

**Young Adult
Reproductive Health
Survey
Romania, 1996**

**Final
Report**

**YOUNG ADULT
REPRODUCTIVE HEALTH SURVEY
ROMANIA, 1996**

FINAL REPORT

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Preface

During the early 1990's Romania experienced major socio-economic and political changes involving virtually all aspects of life for the people of Romania. Therefore, more information was needed to assess the reproductive health status of the population during a period of rapid change in health care that influenced the health of women and children. In 1993, the Romanian Ministry of Health, with technical assistance provided by the Division of Reproductive Health of the Centers for Disease Control and Prevention (DRH/CDC), conducted the first national population based survey of reproductive health (RRHS). The survey was designed to provide the Ministry of Health, international agencies, and nongovernmental organizations (NGO's) active in the area of women's and children's health with essential information on fertility, reproductive practices of women, maternal care, maternal and child mortality, health behaviors, and attitudes toward selected reproductive health issues.

The 1993 RRHS concentrated on in-union women 15-44 years of age. A representative sample survey directed at young adults (of both sexes) to document their sex education, attitudes, sexual behavior and use of contraception had never been carried out in Romania. The Centre for Development and Population Activities (CEDPA) and the International Foundation for Children and Families (IFCF), two adolescent oriented NGO's active in Romania, proposed that a young adult reproductive health survey (YARHS) be conducted in Romania, to improve knowledge about the reproductive health and social problems of young women and men in Romania. Also, survey results could be used to plan effective information campaigns, policies and programs targeting young people, and could be helpful to monitor and evaluate the impact of programs already in place.

The survey was carried out between July and October 1996 with principal support from the Agency for International Development (USAID). This is the first nationwide population-based young adult reproductive health survey conducted in Europe.

A preliminary report was published in April 1997, primarily to meet the needs of public health leaders who wanted to use the results while the data were fresh; we now present the final report.

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We would like to acknowledge all the organizations and persons who contributed to the various phases of the Romania Young Adult Reproductive Health Survey (YARHS). This survey was conducted by the International Foundation for Children and Families (IFCF) who subcontracted the field work to the National Institute for Mother and Child Care (IMCC) and data processing to the National Commission for Statistics (NCS). Technical assistance in survey design, sampling, questionnaire development, training, and data processing was provided by the Division of Reproductive Health (DRH) of the United States Centers for Disease Control and Prevention (CDC). Principal investigators of this study were Dr. Alin Stanescu, national director of the YARHS, and Dr. Fiorina Serbanescu and Dr. Leo Morris from DRH/CDC.

Most of the funding for the YARHS was provided by the Centre for Development and Population Activities (CEDPA) through a grant from the United States Agency for International Development (USAID Grant Number=EUR-0002-G-00-1016-00). Additional funding was provided by the United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF).

We wish to thank the 4,072 women and men who made such a major contribution to our knowledge on young adults' health in Romania by their participation in YARHS. Special thanks are also extended to Dr. Serban Ionescu, Executive Director of the IFCF, Dr. Adrian Georgescu and Gabriel Banceanu, Directors of the IOMC, Luminita Marcu, Survey Project Manager, Lucia Branga, Field Work Coordinator, Dr. Carmen Cruceanu, Training Consultant, Doina Apostol, Data Entry Supervisor, Victor Dinculescu, Director of the Census Division, as well as Randal Thompson, USAID Romania Representative, and CEDPA staff—Kathryn Engustian, Director of the Romania Project, Peggy Curlin, CEDPA's President, and Lucy Ankiewicz, Director of Finance--for their assistance in design, planning and financial management. Many thanks to Mary Ann Micka, USAID Health Representative, for her contribution in the early planning and continued support of the survey and to Roseanne Murphy, former CEDPA director for the Romania Project, who first saw the need for this survey. Also, many thanks to Howard Goldberg, DHR/CDC for his editorial assistance, and to Rose Pecoraro, Graphic Unit, of the Information Resources Management Office of the CDC (IRMO/CDC) for her superb work with the cover design.

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CHAPTER I

INTRODUCTION

1.1 Background

In traditional, predominantly rural societies, women typically marry and start their childbearing at young ages. Consequently, young wives and mothers in these settings generally have the economic and social support of their families and communities. However, traditional norms are weakening; the forces of modernization-urbanization, rising educational attainment, more exposure to mass media, and changes in the status of women have altered every aspect of life, including the patterns and consequences of early childbearing.

Today, owing to these factors and later age at marriage, many young people experience a greater period of time exposed to premarital intercourse, and a higher number of sexual partners, with a higher risk of unintended pregnancies, induced abortions and sexually transmitted diseases. The widening gap between age at first intercourse and first marriage puts more young people at risk and poses increasing concerns for public health.

For young people who do not protect themselves from the risk of unintended pregnancy and sexually transmitted diseases, the consequences can be very serious. Early exposure to unprotected intercourse puts the health of a young mother at higher risk, whether she chooses to bear the child or seek an abortion. At the same time, early marriage and/or childbearing may terminate a young woman's education, limiting her future job prospects. The obstacles faced by infants born to teenage women mirror those of their mothers: they face an elevated risk of illness and death, and of being caught in a cycle of poverty, passed on from one generation to the next. Young men also face consequences from early sexual activity and fatherhood, including exposure to STDs and the need to drop out of school to support their families. Society at large faces several interrelated burdens. First, if a young woman fails to complete her education, her economic contribution to her country, as well as to her family, is likely to be less. Thus, society will not benefit as much from the investment made so far in her education. Second, a country such as Romania will have to struggle to find ways to help support young mothers and their children who are often trapped in poverty. Third, young mothers and their children will incur higher medical care expenses. And fourth, society will have to allocate more resources for supporting abandoned or run-away children.

Despite socioeconomic changes and an increasing number of young people living in urban areas, who are better educated, and more informed about lifestyle options, there are still many young women who have little education and poverty-level incomes. Compared with their counterparts who have better educational and job opportunities, poor women have less control

over their lives, less understanding of their bodies, and less knowledge about and access to family planning. In their marriage and childbearing patterns, these young women are behaving more like their mothers than their peers. For these young women, the doors to better education and employment must be opened, concurrent with better access to family planning information and services.

Finding appropriate responses to these problems has been made all the more complex by recent social changes. Before 1990, Romania was the setting of one of the world's most rigorously enforced pronatalist policy which resulted in very high rates of unintended pregnancy. Under the pronatalist policy enacted in Romania in 1966, abortion and contraception were severely restricted and draconian measures were taken to enforce compliance with the law. After the December 1989 revolution, abortion and contraception were legalized. Clinics were inundated by women seeking abortions, and newly created family planning services were confronted with the task of running a comprehensive program amid severe economic problems, deficient infrastructure, and resistance to modern contraception by both the public and health care providers. Although large quantities of contraceptive supplies (condoms, IUDs, pills, and barrier devices) have been imported by the MOH and recent official statistics (MOH, Anuar de Statistica Sanitara, 1995) report a gradual decrease in abortion rates, Romania continues to have the highest induced abortion rate per 1000 women in Europe (107 abortions/1000 women aged 15-44 in 1994) and 2.1 induced abortions for each birth in 1994 (a decline from 3.2 in 1990).

The 1993 Romanian Reproductive Health Survey (RRHS) (Serbanescu et al.,1995) documented low prevalence of modern contraceptive use and strong reliance on traditional family planning methods whose high failure rates (31 %) led to greater levels of unintended pregnancy. Limited education about sexuality and contraception, mistrust and misinformation about modern methods, lack of adequately trained providers, shortage or uneven distribution of contraceptive supplies, and, in some instances, legal constraints, were major reasons for the continued high rates of unintended pregnancy. Sex education was removed from the school curriculum in the early 1980's and contraceptive counseling was forbidden; the few efforts that have been made to introduce sex and contraceptive education in the secondary schools' curriculum have been hindered by the resistance of both teachers and parents and the lack of adequate training of teachers. According to RRHS, only 4% of women said that they first heard about contraception from their mother, and fewer than 3 % cited a teacher. Overall, the major source of information about any contraceptive method was a friend or acquaintance (45%), followed by mass media (19%), and health care providers (10%). Even though one in five women mentioned mass media, since 1990, when uncensored publications have multiplied, mass media have played a minor role in contraceptive educational efforts. This minor role is due to financial constraints, little interest in health issues relative to the freedom to pursue political and economic topics for the first time, and lack of specialists able to educate the public about family planning in nontechnical terms.

Postabortion counseling is virtually unknown, and prenatal services, though highly attended (94%), do not address postpartum contraceptive needs. Although an increasing number of physicians and nurses are involved in family planning activities in addition to their other tasks,

recent Ministry of Health regulations (Ministerul Sanatatii, 1994) narrowed the eligibility of providers by requiring six months of continuous training in order to obtain "family planning competency." At the present time, only gynecologists may "officially" prescribe contraceptives and insert IUDs. Unfortunately, their contraceptive counseling skills and activities are considerably prejudiced by limited time and motivation. The uninterrupted availability of modern contraceptive methods continues to be an issue of great concern. The absence of contraceptive logistics and managerial skills further contributes to shortages and uneven distribution of these supplies, leading to continued dependence on international donors.

Information is needed to describe these problems more fully among young adults and to better understand their consequences and ultimately design intervention programs to meet their needs in a time of significant changes.

The 1993 RRHS included a short module administered to the 1,596 young adult female respondents (15-24 years of age) comprised of questions regarding the age at which they became sexually active, relationship to their first partner, use of contraception at that time, circumstances surrounding their first pregnancy (if ever pregnant), and communication with their mother concerning contraception. Seventy-seven percent of these women reported that they had had at least one pregnancy, while 24 percent of them had their first pregnancy before they reached 18 years of age. Forty-three percent of pregnancies to young adults were unintended. Overall, slightly over half of the 41 percent reporting sexual experience had premarital sexual intercourse. Overall levels of sexual experience ranged from 30 percent in other urban areas to 43 percent in Bucharest to 46 percent in rural areas. Sexual experience began earlier for young women not married (42% less than 18 years of age) at the time of first intercourse compared with those who were married (32% less than 18 years of age). Only one-fourth of young women whose first sexual intercourse was premarital reported that they or their partner used contraception. Contraceptive use was much lower if they were less than 18 years of age at first intercourse. Most couples reporting contraceptive use employed withdrawal. Most of those not using contraception indicated that they did not expect to have intercourse when they did or they did not know about contraception. If first sexual intercourse was marital, even fewer women reported use of contraception (14%) and, again, withdrawal was the most prevalent method.

Data from the RRHS showed that the annual induced abortion rate for teenagers had increased from 10/1000 in the 3-year period prior to 1990 to 32/1000 in the three year period ending May 1993; a three fold increase. For 20-24 year old women, the increase was from 63 to 153/1000. Although the overall age-specific fertility rate for 15-19 year olds was 49 per 1000, the rate for teenagers with only primary school education was 114 per 1000.

Although most young women have heard about the most commonly used modern methods of contraception, a much lower percentage know where they can obtain them. Unfortunately, how much and what they know, particularly about modern methods, was not completely assessed in the RRHS. Focus group studies of young adults funded by CEDPA have explored knowledge, attitudes, and opinions toward modern methods and have shown a high level of misinformation.

Program officials concluded that there are many issues in the area of reproductive health for young women that deserve further examination; also, there is an immediate need to gather data on young men, about whom little information exists regarding health status, health behaviors, and attitudes and opinions in the area of reproductive health. Taking advantage of the information already gathered in previous studies, a household-based young adult survey, was proposed as the best tool to provide representative data on detailed health issues and behaviors among young adults in Romania. For the proposed 1996 National Young Adult Reproductive Health Survey (YARHS), the Division of Reproductive Health of the Centers for Disease Control and Prevention (DRH/CDC) was invited to provide consultation to the local office of the Center for Development and Population Activities (CEDPA) on questionnaire development, sample design, training and field work supervision, data entry and data management, and data analysis. Since 1985, DRH/CDC provided technical assistance for this type of survey in Jamaica, the Dominican Republic, Costa Rica and 10 cities in 5 other countries of Latin America (Morris L., 1994).

The YARHS was carried out from July to October 1996 after the questionnaire was pretested and the field interviewers were trained. The sample design, which is self-weighting on a national basis, yielded 4,072 complete interviews (2025 for females and 2047 for males) in 308 census sectors (154 urban and 154 rural). The final response rate was 90% (93% for the female sample and 87% for the male sample).

1.2 Objectives of the Survey

Two general objectives of the survey were: a) to provide government authorities, other Romanian institutions, and international agencies with representative data so that informed decisions may be made on the provision of family planning and disease prevention services to young adults of both sexes and on the improvement of sex education and family life projects both inside and outside the school environment; and b) to upgrade the institutionalization of survey capability in Romania.

Specific objectives included: (1) providing information on behaviors related to sexual activity and use of contraception; (2) providing data necessary to develop and implement sexual and health education programs; (3) providing information on the use of maternal child health services and breast-feeding; (4) learning about the sources of contraceptive methods for young adults of both sexes; (5) learning about the attitudes of young adults concerning sexual behaviors, sex education, contraception and the family; (6) providing data for the formulation of action plans, particularly those dealing with access to voluntary family planning services; and (7) providing information on the knowledge of AIDS transmission and prevention.

This preliminary report presents an overview of selected survey results. Tabulations and analysis of data were performed by urban-rural residence and selected socio-demographic characteristics. The final report will address all the topics included in the survey in much greater detail.

CHAPTER II

METHODOLOGY

2.1 Organizational Structure

The Romanian Young Adult Reproductive Health Survey (YARHS) was a collaborative effort with several organizations involved in its design, implementation, and funding. The project was initiated by the Centre for Development and Population Activities (CEDPA), a nonprofit organization which has worked in Romania as an AID cooperating agency for several years and has had vast experience in family planning training and services evaluation. The Division of Reproductive Health (DRH) of the United States Centers for Disease Control and Prevention (CDC) provided assistance in survey design, questionnaire development, training, field work, data entry and editing, and all technical areas of the survey. The International Foundation for Children and Families (IFCF) monitored the local activities and administered the survey budget. The IFCF was also a liaison to other Romanian organizations, including the Institute for Mother and Child Care, which carried out the field work, and the National Commission for Statistics which provided the sampling frame and personnel to perform data entry and edit operations.

Funding for the YARHS was provided principally by the United States Agency for International Development (USAID) through the Centre for Development and Population Activities (CEDPA), by the United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF).

Interviews were administered at the homes of respondents by 20 intensively trained female and male interviewers. There were two female and two male survey teams, each headed by a fieldwork supervisor, and one field work coordinator. Training was carried out immediately before the survey field work began and lasted six days. Interviewer training was organized and conducted by staff from the IMCC and DRH/CDC. In parallel with the first two weeks of field work, a DRH/CDC computer specialist installed data entry/edit software and trained the Romanian staff in its use.

2.2 Questionnaire Content

The questionnaire was first drafted by CDC/DRH consultants based on the core questionnaire used in the 1993 RRHS and YARHS questionnaires used in Latin America. The survey instrument was then reviewed by Romanian experts in adolescents reproductive health and family planning, as well as by CEDPA and USAID. Based on these reviews, a pretest questionnaire was developed and field tested in April 1996. The YARHS questionnaire covered a wide range of topics related to young adults reproductive health in Romania. The specific areas included were:

- Social, Economic and Demographic Characteristics
- Sex Education Inside and Outside of School
- Sexual Behaviors
- Reproductive History and Use of Maternal-child Health Services (Females Only)
- Pregnancy Intendedness and Future Fertility Preferences
- Attitudes Toward Sexuality, Sex Education, Sex Roles, and Contraception
- Use of Contraceptive Methods and Reasons for Non-Use
- Health Behaviors: Gynecologic Exams (Females Only), Smoking and Use of Alcohol
- Knowledge of Contraception, Menstrual Cycle, and Sexually Transmitted Diseases
- Knowledge of AIDS Transmission and Prevention

The questionnaire had two components: (1) A short household module that was used to collect residential and geographic information, as well as selected characteristics about all young adults living in sampled households, and information on interview status. (2) The longer individual questionnaire collected information on the reproductive health topics mentioned above.

Results have been examined by urban-rural residence, demographic, and socio-economic characteristics, making it possible to identify the segments of the population with specific health needs or problems and to identify risk factors associated with certain behaviors.

2.3 Survey Design

The 1996 YARHS was designed to collect information from a representative sample of men and women 15-24 years of age throughout Romania. The universe from which the respondents were selected included all young adults, males and females, regardless of marital status, who were living in Romania when the survey was carried out.

The survey employed a multistage sampling design which allows independent estimates for males and females. The 1992 census was used as the sampling frame (Comisia Nationala pentru Statistica, 1994). Since there were roughly equal numbers of urban and rural households, the sample was designed to be geographically self-weighting.

The first stage of the two-stage sample design was a selection of 308 census sectors (154 for women and 154 for men) with probability proportional to the number of households recorded in the 1992 Census. This was accomplished using a systematic sample with a random start. Census Sectors for women were drawn first. For every sector selected in the female sample, the next contiguous sector was drawn for the male sample. As a result, two independent samples, one for

female, the other for male respondents, were selected and interviewed by female and male interviewers, respectively.

In the second stage of sampling, clusters of households were randomly selected in each census sector chosen in the first stage. Before second stage selection, the number of households in each census sector was updated by the Census Division of the National Commission for Statistics. Cluster size determination was based on the number of households required to obtain an average of 15 interviews per cluster, and ranged from 75 to 85 households. Based on census data and information from the 1993 RRHS (percentage of households with at least one young adult and unoccupied households) and a projected response rate of 90%, a total of 24,000 households were selected in the two samples to obtain interviews for approximately 2,000 females and 2,000 males.

TABLE 2.1A
Results of Household Visits and Interview Status of Eligible Women By Residence
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Households</u>	<u>Total</u>	<u>Residence</u>	
		<u>Urban</u>	<u>Rural</u>
Identified Eligible Women*	15.7	16.2	15.2
No eligible women	81.4	81.7	81.2
Unoccupied Household	2.2	1.4	3.0
Refusals	0.4	0.4	0.3
Resident Not At Home	0.3	0.3	0.3
Total	100.0	100.0	100.0
No. of Households	11,941	5,617	6,324
<u>Eligible Women</u>			
Completed Interviews	93.3	92.3	94.2
Respondent Absent	3.6	4.2	3.2
Respondent Refusal	0.4	0.4	0.4
Respondent no Longer Living in the Household	1.6	2.3	0.8
Other	1.1	0.8	1.4
Total	100.0	100.0	100.0
No. of Eligible Women	2,171	1,065	1,106
Interviewed Eligible Women	2,025	983	1,042

*Includes Women Aged 15-24 with completed interviews, incomplete interviews, women who were absent or who refused to be interviewed.

