TECHNICAL REPORT

Center for Information and Counseling on Reproductive Health
„Tanadgoma“
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Qualitative research on barriers to accessing medical abortion among rural and internally displaced women in Georgia

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RATIONALE

The 2018 document “Human Rights in the Context of Sexual and Reproductive Health and Well-being in Georgia: Country Assessment” of Public Defender (Ombudsman) of Georgia mentions that numerous aspects of the legal and regulatory framework governing abortion appear to be problematic and not aligned with Georgia’s human rights obligations and the World Health Organization guidance.

It also emphasizes that while the Ministry of Health, Labour and Social Affairs Order provides a strong basis for respecting the woman’s dignity and her decision, the mandatory five-day waiting period and the language in the law prioritizing the fetus contradicts international health and human rights recommendations. A report indicates that 23% of the clinics do not offer pre-abortion counseling in an unbiased manner, as prescribed by the Order. For example, it is reported that doctors attempt to dissuade patients from undergoing abortions. In most cases, such efforts fail; however, there are reports of women deciding not to undergo an abortion after such dissuasion. It should also be mentioned that there is no oversight mechanism on the implementation of the Order nor on pre-abortion counseling and the nature and quality of the information to be provided to patients.[1]

It’s noteworthy that World Health Organization recommends the elimination of barriers including the mandatory waiting period, biased counseling, third party authorization requirement, and refusal on the basis of conscience[2].

The Protocol on Safe Termination of Pregnancy, established under the Order of the Minister of Health, provides for the referral of a patient in case of conscientious objection. Under the Protocol, if a medical service provider is against abortion based on ethical or religions grounds, the provider shall immediately refer the patient to other abortion service provider [3]. There are no other regulations on conscientious objection.

1.Abortion Services Availability and Readiness Assessment (Analytical Report), HERA XXI, RFSU, Institute of Social Studies and Analysis, 2015

2.WHO, Safe Abortion: Technical and Policy Guidance for Health Systems, 2nd edition.

3.Protocol “Safe Termination of Pregnancy”, approved by the order №01-182/o of the Miniter of Labour, Health and Social Affairs , dated July 28, 2014, is approved according to the decision of the National Council of Clinical Practice (Guidelines) and National Council for Development, Assessment and Implementation of State Standards for Disease Management (protocol), N3 meeting, on May 20, 2014, chapter 8.1.1, Informing, consultation and decision-making, para. 3, P.8

Under the Order of the Minister of Health, pre-abortion counseling is an interactive process, which includes providing support and additional information to the patient with compassion and without coercion. Information shall be provided in a simple and clear manner, with the guarantee of confidentiality, and based on the woman's needs. According to the Order, during counseling, the doctor is mandated not to express personal views and values. The patient shall also be informed on medical issues related to abortion and the post-abortion period and on legal requirements related to abortion. The patient makes the final decision on the method of abortion after she is fully informed about all possible methods, their advantages and the risks involved [4].

How compatible are Georgia's current legislation and regulations with World Health Organization recommendations and to what extent are regulations under protocol and legislation implemented?

Barriers to the availability and provision of induced abortion services violate women's right to health, private life, as well as their right to bodily integrity. Studies conducted around the world have shown various barriers such as system barriers, lack of awareness, distance from a medical facility and/or limited clinic options, the problems of geographical availability and affordability, waiting period, etc. Such barriers not only hinder fundamental human rights protection, but it might also lead to incorrect decisions made by women with regard to induced abortion, which in return further complicates access to abortion services and causes harm to woman's physical and psychological health.

4.Order №01-74/N of the Minister of Labour, Health and Social Affairs of Georgia, dated October 7 2014, on the" Approval of the Rules of the Artificial Termination of Pregnancy", Annex N1, Article 13

The issue of induced abortion is included in the Maternal & New-born Health Strategy 2017-2030, under the heading of Family Planning. It recognizes that primary healthcare workers do not usually have any (financial) interest in abortion, and therefore are more motivated to prevent abortion than specialists who perform abortions, who do have a financial interest. The Strategy also notes that unless family planning services can compete with the provision of abortion in terms of income for obstetrician/gynecologists, there is little chance that providers will take the time, energy and resources required to counsel clients appropriately and offer them a family planning method of their choice [5].

