doctors, cost of contraceptives, violation of the confidentiality right, territorial inaccessibility), personal and/or individual barriers (fear, a family conflict, have no one to leave your children with) and cultural and mental barriers (unawareness and the reluctance to take or the desire to avoid responsibility displayed by partners/husbands). Inadequate treatment displayed by doctors and violation of the confidentiality right were considered as the two most significant barriers to the availability and provision of safe abortion, though the majority of respondents did not report about having experienced such facts. Apparently, some of the respondents did not consider such facts as significant barriers for themselves.

According to respondents, **the discomfort** related to reception of an abortion service is created by psychological, financial, system-related, territorial and religious factors, such as, feeling depressed and nervous; lack of financial means; the abortion procedure itself and physical pain and distress related to the abortion procedure; long distance to a health-care facility; experiencing a loss of a child; indifference displayed by doctors; harm done to the mother’s health as a result of an abortion; acting against their religious beliefs. *„Words cannot describe what mothers feel at that time. You realize that you are committing a grave crime, but you still do it. That was what I felt. I could realize that it was a big mistake but I simply had to do it” (a woman aged 38, from Tbilisi).*

**Ways to solve the problem:** the respondents offered different solutions to the problems related to abortion:

- Ensuring availability of contraception (for example, reduced prices on contraceptives, free distribution among the population, geographical availability, etc.) and raising public awareness of contraceptives, counselling service provided free of charge (including psychological counselling): *„A doctor used to come to the place I live - to Alvni and she would talk to us informing us about different methods of birth control and she used to distribute some contraceptives free of charge to women who expressed the desire; people here used to be interested and the demand on contraceptives was quite high. It will be good if people are offered such possibilities, it will help decrease the rate of abortions”.* (On the other hand, it should be mentioned that an opposite view was also expressed, meaning that availability of over-the-counter contraceptives may have adverse effect on women’s health, in case they decide to take them arbitrarily without consulting doctors);
- Raising public awareness - Information campaigns, distributing brochures;
- Affordable safe abortion service – *“The service should be affordable for everyone and doctors should enthusiastically share the relevant information” (a woman aged 33, from Senaki);*

*“Why should a pregnant woman, living in a rural area, be deprived of the possibility to pay a visit to a doctor, why should it cost so much? They need the service as much as women living in the urban areas. Nowadays there are frequent cases of children born with different disabilities and why should some mothers be deprived the possibility to learn about their future children’s health? In some cases, getting information in a timely manner will help parents cure a defect during the pregnancy when the baby is still in the womb, even some medicines can cure them. That’s why doctor’s counselling service should be affordable and available” (a woman aged 29, from Senaki);*

- Fight against stereotypes: *„Stereotypes about single women should be overcome and attitudes towards one another should be changed, I think so. All should be treated as equals. If division of a society on the base of status, social or economic situation, etc. was no longer practiced, the world would be a better place to live in” (a woman aged 32, from Senaki);*
- Doctors should observe ethical and professional norms while treating their patients;
- Introducing medical insurance packages, covering an abortion service;
- Medical examination of women should be free or at least affordable;
- Psychological service: *“Psychological support and involvement of psychologists is important in these directions. In general, I think psychologists should be involved in issues related to family planning and they should provide counselling service to people, which should be provided and ensured by the state” (a woman aged 37).*

## Conclusions:

- ***Financial situation and low level of public awareness are the two key factors causing abortion- and family planning-related problems in Georgia. Other factors are closely related to these two factors;***
- ***The barriers to accessing a safe abortion service are as follows: family conflicts, lack of professionalism and indifferent attitude displayed by doctors, contraceptives being not affordable, territorial barriers (geographical unavailability);***
- ***The main discomfort related to the abortion service is the abortion procedure, as well as psychological factors, such as fear, stress, post-abortion psychological problems such as PAS and etc.;***
- ***Another important aspect is low level of awareness among population about reproductive rights, as well as legal supportive mechanisms.***

***The solutions to the problem offered by the respondents include: raising public awareness, fight against relevant cultural stereotypes; availability of effective psychological care; measures taken at the level of health-care service provision, in particular, medical insurance packages and free counselling services.***

## Conclusion

The qualitative survey aiming at identification of the barriers to safe abortion services was carried out by the Association “Hera XXI”; **the purpose of the survey was** to assess different services of safe abortion and availability of family planning methods, as well as identification of the ways of solving problems associated with abortion and family planning in the country.

For the purpose of identification of barriers to accessing induced abortion services, some reasons

for abortion (both general and personal) were analyzed. According to their quality, the reasons can be grouped in three major categories: material, psychological and social.

The results of the survey helped identify the following barriers to accessibility to safe abortion services:

**Material** (lack of finances) and **psychological** (e.g. lack of support from family members) **problems** and **unfavourable social situation** of the respondents participating in the survey often served as a reasons for the women to make decisions regarding the termination of pregnancy or performing life-threatening actions, which, in its turn results in violation of a number of reproductive rights.