Interviews were conducted at the respondents' homes and generally lasted 30 to 50 minutes. In households with more than one eligible woman, all respondents in the 15-24 age group were interviewed. Almost all women selected to participate in the survey agreed to be interviewed and were very cooperative. [Table 2.1A](#) shows that in the 11,941 households selected in the females sample, 2,171 women aged 15-24 were identified and 2,025 were successfully interviewed, for a response rate of 93%. Only 0.4% of selected women refused to be interviewed, while another 5.2% could not be located. Response rates were slightly better in rural areas than in urban areas.

TABLE 2.1B
Results of Household Visits and Interview Status of Eligible Men By Residence
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Households</u>	<u>Total</u>	<u>Residence</u>	
		<u>Urban</u>	<u>Rural</u>
Identified Eligible Men*	16.1	17.0	15.2
No Eligible Men	83.1	81.9	84.2
Unoccupied Household	0.4	0.6	0.3
Refusals	0.2	0.2	0.1
Resident Not At Home	0.2	0.3	0.2
Total	100.0	100.0	100.0
No. of Households	11,981	5,962	6,019
<u>Eligible Men</u>			
Completed Interviews	87.1	89.3	84.7
Respondent Absent	6.6	5.3	8.8
Respondent Refusal	1.4	1.9	1.0
Respondent no Longer Living in the Household	2.4	1.7	3.2
Other	2.4	1.8	3.1
Total	100.0	100.0	100.0
No. of Eligible Men	2,351	1,204	1,147
Interviewed Eligible Men	2,047	1,075	972

*Includes men aged 15-24 with completed interviews, incomplete interviews, men who were absent or who refused to be interviewed.

Similarly, in the male sample, 2,351 15-24 year-old men were identified in 11,981 households. Complete interviews were obtained from of 2,047 eligible males for a response rate of 87% (Table 2. 1B). The response rate was somewhat higher in urban areas and lower in rural areas (89% vs. 85%). If we exclude the 2.4% young men no longer living in the household (who were away at school or temporarily living abroad), the response rate would be 89%. Similarly for women, the response rate would increase to 95 %.

TABLE 2.2
Percent Distribution of Young Adults by Sex and Age Group, by Area of Residence
1992 Census Projected to 1996 and 1996 Young Adult Reproductive Health Survey (YARHS)

Age Group	1992 CENSUS Projections			1996 -YARHS		
	Total	Urban	Rural	Total	Urban	Rural
Females						
15-19	51.3	53.2	48.9	61.2	62.8	59.6
20-24	48.7	46.8	51.1	38.8	37.2	40.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Males						
15-19	51.4	54.0	48.3	64.6	65.7	63.4
20-24	48.6	46.0	51.7	35.4	34.3	36.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

Compared to a cohort projection from the 1992 Census, the age composition of the 1996 YARHS sample reflects an over-representation of adolescents 15-19 years of age, in both the female and male samples. (Comisia Nationala pentru Statistica, 1994). As shown in Table 2.2, the sample population is essentially ten percentage points higher for 15-19 year olds and lower in the 20-24 year old age group when compared to the census population. In both urban and rural areas there is a slightly higher over representation of men 15-19 years old, as high as 15 percentage points in rural areas. This is probably due to the greater difficulty in finding 20-24 year old women and men at home, since they are more likely to be at work or attending university level classes. It may also reflect greater mobility of these young adults, both within the country

and outside of the country. The sample population by marital status is compared with the census in [Table 2.3](#). Overall, there is an underrepresentation of currently married 20-24 year olds. This is probably due to two factors: (1) the sample age composition which is skewed toward younger ages includes fewer married individuals, and (2) married couples living alone, with both wife and husband at work or studying, are more difficult to locate for an interview.

TABLE 2.3
Percent Distribution of Young Adults by Marital Status, by Sex and Age Group
1992 Census Projected to 1996 and 1996 Young Adult Reproductive Health Survey (YARHS)

Age Group	1992 CENSUS Projections*			1996 -YARHS		
	Currently Married	Previously Married	Never Married	Currently Married	Previously Married	Never Married
Females						
Total	36.2	1.1	62.7	26.2	1.9	71.9
15-19	11.7	0.2	88.0	10.0	1.3	88.7
20-24	58.4	2.1	39.6	51.8	2.9	45.3
Males						
Total	16.2	0.3	83.5	6.9	0.1	98.6
15-19	1.9	0.0	98.1	1.3	0.1	98.6
20-24	29.9	0.5	69.7	17.8	1.2	81.0

* The marital status in the Census publication also includes 0.6 % of women with "unknown marital status" who are not shown in this table.

Since there is evidence that both samples have significant, under representation of 20-24 years olds, especially married ones, all results have been weighted to account for differences in the response rates. Except for [Tables 2.1A](#), [2.1B](#), [2.2](#), and [2.3](#), presented in this chapter, all tables in this report present weighted results. The unweighted number of cases, used for variance estimation, are also shown in each table. A detailed description of the methodology used to estimate the adjustment factors for the post-survey weighting of subclasses is shown in Appendix A.

CHAPTER III

CHARACTERISTICS OF THE SAMPLE

General characteristics of young adult females and males with completed interviews, by residence, are shown in [Tables 3A](#) and [3B](#), respectively. These tables report the weighted distribution of each characteristic, adjusted for the differential non-response rates discussed in the previous chapter.

The post-survey weighting of subclasses (in this case: age group, marital status and residence) produce adjusted survey estimates that closely match independent estimates from the 1992 census or projections based on the 1992 census. The Romanian YARHS was designed to provide nationally representative estimates of young adult women and men with particular characteristics. The post-survey weighting enables us to make such estimates (the weighting procedures will be documented in an appendix to the final report).

As can be seen in these tables, slightly over half of female and male young adults are adolescents 15-19 years of age, matching the projections based on the 1992 census that were shown in Chapter II. Thirty-six percent of women had completed high school or had gone onto post-secondary education and young women in urban areas are more likely to have completed high school than their counterparts in rural areas.

As may be expected, fertility is higher in rural areas where 30 % of young women have had a live birth compared to 17% in urban areas. Associated with higher fertility is the fact that almost 40% are currently married or in a consensual union in rural areas compared to 29% in urban areas.

Most respondents are Orthodox (88%) and report their ethnic background as Romanian (90%). Results for these two background variables, which are family related rather than "age" related, are the same as the results obtained in the 1993 RRHS (88% and 90%, respectively). The percentage of respondents reporting their ethnicity to be Hungarian (5%) or Gypsy (3.5%) is also very similar to the 1993 sample. The replication of these results gives us additional confidence in the YARHS sample design, as these two variables have not been shown to be related to non-response differentials.

Finally, a socioeconomic index was created for each respondent based on the amenities available in the household and whether the household contained at least 4 rooms. Equal values were assigned for possession of each of these amenities: flush toilet, central heating, vacuum cleaner, color television, automobile, VCR, telephone and vacation home. The score was divided into three levels for the socioeconomic index: low for respondents with 0-2 amenities, middle (3-5 amenities) and high (6-9 amenities). Only 12% were classified as having high socioeconomic status with the remainder approximately equally divided between low and middle.

TABLE 3A
General Characteristics of Young Adult Women with Completed Interviews by Residence
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	Total	Residence	
		Urban	Rural
Age Group			
15-17	30.4	31.4	29.1
18-19	20.9	21.8	19.8
20-22	31.4	31.0	31.8
23-24	17.3	15.8	19.3
Education Level			
Primary	20.5	12.6	30.6
Some High School	43.5	43.2	44.0
Complete High School	25.1	29.2	19.7
Post High School/University	10.9	15.0	5.7
Number of Living Children			
0	77.0	82.5	69.9
1	17.5	14.3	21.6
2	5.5	3.2	8.5
Marital Status			
Married/Consensual Union	33.5	29.3	38.9
Not Married	66.5	70.7	61.1
Church Affiliation			
Orthodox	87.8	88.1	87.4
Other	11.2	11.3	11.1
None	1.0	0.7	1.5
Ethnic Background			
Romanian	90.0	91.1	87.7
Hungarian	5.0	4.8	5.2
Gypsy	3.5	2.2	5.2
Other	1.5	1.2	1.9
Socio-Economic Status			
Low	42.2	18.4	72.7
Middle	45.5	61.6	24.9
High	12.3	20.0	2.4
Total	100.0	100.0	100.0
Unweighted No. of Cases	(2,025)	(983)	(1042)

TABLE 3B
General Characteristics of Young Adult Men with Completed Interviews by Residence
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	<u>Total</u>	<u>Residence</u>	
		<u>Urban</u>	<u>Rural</u>
Age Group			
15-17	31.3	33.8	28.3
18-19	20.2	20.2	20.0
20-22	28.9	29.0	28.7
23-24	19.7	17.0	23.0
Education Level			
Primary	21.0	14.0	29.6
Some High School	51.5	50.8	52.3
Complete High School	18.2	22.2	13.3
Post High School/University	9.3	13.0	4.8
Number of Living Children			
0	93.3	93.8	92.6
1	5.7	5.2	6.4
2+	1.0	1.0	0.9
Marital Status			
Married/Consensual Union	14.4	13.9	14.9
Not Married	85.7	86.1	85.1
Church Affiliation			
Orthodox	89.2	90.1	88.0
Other	10.4	9.3	11.8
None	0.3	0.6	0.2
Ethnic Background			
Romanian	89.2	93.0	84.7
Hungarian	5.4	5.2	5.6
Gypsy	3.5	1.4	6.0
Other	1.9	0.4	3.7
Socio-Economic Status			
Low	38.7	16.2	66.2
Middle	45.8	58.6	30.2
High	15.5	25.2	3.6
Total	100.0	100.0	100.0
Unweighted No. of Cases	(2,047)	(1,075)	(972)

Results for the young men are similar ([Table 3B](#)). However, young women appear to be slightly better educated, both in urban and rural areas. A much lower percentage of men are married, only 14%, with virtually no urban-rural differential. Their later age of marriage is reflected in the lower proportion reporting living children compared to their female counterparts.

The distribution of church affiliation and ethnic background for males is essentially the same as that reported by the female sample. A slightly lower percentage of males are classified as lower socioeconomic, but the overall distribution is similar to the female sample.

CHAPTER IV

SEX EDUCATION

Over recent decades, concerns about teenage sexuality, pregnancy and sexual health have been mounting worldwide. Due to socio-economic and cultural changes, young people, especially adolescents, are sexually active at earlier ages than they have been in the past. They are more likely to have experienced premarital sexual intercourse, a greater number of sexual partners and a higher incidence of unintended pregnancy and sexually transmitted diseases (STDs). The negative consequences of adolescent sexual behaviors could also have disastrous long-term influences on their lives. The long-term effects include lower level of education, reduced range of employment opportunities, greater risk of fertility impairment and marital dissolution, and even shorter life expectancy since, in the last decade, AIDS has rapidly become a leading cause of death among men and women 25-44 years of age (Hein K., 1991).

Addressing unintended pregnancy and sexuality is a complex task. Prevention programs aiming to reduce the rate of adolescent pregnancy and STDs require a multifaceted approach. School-based sex education is one important component of a broader effort. A number of studies have demonstrated that quality sex education programs can delay the onset of sexual activity and increase the use of contraception (Kirby D. et al., 1994; Dawson DA, 1986).

In many countries sex education in school is mandatory. It is often taught from the first to 12th grade as a component of the health and physical education curriculum and aims to increase knowledge about human sexuality, sexually transmitted diseases, AIDS prevention, contraception and abstinence.

Currently, in Romania, sex education is not included in the school curriculum. Under the previous regime, elements of reproductive biology were taught in high school in the biology and human anatomy classes and short lectures about venereal diseases were sometimes taught by visiting health professionals. Often, these extra-curriculum lectures were held separately for boys and girls. After 1990, with the continuous support of several international agencies, local nongovernmental agencies (NGO's) started to send volunteers to lecture in high schools about methods of birth control and sexually transmitted diseases. These lectures have to be approved by the local school boards and their content varies from one organization to another. Thus, sex education in some areas is sporadic or nonexistent and the quality and amount of information is variable.

It is essential for Romanian teens to have quality sex education curricula in their schools. They acquire sexual information and sometimes misinformation from a variety of sources, including family, peers, media, and recently, in alarming proportion, from pornographic movies

and literature. A well designed compulsory sex education curriculum should be developed and implemented throughout the Romanian school system. It should cover, in addition to reproductive physiology and biology, information on STD's (including AIDS), methods of contraception, and psychological and social considerations of sex roles and sexual relationships. Only then would myths and misconceptions be corrected enhancing the likelihood that intimate relationship will be based on caring, affection and awareness of the other person's feelings.

One of the objectives of the YARHS was to examine whether young people in Romania favor sex education in schools and to explore their opinions about the best age to start sex education. In addition, the survey was designed to explore young adults' exposure to sex education in school and discussions about sex education topics at home. Information about exposure to sex education could provide useful correlates with age at first sexual intercourse and with contraceptive use at first intercourse among young adults.

4.1 Opinions about Sex Education In School

Both young women and men overwhelmingly supported sex education in school, regardless of their age, residence, education, and socio-economic status ([Tables 4.1.1A](#) and [4.1.1B](#)) . Over 93% felt that reproductive biology, birth control methods, and STDs topics should be part of the school curriculum. These beliefs were more common among young adults living in urban areas, with higher level of education (complete high-school or more), and with higher socio-economic status (middle or high).

Among the 6% of respondents who opposed sex education in school, more than half thought that sex education should be taught at home, and a third believed that sex education encourages the early onset of sexual activity. Among different subgroups, respondents' opposition to sex education in school never exceeded 15% for either females or males.

Young adults who agreed on the need for school-based sex education were also asked their opinion about the best grade level to start each topic of sex education. [Tables 4.1.2A](#) and [4.1.2B](#) show that, overall, 44% of females and 39% of males wanted sex education classes in primary school (before age 15) and 12% of respondents supported these courses in 7th grade or earlier. In addition, 21 % of young adults said that sex education should start in the 9th grade (age 15). Thus, two in three females and three in five males wanted sex education courses to start before the 10th grade (age 16). Residents of urban areas, young adults aged 20-24, and high-school graduates, were slightly more likely than others to say that sex education should be taught before the 10th grade and in elementary school.

Opinions of young adults on the best time to start specific sex education topics are shown in [Figure 4.1](#). Among respondents who supported sex education in school, there was not much variation in opinions about when to start specific topics of sex education but women were slightly

TABLE 4.1.1A
Opinions of Young Adult Women on Teaching Sex Education in Schools
By Sex Education Topic By Selected Characteristics of Women
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Think That Sex Education Should Be Taught in School		Sex Education Topics		
	%	No. of Cases	How Pregnancies Occur %	Methods of Birth Control %	Sexually Transmitted Diseases %
Total	93.9	(2,025)	93.9	93.6	93.9
Residence					
Urban	96.9	(983)	96.9	96.8	96.9
Rural	90.1	(1,042)	90.1	89.6	89.9
Age Group					
15-17	93.5	(738)	93.5	93.1	93.3
18-19	94.1	(501)	94.1	93.7	94.1
20-24	94.2	(786)	94.2	93.9	94.1
Education Level					
Primary	84.6	(460)	84.6	84.6	84.6
High School	95.2	(917)	95.2	94.8	95.0
HSD&PostHS	97.8	(648)	97.8	97.2	97.8
Socioeconomic Status					
Low	89.4	(917)	89.4	89.0	89.3
Middle	97.1	(876)	97.1	96.6	97.0
High	98.1	(232)	98.1	98.1	98.1

TABLE 4.1.1B
Opinions of Young Adult Men on Teaching Sex Education in Schools
By Sex Education Topic By Selected Characteristics of Men
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Think That Sex Education Should Be Taught in School		Sex Education Topics		
	%	No. of Cases	How Pregnancies Occur %	Methods of Birth Control %	Sexually Transmitted Diseases %
Total	94.1	(2,047)	94.1	93.7	93.8
Residence					
Urban	96.9	(1,075)	96.9	96.6	96.6
Rural	90.7	(972)	90.7	90.3	90.4
Age Group					
15-17	92.5	(805)	92.4	92.2	92.3
18-19	95.9	(517)	95.9	95.5	95.7
20-24	94.4	(725)	94.4	94.0	94.0
Education Level					
Primary	85.5	(473)	85.5	85.3	85.2
High School	95.4	(1,065)	95.4	94.8	94.9
HSD&PostHS	98.3	(509)	98.3	98.3	98.3
Socioeconomic Status					
Low	90.4	(786)	90.3	90.1	90.1
Middle	96.2	(943)	96.2	95.6	95.7
High	97.4	(318)	97.4	97.4	97.4