Sexual and reproductive health, rights and well-being are regarded in the context of fundamental human rights recognized by Georgia's Constitution and laws, international and regional human rights treaties ratified by Georgia. Issues of reproductive health are directly linked to such fundamental rights as the right to life and health care including the right to access health care services, non-discrimination, the right to privacy, self-determination, to be free of inhumane and degrading treatment and so on.

In light of current legislation and regulations, barriers to accessing abortion is a serious concern among rural and internally displaced women due to: low access to information on abortion procedure; women's lack of knowledge about their rights and right to freedom of choice; provider's neglect of pre-abortion counseling; provider's neglect of woman's right to choose.

5.Georgia Maternal and New-born Health Strategy 2017-2030, Ministry of Labour, Health and Social Affairs

GOAL AND OBJECTIVES

GOAL

The goal is to study barriers to accessing medical abortion among rural and internally displaced women in Georgia

OBJECTIVES

- Study the current factors that hinder access to medical abortion
- Study the nature of pre-abortion counseling in the context of access to medical abortion
- Study the impact of the 5-day waiting period on the access to safe abortion

GEOGRAPHIC SCOPE

The qualitative research was conducted in the following three cities of Georgia: Tbilisi, Batumi and Zestafoni

RESEARCH METHODOLOGY AND THE NUMBER OF PARTICIPANTS PER MUNICIPALITIES

- Zestafoni Municipality: 2 focus group discussions, 5 in-depth interviews, total participants - 22
- Adjara region: 2 focus group discussions, 5 in-depth interviews, total participants - 20

  Tbilisi: 19 in-depth interviews
- Total participants – 61

CRITERIA FOR THE SELECTION OF RESPONDENTS

- Woman of reproductive age (18-46 years old) is resident of 1. Municipalities of Adjara region 2. Zestafoni municipality in Imereti region; 3) Internally Displaced compact settlement of Tskneti in Tbilisi municipality;
- Willing to participate in the research on a voluntary basis;
- Have experienced medical abortion in the last 5 years (65% of respondents);
- Haven't experienced medical abortion, but have experienced surgical abortion (35% of respondents);
- Sign an informed consent for participation in the research.

PARTICIPANT RECRUITMENT AND ETHICAL ISSUES

Nonprobability Convenience Sampling qualified as the nonprobability method was used for sampling, during which all individuals under the study group (rural and internally displaced woman of reproductive age) who met selection criteria is proposed to participate in the research study.

ETHICAL ISSUES

Research protocol, questionnaires and form of informed consent were approved by the Institutional Review Board (IRB00009520, IORG0005619) of "Health Research Union" (certificate # 2020-1, 14/01/2020).

DATA COLLECTION AND ANALYSIS

The audios from focus group discussions and in-depth interviews were recorded per prior agreement with respondents. Detailed transcripts of focus group discussions and in-depth interviews were prepared based on audio recordings following the fieldwork. With the computer program ATLAS.ti, data was processed with the aim of identifying qualitative aspects of primary tendencies, based on which analysis was conducted. This report presents data collected in the framework of qualitative research thematically structured by sub-chapters.

TYPICAL PORTRAIT OF RESPONDENT

Maka, 34 years old. Has a spouse and 3 children. The family lives in the mountainous village of Adjara. Maka is a housewife. Her spouse is the only employed family member and the monthly income of a household is 750 Gel. Household income is not sufficient to raise children in decent conditions, the couple doesn't plan on having more children. Maka uses the calendar method as a birth control, about which she heard from other women (she prefers this method since it doesn't require additional funds), but as she points out, it's not always foolproof. There have been cases when she has arbitrarily taken medication to terminate the pregnancy and says that sometimes it worked and sometimes – did not. So far, she has experienced 4 abortions, including one medical abortion.