**The problems of geographical availability** – especially faced by women living in rural areas far from a regional centre and/or women living in the mountainous regions of the country and is closely associated with economic factors; e.g. for relatively well-off respondents remoteness from a health-care facility does not represent a barrier (from the viewpoint of costs associated with the travel to the health-care facility), unlike the hard-up respondents. **It is of utmost importance for a state policy to maximally support realization of reproductive rights and to ensure equal access to and equal availability of medical services for the population concerned.**

**Lack of financial availability of abortion services** – because of the high costs associated with abortion services, women often have to borrow from a bank or to resort to illegal abortion.

**Pre-abortion counselling service gaps** – majority of the women participating in the survey had not undergone appropriate examinations before an abortion procedure (the patients who did, only had had ultrasound examinations and general blood tests); complete information of the patients' health status had not been collected; some facts of violation of confidentiality were revealed; the patients were not fully informed about possible post-abortion complications; The patients were not informed in writing about the possibility to delay or cancel abortion if desired by the patient; only a small part of the women interviewed had been fully informed about different methods of abortion (as in majority of cases the respondents had received their abortion services at early gestational ages (2-8 weeks), a vacuum aspiration procedure (so called "mini abortion") was the method preferred by the women).

**The five-day waiting period** is considered inefficient by many women participating in the survey, based on the argument that women make decision to have an abortion after considering too many factors and do not easily change their decisions. Delays in the provision of the abortion service: a) put a strain on the psychological state of women; b) create geographic barriers for women living in rural areas far from a regional centre and/or women living in the mountainous regions of the country.

**Gaps in post-abortion care** – like in case of a pre-abortion counselling service, patients are not fully informed about the components of post-abortion care or the service remains completely unavailable.

Low level of awareness of **issues concerning family planning** among the respondents is noticeable: part of the respondents had never heard of contraception and some associate contraception with only medicines. The level of awareness of emergency contraception among the respondents is even lower.

Considering the above mentioned, the problems associated with receiving safe abortion services are due to systemic (e.g. services (pre-abortion counselling service, post-abortion care, the five-day waiting period), legislative, etc.)), geographic (remoteness), individual (decision-making, psychological and emotional state) and economic factors, which can be summarized into two major characteristics (analogues to the reasons for abortion): a material factor and lack of awareness.

## RECOMMENDATIONS

- Provide women with the opportunity for making free and informed decision on safe abortion and family planning, through providing free and non-discriminatory environment;
- Revise Article 140 of the Law of Georgia on Health Care, and define the abortion advertising. Identify and dissociate from abortion advertising, distinguish between advertising abortion and informing women about safe abortion;
- Integrate sexual and reproductive health and rights issues in the editorial policy of the Public Broadcaster – prepare information programmes and coverage on issues related to sexual and reproductive health and rights, for the purpose of raising public awareness;
- Strengthen information campaign on safe abortion: information meetings with population, information leaflets, brochures; ensure fulfillment of objectives envisaged in the maternal and newborn healthcare strategy and relevant action plan, including in the field of family planning and adolescent sexual and reproductive health;
- Finance preventive programs at the municipal level for the purpose of reducing number of undesirable pregnancies;
- Revise the state-funded Rural Physician Program, for the purpose of inclusion of sexual and reproductive health counselling service in the programme;
- Create an inter-healthcare facility referral system tailored to the needs of women living in rural areas, for the purpose of ensuring awareness raising, consultancy and availability of sexual and reproductive health services;
- Compile a list of essential medications and ensure inclusion of modern methods of contraception, including that of emergency contraception;
- Introduction/reinforcement of the component of psychological support in the pre- and post-abortion counselling service; ensure management and treatment of Post-Abortion Syndrome (PAS);
- Introduction of differentiated packages, for socially vulnerable and rural women, in the universal health care programme, for the purpose of enhancing affordability of the safe abortion services;
- Ensure support for the implementation of the quality control mechanisms envisaged by nationally applicable guidelines and protocols and introduction of Internal and external audits for the purpose of quality assurance;
- Introduce principles for supporting supervision in healthcare facilities, for the purpose of ensuring timely response to the results of monitoring and provision of high quality services;
- Overview the legislation on the five-day waiting period, re-evaluate its efficiency and perform an evidence based review of the decision on the increase in the waiting period under the 2014 amendment to the Law of Georgia on Health Care (Chapter 23, Article 139, paragraph B);
- Facilitate access to the services of safe abortion and family planning performed at an early gestational age, in primary health care facilities, for the purpose of prevention of post-abortion complications and repeated abortion;
- Include family planning services and modern methods of contraception in the basic package of the Universal Healthcare Program, for target group of beneficiaries;