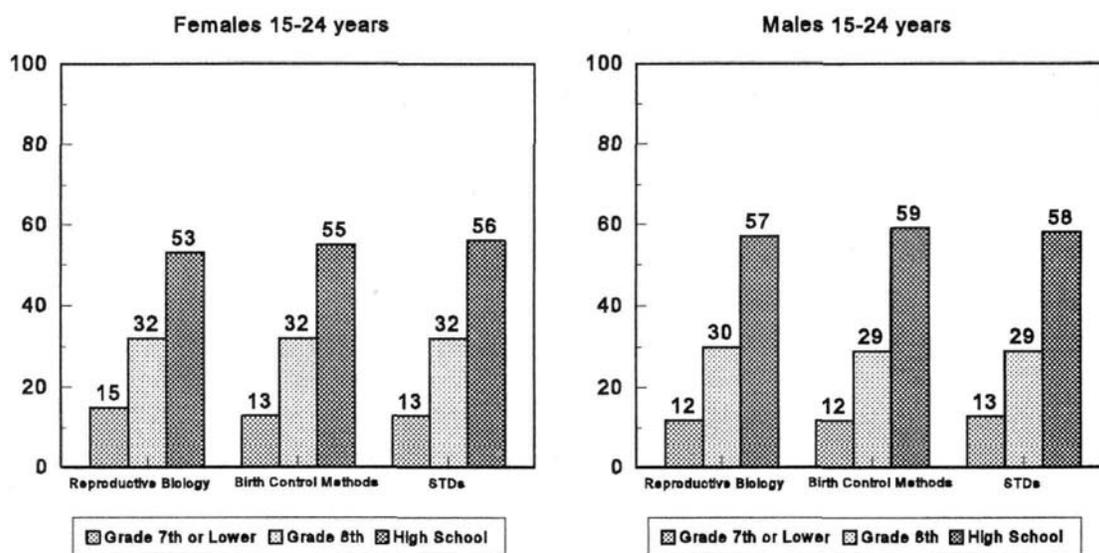
TABLE 4.1.2A
Opinions of Young Adult Women On the Best Age to Introduce Sex Education in Schools
By Characteristics of Women
Women Aged 15-24 Who Agreed with School-Based Sex Education
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Characteristics</u>	<u>What is the Best Age to Introduce Sex Education In School ?</u>						<u>No. of Cases</u>
	<u>Under 13</u>	<u>Age 13</u>	<u>Age 14</u>	<u>Age 15</u>	<u>Age 16+</u>	<u>Total</u>	
Total	5.7	6.9	31.8	21.2	34.4	100.0	1,892
<u>Residence</u>							
Urban	6.5	8.1	32.1	21.8	31.5	100.0	955
Rural	4.5	5.3	31.4	20.5	38.2	100.0	937
<u>Age Group</u>							
15-17	4.7	6.2	27.8	24.4	37.0	100.0	687
18-19	3.3	6.4	33.5	19.7	37.0	100.0	467
20-24	7.4	7.6	33.5	20.0	31.6	100.0	738
<u>Education Level</u>							
Primary	7.5	8.5	32.0	19.1	32.9	100.0	386
High School	4.9	5.7	29.2	23.1	37.1	100.0	872
HSD&PostHS	5.7	7.5	34.8	20.2	31.8	100.0	634
<u>Socio-Economic Status</u>							
Low	4.1	6.5	32.9	20.4	36.1	100.0	816
Middle	7.4	7.2	31.7	21.2	32.5	100.0	848
High	4.2	7.5	28.4	24.1	35.8	100.0	228

TABLE 4.1.2B
Opinions of Young Adult Men On the Best Age to Introduce Sex Education in Schools
By Characteristics of Men
Men Aged 15-24 Who Agreed with School-Based Sex Education
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	What is the Best Age to Introduce Sex Education In School ?					Total	No. of Cases
	Under 13	Age 13	Age 14	Age 15	Age 16+		
Total	6.7	4.8	28.0	21.4	39.1	100.0	1,924
Residence							
Urban	5.9	4.0	29.5	23.6	37.0	100.0	1,045
Rural	7.6	5.8	26.2	18.5	41.9	100.0	879
Age Group							
15-17	5.4	3.7	24.4	23.7	42.7	100.0	743
18-19	4.5	4.8	28.1	17.5	45.1	100.0	494
20-24	8.3	5.4	30.3	21.6	34.4	100.0	687
Education Level							
Primary	5.6	3.0	25.2	20.7	45.6	100.0	400
High School	6.8	5.4	25.3	21.9	40.6	100.0	1,024
HSD&PostHS	7.1	4.8	35.0	20.9	32.2	100.0	500
Socio-Economic Status							
Low	7.0	4.5	23.3	20.2	45.0	100.0	702
Middle	6.2	5.0	29.7	22.3	36.9	100.0	910
High	7.2	4.7	34.3	21.7	32.1	100.0	312

FIGURE 4.1
OPINIONS ABOUT THE BEST TIME TO START SEX EDUCATION IN SCHOOL
BY SPECIFIC TOPIC AND GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



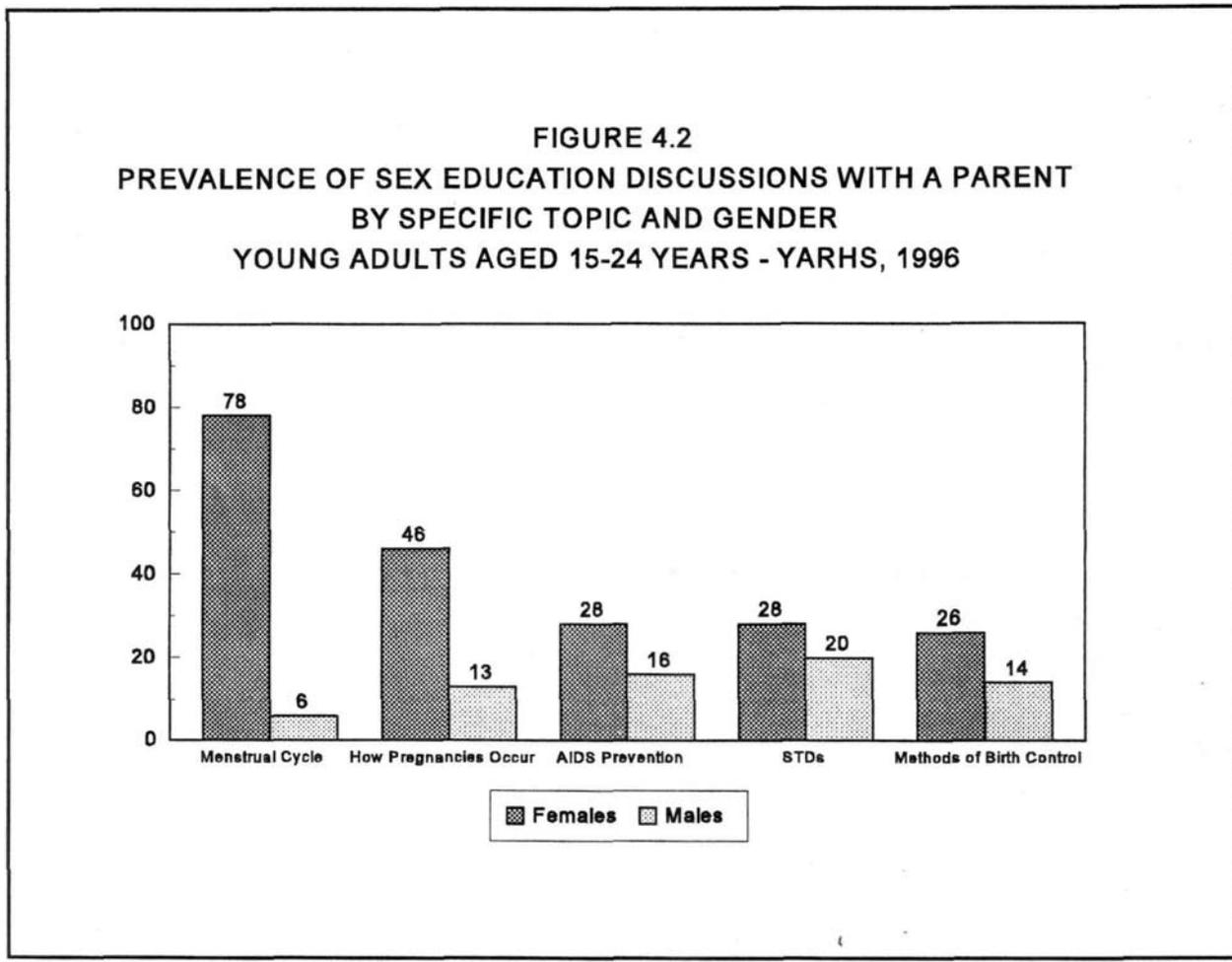
more likely to endorse earlier classes for each topic. Overall, the average grade level recommended by both women and men for starting sex education was 8-9th grade, regardless the topic.

4.2 Discussions About Sex Education Topics with Parents

In order to examine the impact of sex education on sexual and contraceptive behaviors we explored young adults' exposure to sex education separately in school and at home. Respondents were asked if they had ever talked to their parents about the menstrual cycle, how pregnancy occurs, birth control methods, and STDs (including AIDS).

[Figure 4.2](#) and [Table 4.2.1](#) show the percentage of young adults who had received information from their parents about selected sex education topics by age group and gender. Overall, 80% of young women had talked about at least one sex education topic with their parents. The

proportion who discussed specific topics ranges from 78 % for menstrual cycle to only 26 % for methods of birth control. Only 28% of young women had discussed about STDs or AIDS with a parent. Conversely, young males were much less likely than young females to have conversations on sex related issues with a parent. Only one fourth of young men had parental discussions regarding at least one topic, ranging from 20% when the topic was STDs to 6% if the topic was the menstrual cycle. Talking to a parent about methods of birth control was far less prevalent among males (14%) compared to females (26%).



[Table 4.2.1](#) also shows that teenage girls (15-17 and 18-19 years old) were slightly more likely to have had discussions at home about any sex-related issues than 20-24 year-olds (83 % and 79%, respectively, vs 78%). However, a substantially higher proportion of female teens than of the 20-24 year olds reported having discussed with one of their parents about AIDS, other STDs and contraception. For example, talking to parents about AIDS and other STDs had increased by 50% and 30%, respectively, among the younger cohorts compared to the oldest cohort.

TABLE 4.2.1
Percentage of Young Adults Who Have Discussed Sex Education Topics with Their Parents
By Specific Topic by Age Group and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Sex Education Topic</u>	<u>Women</u>				<u>Men</u>			
	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>
<u>Any Topic at Home</u>	79.6	82.6	78.8	78.0	25.5	27.1	28.1	23.3
Menstrual Cycle	78.3	81.2	77.1	76.9	5.8	5.6	6.1	5.9
How Pregnancies Occur	46.3	46.8	48.2	45.2	12.6	11.9	13.6	12.6
AIDS Prevention	27.9	34.8	32.3	21.6	15.9	18.9	19.6	12.4
STDs	27.9	31.1	32.3	24.0	20.3	21.9	22.6	18.4
Methods of Birth Control	25.9	26.8	31.6	22.9	14.1	13.7	17.1	13.2

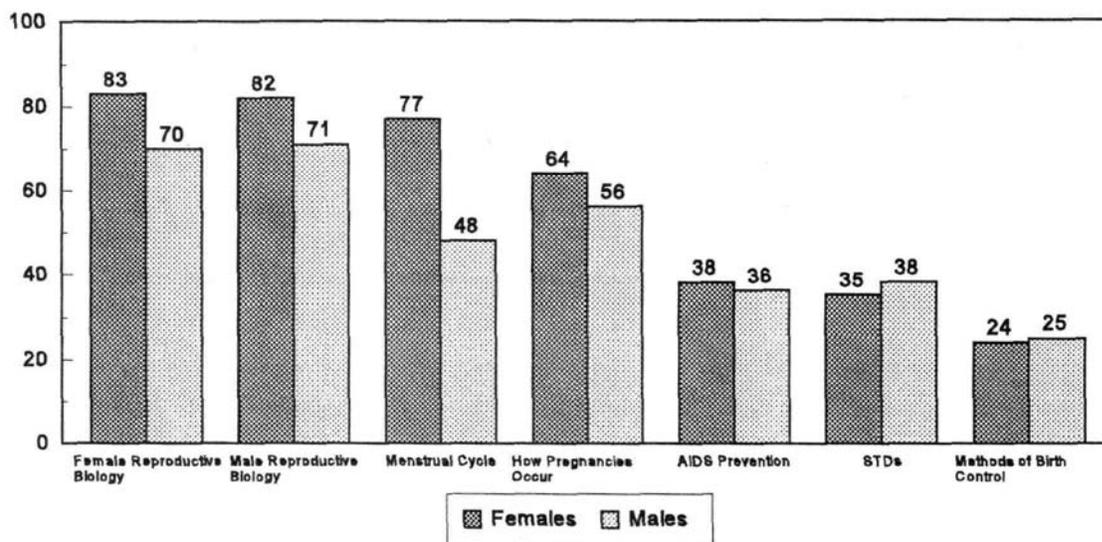
The increasing concern about the threat of AIDS epidemics in recent years is the most likely explanation for the higher prevalence of this topic in parent-child conversations. Meanwhile, the conversations about contraception rose modestly among 15-17 year-olds and more striking among 18-19 year-olds (39%).

The same trend, but more discreet, has occurred among young males. Male teens were slightly more likely to have discussed about a sex-education topic at home (27% and 28%, vs 23%) mostly because they talked more about AIDS and STDs.

These findings cannot be interpreted without taking into account the exposure to sex education in schools. Since younger respondents also reported more school-based education about STDs, AIDS, and methods of birth control (see [Table 4.3](#)), they may have been stimulated to ask their parents about these topics. In fact, respondents who reported classes on STDs, AIDS, and contraception were twice more likely to report parent-child conversations about these topics (not shown). The association between formal and parental sex-education may potentially indicate differences in the recall of those who did not have classes and who may not remember talking with

parents about sex issues, and those who remember they had formal instruction which may have triggered home conversations. Also, recall differences may explain in part why 20-24 years olds, who did not benefit from formal instruction on STDs, AIDS or contraception, were also less likely to report parental conversations on these topics. However, the change over time in reports of STDs, AIDS or contraception topics in both parental discussions and school based sex education are entirely consistent with the recent developments after 1990 when media have started to discuss these health issues more openly and several NGO's launched sex-education campaigns in schools or other formal settings.

**FIGURE 4.3.1
PREVALENCE OF SEX EDUCATION IN SCHOOL
BY SPECIFIC TOPIC AND GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996**



4.3 Sex Education Instruction in School

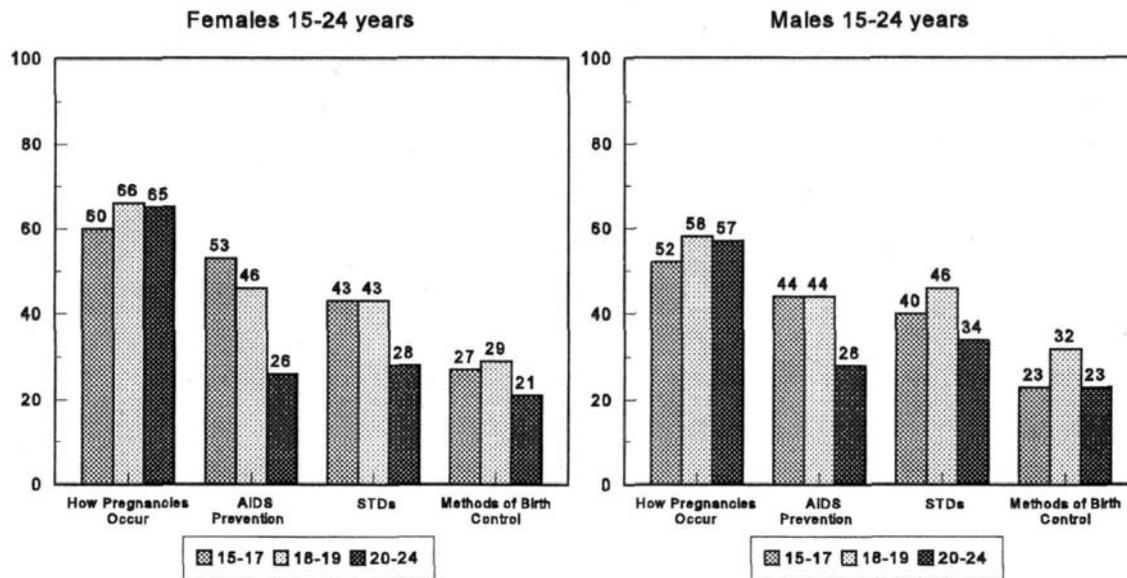
All young adults were asked whether they received formal instruction in school in reproductive biology, contraception, STDs, and AIDS prevention. Those who reported exposure to formal instruction were asked the grade at which they first took courses on each specific topic. These data will be included in the final report.

TABLE 4.3
Percentage of Young Adults Who Have Had Sex Education in School By Specific Topic
By Age Group and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Sex Education Topic</u>	<u>Women</u>				<u>Men</u>			
	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>
<u>Any Topic at School</u>	88.4	87.5	86.9	89.6	77.2	77.9	77.6	76.7
Female Reproductive Biology	82.7	79.7	82.5	84.7	69.5	68.3	67.9	70.0
Male Reproductive Biology	81.8	78.5	81.9	83.8	71.0	70.9	70.3	71.3
Menstrual Cycle	77.4	72.3	76.1	81.2	48.0	46.1	46.4	49.9
How Pregnancies Occur	63.6	59.7	66.1	65.0	55.6	51.5	58.0	57.2
AIDS Prevention	38.2	53.0	45.5	25.8	36.2	43.9	43.9	28.0
STDs	35.2	42.6	42.6	27.5	38.2	40.4	45.8	33.6
Methods of Birth Control	24.4	27.2	28.8	20.7	24.7	22.8	31.9	23.0

[Table 4.3](#) and [Figure 4.3.1](#) show the percentage of young adults who reported formal sex education on specific topics, by age and gender. Overall, most young women and men had at least one school-based course or class on sex education. About 88% of young women reported courses on one of the seven topics listed. However, women were more likely to have had courses on reproductive biology, menstrual cycle, and how pregnancy occurs (82%, 77%, and 64%, respectively) than courses on AIDS, other STDs, and contraceptive methods (38%, 35%, and 24%). Similarly, young men had more biology courses and less instruction about STDs and contraception.

FIGURE 4.3.2
PREVALENCE OF SEX EDUCATION IN SCHOOL BY SPECIFIC TOPIC
BY AGE GROUP AND GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



Compared with respondents aged 20-24, adolescents reported higher levels of formal instruction on AIDS prevention and STDs (Table 4.3 and Figure 4.3.2). For example, AIDS prevention classes were reported by twice as many teens as 20-24 year-old women. These findings demonstrate that formal instruction in these topics has improved recently, perhaps as a result of the voluntary work of local NGOs in high-schools.

CHAPTER V

KNOWLEDGE OF CONTRACEPTION AND FERTILITY

During the previous regime, as a component of the pronatalist policy, family planning was officially banned in Romania and a systematic campaign to misinform the public about modern contraception was mounted at all levels, in schools, in the mass-media, and at work sites. The consequences of this policy resulted in fear and mistrust of modern methods, low prevalence of their use, and high reliance on traditional contraception, which persisted after the change of government and the introduction of a national family planning program.

The 1993 RRHS revealed high levels of awareness of several modern methods (condoms, oral contraceptives, and IUD), including knowledge about their availability. Most women knew at least one place where they could obtain a modern method but the gap between awareness of any method and its source was significant, reaching almost 30 percentage points for such commonly used methods as condoms and IUD. However, there was a great deal of variability in both awareness about FP methods and knowledge of a source of supplies. Among 15-24 year olds, the awareness of modern methods exceeded that of traditional methods (90% vs. 68%) and the awareness of youth specific methods (e.g., condom and the pill) was higher than among older women.