KEY FINDINGS

EXPERIENCE OF MEDICAL ABORTION

Those respondents who have experienced medical abortion note that medical abortion is comfortable, simple, less painful and safe.

Participants of the research mentioned the following as sources of information on medical abortion: doctor, another woman (friend, close acquaintance, relative) who had experienced successful medical abortion and social network

Those respondents who had a positive experience of medical abortion suggest it to other women as well, whereas those women who haven't experienced medical abortion or have experienced it unsuccessfully (unsuccessful experience implies a requirement of additional medical intervention) suggest surgical abortion to other women.

EXPERIENCE OF SURGICAL ABORTION

Respondents who have only experienced surgical abortion note that they've never heard of medical abortion, or they've heard of it but still prefer surgical abortion. It's due to various reasons, in particular:

- They are afraid of medical abortion because they believe that drugs are dangerous in general.
- They believe surgical abortion to be more trustworthy than medical abortion. This attitude derives from other's unsuccessful experience when women needed additional medical manipulations (aspiration).
- Cost of surgical abortion is more affordable.
- They don't' like the additional routine visit necessary for medical abortion (it should be mentioned that majority of respondents with the experience of medical abortion state that they didn't have a third visit to the doctor since they believed to have no problems. Only a small proportion of participants say that they rechecked the results of medical abortion and referred to a doctor for an ultrasound even though they felt well).

DESCRIPTION OF ABORTION SERVICE DELIVERY

When speaking about the experience of abortion, participants of the research have described pre-abortion process that can be conditionally divided into 3 stages: 1) General practice of receptionists' attitudes 2) pre-abortion consultation 3) 5-day waiting period.

GENERAL PRACTICE OF RECEPTIONISTS' ATTITUDES

It should be noted that the majority of respondents living in the regions speak about clinic receptionists' attempt influence on the patient's decision. When they find out about the woman's intent, clinic employees try to persuade the woman not to terminate the pregnancy. Participants of the research note that such advice often has a religious basis.

PRE-ABORTION COUNSELING

Respondents note that during the counseling doctor attempts to dissuade a patient from undergoing an abortion, albeit all the participants of the research indicate that they haven't changed their decision to have an abortion after such dissuasion.

It is noteworthy that respondents have different experience of the Pre-abortion counseling process and, therefore, it is challenging to argue about the aims and objectives of pre-abortion counseling.

Respondents have a different experience with the following issues:

- Provision of information on methods of abortion
- Possibility of choosing abortion method
- Provision of information on possible complications
- Provision of information materials
- Informing-counseling about contraception
- Obtaining informed consent

Small proportion of participants speak about receiving information on abortion methods and possibility of choosing a method, albeit some speak about the fact that the doctor offered only one method that they accepted due to their trust toward the doctor.

Proportionally small number of respondents speaks of being told in advance about possible complications of abortion. Some mention that the doctor provided the phone number only after the procedure and instructed to call in case of excessive bleeding.

Part of respondents mention that they received an information booklet (patient guide), but some didn't have a similar experience.

Part of interweavers note that they signed the form of informed consent, some say that they didn't undergo this procedure.

Small proportions of respondents mention that the doctor provided information on methods of family planning. They mostly offered method of contraception is Birth Control Implant. Only a small proportion speaks about contraceptive pills, sterilization and condoms.

5-DAY WAITING PERIOD

Majority of respondents speak about doctors giving them a waiting period, albeit all note that they haven't changed their decision in this period. Small proportion of participants only mentions that they've heard that women changing their decision on abortion during a 5-day waiting period. Only a small proportion of participants note that they haven't waited for 5 days and underwent the surgical abortion manipulation during the first visit.