- ☛ Train pharmacists in providing clients with information about emergency contraception and abortion pills;
- ☛ Promote inclusion of the knowledge related to sexual and reproductive health and relevant skills development in teachers' professional development programmes;
- ☛ Facilitate education on the management of healthcare facilities based on the principles of patient-oriented services;
- ☛ organize trainings for healthcare service providers on approaches based on gender sensitivity and human rights, for the purpose of provision of patient-oriented services;
- ☛ organize trainings for family physicians and gynecologists in the technologies related to family planning methods and counselling on safe abortion services;
- ☛ Organize trainings for nurses living in rural areas on counselling on methods of family planning and counselling on safe abortion, serving the purpose of facilitating realization of reproductive rights of women living in rural areas far from regional centres and/or women living in the mountainous regions;
- ☛ Organize trainings for psychologist on sexual and reproductive health, in the context of physical, social, and mental welfare;
- ☛ State shall ensure the statistics of cases, in which doctor refuses to perform abortion services on religious grounds, and refers women to another doctor; prevent the threat of human resources deficit;
- ☛ Revise and update the protocol on safe abortion, in accordance with the terms indicated in the same protocol;



## Annex 1: In-depth Interview Guideline

### (Discussion Plan)

I would like to greet you and introduce myself to you. I am \_\_\_\_\_ and I represent “Hera XXI”. The Association “Hera XXI” is conducting a survey aiming at identifying some common barriers to availability of safe abortions among the women of reproductive age. For this purpose a series of interviews has been planned, and based on the analysis of these interviews an analytical report will be developed.

The sole purpose of your interviews being recorded in the form of audio files is to analyze them later (the files will help us remember all the information you provide us with). The files will only be kept with the Association “Hera XXI” and some excerpts from your interviews – a sentence or two – can be used in the report or anywhere observing your right to confidentiality and anonymity i.e. without personally identifiable information such as your name, surname, and other personal data. If you agree with the conditions offered by us, we can start the interview and, please answer each question as honestly as possible.

(a note for the interviewer: while introducing yourself to the respondents and explaining to them the purpose of the survey, you should make sure that your respondents are informed about the fact that their right to anonymity will be strictly observed, i.e. their identity will not be disclosed either in the survey results or anywhere; briefly explain to them the principle used in selecting them for the interviews and ask for their consent to be interviewed before you start interviewing them).

1. Ask your respondent to give a brief information about herself (her age, her marital status, her family, education, occupation, etc. - primary data).
2. Are you married or have you ever been married? **(if yes)** – How long have you been married / how long were you married? Do you have a child/children? How many children do you have? How old is your child/are your children? **(A note for the interviewer: ask the following questions to every respondent, irrespective of the fact whether they are married or not at the moment of the interview)** What do you think about large families, i.e. families with three or more children? What does the “Marriage”, “family” and “children” mean for you? What do you think can be the most common reasons women choose to have an abortion?
3. How many abortions have you had? When did you have your first and last abortions **(A note for the interviewer: ask the respondent to name the year she had her first abortion and the year she had her last abortion)**? How old were you at the time you had your first abortion?
4. What was your gestational age at the time of your first abortion **(A note for the interviewer: if the respondent has had several abortions, ask her to name an average gestational age at the time of abortions)**? If your gestational age at the time of your referral to an abortion service was 12 weeks, what was the waiting period you were given before you received the abortion service?
5. What served as the main reason for having an abortion in your case? (e.g.: territorial, cultural, social, religious) How long did it take you to decide to have an abortion? What did you feel while making a decision to have an abortion? What or who helped you to make a decision to have an abortion? Did you make the decision to have an abortion independently?
6. Were anyone involved in the process of making decision regarding abortion and if yes to what extent were they involved? (e.g.: your spouse/partner, family members, etc.). Do you make decisions regarding the family planning or the use of a method of contraception together you're your spouse or partner? In general, who should make the decisions regarding the above mentioned?

7. What type of abortion had you planned to have? **(A note for the interviewer: e.g.: before her last abortion; or you may ask her whether she had considered a type of abortion she would have, before her visit to the health-care facility).** Have you ever asked for advice regarding a method of abortion? **(if yes)** Who did you ask for advice regarding a method of abortion?
8. Is there a health-care facility providing medical abortion service near the place you live? (if no) Where do you have to go to receive appropriate service when you have decided to have an abortion? How do you have to travel to the health-care facility providing medical abortion service and what is an average transportation cost? Do you think that the transportation is affordable?