These data were the first nationally representative information about family planning awareness and constitute the baseline for the information-education-communication (IEC) efforts launched soon after as a component of the family planning program. Two major goals of the IEC activities are to heighten contraceptive knowledge and use among youth and promote reduction in risk-taking behaviors.

An important objective of the YARHS was to explore further the level of knowledge of family planning methods and their sources among young people in the aftermath of intensified IEC efforts. In both samples, respondents were asked, in reference to ten modern and traditional contraceptive methods, if they have ever heard about each, from whom, if they know how they are used, and if they know where they could be obtained.

5.1 Knowledge of Family Planning Methods

[Tables 5.1.1A](#) and [5.1.1B](#) show that, almost all young women (95%) and men (97%) have heard of at least one modern method and most of them have heard of a traditional method (74% and 75%, respectively). Knowledge of all methods increased with age, but especially for IUD, tubal ligation and traditional methods.

TABLE 5.1.1A
Percentage of Women Who Have Heard of Contraceptive Methods And Know How to Use Them
By Specific Method By Age Group
Women Aged 15-24 Years
Young Adult Reproductive Health Survey: ROMANIA, 1996

Contraceptive Method	Have Heard of Specific Methods				Know How to Use Specific Methods*			
	Total	15-17	18-19	20-24	Total	15-17	18-19	20-24
<u>Any Modern Method</u>	<u>95.0</u>	<u>92.1</u>	<u>94.0</u>	<u>97.2</u>	<u>73.2</u>	<u>60.6</u>	<u>71.3</u>	<u>81.8</u>
Condom	93.0	90.4	92.8	94.6	67.4	56.4	66.3	74.8
Pills	82.3	72.5	82.3	88.4	35.1	20.1	34.9	44.5
IUD	69.1	44.7	69.2	84.3	35.7	15.5	30.5	50.6
Tubal Ligation	40.5	23.9	41.4	50.4	24.0	11.7	24.4	31.4
Spermicides	30.1	16.9	29.9	38.5	18.1	6.7	15.0	26.5
Vasectomy	20.3	10.9	24.2	24.6	11.5	5.6	12.6	14.7
Diaphragm	12.6	7.3	15.5	14.8	6.2	2.8	5.5	8.6
Injectables	12.2	9.2	10.6	14.9	6.7	4.8	4.4	9.0
Mean No. of Modern Methods	3.6	2.8	3.6	4.1	2.0	1.2	1.9	2.6
<u>Any Traditional Method</u>	<u>74.0</u>	<u>47.8</u>	<u>76.8</u>	<u>89.4</u>	<u>63.3</u>	<u>34.2</u>	<u>63.2</u>	<u>81.5</u>
Withdrawal	57.5	24.2	57.8	78.1	51.0	19.4	48.5	71.7
Calendar	64.4	40.3	67.7	78.0	45.5	23.8	46.7	58.5
<u>Mean No. of FP Methods</u>	<u>4.8</u>	<u>3.4</u>	<u>4.9</u>	<u>5.7</u>	<u>3.0</u>	<u>1.7</u>	<u>2.9</u>	<u>3.9</u>
Unweighted No. of Cases	2,025	738	501	786	2,025	738	501	786

* Includes respondents who said they know how the method is used or how it works in the case of long term methods; those who have never heard of a specific method were assumed not to know how that method is used.

Generally, with the exception of male-controlled methods (e.g., condom, withdrawal), awareness of family planning methods was higher among women than among men. For all young adults, the most widely known method was the condom, recognized by 93% of women and 97% of men. It was followed by the pill, known by 82% of women and 66% of men, IUD, (69% and 39%, respectively), and female sterilization (41% and 24%, respectively).

TABLE 5.1.1B
Percentage of Men Who Have Heard of Contraceptive Methods And Know How to Use Them
By Specific Method By Age Group
Men Aged 15-24 Years
Young Adult Reproductive Health Survey: ROMANIA, 1996

Contraceptive Method	Have Heard of Specific Methods				Know How to Use Specific Methods*			
	Total	15-17	18-19	20-24	Total	15-17	18-19	20-24
<u>Any Modern Method</u>	<u>97.3</u>	<u>95.6</u>	<u>97.3</u>	<u>98.4</u>	<u>91.8</u>	<u>85.4</u>	<u>92.1</u>	<u>95.8</u>
Condom	96.9	94.7	97.3	98.2	91.5	84.4	92.1	95.8
Pills	66.3	51.8	65.8	75.8	34.1	19.8	32.4	44.0
IUD	39.1	21.9	37.7	50.8	24.2	9.6	22.6	34.2
Tubal Ligation	23.7	13.0	23.5	30.7	13.5	5.7	12.9	18.8
Vasectomy	20.2	12.0	20.1	25.5	11.4	5.4	12.8	14.6
Spermicides	15.4	8.4	17.6	19.0	9.6	4.4	9.7	13.0
Injectables	11.2	6.7	10.6	14.2	5.9	2.8	6.0	7.9
Diaphragm	8.9	5.0	9.8	11.0	4.5	1.7	5.0	6.0
Mean No. of Modern Methods	2.8	2.1	2.8	3.2	1.9	1.3	1.9	2.3
<u>Any Traditional Method</u>	<u>74.8</u>	<u>52.1</u>	<u>78.5</u>	<u>88.2</u>	<u>70.0</u>	<u>42.3</u>	<u>73.8</u>	<u>86.2</u>
Withdrawal	65.2	44.2	74.0	83.1	66.0	38.4	71.3	84.6
Calendar	45.8	26.8	47.4	65.8	38.6	15.0	37.1	54.4
Mean No. of FP Methods	4.0	2.8	4.0	4.7	3.0	1.9	3.0	3.7
Unweighted No. of Cases	2,047	805	517	725	2,047	805	517	725

* Includes respondents who said they know how the method is used or how it works in the case of long term methods; those who have never heard of a specific method were assumed not to know how that method is used.

Consistent with 1993 survey findings, the least known modern methods were those that are very seldom used in Romania (diaphragm, injectables, and vasectomy). The average number of family planning methods recognized was 4.8 methods for women (including 3.6 modern methods) and 4.0 methods for men (including 2.8 modern methods). The number of

methods known was directly correlated with respondents' ages, ranging from 3.4 to 5.7 among women and 1.7 to 3.9 among men. Compared to the 1993 survey, the awareness of contraception among young women increased moderately from 90% to 95% for modern methods and from 68% to 74% for traditional methods.

Very often the awareness of contraceptive methods is used interchangeably with knowledge of methods. A major criticism of this practice is that it may overstate the level of contraceptive knowledge without exploring the extent of the information possessed by those who can identify contraceptive methods. The set of questions asked in the RRHS to explore family planning awareness, was supplemented in YARHS with an additional question about knowledge of how each method or procedure is used.

As seen in [Tables 5.1.1A](#) and [5.1.1B](#) and [Figure 5.1](#), the knowledge of use among women was significantly lower than awareness (73% vs. 95%) but only slightly lower among men (91% vs. 97%) whose claim of knowledge about condom use was almost universal.

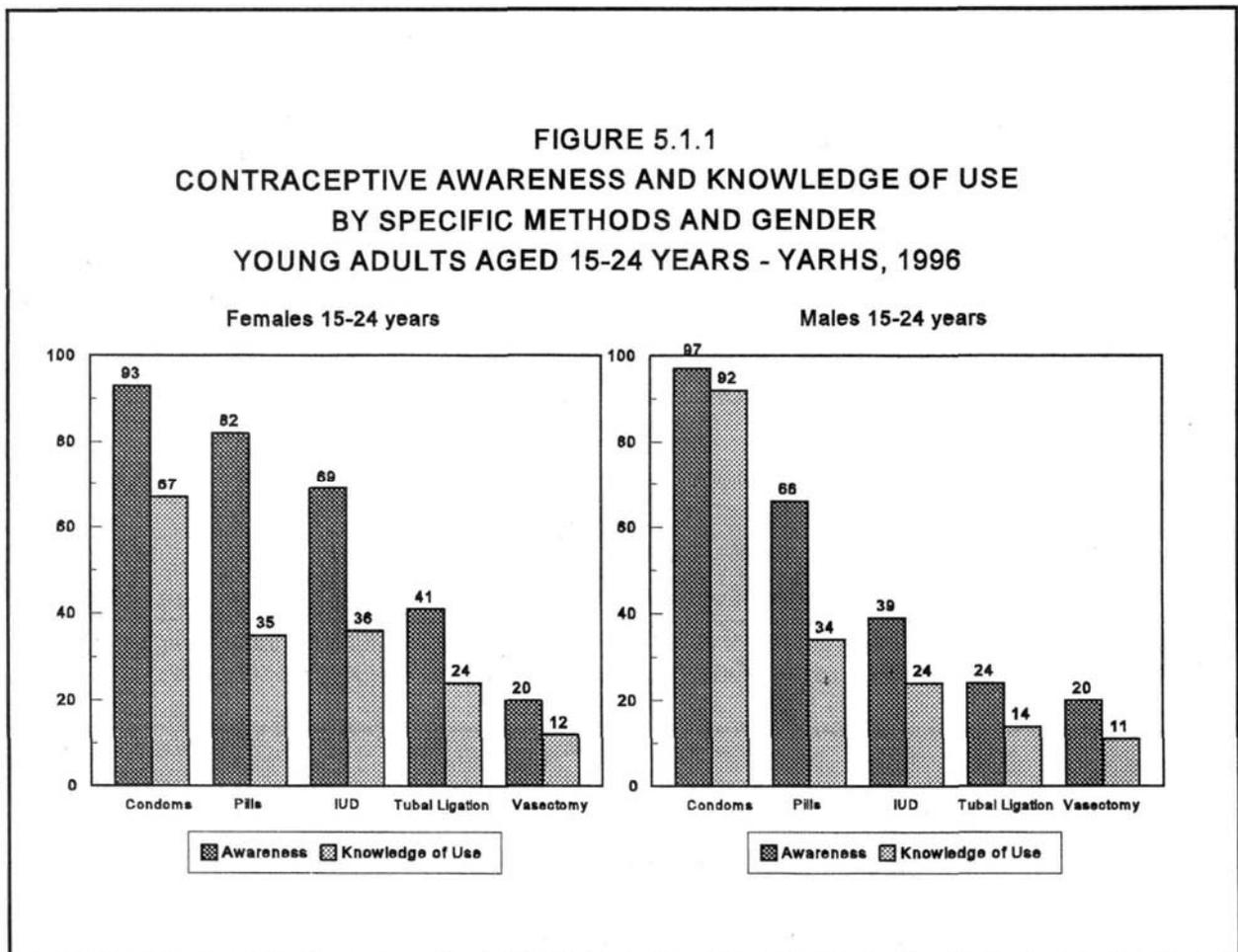


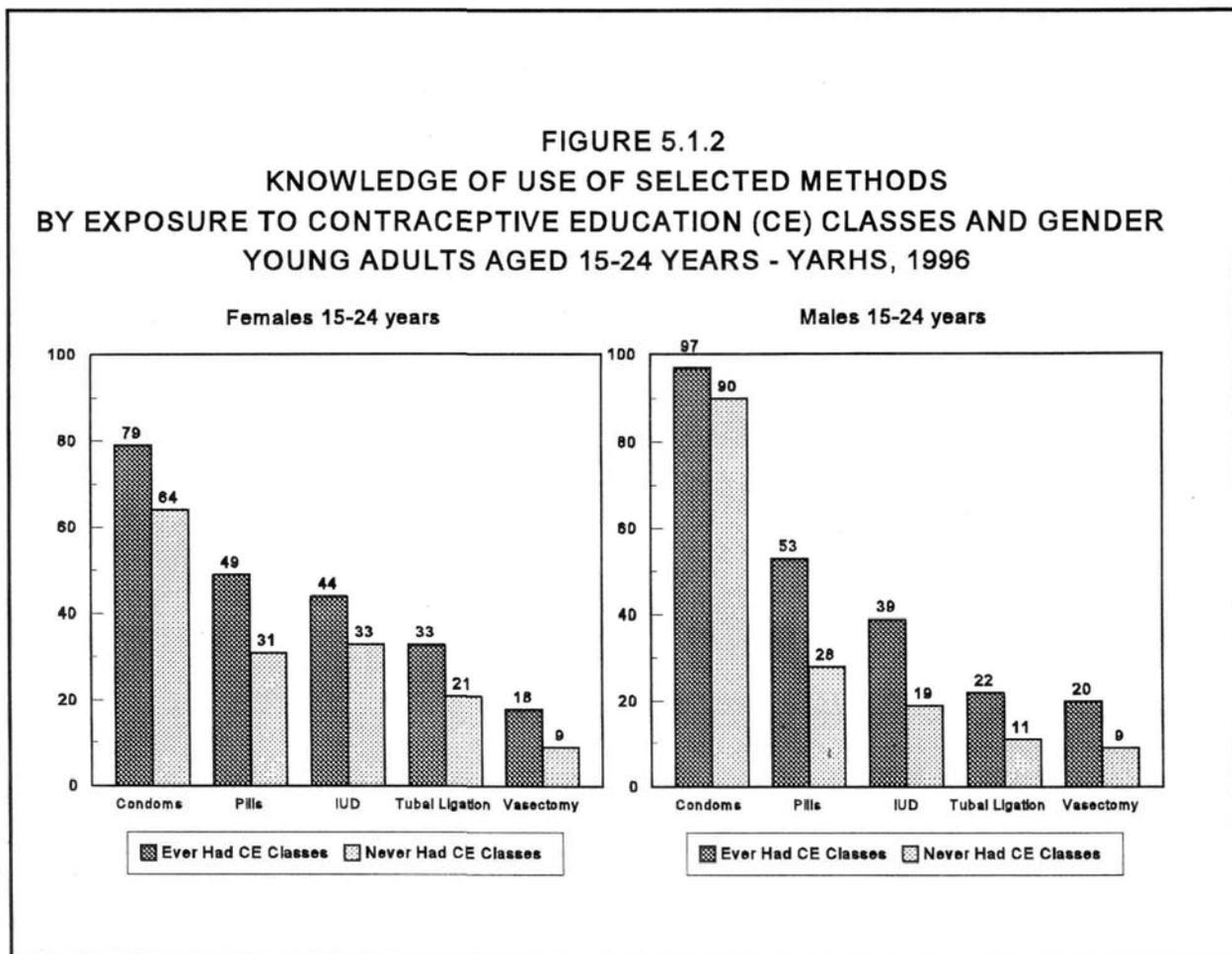
TABLE 5.1.2
Percentage of Young Adults Who Know How Contraceptive Methods Are Used
By Specific Method By School Based Contraceptive Education (CE)
Young Adult Reproductive Health Survey: ROMANIA, 1996

Contraceptive Method	Women			Men		
	Total	Never Had	Ever Had	Total	Never Had	Ever Had
		CE	CE		CE	CE
<u>Any Modern Methods</u>	<u>73.2</u>	<u>69.1</u>	<u>85.8</u>	<u>91.8</u>	<u>89.9</u>	<u>97.7</u>
Condom	67.4	63.6	79.3	91.5	89.7	97.0
Pills	35.1	30.7	48.5	34.1	28.0	52.6
IUD	35.7	33.1	43.6	24.2	19.4	38.6
Tubal Ligation	24.0	21.0	33.1	13.5	10.7	22.1
Spermicides	18.1	15.7	25.6	11.4	7.1	17.4
Vasectomy	11.5	9.4	17.9	9.6	8.6	19.9
Injectables	6.7	4.5	13.3	5.9	4.4	10.6
Diaphragm	6.2	4.5	11.1	4.5	2.9	9.3
Mean No. of Modern Methods	2.0	1.8	2.7	1.9	1.7	2.7
<u>Any Modern Methods</u>	<u>63.3</u>	<u>61.9</u>	<u>67.5</u>	<u>70.0</u>	<u>66.2</u>	<u>81.4</u>
Withdrawal	51.0	51.6	48.8	66.0	62.6	76.3
Calendar	45.5	41.3	58.5	38.6	33.9	52.8
Mean No. of FP Methods	3.0	2.7	3.8	3.0	2.7	4.0
Unweighted No. of Cases	2,025	1,521	504	2,047	1,529	518

With the exception of condom and withdrawal, the knowledge of how to use specific methods was higher for women than for men. However, for both groups, the knowledge of method use dropped to less than a half of its awareness for several methods (IUD, the pill, vasectomy, diaphragm, and injectables) and was positively correlated with respondents' ages. Using the

more stringent definition of contraceptive knowledge, the average number of known modern methods dropped to only two methods in each group.

Young women and men whose school based sex education included lectures about contraceptive methods were much more likely to know how to use birth control methods (Table 5.1.2 and Figure 5.1.2). Overall, the knowledge of how to use at least one method was 25% higher among women who had had such courses than among those who had not. The largest differences (about two to one ratio) were for less commonly used methods: vasectomy, diaphragm, and injectables. Among men, knowledge of use improved greatly with sex education for most methods, even for those most commonly in use (e.g., IUD and the pill). Knowledge about withdrawal was not affected by sex education among women but improved among men. Young adults who had had contraceptive courses in school knew, on average, one modern method more than those who had not received such education.



5.2 Knowledge of Source of Contraception

Another indicator commonly used in evaluating IEC efforts is the knowledge of source(s) of contraception. The YARHS found that 87% of young women and 91% of men could name at least one source for contraception (Table 5.2.1). Knowledge about contraceptive source among young women had increased 10 percentage points compared to three years ago (from 77% in 1993).

TABLE 5.2.1
Percentage of Young Adults Who Know Where to Get Contraceptives
By Specific Method By Age Group and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

Contraceptive Method	Women				Men			
	Total	15-17	18-19	20-24	Total	15-17	18-19	20-24
<u>Any Modern Methods</u>	86.7	80.2	86.6	90.7	91.2	85.4	91.4	94.8
Condom	83.5	76.4	84.0	87.8	90.5	84.4	91.0	94.3
Pills	66.0	52.0	68.2	73.7	53.3	36.9	55.1	63.0
IUD	49.4	25.3	46.4	65.6	28.8	12.4	28.1	39.6
Tubal Ligation	30.3	15.9	30.3	39.4	15.9	6.9	14.6	22.2
Spermicides	24.5	11.7	22.9	33.1	12.0	5.7	14.3	15.1
Vasectomy	13.5	6.4	16.2	16.9	14.0	7.4	13.2	18.5
Injectables	7.4	4.9	4.9	10.0	7.6	3.7	7.6	10.1
Diaphragm	7.2	2.9	7.7	9.6	4.9	1.7	6.0	6.6
Mean No. of FP Methods	2.8	2.0	2.8	3.4	2.3	1.6	2.3	2.7
Unweighted No. of Cases	2,025	738	501	786	2,047	805	517	725

Young people were more likely to know a source for methods commonly used by young adults (e.g., condoms and pills) than for less commonly used methods. For instance, 84% of women and 91% of men knew where to obtain condoms and 66% women and 53% men knew a

source for pills, but very few knew where to get injectables or diaphragms. Only 30% of the women and 16% of the men were able to correctly identify where a tubal ligation can be performed. On average, young adults could identify sources for 2-3 modern methods, condoms' usually being one of them.