Those respondents who have experienced a 5-day waiting period note that when there's a firm decision to have an abortion, the waiting period doesn't change anything and only complicates a woman's condition.

BARRIERS TO ABORTION AMONG RURAL AND INTERNALLY DISPLACED WOMEN

Respondents spoke about factors that hinder access to abortion, which revealed 3 main barriers, in particular: 1. Cost of abortion 2. Distance of the clinic and transportation problem 3. Problem of child-care

COST OF ABORTION AS THE BARRIER TO ACCESSING ABORTION

Participants note that medical abortion is more expensive than surgical abortion (medical abortion ranges from 150-230 Gel; surgical abortion – 90-200 Gel. Costs differ based on cities, clinics and methods of abortion). Participants of the research mentioned that women with insufficient finances for abortion are forced to refer to self-induced abortion, which, in case of an adverse event, often leads to health problems and/or involuntary childbirth. They mentioned following as self-induced abortion: medication (Cytotec), hot bath, vodka and milk solution, jumping from a high place, lifting weights. The most common among the listed measures is the medication, which, as participants mentioned, is difficult to purchase at the moment because it requires a prescription to be dispensed.

Participants mentioned the following as the source of information on self-induced abortion methods: Pharmacy, internet and another woman (close acquaintance, neighbor, relative) who have experienced successful self-induced abortion.

DISTANCE OF THE CLINIC AND TRANSPORTATION PROBLEM AS THE BARRIER TO ACCESSING ABORTION

The transportation problem is substantial for women living in mountainous villages and remote areas. They note that travel is expensive and time-consuming. They mentioned that it's especially challenging in winter when roads close due to bad weather conditions.

PROBLEM OF CHILDCARE AS THE BARRIER TO ACCESSING ABORTION

Only one participant of the research noted that childcare presents a barrier to seeking an abortion.

AWARENESS ABOUT REPRODUCTIVE RIGHTS, FAMILY PLANNING AND ABORTION METHODS

Even though the research didn't aim to assess women's level of knowledge about the objectives, the research revealed low awareness of respondent regarding reproductive rights, family planning and abortion methods.

EXPERIENCE OF MEDICAL ABORTION

Those respondents who have experienced medical abortion note that medical abortion is comfortable, simple, less painful and safe.

RESPONDENT 2: It doesn't require anesthesia. Isn't painful, there's no risk of infection as well.

RESPONDENT 1: It's less painful than when you enter the body with a rough blunt object. Psychologically it's perceived as the menstrual cycle and this is a great plus.

Participants of research mentioned the following as sources of information on medical abortion: doctor, another woman (friend, close acquaintance, relative) who had experienced successful medical abortion and social network

RESPONDENT: I don't know, I've heard of it, heard from neighbors, relatives, it's a much easier way. I'm timid, to begin with, I was afraid of surgery and that if the fetus is small, it's possible to undergo a medical abortion.

RESPONDENT 6: Friend suggested the medical abortion, told me to see a doctor and I asked if I could achieve the result with medical abortion, I didn't' want to undergo surgical abortion anymore

RESPONDENT 1: I've obtained information about abortion on the internet before going to the clinic. I've also heard about it from one of my close acquaintances.

Those respondents who had a positive experience of medical abortion suggest it to other women as well, whereas those women who haven't experienced medical abortion or have experienced it unsuccessfully (unsuccessful experience implies a requirement of additional medical intervention) suggest surgical abortion to other women.

RESPONDENT 7: I'd suggest medical abortion because there's less fear factor and pain. It's a simple procedure. Doesn't require physical contact.

RESPONDENT 5: My close acquaintance underwent the medical abortion in the same period and it was such a catastrophe, she was bleeding excessively before she reached the clinic, I couldn't risk it after that and chose the surgical way.

INTERVIEWER: What prompt you to suggest surgery? Because of your experience?
RESPONDENT: Yes, curettage was still necessary in my case.