**(A note for the interviewer: if your respondent has received abortion services offered by illegal facilities, ask her how far the facility was).**

9. Is the travel to the health-care facility associated with any difficulty (is the the health-care facility very far from the place they live; does it take her long to get to the health-care facility)? How long does it take her to get to the health-care facility? How many hours or days do you have to miss from your work or studies to receive a pre-abortion consultation and an abortion service?
10. If anyone accompanied you when you visited a health-care facility to receive an abortion service, did they have to miss work?
11. **If the respondent has a child/children**, ask her: Have you had a problem leaving your child/children? Have you had any salary deductions due to the missed work (due to missed hours or days)? Have you had to visit a health-care facility twice (to receive a pre-abortion consultation and abortion service)? Have you ever had to find a place to spend a night, while being away from your home, in order to avoid travel in case of need for a repeated visit? **(if yes, ask the respondent to name the type of accommodation they used to spend a night; e.g. with a relative, with a friend, renting an apartment near the health-care facility; booking a room at a hotel, etc.; and ask about the cost she had in relation to spending a night away from her home (including a present she had to buy for her relative or friend for allowing her to stay with them for a night)).**
12. Can you describe the abortion service provided to you at a health-care facility as affordable? If you considered abortion service price not affordable, did the health-care facility offer you an alternative health-care facility where you could receive an abortion service affordable for you?
13. What were your emotions and feelings associated with your first visit to a health-care facility providing abortion service? Had you already made a firm decision concerning having an abortion when you visited a health-care facility? **(A note for the interviewer: If the respondent have had several abortions, ask her whether she had made a firm decision concerning having an abortion every time she visited a health-care facility). (If not),** Why? Do you think that women paying their first visit to a healthcare-facility to have an abortion need any psychological support i.e. a support provided by a psychologist?
14. Had your doctor tried to dissuade you from having an abortion **(A note for the interviewer: if the respondent has only used abortion service provided by unlicensed doctors, ask her the same question about unlicensed doctors)?** (if yes) What were the arguments used by the doctor (e.g.: arguments of a medical, ethical, social, or religious character)?
15. Did you receive a pre-abortion consultation service when paying a visit to a health-care facility to have an abortion? **(A note for the interviewer: explain to your respondent what a pre-abortion consulta-**

**tion means<sup>10</sup>. (If yes)** Who conducted the consultation (a gynecologist, a family doctor specialized in the reproductive health care, a nurse, a midwife or someone else)? Had your doctor helped you to make an informed decision? Were you given an opportunity to learn about abortion procedures from a patient's guide?

16. What was a general attitude displayed towards you by the medical personnel you had communicated with? Did you experience any kind of discrimination (on the grounds such as: your age, status, ethnic origin, religion)? **(If the patient has experienced discrimination on the grounds of her age)** What was the reason for the doctor's refusal to provide an abortion service? Did the doctor ask for your parent's or guardian's attendance or consent? (In case your patient was a minor at the time of her abortion) Did you signed an informed consent form yourself?
17. Where did the pre-abortion consultation take place? How many people attended the pre-abortion consultation? Did the environment give you a sense of security? Were your rights to anonymity and confidentiality protected? Did the medical personnel at the health-care facility provide you with the information about who should you address your complaints to in case your rights were violated? Did the doctor display empathy and support? Did the doctor ask questions to get detailed information about you? Did you have required medical examinations before abortion? Did your doctor inform you about different methods of abortion? Did your doctor recommend any of the abortion methods which he/she thought was appropriate in your case?
18. Did your doctor inform you about possible complications **(A note for the interviewer: do not give your respondent a list of possible complications; your respondent has to name possible complications; if your respondent fails to name any possible complication, give them a clue: some of the possible complications include: uterine rupture, bleeding, cervical tears, death, infectious complications)** and advantages and disadvantages associated with each abortion method? Was it you or your doctor who made the final decision regarding the method of abortion? Were you informed about the possibility to delay or cancel abortion if desired by you - the patient? Was the language used by the doctor understandable for you? Was there anything not quite understandable for you in the information provided by your doctor? Were you sufficiently informed about possible complications and how did your doctor inform you about them **(A note for the interviewer: e.g.: ask your respondent whether their doctor highlighted particular possible complications and whether he/she informed her about the circumstances which might serve as the cause for possible complications)**? How can you evaluate the consultation service you have received from your doctor; was it unbiased **(A note for the interviewer: "biased" consultation means pressure used by a doctor to persuade a patient to have or dissuade a patient from having an abortion)**?
19. Did you receive a pre-abortion consultation service or were you informed about abortion in writing **(A note for the interviewer: information about abortion provided in writing means providing a patient with a patient's guide and an informed consent form, with detailed information about abortion)**?
20. Did your doctor refused to conduct an abortion procedure on some religious grounds? (If yes) Did your doctor referred you to another doctor or another health-care facility? What did you do after their refusal? Do you think that doctors might have had to behave differently in your case?
21. Please, recall your emotions and feelings after your pre-abortion consultation. Were you sure that you had made the right decision to have an abortion? Tell us about your positive and negative emotions and feelings and experience. Was the pre-abortion consultation service received at the health-care facility helpful, or not?

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10 A pre-abortion consultation includes discussing the following issues: methods of abortion and possible complications; consulting and helping patients to choose a method of abortion and supporting and allowing patients to make a decision independently; consulting patients on issues regarding family planning; procedures used by doctors to receive an informed consent from the patient in writing.