Knowledge of source was positively correlated with age for both women and men for every contraceptive method (Table 5.2.1). However, compared to the 1993 survey, knowledge of source among female adolescents had improved more rapidly than among 20-24 year olds (13 and 5 percentage points increase, respectively).

Among young adults, knowledge of contraceptive source was not significantly influenced by marital status. With the exception of the IUD, knowledge of source for each method was very similar among ever married and never married respondents.

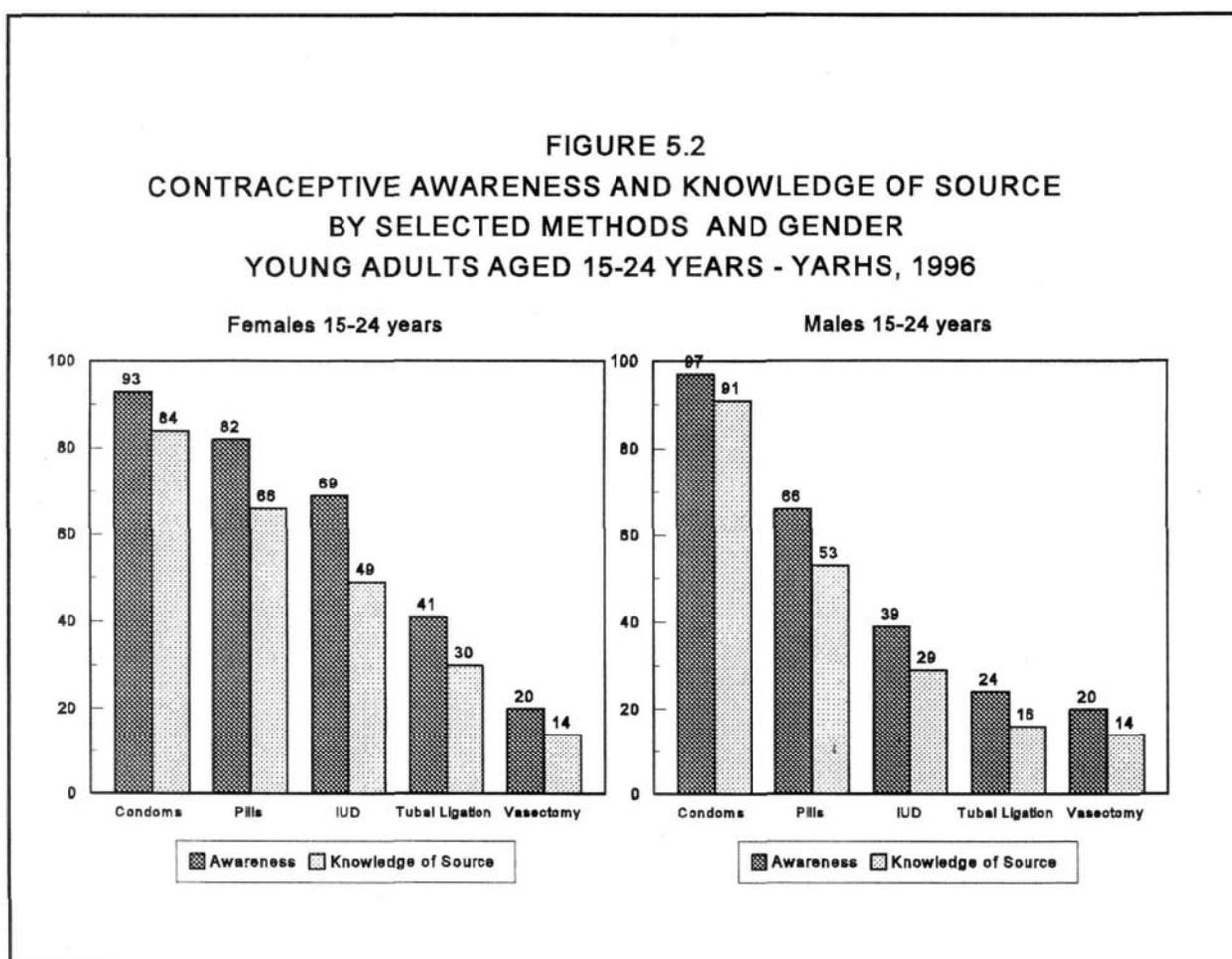


TABLE 5.2.2
Percentage of Young Adults Who Know Where to Get Contraceptives
By Specific Method By Marital Status and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

Contraceptive Method	Women			Men		
	Total	Ever	Never	Total	Ever	Never
		Married	Married		Married	Married
<u>Any Modern Methods</u>	86.7	86.6	86.7	91.2	94.7	90.5
Condom	83.5	82.1	84.3	90.5	94.2	89.8
Pills	66.0	66.1	65.9	53.3	58.1	52.3
IUD	49.4	61.8	42.4	28.8	49.0	25.0
Tubal Ligation	30.3	33.5	28.6	15.9	20.0	15.1
Spermicides	24.5	29.2	21.9	12.0	13.6	11.7
Vasectomy	13.5	11.5	14.7	14.0	12.1	14.3
Injectables	7.4	7.9	7.1	7.6	13.5	6.5
Diaphragm	7.2	6.6	7.5	4.9	5.5	4.8
Mean No. of FP Methods	2.8	3.0	2.7	2.3	2.7	2.2
Unweighted No. of Cases	2,025	570	1,455	2,047	156	1,891

Not all young adults know where they can obtain the modern methods they have heard about ([Figure 5.2](#)) and the gap between knowledge of any modern method and knowledge of their sources is not significantly influenced by gender (ten percentage points for women and seven percentage points for men); however, for men and women, the gap varies greatly by specific methods, especially for the more widely known methods. For example, the knowledge of source is just slightly below condom awareness (nine percentage points among women and 6 percentage points among men) but is lower for pills (16 percentage points and 13 percentage points respectively) and for IUD (20 percentage points among women and 10 percentage points among men).

5.3 First Source of Information About Contraception

The 1993 RRHS found that among women 15-44 years of age the main source of information about birth control methods was a friend or acquaintance (45%), followed by mass-media (19%), and health care providers (10%). Young women, 15-24 years of age, reported the same first sources as older women. Almost 40% of young women found out about contraception in discussions with a friend or acquaintance, 24% from mass-media or books, and 9% from a health care provider (Serbanescu F. and Morris L., 1996). Only 7% of the young women surveyed said that they had first heard about contraception from their mothers.

TABLE 5.3A
First Source of Information About Contraception By Specific Method
Women 15-24 Years of Age Who Have Heard About Specific Methods of Contraception
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

First Source of Information About Contraception	Contraceptive Method						
	Total	Condom	Pills	IUD	Tubal Ligation	Calendar	Withdrawal
Friend	27.2	39.4	27.6	25.5	15.6	30.7	25.3
Colleague	12.7	20.6	13.9	11.2	9.7	11.2	8.8
Health Provider/Pharmacist	11.8	3.8	13.1	20.9	23.6	5.4	2.3
TV or Radio	9.7	13.5	12.4	8.0	10.2	1.9	0.5
Mother	9.5	5.0	9.9	8.9	10.9	21.5	7.9
Father or Other Relative	8.7	5.2	10.1	10.5	10.9	12.5	7.2
Partner	6.4	4.2	0.4	0.6	0.3	2.1	40.5
Brochures/Newspapers/Magazines	4.2	2.2	4.4	4.1	4.1	4.4	2.4
School	3.6	2.5	3.5	3.0	4.0	4.7	1.0
Books	2.9	0.6	1.4	2.0	6.5	3.2	1.7
User	1.9	1.2	2.0	4.3	2.3	1.1	1.2
Other	1.6	2.0	1.5	1.0	2.0	1.6	1.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

These findings explained in part the poor quality of contraceptive information, often acquired through rumors, and argued for heightening the public health efforts in educating youth through official channels (school, mass-media, health providers) about the benefits of contraception and the availability of family planning products and services.

As shown in [Table 5.3A](#), the first source of information for young women continue to be a friend (27%) or a colleague (13%), followed by media (17%) and health providers (12%). Ten percent have first heard about contraception from their mothers and 6% from their partners. Only 4 % cited the school courses as the first source of contraceptive information. It is worth noting that, compared to the previous survey, there has been a slight increase in the contribution of the health providers (from 9% to 12%) and of the young women's mothers (from 7% to 10%) in spreading contraceptive information. Mass media continue to play a limited role in contraceptive educational efforts, even though one in six young women mentioned it as the first source of information.

TABLE 5.3B
First Source of Information About Contraception By Specific Method
Men 15-24 Years of Age Who Have Heard About Specific Methods of Contraception
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

First Source of Information About Contraception	Contraceptive Method						
	Total	Condom	Pills	IUD	Tubal Ligation	Calendar	Withdrawal
Friend	50.0	71.4	46.5	36.5	21.9	40.9	66.4
TV or Radio	11.9	8.6	15.8	15.6	29.2	3.2	1.5
Partner	7.7	0.4	6.9	9.7	3.2	33.4	4.0
Brochures/Newspapers/Magazines	7.0	2.0	7.1	10.8	17.7	3.8	2.1
Colleague	5.5	7.1	5.6	5.8	4.8	4.2	4.1
Father or Other Relative	3.2	3.5	3.5	4.1	3.0	2.9	3.5
School	2.5	1.4	3.8	3.8	4.5	3.2	0.5
Health Provider/Pharmacist	2.4	1.1	2.5	5.0	5.7	0.7	0.6
Somebody Who Use It	1.6	0.4	0.8	0.9	0.8	0.4	6.2
Mother	1.5	0.7	1.9	2.8	2.2	2.9	0.4
Books	1.5	0.3	1.0	2.1	4.0	1.8	0.9
Alone	1.2	0.0	0.0	0.0	0.0	0.1	6.7
Other	3.7	3.2	4.5	3.0	3.2	2.4	3.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

There is little variation in the first source of information for specific modern methods. However, more women mentioned that they heard about the calendar from their mothers (22%) and about withdrawal from their partners (41 %).

Likewise, more than half of young men first heard about a contraceptive method from a friend or acquaintance ([Table 5.3B](#)). Other major sources were the mass-media (21%) and their partners (8%). Discussions with parents were sporadic~3% said they found out about contraception by talking with their fathers and 2% with their mothers—and health providers were only seldom mentioned (2%). Interestingly, men were much more likely to mention mass-media as the first source of information for modern methods: tubal ligation (51%), IUD (29%), and the pill (24%). One third found out about the calendar method from their partners and two thirds first heard about withdrawal from a friend.

5.4 Knowledge of the Most Fertile Time in a Woman's Menstrual Cycle

Knowledge of the most fertile time in a woman's menstrual cycle is an important measure of the men and women's ability to assess the risk of pregnancy occurrence during unprotected intercourse and thereby an indicator of their potential to prevent unintended pregnancies.

Correct knowledge regarding sexuality and family planning was seriously lacking in 1993, particularly among younger respondents. Overall, more than a half of women of reproductive age were unable to correctly identify the most fertile time during a woman's menstrual cycle. Only 27% of 15-19 year olds and 52% of 20-24 year olds had correct information on this basic concept of fertility.

The 1996 YARHS found that the quality of sexual education continues to be inadequate ([Table 5.4.1](#)). Slightly over one third of 15-24 year old women knew that a woman is most likely to become pregnant halfway between two menstrual periods. Even fewer young men had this knowledge (32%). The proportion saying they are not sure or do not know was similar among women and men (44% and 45%). Adolescents continue to have more limited knowledge about menstrual cycle than the 20-24 year olds. Knowledge increased significantly with education. Respondents with some high school education were twice (three times for young men) as likely to have correct knowledge about the menstrual cycle as respondents with primary education. Knowledge among high school graduates and university students topped at 60% among women and 55% among men. Essentially, in the time between the two surveys, there was no significant change in the level of knowledge on menstrual cycle among young women.

Women's knowledge of the menstrual cycle is a common indicator for evaluating the level of sexual education. Although Romania does not have a cohesive sex education program, basic concepts of female reproductive biology are taught in high school as a part of the biology

TABLE 5.4.1
Time When Young Adults Think It Is The Most Likely During Menstrual Cycle
For a Woman to Become Pregnant
By Age Group And Education and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>Total</u>	<u>Age Group</u>		<u>Education</u>		
		<u>15-19</u>	<u>20-24</u>	<u>Primary School</u>	<u>High School Incomplete</u>	<u>High School Graduate+</u>
<u>Women</u>						
Halfway Between Two Periods	36.2	26.6	46.4	12.4	27.6	60.3
The Week Before Menstruation, During Menstruation, or The Week After	11.1	1.0	11.3	8.9	11.9	11.5
Anytime	8.3	8.5	8.0	7.7	10.3	6.1
Do Not Know	44.4	54.0	34.3	71.1	50.2	22.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,025	1,238	786	460	917	648
<u>Men</u>						
Halfway Between Two Periods	31.7	21.4	42.7	9.4	28.2	55.2
The Week Before Menstruation, During Menstruation, or The Week After	16.2	13.9	18.7	11.0	16.1	20.4
Anytime	7.4	9.7	5.1	7.7	9.1	4.1
Do Not Know	44.6	55.1	33.5	71.9	46.5	20.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,047	1,322	725	473	1,065	509

curriculum. [Table 5.4.2](#) shows that students who had received courses in female reproductive biology were almost twice as likely to place the time of maximum fecundability during the menstrual cycle correctly as students who had not. However, a sizable proportion of women (41%) and men (37%) who attended such courses did not know even how to respond to the question about the most probable time for a woman to become pregnant.

Young adults who had discussions with a parent about menstrual cycle had better knowledge about this issue than those who did not. These discussions effectively increased knowledge by 25% among women and 50% among men. Thus, both formal instruction and dialogues with the parents about the menstrual cycle could be effective means of disseminating basic concepts of fertility. However, exposure to this topic does not guarantee correct information, since more than a third of young adults who acknowledged education on menstrual cycle either in school or at home still had no basic concepts of fertility.

TABLE 5.4.2
Time When Young Adults Think It Is The Most Likely During Menstrual Cycle
For a Woman to Become Pregnant
By Parental Discussions and Sex Education (SE) in School on that Topic
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Women</u>	<u>Total</u>	<u>Parental Discussions</u>		<u>SE In School</u>	
		Never Had	Ever Had	Never Had	Ever Had
Halfway Between Two Periods	36.2	30.3	37.9	22.7	40.2
The Week Before Menstruation, During Menstruation, or The Week After	11.1	10.3	1.4	1.8	11.0
Anytime	8.3	7.5	8.5	9.8	7.8
Do Not Know	44.4	51.9	42.3	55.7	41.1
Total	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,025	446	1,579	477	1,548
<u>Men</u>		<u>Never Had Ever Had</u>		<u>Never Had Ever Had</u>	
Halfway Between Two Periods	31.7	30.8	46.7	22.9	41.3
The Week Before Menstruation, During Menstruation, or The Week After	16.2	15.7	5.0	5.5	17.0
Anytime	7.4	7.6	4.4	8.8	6.0
Do Not Know	44.6	45.9	23.8	52.9	35.7
Total	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,047	1,930	117	1,084	963

CHAPTER VI

SEXUAL BEHAVIOR

Adolescent sexual activity, childbearing and high abortion rates are of growing concern in Romania. Recent trends raise fundamental concerns about the health and education of teenage mothers; the health and social development of children born to these young women; the well-being of teenage men exposed to sexually transmitted diseases or who quit school to support young families; and society's losses and obligations incurred by adolescents and their children who are not able to become fully productive and independent citizens.

Finding appropriate responses to these problems has been made more complex by the recent social changes. Increasingly, people live in urban areas and are better educated and informed about lifestyle options, but attitudes toward sex, motherhood and attendant public policy are still influenced by the mores formed by yesterday's traditional society. In traditional, predominantly rural societies, it is the norm for women to marry and start their childbearing at young ages. Consequently, young wives and mothers in these settings generally have the economic and social support of their families and communities. However, traditional norms are weakening; the forces of modernization-urbanization, rising educational attainment, more exposure to the mass media, and changes in the status of women have altered every aspect of life, including the age patterns of the sexual activity, marriage, and motherhood.

The 1993 RRHS found that young women, compared to older cohorts, were more likely to have experienced premarital sexual intercourse, had a longer interval between first intercourse and first marriage, were older at their first birth, and were less likely to use contraception. Their longer exposure to premarital sex and their desire to postpone childbearing, in the absence and/or low acceptance of effective contraceptive methods, have led to more time spent at risk of unintended pregnancy and STDs. As a result, pregnancy rates to young women, most of them mistimed or unwanted, increased considerably. So did legally induced abortion. In the years immediately following abortion legalization, abortion rates among 15-24 years old increased 2-3 times. Young women accounted for 27% of the total abortion rate during 1990-1993. Increased use of abortion has also had an escalating effect on the pregnancy rate because an abortion hastens a woman's return to the risk of conception (Serbanescu et al., 1995).

These findings may underestimate the true extent of social and behavioral changes that have occurred recently among young adults, since sex before marriage and nonmarital pregnancies are routinely underreported in countries like Romania where strong traditions view premarital sex as morally wrong and condemn childbearing out of wedlock. However, some overreporting is also possible, especially among young men; unlike females, young men benefit

from social sexual permissiveness and may tend to exaggerate their sexual experience, feeling that they are expected to have had sex.

6.1 Sexual Experience

The YARHS questionnaire included a series of questions regarding the age at which young adults became sexually active, relationship to their first and last sex partner, lifetime and current (within the last three months) number of sex partners, coital frequency, contraceptive use at first intercourse, and communication with their partners concerning contraception. Information about contraception use are presented in Chapter VII. Not a single respondent, man or woman, refused to answer questions on sexual experience.