EXPERIENCE OF SURGICAL ABORTION

Respondents who have only experienced surgical abortion note that they've never heard of medical abortion, or they heard of it but still prefer surgical abortion. It's due to various reasons, in particular:

1. They are afraid of medical abortion because they believe that drugs are dangerous in general.

2. They believe surgical abortion to be more trustworthy than medical abortion. This attitude derives from other's unsuccessful experiences when a woman needed additional medical manipulations (aspiration).

3. Cost of surgical abortion is more affordable.

4. They don't' like additional routine visit necessary for medical abortion (it should be mentioned that majority of respondents with experience of medical abortion state that they didn't have a third visit to the doctor since they believed to have no problems. Only a small proportion of participants say that they rechecked the results of medical abortion and referred to a doctor for an ultrasound even though they felt well).

RESPONDENT: You know what, It's not like I completely descended from the sky not to have heard of anything but I haven't really heard of medical abortion. For some reason, I haven't.

RESPONDENT: Of course it's harmful and I wouldn't suggest it to anybody (the topic of discussion is medical abortion).

RESPONDENT: You might still need curettage after you take the medicine and then the cost will be more expensive, first medicine and then curettage, and I chose surgical abortion.

INTERVIEWER: Why did you prefer surgical abortion?
RESPONDENT: With medicine, it would cost around 100 Gel and "mini" costs 60 Gel and I chose it mostly because of the price.

RESPONDENT: With the surgical abortion, you will visit the clinic once and it's done and with that (the topic of discussion is medical abortion) you're not sure and still have to go there afterward. In the case of surgical one, you know for sure it's done.

INTERVIEWER: If I understood correctly, the third visit is planned as a routine visit during those consultations?
RESPONDENT 9: Yes, they strictly require that but as you heard, almost nobody goes there if they feel well.

DESCRIPTION OF ABORTION SERVICE DELIVERY

When speaking about the experience of abortion, participants of the research have described the pre-abortion process that can be conditionally divided into 3 stages:
1) relations with the reception 2) pre-abortion counseling 3) a 5-day waiting period.

Relations with the reception

It should be noted that the majority of respondents living in the regions speak about clinic reception workers' attempt at intervening with a patient's decision. When they find out about the woman's intent, clinic employees try to persuade the woman not to terminate the pregnancy. Participants of the research note that such advice often has a religious basis.

RESPONDENT: … I gave birth to my three children here and have gone here for counseling for years and that's why they gave me friendly advice: it's a sin, don't do this, don't get rid of it because it's god's will.

RESPONDENT 5: When I came here, I told the person to write me a cheque for abortion, to which s/he replied - what can I say, you are a good lady and how can you undergo abortion during this fasting. How could the person know that I was religious and devoted to church, a person religious to an extent, or at least strongly religious person wouldn't do this, strongly religious - in quote marks. I don't' know what happened to me at that moment…

INTERVIEWER: Who did you meet at first?
RESPONDENT: I spoke with the receptionist, said what I wanted and the person told me right away if I could keep it and not get the abortion, advised me to think about it, gave me counseling.

PRE-ABORTION COUNSELING

Respondents note that during counseling doctor attempts to dissuade a patient from undergoing an abortion, albeit all the participants of the research indicate that they haven't changed their decision to have an abortion after such dissuasion.

MODERATOR: What do you think, is pre-abortion counseling necessary?

RESPONDENT: Yes of course. I was very upset when I went there and the person tried very hard to dissuade me from undergoing the abortion. Unfortunately, in my case it was futile.

RESPONDENT 1: At first the person begged me to keep it … talked about everything s/he could, but I didn't budge an inch, I was given a 5-day waiting period.

The fact that respondents describe the counseling process differently is conspicuous and due to that, it's challenging to discuss the comprising goals and issues of pre-abortion counseling.