22. **(In case your respondent have had an abortion since October 2014)** Did your doctor inform you about the five-day waiting period before receiving an abortion service? Did you use the five-day waiting period before having an abortion or did you refer to another health-care facility before the expiration of the five-day waiting period? Did you have a so called “illegal abortion”? Did you use a method of self-induced abortion? How long did it take you to visit a doctor to have an abortion after your pre-abortion consultation? **(A note for the interviewer: in case your respondent had more than one abortion, ask her about each case separately).** Has your doctor ever offered an opportunity of using an alternative method in order to avoid the five-day waiting period, especially in case you live in a rural area or far from the health-care facility providing an abortion service (e.g.: referring you to another health-care facility; changing some records in your anamnesis, such as replacing the entry of abortion with a spontaneous abortion, or insertion of an intrauterine contraceptive device, etc.)?

**(Ask the respondents who: a) had abortion(s) before 2014, b) only have had so called “illegal abortion(s)” or c) have had abortions since 2014 but were not informed about the five-day waiting period, whether they have heard about the five-day waiting period and (if they have), ask them about the sources of the information and what they think about it. In addition ask them if their relatives or friends have ever heard of the five-day waiting period (in case they have) and about the sources of the information and what they think about the five-day waiting period.)**

23. **(A note for the interviewer: if your respondent has never heard of the five-day waiting period, you have to skip the question # 23)** Does or how does the five-day waiting period meet your requirements? Do you think that the five-day waiting period helps decrease the number of abortions or, in general, has an influence on a woman’s decision regarding an abortion? How do you think the five-day waiting period effect the emotions and feelings of women? Can a woman feel regret over her decision to have an abortion during the five-day waiting period? Do you think that the five-day waiting period can help create time-related and territorial barriers (e.g., a repeated visit to a health-care facility to receive an abortion service, especially for women who live in regions or rural areas and have to travel a long distance to get to a health-care facility providing abortion service? Do you think that the five-day waiting period should exist?
24. Have you ever changed your mind regarding your decision to have an abortion? Why? Was there anyone who influenced your decision? **(If yes)** What kind of influence did you experience? Who had an influence on your decision?
25. As for the abortion procedures: Have you ever had pre-abortion ultrasound examinations? Have you ever had any pre-abortion laboratory examinations?
26. What did you feel while having a pre-abortion ultrasound examination? Did you hear the foetal heart beat or see the foetus on the screen? Did it have an effect on your emotions and make you change your decision to have an abortion? Did you ask or were you told about the sex of the foetus? If yes, was it a girl or a boy? Did it make you change your decision to have an abortion?
27. Have you heard about self-induced abortion? **(if yes)** What information do you have on self-induced abortion and who provided you with the information? Have you ever used a self-induced abortion method? **(If yes)** Which self-induced abortion method have you used **(A note for the interviewer: DO not list self-induced abortion methods for your respondent, allow her name the method(s) she has used. If the respondent has not understood the term “self-induced abortion” correctly, explain its meaning briefly: e.g., taking drugs; taking home-brewed herbal remedies; having hot baths; uterine washing and physical loading)**? Did the above mentioned methods cause any complications, e.g. bleeding, etc.? **(If yes)** Who did you refer to? What were the reasons for your decision to use a self-induced abortion method?
28. What kind of post-abortion service did you receive right after the abortion? Were you offered a psychological support, i.e. a consultation with a psychologist? Were you offered an appointment 7-14

days after an abortion procedure? Did you receive a consultation about family planning and/or methods of contraception? **(If yes)** Who provided the consultation service about family planning and/or methods of contraception? Was the information material – printed booklets about abortion, family planning service, modern methods of contraception and where and how woman living in Georgia can buy the contraceptives or get appropriate service – available in the health-care facility?

29. Do you use any method of contraception at the given moment? **(If yes)** Which method of contraception do you use at the given moment? Do you think that the contraception method is effective? Would you like to change the contraception method you are using currently?
30. Have you heard of the emergency contraception? **(A note for the interviewer: If the respondent has heard of the emergency contraception, ask her the following questions)** Have you ever used an emergency contraception? Where did you purchased an emergency contraception means? Was it affordable or available? Did you consult your doctor before using the emergency contraceptive? **(A note for the interviewer: if your respondent tells you that she did not consult her doctor before using the emergency contraceptive, give her a booklet about the emergency contraception and ask her the following questions)** Would you have used an emergency contraceptive in case you had had information about emergency contraception? Would you have used an emergency contraceptive as an abortion alternative? **(A note for the interviewer: ask the following questions to all respondents)** Do you think that that emergency contraception helps women to avoid abortion? Would you use an emergency contraceptives?
31. What do you think are some problems associated with abortion and/or family planning in the country? What are the barriers to the availability and provision of safe abortion? What is the worst thing related to the abortion service (according to the personal experience of your respondent and according to the general opinion? What are some solutions to the problems related to abortion?
32. Would you like to add anything? Or is there any abortion- an/or family planning-related issue. Which was not covered in the interview and you would like to comment on?