TABLE 6.1.1A
Reported Sexual Experience of Young Adult Women 15-24 Years of Age
By Marital Status At Time of First Sexual Experience By Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age (years)</u>	<u>Reported Sexual Experience</u>			<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>No Sexual Experience</u>	<u>After Marriage</u>	<u>Before Marriage</u>		
Total (15-24)	53.7	21.4	24.9	100.0	2,025
15	98.0	1.2	0.8	100.0	242
16	90.2	4.5	5.3	100.0	254
17	84.6	4.4	11.0	100.0	242
18	72.3	9.3	18.4	100.0	235
19	56.2	16.3	27.5	100.0	266
20-22	31.6	32.4	36.1	100.0	511
23-24	16.7	43.0	40.3	100.0	275

As shown in [Tables 6.1.1A](#) and [6.1.1.B](#), less than half of 15-24 year-old women and two-thirds of 15-24 year-old men have ever had sexual intercourse. While the likelihood of having had intercourse increases steadily with age, sex among very young teenagers, especially females, is uncommon. Only 9% of 15-17 year old women and 24% of 15-17 year old men have ever had sex. In fact, even later in the teenage years (18-19), only one in three girls is sexually experienced. This contrasts with two out of three 18-19 year old boys who have had sex. Overall, almost 80% of teenage girls and 59% of teenage boys were virgins (see also [Tables 6.1.2A](#) and [6.1.2B](#)). Conversely, sex is very common among 20-24 year-olds. Two out of three 20-22 year-old women, five out of six 23-24 year-old women, and virtually all 20-24 year-old men were sexually experienced.

Young adults in Romania now tend to marry later than they did previously. In 1996, only 7% of teenagers and 52% of 20-24 year-old women have ever been in a formal marriage (data not shown). Three decades ago, three times more teenagers (22%) and 50% more 20-24 year olds (76%) have ever been married (Demographic Yearbook, 1976). Although sexual abstinence before marriage is still common in Romania, an increasing proportion of young women will have intercourse before marriage ([Figure 6.1](#)).

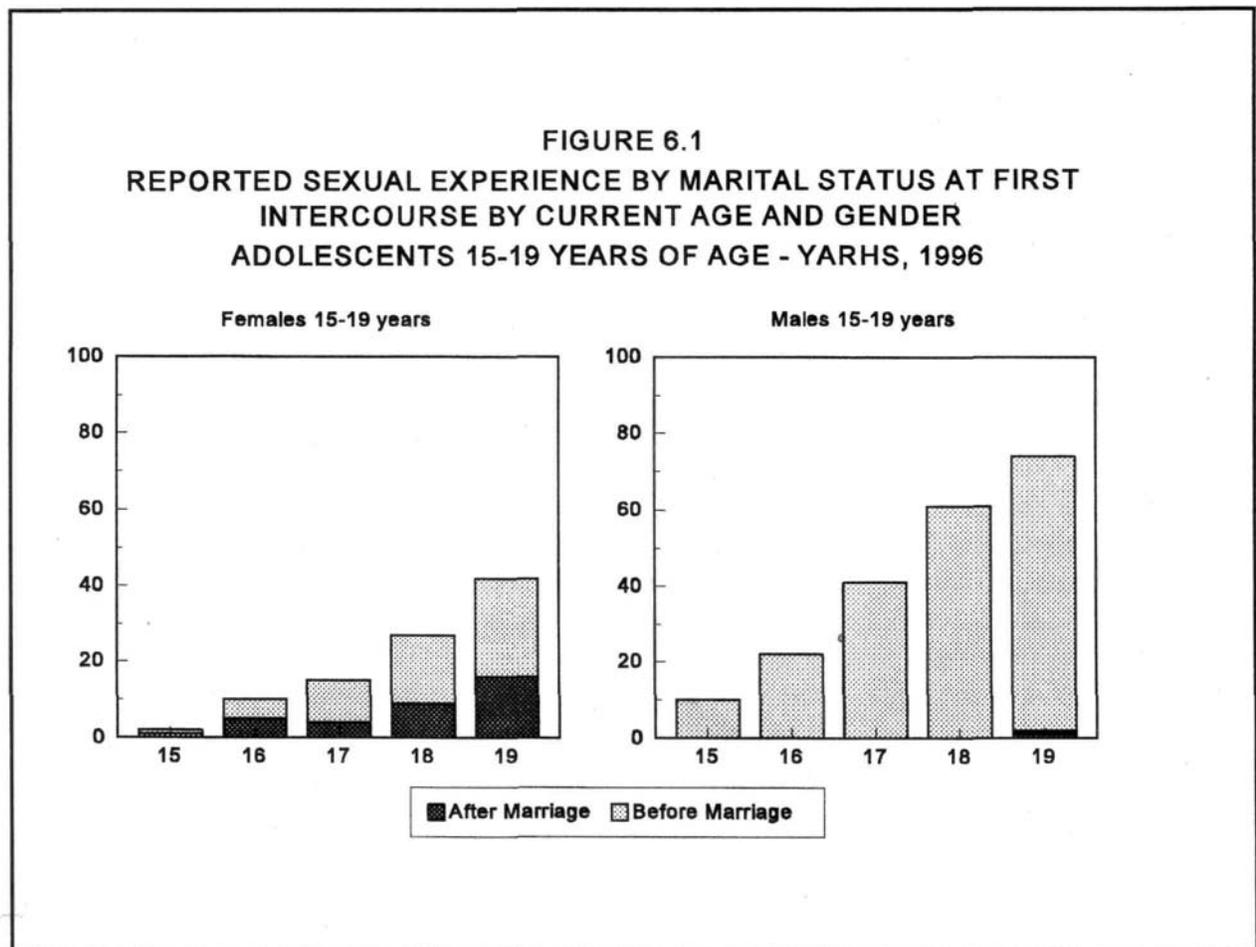


TABLE 6.1.1B
Reported Sexual Experience of Young Adult Men 15-24 Years of Age
By Marital Status At Time Of First Sexual Experience By Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age (years)</u>	<u>Reported Sexual Experience</u>			<u>Total</u>	<u>Unweighted</u> <u>No. of Cases</u>
	<u>No Sexual</u> <u>Experience</u>	<u>Marital</u> <u>Experience</u>	<u>Premarital</u> <u>Experience</u>		
Total (15-24)	33.6	0.8	65.6	100.0	2,047
15	89.6	0.4	10.0	100.0	275
16	78.1	0.0	21.9	100.0	265
17	58.7	0.0	41.3	100.0	265
18	38.6	0.0	61.4	100.0	247
19	26.6	0.5	72.9	100.0	270
20-22	7.9	1.1	91.0	100.0	453
23-24	5.7	1.8	92.4	100.0	272

Overall, slightly more than half (25%) of the 46 percent of women reporting sexual experience had premarital sexual intercourse ([Table 6.1.1A](#)). This contrasts sharply with the pattern of sexual activity among men, who virtually never wait to have the first intercourse with their brides ([Table 6.1.1A](#)). Among sexually experienced youth, adolescents are more likely to report premarital sex. Sixty-four percent of women and 100% of men who reported sexual experience as teenagers, were not married when they first had sex.

The overall levels of sexual experience of young adults were not significantly different in urban and in rural areas for either 15-19 or 20-24 year-olds ([Tables 6.1.2A](#) and [6.1.2B](#)). However, the levels of premarital intercourse appears to be much higher among young women in urban areas than in rural areas. Two-thirds of the young sexual experienced women in urban areas reported they had not been married at the time of first intercourse and the proportion rises

to 80% if first sex occurs during the teenage years. By comparison, in rural areas, only slightly more than one-third of young women and 43% of teenagers reported sex outside marriage.

Several factors could have contributed to regional differences in premarital sex. First, women in rural areas are more likely to marry in their teenage years; 17% of rural teenagers and 66% of 20-24 year olds have ever been married but in urban areas only 8% of 15-19 year-old women and 57% of 20-24 year-olds have done so (not shown). Secondly, rural young women

TABLE 6.1.2A
Reported Sexual Experience of Young Adult Women 15-24 Years of Age
By Marital Status at Time of First Sexual Experience
By Residence and Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age & Residence</u>	<u>Reported Sexual Experience</u>			<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>No Sexual Experience</u>	<u>After Marriage</u>	<u>Before Marriage</u>		
All Women					
15-19	79.8	7.3	12.9	100.0	1,239
20-24	26.3	36.1	37.6	100.0	786
Total	53.8	21.3	24.9	100.0	2,025
Urban					
15-19	80.6	3.8	15.5	100.0	617
20-24	25.7	28.4	45.9	100.0	366
Total	54.9	15.4	29.7	100.0	983
Rural					
15-19	78.7	12.2	9.2	100.0	622
20-24	27.0	45.2	27.8	100.0	420
Total	52.3	29.0	18.7	100.0	1,042

TABLE 6.1.2B
Reported Sexual Experience of Young Adult Men 15-24 Years of Age
By Marital Status at Time of First Sexual Experience
By Residence and Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age & Residence</u>	<u>Reported Sexual Experience</u>			<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>No Sexual Experience</u>	<u>After Marriage</u>	<u>Before Marriage</u>		
All Men					
15-19	58.7	0.2	41.1	100.0	1,322
20-24	7.0	1.4	91.6	100.0	725
Total	33.6	0.8	65.6	100.0	2,047
Urban					
15-19	57.6	0.2	42.2	100.0	706
20-24	5.5	0.7	93.8	100.0	369
Total	33.6	0.4	66.0	100.0	1,075
Rural					
15-19	60.0	0.3	39.7	100.0	616
20-24	8.7	2.2	89.1	100.0	356
Total	33.5	1.2	65.3	100.0	972

are more likely to grow up in families with strong traditional values. Stronger family ties, parental control of dating, strict mothers' upbringing, and a higher emphasis on virginity at first marriage are more common in rural areas. Thirdly, young women in rural areas are more likely to be influenced by community and religious restraints than those who grow up in urban areas. Lastly, young women in rural areas are less well educated and less capable of controlling

their reproductive lives than urban women; young urban women are almost twice as likely as rural women to have completed 12 or more years of education.

On average, there were no significant regional differences in males' sexual experience, in part because, regardless of residence, men begin having sex younger and marry later than females, and thus the first sexual experience is almost always premarital.

TABLE 6.1.3A
Reported Sexual Experience of Young Adult Women 15-24 Years of Age
By Marital Status at Time of First Sexual Experience
By Education and Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age & Education</u>	<u>Reported Sexual Experience</u>			<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>No Sexual Experience</u>	<u>After Marriage</u>	<u>Before Marriage</u>		
All Women					
15-17	91.0	3.3	5.7	100.0	738
18-19	63.7	13.0	23.3	100.0	501
20-24	26.3	36.1	37.6	100.0	786
Total	53.8	21.3	24.9	100.0	2,025
Primary Education					
15-17	84.4	11.4	4.2	100.0	219
18-19	35.8	36.8	27.4	100.0	121
20-24	12.8	65.6	21.6	100.0	120
Total	48.3	36.2	15.5	100.0	460
Some High School					
15-17	93.4	0.1	6.5	100.0	503
18-19	71.6	10.1	18.2	100.0	168
20-24	16.0	42.8	41.2	100.0	246
Total	62.2	17.0	20.8	100.0	917
High School Complete or More					
15-17	*	*	*	100.0	16
18-19	73.3	3.3	23.3	100.0	228
20-24	36.2	23.9	39.9	100.0	420
Total	46.6	18.2	35.2	100.0	648

*/Less than 25 women in that category

TABLE 6.1.3B
Reported Sexual Experience of Young Adult Men 15-24 Years of Age
By Marital Status at Time of First Sexual Experience
And by Education and Current Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Current Age & Education</u>	<u>Reported Sexual Experience</u>			<u>Unweighted</u>	
	<u>No Sexual Experience</u>	<u>After Marriage</u>	<u>Before Marriage</u>	<u>Total</u>	<u>No. of Cases</u>
All Men					
15-17	75.6	0.2	24.2	100.0	805
18-19	32.3	0.3	67.4	100.0	517
20-24	7.0	1.4	91.6	100.0	725
Total	33.6	0.8	65.6	100.0	2,047
Primary Education					
15-17	82.8	0.5	16.7	100.0	273
18-19	40.6	0.0	59.4	100.0	114
20-24	12.6	3.4	84.0	100.0	86
Total	52.8	1.3	45.9	100.0	473
Some High School					
15-17	73.0	0.0	27.0	100.0	516
18-19	34.0	0.6	65.4	100.0	225
20-24	6.1	0.6	93.3	100.0	324
Total	37.2	0.4	62.4	100.0	1,065
High School Complete or More					
15-17	*	*	*	100.0	16
18-19	25.3	0.0	74.7	100.0	178
20-24	6.2	1.6	92.2	100.0	315
Total	12.0	1.1	86.9	100.0	509

*/ Less than 25 men in that category

Young adults' sexual experience by marital status at the time of first sexual experience is shown by education in [Tables 6.1.3A](#) and [6.1.3B](#). The influence of education should be interpreted with caution because many young adults are still in school. For this reason, we look at education differentials within narrower age subgroups.

Among different age subgroups, education is a strong predictor of delayed sexual activity among young women but not among young men. This effect is most visible among 20-24 year-olds, who have completed their teenage years and are more likely to have achieved a secondary education. Women aged 20-24 with twelve or more years of education were much more likely not to have had sex (36%) than women with some high school education (16%) and their peers with only primary education (13%). Similarly, for 18-19 year-old girls, the higher the level of education they had, the more likely they were to be virgins. However, premarital sexual experience follows a different pattern. It is most prevalent among women with complete high school or higher levels of education (two thirds of sexually experienced women had premarital sex) and least frequent among women with primary education (only 30% of sexually experienced had sex before marriage).

By contrast, education is directly correlated with sexual experience among men; sexual experience was most common among men with the highest levels of education, regardless the age. Since most sexual activity among young men takes place outside marriage, there is no significant gradient of premarital intercourse by education. Differentials in age at first intercourse among different subgroups of sexually experienced young adults is best illustrated in [Figure 6.1.2](#) and [Tables 6.1.4A](#) and [6.1.4B](#).

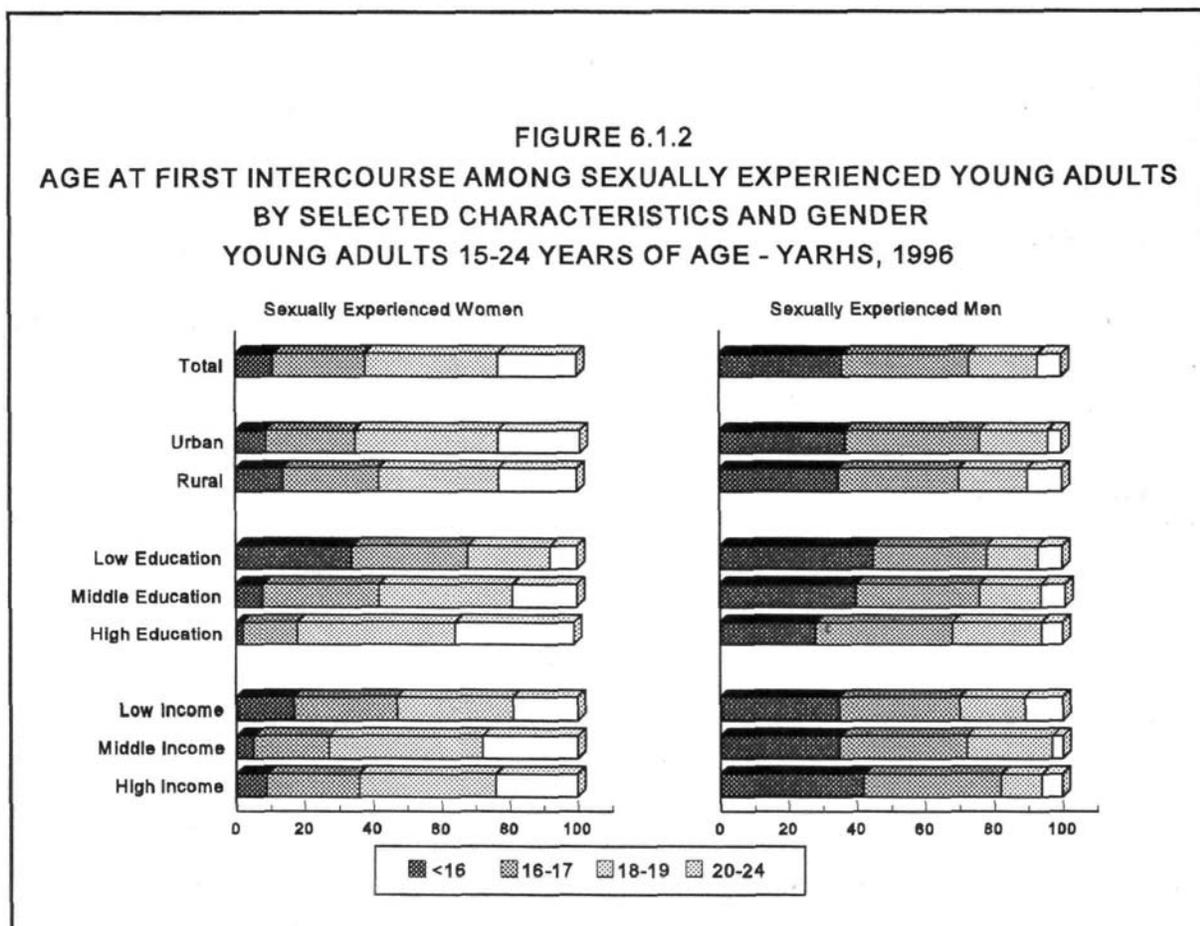


TABLE 6.1.4A
Age At First Sexual Experience by Selected Characteristics
Among Women Aged 15-24 Reporting Sexual Experience
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Characteristics</u>	<u>Age At First Intercourse</u>				<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u><16</u>	<u>16-17</u>	<u>18-19</u>	<u>20-24</u>		
Total	11.4	26.6	38.9	23.1	100.0	788
<u>Residence</u>						
Urban	8.9	25.5	41.9	23.7	100.0	337
Rural	14.4	28.0	35.1	22.5	100.0	451
<u>Marital Status at First Intercourse</u>						
Married	12.1	22.3	41.6	24.0	100.0	363
Not Married	10.7	30.4	36.5	22.4	100.0	425
<u>Education Level</u>						
Primary School	33.7	33.8	24.2	8.3	100.0	212
High School Incomplete	7.6	34.1	39.5	18.8	100.0	276
High School Complete or More	2.3	16.3	46.4	35.0	100.0	300
<u>Socio-Economic Status</u>						
Low	17.4	30.4	33.5	18.6	100.0	407
Middle	5.3	22.1	44.6	28.0	100.0	297
High	8.5	27.5	40.1	23.9	100.0	84

Among young women who reported sexual activity, the onset of intercourse is rather late (see [Table 6.1.4A](#)). Overall, only 38% of them reported sexual intercourse before age 18 and only 11% before age 16. Rural women were slightly more likely to have had early intercourse, but they also marry earlier than urban women. Young women who were not married at the time

TABLE 6.1.4B
Age At First Sexual Experience by Selected Characteristics
Among Men Aged 15-24 Reporting Sexual Experience
Young Adult Reproductive Health Survey; ROMANIA, 1996

<u>Characteristics</u>	<u>Age At First Intercourse</u>				<u>Unweighted</u>	
	<u><16</u>	<u>16-17</u>	<u>18-19</u>	<u>20-24</u>	<u>Total</u>	<u>No. of Cases</u>
Total	36.1	36.8	20.4	6.7	100.0	1208
<u>Residence</u>						
Urban	37.1	38.6	20.4	3.9	100.0	641
Rural	34.9	34.6	20.4	10.1	100.0	567
<u>Education Level</u>						
Primary School	44.6	33.0	15.3	7.2	100.0	185
High School Incomplete	39.7	35.7	17.8	6.8	100.0	588
High School Complete or More	27.8	39.9	26.0	6.3	100.0	433
<u>Socio-Economic Status</u>						
Low	34.6	34.9	19.0	11.5	100.0	417
Middle	35.1	37.2	24.5	3.2	100.0	577
High	42.3	39.9	12.2	5.6	100.0	214

of first intercourse were more likely to have had intercourse before age 18 (41%) than women whose first intercourse was marital (34%). Age at first intercourse is inversely correlated to educational attainment. More than two-thirds of women with low levels of education initiated sexual activity before age 18 and 33% before age 16. Conversely, less than 20% of women with 12 or more years of education had had intercourse before age 18. These findings have important implications for sex education efforts, which routinely target high-school students. If all young women have to be taught about using contraception before they have intercourse, sex education programs need to begin in elementary school. The patterns of first intercourse differ also by socio-economic status. Young women of low socio-economic status were more likely to be sexually experienced (data not shown) and much more likely to have had sex by age 18 (48%)

compared to women with middle or high status (27% and 36%, respectively). However, the socio-economic differences are likely to reflect, in part, differences in education, as less well educated women are more likely to be poor.