Respondents have a different experience with the following issues:

- Provision of information on methods of abortion
- Possibility of choosing abortion method
- Provision of information on possible complications
- Provision of information materials
- Informing-counseling about contraception
- Obtaining informed consent

A small proportion of participants speak about receiving information on abortion methods and the possibility of choosing a method, albeit some speak about the fact that the doctor offered only one method that they accepted due to their trust in the doctor.

RESPONDENT: Yes, I received information on surgical and medical abortions and was asked which one I'd choose. I said I'd choose medical abortion.
RESPONDENT: I don't know, the person directly told me I should get a medical abortion.

A small proportion of respondents speak about being told in advance about possible complications of abortion. Some mention that the doctor provided the phone number only after the procedure and instructed to call in case of excessive bleeding.
Respondent 5: There was no such thing, the person didn't speak about complications for sure, at the end of the procedure I was given a phone number and was told to call upon noticing something.

RESPONDENT: Yes I've been told. It could've been followed by excessive bleeding and severe pain and I should've given a call if necessary.

A proportion of respondents mention that they received an information pamphlet (patient guide), but some didn't have a similar experience.

INTERVIEWER: Were you given this brochure before the 5-day waiting period or afterward?
RESPONDENT: I've read it before.

INTERVIEWER: Were you provided an information pamphlet about abortion-related issues?
RESPONDENT: No, there was no such thing.

A proportion of respondents note that they signed the form of informed consent, some say that they didn't undergo this procedure.

RESPONDENT: I didn't receive such a thing. Nor did I sign anything.
RESPONDENT: I was asked to read and sign if I wanted and I said that I agree with everything and didn't read it, I signed it.

A small proportion of respondents mention that doctor provided information on methods of family planning. They mostly offered the use of the intrauterine device and implant. Only a small proportion speaks about contraceptive pills, sterilization and condom.

INTERVIEWER: Did they speak about family planning, types of protection?
RESPONDENT: No, not at all

MODERATOR: Did the doctor provide information about methods of contraception?
RESPONDENT: We didn't talk about it. I've never taken anything before, only counted numbers. During my visit before this abortion, the doctor told me to take care of myself, I had polyps, said that we should take care of that and afterward, he would insert an intrauterine device.

INTERVIEWER: Did the doctor talk about family planning?
RESPONDENT 1: Yes, told me to visit for ampoule or insert an intrauterine device.

5-DAY WAITING PERIOD

The majority of respondents speak about doctors giving them a waiting period, albeit all note that they haven't changed their decision in this period. A small proportion of participants only mention that they've heard of women changing their decision on abortion during a 5-day waiting period. Only a small proportion of participants note that they haven't waited for 5 days and underwent the manipulation during the first visit.

RESPONDENT 5: Yes but I didn't want to. I have severe toxicosis during these 5 days and wanted to promptly get rid of it, but they told me no and gave me 5 days to think about it, I had already decided to do it and that's what I did.

MODERATOR: Yes, I'm asking about that, do you know people who changed their decision to get an abortion in 5 days?
Respondent: Yes, I know one person, she gave birth.

RESPONDENT 2: No it's not necessary. My condition worsened, I got angry.

RESPONDENT 3: I don't know, nothing much, I was very nervous, I really wanted to do it and the sooner it would end, the better it'd be.

INTERVIEWER: Now could you speak about that several-day waiting period? Did it change anything in your decision?
RESPONDENT: No, I firmly decided to terminate it

MODERATOR: Think about it for 5 days, I'm obliged by the law – have you been told something like this? do you remember such wording?
RESPONDENT: No, no

MODERATOR: Did you undergo the procedure the same day or was it scheduled another day?
RESPONDENT: No, I asked not to go home, said there was no point and I got the abortion the same day.

Those respondents who have experienced a 5-day waiting period note that when there's a firm decision to undergo an abortion, the waiting period doesn't change anything and only complicates a woman's condition.

RESPONDENT 9: I'm worse even if it's just one extra day and these 5 days are very hard for me. These 5 days are torture if someone doesn't want it for sure and has decided not to give birth.