***Thank you for the interesting interview!***



## **Annex 2: Women's Stories**

### **MARIAM 26, FROM TBILISI**

I am a psychologist and I work at a nongovernmental organization as a psychologist. I have never been married. When I learned about my unplanned pregnancy, I decided to have an abortion. I was not ready to have a child and, besides, my family would disapprove of me having a child outside of marriage. I live with my mother and my brother. In addition, at that time, I was dating a man who was my temporary partner and he did not want the child either. As soon as I learned about the pregnancy, I decided to go straight to the gynecologist. It was during the fourth week of my pregnancy, and I knew I would have had to deal with even more emotional distress in case I had postponed the procedure. Therefore, the most important thing for me was to have that abortion done as soon as possible. The consultation with a gynecologist and the abortion procedure were quite expensive. Besides, I needed medicines after the procedure. I could not afford it as I was studying and I was not earning a stable income. Fortunately, I had worked in Batumi that summer and I had saved some money. My first visit to the clinic was rather dissatisfying. The first question the doctor asked me was whether I was married. Even though I went there determined to have an abortion, it was hard for me to make a final decision. The situation in the clinic was far from comfortable. During the consultation, some people would walk into the doctor's office either to tell her something or to borrow something and then they would walk out of the office; there was no such thing as anonymity there. There were a lot of people in the waiting room as well. A woman who had entered the doctor's office before me was having her abortion carried out directly in the office, so that I could see the surgical instruments being rinsed off blood. It was totally depressing. Doctors tend to stigmatize women who come to them to have an abortion. They do everything without showing any emotions. The procedure is inconvenient. They are not supportive at all. They regard you as the one who has made a big mistake and not as the one who needs their support.

### **ANA 23, FROM IMERETI**

I had an abortion a year ago. I got married when I was 22 and got pregnant right away. I was very happy and had great plans. I did not know then that I was pregnant with twins, but I used to think about when and how my baby would be born. During my first prenatal visit with a doctor I was told that something was not as it should have been. 10 days later I paid my second visit and the doctor told me that the fetuses had not developed or grown any millimeters, neither their heart beat could be heard, therefore, they concluded that it was an involuntary fetal loss – a miscarriage. This was a very big stress, which I am still struggling to overcome. I had never ever thought about abortion before that. The doctor sounded categorical when she told me that the abortion was inevitable. I had an abortion under an enormous emotional pressure. The decision was made only on the basis of an ultrasonography. The doctor told me that a medication abortion procedure was to be performed immediately. She did not even lead me to a doctor's office. The decision was made right in the hall, where there were dozens of people. Then someone advised her to have additional medical examinations done before abortion and it was then when she finally took me into a separate room, though we were not alone there either, as nurses were coming in and out that room. I found myself way more stressed because of the doctors' behavior there. I am a lawyer and later I learned that the procedures were against all rules. I phoned the Ministry of Health, where I was told that the doctor had first to confirm whether it had been a miscarriage or a fetal growth restriction and developmental delay. They had not done so. In addition, it turned out that the medication abortion is not subject to inpatient hospital care and therefore I could not get any notice of illness. I had missed an exam at the university due to that abortion and as I failed to submit a notice of illness, I had problems to take that exam.

## **MARITA 27, FROM TBILISI**

I had to move to a rural area when I got married. I had my first abortion when I was 21. It was soon after I had had my first baby when I learned about my second pregnancy. My husband's family made the decision that we couldn't afford having the second baby as we were being financially supported by my parents-in-law. It was because of that dependence that we couldn't act against their will; otherwise I could have found myself homeless living on the streets with a newborn baby. I preferred to give up thinking about the second baby. It was such a difficult decision that I wished I could die. But eventually I decided to have an abortion, I already had a child and he needed me as a mother. I was 26 when I had my second abortion. Then I was already divorced and was not morally, psychologically or financially ready to have another baby. I felt that I needed a psychologist's help even before my visit with a gynecologist. Doctors take things like this easy; I cannot say that they treat patients badly or do not pay any attention to them... but still... I disapprove of the law on abortion, which envisages a five-day waiting time for a woman to make a final decision about whether to proceed with an unplanned pregnancy or not. This makes the process even more complicated as the women are under enormous pressure while making the decision on abortion. When they send you back and you know that you have to come back to the place again, it only adds to your stress. Especially when you have to travel from a village to the town. When a woman goes to the town and then again after five days, people may guess that the reason for your visits is abortion.