Early age at first intercourse is much more common among men than women ([Table 6.1.4B](#)). One in three men reporting sexual experience had had intercourse before age 16, nearly three in four before age 18, and almost all had had intercourse before turning age 20. Age at first intercourse is not influenced by place of residence, but varied inversely with the educational attainment. Although fewer men with only primary education were sexually experienced, those who reported ever having had intercourse were more likely to have sex before age 18 (78%) compared to their more numerous sexually experienced peers with 12 or more years of schooling (67%).

Premature timing of first intercourse among males is influenced significantly by the respondents' socio-economic status. Fewer men with low socio-economic status reported having had sex by age 18 compared to men with high status (70% vs. 82%). A possible explanation for this pattern is that men coming from affluent families, or who live alone and can support themselves, have more economical resources and less stringent family restrictions, live mostly in urban areas where they are exposed to more opportunities for casual sex, and feel more in control of their sexual choices than men with low socioeconomic status. It is also possible, of course, that this pattern does not reflect a real difference in behavior, but merely a difference in the perceptions of what these men believe is social acceptable or desirable to share with an interviewer.

6.2 Current Sexual Activity

Information about current sexual activity is crucial in estimating the proportions of women who are at risk of having an unintended pregnancy and therefore in need of contraceptive services. It also has major implications in the selection of a contraceptive method which best suits the reproductive behavior and fertility preferences of each individual. Detailed information on the proportion of young adults using family planning and their contraceptive choices are shown in Chapter VII.

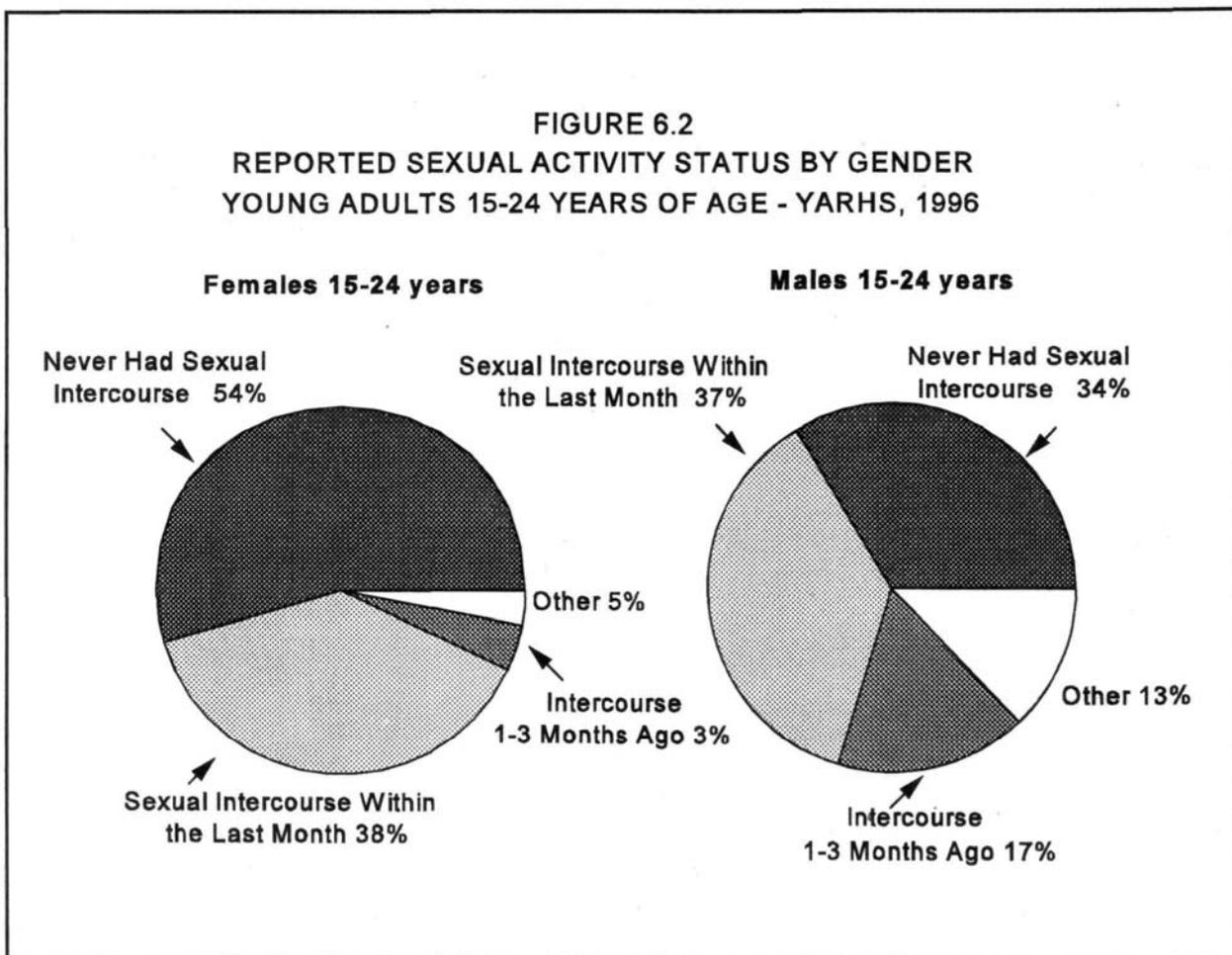
Overall, 46% of the women and 66% of the men aged 15-24 reported that they had had sexual intercourse ([Figure 6.2](#) and [Tables 6.2](#)). Only 41% of all young women and 53% of young men, had had intercourse within the last three months. However, if we exclude the virgins, 89% of the sexually experienced females and 80% of males had had intercourse during the 3 months preceding the survey (i.e., currently sexually active).

TABLE 6.2
Sexual Activity Status Among Young Adults
By Marital Status and Gender
Young Adults Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Sexual Activity Status</u>	<u>Total</u>	<u>Marital Status</u>		<u>Age Group</u>	
		<u>Married/ In Union</u>	<u>Previously & Never Married</u>	<u>15-19</u>	<u>20-24</u>
Females					
Never Had Intercourse	53.8	0.0	80.8	79.8	26.3
Ever Had Intercourse	46.2	100.0	19.2	20.2	73.7
• Within the Last Month	37.5	89.7	11.3	15.3	60.9
• 1-3 Months Ago	3.5	3.7	3.5	2.3	4.8
• Over 3 Month Ago but Within Last Year	3.3	3.9	3.0	1.6	5.2
• One Year or Longer	1.2	0.8	1.4	0.7	1.7
• One Month or Longer-Unknown Interval	0.7	1.9	0.1	0.3	1.1
Total	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,025	531	1,494	1,239	786
Males					
Never Had Had Intercourse	33.6	0.0	39.2	58.7	7.0
Ever Had Had Intercourse	66.4	100.0	60.8	40.3	93.0
• Within the Last Month	36.6	93.2	27.1	15.4	59.1
• 1-3 Months Ago	16.5	4.6	18.4	12.4	20.7
• Over 3 Month Ago but Within Last Year	10.0	1.7	11.4	10.8	9.1
• One Year or Longer	2.8	0.0	3.3	2.4	3.3
• One Month or Longer-Unknown Interval	0.6	0.5	0.6	0.3	0.8
Total	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,047	146	1,901	1,322	725

Although more males reported ever having had sexual intercourse (66%) and more reported having had intercourse during the three months before the interview (53%), the rate of current sexual activity among sexually experienced males (that is, if we exclude the 33% who never had sex) is in fact lower than that among females (80% vs. 89%). The chief contributor to this difference in current sexual activity is the disparity in marital status among males and females. Women were more likely to be married than men and married women are more likely to have current sexual relationships. If we exclude married women, who have much higher rates of current sexual activity than those not currently in union (93% vs 77%), the current sexual activity among noncohabitating young females and males is similar (77% and 75%).

FIGURE 6.2
REPORTED SEXUAL ACTIVITY STATUS BY GENDER
YOUNG ADULTS 15-24 YEARS OF AGE - YARHS, 1996



[Table 6.2](#) also illustrate sexual activity status among adolescents and 20-24 year olds. As expected, fewer teenagers reported current sexual activity. Only 18% of teen females and 40% of teen males reported having had sex within the previous 3 months. By comparison, 66% of 20-24 year-old females and 80% of 20-24 year-old males were currently sexually active. However, if we look only at sexually experienced young adults, age differences in reports of current sexual activity disappear for women and narrow for men. Teenage nonvirgin females were currently as sexually active as 20-24 year-olds (87% vs. 89%), whereas sexually experienced male teens were less sexually active than 20-24 year-olds (69% vs. 86%). However, within each age group, the rates of current sexual activity are higher among females than among men because females marry several years earlier.

6.3 Number of Sexual Partners

Number of sexual partners is considered one of the best predictors of the risk of sexually transmitted diseases (STDs). In YARHS, all sexually experienced respondents were asked how many sexual partners they had had in the three months preceding the interview and during their lifetime. The differences in numbers of sexual partners are presented for both women and men by marital experience in [Table 6.3](#).

Overall, most sexually experienced respondents (88% of women and 65% of men) had only one sexual partner in the three months before the interview. Few of them (11% of women and 20% of men) had no current sexual relationship. Few had two or more sexual partners within the previous 3 months. The data do not allow us to differentiate whether they had concurrent partners or had switched partners.

Almost all young adults who were married or living with a partner reportedly were monogamous (93%). Conversely, those in noncohabitating relationships, particularly males, were more likely to report multiple sexual partners in the 3 months preceding the survey. About 4% of females and 24% of males with current sexual activity reported having had intercourse with two or more partners.

On average, young females had also fewer lifetime sexual partners than young males, in part because they start sexual intercourse later. Among women who have ever had sex, only 19% reported two or more lifetime partners. Married women and those living in consensual unions were four times less likely to report more than one lifetime partner than those in noncohabitating relationships (10% vs. 43%). Among sexually experienced men, however, we found no significant difference in the number of lifetime partners by marital status. The majority of young males reported two or more sexual partners (87%) and 60% reported four or more sexual partners.

TABLE 6.3
Number of Sexual Partners During the Last Three Months and Lifetime
Among Sexually Experienced Young Adults
By Marital Status and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>No. of Sexual Partners</u>	<u>Women</u>			<u>Men</u>		
	<u>Total</u>	<u>Married/ In Union</u>	<u>Previously & Never Married</u>	<u>Total</u>	<u>Married/ In Union</u>	<u>Previously & Never Married</u>
<u>Within the Last 3 Months</u>						
None	11.1	6.1	24.3	19.7	1.7	24.7
One	87.8	93.4	72.9	64.9	93.4	57.1
Two	0.5	0.2	1.4	9.8	3.4	11.6
Three or More	0.5	0.3	1.0	5.4	1.5	6.4
Refused to Answer	0.1	0.0	0.4	0.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
<u>Lifetime</u>						
One	80.9	89.9	57.2	13.0	18.7	11.5
Two	9.6	5.7	19.7	11.4	6.8	12.6
Three	4.3	1.7	11.0	13.6	13.1	13.7
Four or More	4.7	2.2	11.1	60.3	61.3	60.0
Refused to Answer	0.7	0.5	1.1	1.7	0.0	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	788	531	257	1,208	146	1,062

CHAPTER VII

PREGNANCY EXPERIENCE

Soon after Romania reversed its restrictive policy on abortion and contraception, in December 1989, abortion on request became the principal means of fertility control while the use of modern contraceptives remained very low. As fertility dropped to below replacement level, induced abortion reached unprecedented high rates in the early 1990's, surpassing the abortion estimates reported by any other country in the region, including those reported for Russia, which until recently had the world's highest rate (Popov, 1996). The abortion rate dropped from 182 abortions per 1000 women aged 15-49 in 1990, to 123 abortions per 1000 women in 1992, and 93 per 1000 in 1994, but less than one in ten women of reproductive age used effective contraceptive methods to prevent unintended pregnancies between 1990 to 1993 (Serbanescu et al., 1995). Despite this substantial decline, which continued at a slower pace in 1995 (87 abortions per 1000 women 15-49) and 1996 (78 abortions per 1000 women 15-49), abortion rates continue to be very high. It's widespread availability and public acceptance, compounded by high reliance on traditional contraceptive methods, limited access to more effective contraceptives and prevailing misconceptions about modern methods, continue to place induced abortion as the most important method of fertility control in Romania.

7.1 Lifetime Experience with Pregnancy

Similar to the 1993 findings, in the 1996 YARHS, fewer than half of young women reported sexual experience (41% and 46%, respectively) and only half of them reported premarital sexual intercourse (22% and 25%, respectively). The proportion of young women who have ever had sexual intercourse increased rapidly with age. In 1996, only 2% initiated intercourse by age 15, about 10% by age 16, almost 30% by age 18, and the majority of 20-24 year olds reported having had sexual experience (see Chapter 6). Among sexually experienced women, however, premarital sexual activity was inversely correlated with age. The proportion reporting premarital intercourse was higher among teenagers (64%) than among 20-22 year olds (53%) and 23-24 year olds (48%), presumably due to the recent decline in the age at first intercourse and increase in the age at first marriage, documented by the 1993 survey (not shown). Notably, these trends may affect the outcomes of young women's sexual behavior, with a direct impact on the prevalence of unintended pregnancy and the recourse to abortion.

[Table 7.1.1](#) shows the percentage of young women reporting at least one pregnancy in the 1996 YARHS and the distribution of these women by the number of lifetime pregnancies by background characteristics. Overall, 32% of women aged 15-24 years have ever been pregnant.

TABLE 7.1.1
Percentage of Women Aged 15-24 Who Have Had at Least One Pregnancy and Percent Distribution
of These Women by the Number of Lifetime Pregnancies
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	% Ever Pregnant*		Number of Pregnancies Among Women Who Have Ever Had a Pregnancy					No. of Cases
			1	2	3	4+	Total	
Total	32.2	(2,025)	54.7	24.1	10.4	10.8	100.0	523
Residence								
Urban	28.5	(983)	54.9	24.6	10.9	9.7	100.0	181
Rural	36.9	(1,042)	54.6	23.7	9.8	11.9	100.0	342
Age Group								
15-17	4.2	(738)	68.8	31.2	0.0	0.0	100.0	30
18-19	19.8	(501)	76.9	20.8	1.5	0.8	100.0	95
20-24	54.9	(786)	50.6	24.3	12.2	12.9	100.0	398
Marital Status								
Ever Married/In Union	84.0	(570)	52.8	25.0	11.0	11.2	100.0	478
Never Married	3.5	(1,455)	80.9	11.9	2.4	4.8	100.0	45
Education								
Primary	44.8	(460)	48.8	26.7	11.9	12.7	100.0	178
Some High School (HS)	29.9	(917)	50.2	23.8	12.1	13.8	100.0	205
HS Complete& PostHS	27.6	(648)	66.2	22.1	6.6	5.1	100.0	140
Socioeconomic Index								
Low	44.0	(917)	48.2	26.5	12.0	13.3	100.0	337
Middle	24.7	(876)	63.7	19.4	8.9	8.0	100.0	156
High	19.1	(232)	63.5	28.0	4.3	4.3	100.0	30
Ethnicity†								
Romanian	31.0	(1,823)	56.5	23.6	9.3	10.6	100.0	453
Hungarian	27.1	(99)	‡	‡	‡	‡	100.0	20
Gypsy	69.3	(71)	48.7	22.4	16.1	12.8	100.0	43

* Includes 72 women currently pregnant, of whom 42 women had no prior pregnancy

† Excludes 32 women of other ethnicity

‡ Estimate based on fewer than 25 unweighted observations in the cell and has been suppressed

As expected, women in rural areas, who typically marry earlier, were also more likely than urban women to have had a pregnancy (37% vs. 29%). The cumulative proportion of any cohort of young women who experienced pregnancy increases with each year of age. The proportion of women who have had a pregnancy increased rapidly from 4% among 15-17 year olds, to 20% among women aged 18-19, and 55% among 20-24 year olds. Strongly correlated with age, differences in pregnancy experience were also substantial by marital status. The majority of ever married young women (84%) have had at least one pregnancy whereas only 4% of never married women reported such experience. Pregnancy experience was inversely correlated with education and socio-economic status, with the highest percentage of pregnancies reported by lesser educated women (45%) and women with low socioeconomic status (44%). Not surprising, a much higher proportion of Gypsy women, who tend to marry young and have a higher ideal number of children, reported having had a pregnancy compared with other ethnic groups.