RESPONDENT: Well, there's no need for the waiting period, when a woman makes a decision, nothing changes.

BARRIER TO ABORTION AMONG RURAL AND INTERNALLY DISPLACED WOMEN

Respondents spoke about factors that hinder abortion, which revealed 3 main barriers, in particular: 1. cost of abortion 2. The distance of the clinic and transportation problem 3. problem of childcare

COST OF ABORTION AS THE BARRIER TO ACCESSING ABORTION

Participants note that medical abortion is more expensive than surgical abortion (medical abortion ranges from 150-230 Gel; surgical abortion – 90-200 Gel. Costs differ based on cities, clinics and methods of abortion). Participants of research mentioned that women with insufficient finances for abortion are forced to refer to self-induced abortion, which, in case of an adverse event, often leads to health problems and/or involuntary childbirth. They mentioned the following as self-induced abortion: medication (Cytotec), hot bath, vodka and milk solution, jumping from a high place, lifting weights. The most common among the listed measures is the medication, which, as participants mentioned, is difficult to purchase at the moment because it requires a prescription to be dispensed.

Participants mentioned the following as the source of information on self-induced abortion methods: Pharmacy, internet and another woman (close acquaintance, neighbor, relative) who have experienced successful self-induced abortion.

RESPONDENT 3: Yes I've heard about it. Some take medicine, some lift weights, some inject calcium and something else into the vein, there are such cases and I think it's mostly because of insufficient finances…

RESPONDENT 6: I was also advised to take some pill or drink vodka and milk solution. I've heard from many people that they'd see a doctor and risk it if it cost 50 Gel instead of 100 Gel. For that reason, they take some drugs, drink various decoction and it's not good.

RESPONDENT 4: I have done it. I didn't have the means to see a doctor, I bought Cytotec that costs 5 Gel. I took one pill, put two pills under my cheeks and one inserted vaginally.

INTERVIEWER: And what was the result of it?

RESPONDENT: It didn't' work and I still needed to see a doctor, the fetus was damaged and I had to get an abortion but with the doctor this time.

RESPONDENT: Once there was a case of a girl who came from the village, she took medicine arbitrarily, but this medicine didn't work. She came down here for an ultrasound. The fetus wasn't damaged and the girl was already a 3-months pregnant Doctor couldn't perform an abortion and she was left with the baby who was born and grew up healthy (laughs).

RESPONDENT 8: Actually, it's not an affordable price for the majority (the topic of discussion – the cost of abortion) and they are forced to buy the medicine they used to take before, I'm talking about Cytotec. I've taken it years ago when it was being sold without a prescription. It didn't' remove it but the pregnancy was terminated, I did not bleed but the fetus was damaged.

Participants mentioned the following as the source of information on self-induced abortion methods: Pharmacy, internet and another woman (close acquaintance, neighbor, relative) who have experienced successful self-induced abortion.

RESPONDENT 4: You can find anything on the internet and the same thing occurred at my workplace. My coworker was pregnant and we supported her because it's a problem all women share, she bought medicine and put it under her tongue every hour. When I exclaimed that I might be pregnant, I was given a similar advice, I was told how now I had to go down there for a visit, wait, and all that.

RESPONDENT 2: For example, I know that women are told in pharmacies that Cytotec is the same medicine that doctors order There you pay 160 Gel and cytotec costs 30 tetri.

DISTANCE OF THE CLINIC AND TRANSPORTATION PROBLEM AS THE BARRIER TO ACCESSING ABORTION

The transportation problem is substantial for women living in mountainous villages and remote areas. They note that the cost incurred for travel is expensive and time-consuming. They mentioned that it's especially challenging in winter when roads close due to heavy snow.

RESPONDENT: Especially in winter when roads are closed, there's snow

MODERATOR: Roads are frequently closed, was there such a case this winter?
RESPONDENT: Yes, yes

MODERATOR: Are there cases of central roads not being cleaned?
RESPONDENT: It's not possible to do so in severe colds and heavy snow.