## **EKA 28, FROM KVEMO KARTLI**

I have been married for 9 years and I have 3 children. I am a lawyer and I run my own business. I have had abortions twice and in both cases I had the abortions during the fourth week of my pregnancies. First time I had been given abortion pills at a medical facility and the second time I took them myself. The first time it was soon after I had had one of my babies and I had some health-related problems and was taking some medicines, and I thought it was risky to have a baby then. The only people in our family who knew about that pregnancy were my husband and me and we made the decision together. I consulted with a gynecologist to help me choose the right type of abortion procedure. The medication abortion might seem the easiest, but actually it is not. I could not make a decision until the last minute. Doctors tried to dissuade me from having an abortion, saying it might have been a boy. But eventually I had that abortion. On my first visit with the gynecologist I was told that I could have had the abortion only after five days. I came back only after 10 days. This waiting period adds to your stress and can lead to prolonging the suffering and deepening the regret, as, if a woman is determined to have an abortion, a five-day waiting time can do nothing to make her change her mind. When I decided to have an abortion for the second time, I went to the chemist's and bought the pills they had given me in the medical center during my first abortion and I took them. I did not have any complications. My advice to everyone is to try to prevent such problems and to ensure that they will not have to regret something they have done. I advise them to use contraception. Nowadays women are offered a variety of ways of birth control.

## **MAIA 35, FROM SAMEGRELO**

I was married for 6 years. Now I am divorced. I have a child. I am a housewife now, even though I have received higher education. I had an abortion in 2016 at the age of 33 and it was during the fifth week of my pregnancy. The reason for my decision was that I had divorced my husband not long ago. Bringing up a child in a single parent family did not appeal to me and that was why I made the decision to have an abortion. First I hesitated, however after realizing my situation, I understood that I would not be able to bring up a child as a single parent. Reasons for a decision to have an abortion include economic problems or unplanned or unwanted pregnancies (pregnancies outside of mar-

riage). I decided to have a self-induced so called “mini abortion”. It was an early stage of pregnancy and I knew I would have been advised to have the “miniabortion” if I had consulted with a gynecologist. Therefore, I decided not to consult with anyone. My doctor had tried to dissuade me from having an abortion, saying that I could have helped improve the demographic situation in my country by giving birth to a healthy child and I was 33 years old then. But I did not listen to her. My doctor informed me about the five-day waiting time before the abortion but I wanted to have the abortion as soon as possible, as I could realize that the older the fetus would grow, the more difficult it would have been for me to make such a decision. Therefore, I made a spur-of-the-moment decision and had the abortion the same day. The doctor registered the procedure as a premature termination of pregnancy. I think that the five-day waiting time before abortion can do little to reduce the number of abortions. Involvement of a psychologist, assistance and support on the part of social agencies, support from a lawyer, etc. might make sense, otherwise it is in vein. Judging from my experience, our mentality and the attitude towards single mothers displayed by the state and the society are the primary causes of increasing number of abortions in our country.

### **EKA 35, FROM GURIA**

I am a housewife and my highest attained level of education is secondary education. I have two children. I have been married for 17 years and have had 15 abortions during this period. I had my first abortion at the age of 19 and my last abortion three years ago, at the age of 32. In general, I had my abortions from the sixth to the eighth week of my pregnancies. The main reason was the extreme poverty. My husband was the initiator of the abortions as he found it difficult to sustain our family. Every time I found it hard to make such a decision. I worried a lot but there was nothing else to be done. I had almost all the abortions in medical facilities. Doctors had never tried to dissuade me from having those abortions. I used to be given 2025 minutes to make the decision and then I had abortions. I had never had any medical examinations; though doctors used to inform me about possible complications. I remember once a doctor told me that after so many abortions I might have had problems getting pregnant or problems with my ova. It was only once when I decided to perform a self-induced abortion myself – I took some activated charcoal and it cost me a lot as I came down with inflammation. I did it because I could not afford a visit with a gynecologist. I have never heard of a five-day waiting time. I used to make these decisions without a help from a doctor. I used to ask myself whether I could afford another child or not. In general, if a woman makes a decision to have an abortion, it means that she cannot afford another child as she lacks appropriate conditions. Therefore, I think that this five-day waiting time only adds to the stress for any woman.

### **MAKA 26, FROM KVEMO KARTLI**

I was at school when I got married and I did not continue my studies. I have been married for 10 years and have three children. My first pregnancy ended with an abortion. I was 16 and it appeared that my body was not ready for pregnancy. The doctor told me then that my child and I might both die and I was obliged to have an abortion. I had my second abortion at the age of 17 and the reason again was a poor health of the fetus. I had three more abortions and the reason was unfavorable financial situation, i.e. poverty. I felt no regret or fear when I had my first two abortions as I was very young and my health was concerned. As for the subsequent abortions, I felt terrible, but I had no choice. I knew I could not bring them up and I preferred abortion to watching my own children being starved. Besides, I did not make these decisions alone my husband, my mother-in-law, my sister-in-law, and other family members were all involved. Doctors tend to be very cold and indifferent. Instead of taking care of their patients, the only thing they care about is money. I do not know whether this can be considered as a discrimination or not, but I think that the reason for them being so indifferent and inattentive was the fact that I was from a village and I did not know much. Now we

are not allowed to pay some extra money to doctors for the service they provide, and they are not at all interested in how we feel, what problems we have, etc. It should not be so – doctors should not be focused on making money. The main problem for women living in rural areas is that we do not know much about contraception. If I had known about the existence of emergency contraception, I could at least have had fewer abortions. We do not even know where to get this information. Doctors feel reluctant to answer the questions we ask them and who else should we ask?

### **GVANTSA 36, FROM KAKHETI**

I have been married for 19 years and I have two children. They are 18 and 13 years old. I have had two abortions. I had the second abortion two years ago. It was during the third months of my pregnancy. It took me a long time to decide to have an abortion. It was because I wanted a son. I have heard that some woman decide to have an abortion because they can't afford another baby as they are poor. But there are also the cases of selective abortion. Fathers always want to have sons and women often decide whether to have an abortion or not only after they find out their unborn babies' sex. I have heard that some woman decide to have a self-induced abortion: lifting heavy things and so on. I tried lifting heavy things but it did not work and I was obliged to visit a doctor. I was treated normally at the hospital. They asked me a lot of questions, talked to me, examined me and gave me a five-day waiting time. I went back in a week and had an abortion.

### **SOPHO 35, FROM KAKHETI**

I did not continue studies after graduating from a secondary school and now I work at a village bakery. I have two children. I have had an abortion only once. That was because I could not afford another child as my child went to school and needed so many things, and my husband was unemployed at that time. This is the most common reason for women to decide to have an abortion as, I think, all women desire children. Some couple in the village decide to have abortion because they want a son and they learn that their future child is going to be a girl. The selective abortion of female fetuses is quite frequent. It did not take me long to decide to have an abortion. I had no choice and postponing the abortion was useless. My husband knew about it, but it was me who decided to have an abortion. I think that women should decide such things. A medical center is not far from the place where we live, but the service there is expensive. I could not afford it. My neighbor had told me about a woman who performed abortions and did not charge much. So I went to that woman. It was not very cheap but her service was not as expensive as that provided in the medical center. I left my child with my husband and went to that woman accompanied by one of my neighbors. We had called her in advance and she was waiting for us. We did not ask anything to each other – I did not have anything to ask her and neither did she. She performed the abortion as she thought was appropriate. When she noticed that I was a bit nervous, she tried to comfort me and she performed the procedure only after I had calmed down. I have heard a lot of stories about the women who have self-induced abortions. My neighbors have told me about hot bathes, some herbs, about women who lift heavy things or take some pills. Of course, the problem is that women cannot afford to go to a hospital and have the procedure performed safely, but when you have no choice, you risk. Everything depends on finances

### **NATIA 28, FROM SAMTSKHE–JAVAKHETI**

I have three children; they are 10, 8 and 2 years old. I am a housewife now, even though I have received higher education. I have had six abortions. In all the cases I made the decision together with my husband. The main problem in rural areas is the remoteness from medical facilities. I live in a village and I have to go to the town to consult with a doctor or to have an abortion. The distance is

long, the journey is expensive. The cost of the procedure itself is expensive, and I had to pay more and more every time I had an abortion. I had a problem of leaving my children. I took them with me several times. Last time I had an abortion, I asked my friend to stay with them as there were not young and I could not take them with me. I have never heard of a fiveday wait time, but in my case it would not have worked. I would not have changed my mind. It would have increased my expenses and that is all. Contraception is another problem for us – for the women living in rural areas. There is no chemist's near the place where we live. In addition, we have financial problems as well. We do not have much information. I learned about the existence of emergency contraception not long ago.

## **TAMUNA 29, FROM SAMEGRELO**

I have been married for 10 years and I have two children. I have had an abortion only once. What made me arrive to this decision was the poverty and material problems I had. Then I found out that the fetus had some problems with growth and development and I finally decided to have an abortion. I made this decision independently; my husband knew nothing about it. In general, I think that such decisions should be taken jointly by a couple, but I found it difficult to inform my husband about it. I do not earn anything and as long as I did not tell anything to anyone, I had to borrow some money from one of my acquaintances to pay for the abortion procedure. I did not feel secured in the hospital. I was with the doctor and the nurse in the doctor's office but the door was open and other nurses and doctors came in and out. Another doctor took the form I had filled in with my personal information and took it somewhere, etc. The doctor asked me some questions before the procedure, but our conversation was far from being open and sincere, it was much more moneyoriented. Money is something that doctors are interested in the most. I had not informed about the fiveday wait period. I searched and found the information myself, but it made no difference. It only makes it easier for others to learn about your intention to have an abortion; they might decide to interfere and try to dissuade you from having an abortion. Otherwise, if a woman has decided to have an abortion, she will not change her mind in five days.