MODERATOR: What's your assessment, is the transportation hindering factor for a person to travel and receive medical services or not?
RESPONDENT: Yes, it might be. It is for people living in rural and a bit remote areas

MODERATOR: Thus, for women living in the village to travel back and forth, it takes 7 hours just to commute plus a minimum of one hour of procedure delivery, consultation with a doctor if you're not waiting in the queue
RESPONDENT: When you travel from there, you cannot go back the same day.

INTERVIEWER: What is the cost of transportation?
RESPONDENT: one way costs 20 Gel. There's a way to commute. You have to leave in the morning to be here in the evening. Then you have to spend the night here. I have a place to stay in Batumi. Have family members here. For other women who don't have a place to stay, it might be a problem. It depends.

PROBLEM OF CHILDCARE AS THE BARRIER TO ACCESSING ABORTION

Only one participant of the research noted that childcare presents a barrier to seeking an abortion.

RESPONDENT: If a woman doesn't have a child caregiver, it's a problem as well. She has to leave a child three times. (Due to number of visits for medical abortion)

AWARENESS ABOUT REPRODUCTIVE RIGHTS, FAMILY PLANNING AND ABORTION METHODS

Even though the research didn't aim to assess women's level of knowledge about the objectives, research revealed low awareness about reproductive rights, family planning and abortion methods. A proportion of participants expressed their desire to increase the access to information and named one of the ways to achieve it, in particular, information brochures

RESPONDENT 6: Personally I'd preferred that, I'm in a way obsessed with these brochures and information, more information should be accessible

RESPONDENT 7: If we have more information about this, there might be fewer cases of abortion at least.

CONCLUSIONS

The following conclusions can be drawn from this research:

1. Mandatory 5-day waiting period in most cases doesn't impact a woman's decision and only presets a hindering and stressful factor in abortion service delivery.

2. Additional routine visit (which isn't required by international and national guidelines, but is frequently mentioned by respondents) to a doctor to confirm medical abortion success in the majority of cases hinders the selection of medical abortion as a method. It's safe to say that emphasis on such necessity causes women's distrust towards this method (contrary to surgical abortion when additional visits are necessary only in case of particular complaints)

3. Low income, transportation problems, the distance of clinics put women living in rural areas (including internally displaced person) under the risk of self-induced abortion or/and forces them to keep the fetus violating the rights to healthcare, private life, as well as woman's right to bodily integrity.

4. Clinic administration's intervention to have an impact on woman's decision, puts women in an uncomfortable position, violate international conventions on human rights, especially rights to healthcare and isn't compliance with quality and person-centered services

5. Rural and internally displaced women's awareness about contraception, abortion methods and available medical services is low.

6. Participant's diverse experiences on pre-abortion counseling process, Raises doubts on compliance of practical implementation with pre abortion counseling standards in the country.

RECOMMENDATIONS

1. The practice of medical abortion needs to be in line with national guidelines and international recommendations (elimination of the third visit) in aim to remove barriers such as transportation, distance from the clinic, additional financial costs, etc., which are particularly relevant in mountainous villages and remote areas. All abovementioned is especially important to reduce clinic visits in times of pandemic.

2. It's important to revise the 5-day waiting period that presents an additional barrier to woman's rights to bodily integrity and healthcare, but also in terms of the number of visits to the clinic and finances.

3. It's important to raise women's awareness about their reproductive rights, family planning and abortion methods, which should be done in women's counseling centers, maternity hospitals, as well as on a primary healthcare basis.

4. Practical implementation of counseling in accordance with the National Protocol on Safe Termination of Pregnancy is essential.

5. The training of medical providers is important to ensure quality, unbiased, and person-centered services on every level of service delivery.

6. It's necessary to develop and enact control-mechanisms to oversee the quality of abortion services (besides medical procedure)

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