Among the 32% of young women who have ever had a pregnancy, 55% have had only one pregnancy, 24% had two pregnancies, and 21% had three or more pregnancies. Again, women 20-24 years of age were more likely than adolescents to have had two or more pregnancies (49% vs. 25%) with 13% of them reporting four or more pregnancies. Similarly, married women were also much more likely than unmarried women to have had a repeat pregnancy (47% vs. 19%). The likelihood of a repeat pregnancy was inversely correlated with education and socioeconomic level. Almost one in two women with low education or socioeconomic levels have had two or more pregnancies whereas only one in three women with high socioeconomic or educational levels reported more than one pregnancy.

The overall pregnancy experience among women 15-24 years of age increased slightly from 30% in 1993 to 32% in 1996. Between the two surveys, the proportion of women aged 15-19 reporting that they have ever had a pregnancy increased from 9% to 11% whereas the proportion of females aged 20-24 with pregnancy experience remained unchanged (55%). None of these changes were statistically significant. Among sexually experienced women aged 15-24, however, the proportion with at least one pregnancy had declined from 75% to 70%, reflecting the increase in use of modern contraceptives among never married women (see Chapter 8).

[Table 7.1.2](#) presents the percent distribution by outcome of all pregnancies among women 15-24 years of age in Romania. About one in two pregnancies (52%) resulted in a live birth, 38% in induced abortion and 9% in spontaneous abortions. Consistent with the findings of the 1993 RRHS, induced abortion is commonly used by young women as a method of fertility regulation but its prevalence varies substantially by their background characteristics. For example, urban young women had a higher likelihood to end a pregnancy through abortion than rural women (44% vs. 33%) whereas their likelihood to carry the pregnancy through term was significantly lower (44% vs. 60%). Recourse to induced abortion was lower among 15-19 year olds than among 20-24 year olds (32% vs. 43%), and much lower among ever married women than among never married (35% vs. 70%). The likelihood that a pregnancy would end in abortion varied directly with education (from 34% among less educated women to 43% among

TABLE 7.1.2
Percent Distribution of Pregnancies Among Women 15-24 Years of Age by Pregnancy Outcome
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Pregnancy Outcome				No. of Pregnancies*
	Live Birth	Induced Abortion	Miscarriage	Total	
Total	52.4	38.1	9.4	100.0	905
Residence					
Urban	43.9	44.3	11.8	100.0	300
Rural	60.3	32.5	7.2	100.0	605
Age Group**					
15-19	58.7	31.8	9.5	100.0	427
20-24	47.7	42.9	9.4	100.0	478
Marital Status†					
Ever Married/In Union	55.9	34.9	9.2	100.0	817
Never Married	18.0	70.8	11.2	100.0	88
Education					
Primary	59.9	34.3	5.8	100.0	325
Some High School (HS)	49.7	38.5	11.8	100.0	388
HS Complete& PostHS	47.6	42.6	9.8	100.0	192
Socioeconomic Index					
Low	57.7	33.7	8.6	100.0	638
Middle	45.0	44.0	11.0	100.0	227
High	31.1	57.9	11.0	100.0	40
Ethnicity‡					
Romanian	51.7	38.9	9.4	100.0	775
Hungarian	40.4	41.9	17.7	100.0	41
Gypsy	62.3	31.9	5.8	100.0	78
Pregnancy Order					
First Pregnancy	67.8	21.9	10.4	100.0	481
Second Pregnancy	46.2	46.3	7.5	100.0	226
Third or higher Pregnancy	24.4	66.1	9.5	100.0	198

* Excludes 72 current pregnancies and one stillbirth

** Maternal Age at the time of Pregnancy Outcome

† Marital Status at the time of Pregnancy Outcome

‡ Excludes eleven pregnancies among women of other ethnicity

women with the highest education level) and with socioeconomic status (from 34% among low-SES women to 58% among high-SES women). Although not significant due to small sample size, Romanian and Hungarian women were more likely than Gypsies to rely on abortion (39% and 42%, respectively, vs. 32%).

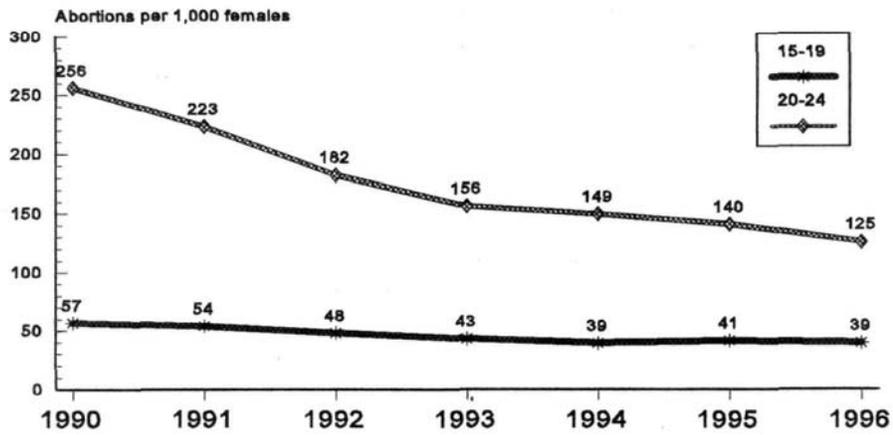
Recourse to abortion was also heavily influenced by pregnancy order. Women with no prior pregnancies were the least likely to have pregnancies ending in abortion (22%) and the most likely to have a live birth (68%). Women with a prior pregnancy had an equal likelihood to resort to abortion or to keep the pregnancy, whereas women with two or more prior pregnancies were substantially more likely to end their pregnancies in abortion (66%) than in live birth (24%). Thus, the induced abortion to live birth ratio was directly correlated with the pregnancy order, increasing from 0.3/1 among women with no prior pregnancy, to 1/1 among women with a prior pregnancy, to almost 3/1 among women with two or more prior pregnancies.

7.2 Age Specific Pregnancy Rates and Trends

Both the absolute number of abortions and the abortion rates declined abruptly in the early 1990s. After the 1990 surge in the level of induced abortion, with a world record rate of 182 abortions per 1000 women aged 15-49 (almost one million induced abortions), the official rates declined steadily to 123 abortions per 1000 women in 1992, 93 per 1000 in 1994, and 78 per 1000 in 1996 (Romanian Ministry of Health, Center for Health Information, 1997). But despite this significant decline, Romania's abortion rates continue to be among the highest in the world. Similar declines have also been noted in other Eastern European countries and in countries of the former Soviet Union, which share with Romania the same history of legalization of induced abortion on demand in the mid-1950s (reversed in Romania in 1966 and reinstated in 1989) and widespread abortion acceptability often referred to as an "abortion culture" (Perlez J., 1996). In the same period of time, the abortion rate in Russia (including mini-abortions) decreased from 114 abortions per 1000 women 15-49 in 1990, to 95 abortions per 1000 in 1992, 82 abortions per 1000 in 1994, and 74 per 1000 in 1995 (Goskomstat, 1996).

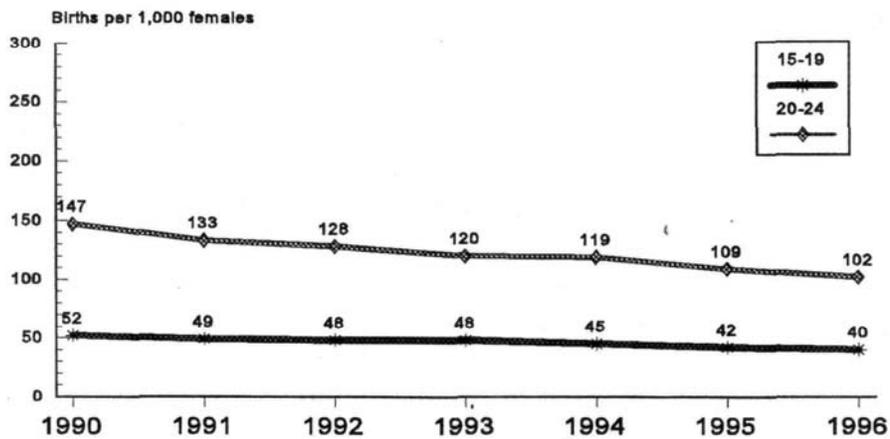
According to vital records in Romania, 25% of all abortions were obtained by women aged 20-24 years but less than 7% were obtained by 15-19 year olds. Paralleling the trend for all women, the abortion rates among these younger age-groups have registered a similar decline ([Figure 7.2.1](#)). The decline was steeper for 20-24 year olds, whose 1996 abortion rate was half the rate reported in 1990 (125 abortions per 1000 vs. 256 abortions per 1000, respectively), than for 15-19 year olds whose 1996 rate was 30% lower than in 1990 (39 per 1000 vs. 57 per 1000, respectively). At the same time, birth rates per 1000 women aged 15-24 declined from 147 per 1000 to 102 per 1000 among women aged 20-24 and from 52 per 1000 to 40 per 1000 among 15-19 year olds ([Figure 7.2.2](#)). As a result, the abortion-to-live-birth ratio for these age groups also declined. The abortion ratio for 20-24 year olds dropped from 174 to 122 abortions per 100 live births between 1990 and 1996 and from 110 to 97 abortions per 100 live births among 15-19 year olds.

FIGURE 7.2.1
AGE SPECIFIC ABORTION RATES FOR FEMALES 15-24 YEARS
ROMANIA, 1990-1996



Source: Center for Health Information, Romanian Ministry of Health

FIGURE 7.2.2
AGE SPECIFIC FERTILITY RATES FOR FEMALES 15-24 YEARS
ROMANIA, 1990-1996



Source: Center for Health Information, Romanian Ministry of Health

The official abortion statistics are based almost exclusively on hospital registration data. However, it is not possible to estimate the true extent of the decline in abortion levels based on these statistics because of under reporting of abortions performed in the recently developed private sector, inherent problems related to hospital registration data, and little information on clandestine abortions (self-induced or induced by lay persons). Furthermore, vital records are unable to identify characteristics of women at high risk of unintended pregnancy and subsequent pregnancy termination, nor are they able to link abortion utilization with contraceptive use.

TABLE 7.2
Three-Year Period Age Specific Fertility and Abortion Rates per 1000 Women
By Selected Characteristics
Women 15-24 Years of Age, ROMANIA, RHS-1993 and YARHS-1996

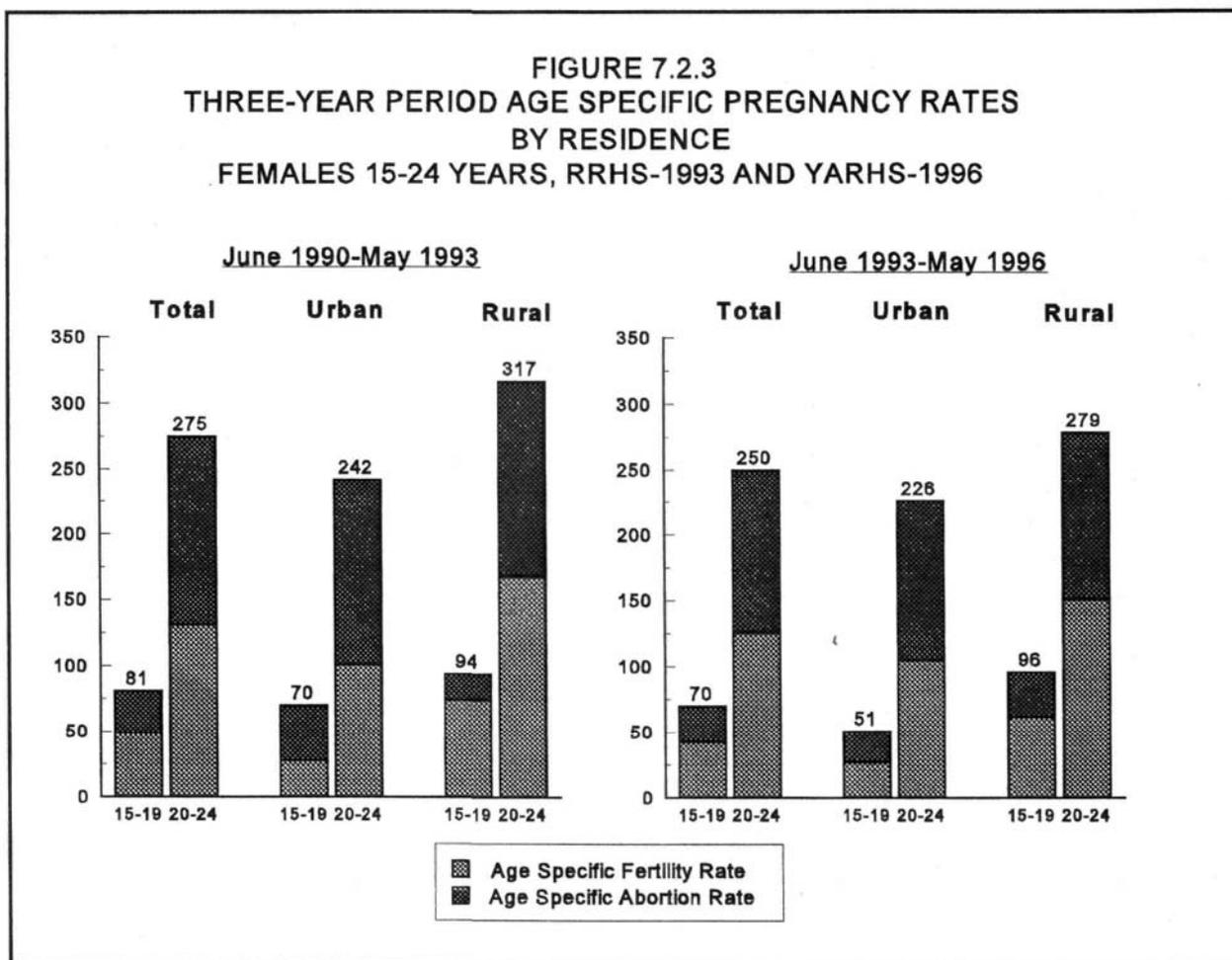
Characteristics	Age Specific Fertility Rates				Age Specific Abortion Rates			
	1993 RRHS*		1996 YARHS†		1993 RRHS*		1996 YARHS†	
	15-19	20-24	15-19	20-24	15-19	20-24	15-19	20-24
Total	49	131	42	126	32	144	28	124
Residence								
Urban	28	101	27	105	42	141	24	121
Rural	74	168	62	151	20	149	34	128
Education								
Primary	117	200	135	201	77	242	56	232
Some High School (HS)	48	167	22	166	26	197	26	163
HS Complete or More	23	98	13	83	18	97	14	73
Socioeconomic Index								
Low	86	170	79	182	36	159	42	150
Middle&High	22	103	17	79	28	134	18	102

* Events occurring between July 1990 -- June 1993

† Events occurring between July 1993 -- June 1996

Consistent with the vital records data, the 1996 YARHS also found a downward trend for both abortions and live births. Data from the RRHS ([Table 7.2](#)) showed that the induced abortion rate for the 3-year period prior to June 1993 was 32/1000 for teenagers and 144/1000 for 20-24 year old women. The three-year period age-specific abortion rates estimated in the 1996 survey were slightly lower for both adolescents and young adults (28/1000 and 124/1000, respectively) but, compared to other European countries, they remain very high, particularly for 20-24 year-olds. In the 14 subgroup categories (7 subgroups by 2 age groups) shown in [table 7.2](#), declines in the abortion rates ranged from 13 to 43 percent for 11 of the 14 subgroups. No change was registered in one subgroup and only two subgroups showed an increase; 15-19 year olds living in rural areas and lower socioeconomic status (SES) 15-19 year olds.

Overall, three year age-specific fertility rates have also declined slightly between 1993 and 1996 (from 49/1000 to 42/1000 for women aged 15-19 years and from 131/1000 to 126/1000 for 20-24 year olds) but the rate for some subgroups remain very high (e.g. fertility among teenagers with only primary school education was 117/1000 and 135/1000, respectively).



Of the 14 subgroups shown in [table 7.2](#), age specific fertility declined from 10 to 54 percent in 8 of the 14 subgroups. Four subgroups showed essentially no change and only two subgroups increased; 15-19 year olds with only a primary education and lower SES 20-24 year olds.

[Figure 7.2.3](#) shows three year age specific pregnancy rates ending in May 1993 and May 1996, among rural and urban women. Overall, pregnancy rates have declined more rapidly among 15-19 year olds than among 20-24 year olds (14% decline vs. 9% decline, respectively). However, this decline is exclusively the result of lower pregnancy rates among urban adolescents whereas pregnancy rates among rural adolescents remained unchanged. In rural areas, the opposite is true, as there has been no decline among adolescents but a 12% decline among 20-24 year olds.

7.3 Planning Status of Pregnancy

As shown in [Figure 7.2.3](#), almost one of every ten adolescents and three of every ten 20-24 year old women become pregnant each year during the 1990's. Of these pregnancies, almost a half were unintended, that is wanted at a later time or not at all ([Table 7.3](#)).

To allow comparisons and to study trends over time, the 1996 YARHS asked respondents to recall for each pregnancy, including those in progress, whether the pregnancy was intended (wanted at the time it occurred) or unintended. Contrary to the 1993 survey, no attempts was made to further classify unintended pregnancies as either mistimed or unwanted since other studies have shown that young, unmarried women tend to misinterpret mistimed pregnancies as unwanted or they may be not be able to further differentiate unintended pregnancies, because they have not yet thought seriously about the number and timing of their pregnancies. One common problem in collecting data on the intendedness of pregnancies in fertility surveys is the incomplete reporting of induced abortions; abortion under-reporting necessarily implies that unintended pregnancies will be under-reported to the extent that abortions are under-reported. In this survey, the number of abortions reported within the year preceding the survey was comparable with the official statistics for the same age groups. However, both sources may have under represented the real abortion prevalence. Another factor which may influence the survey estimates is a certain degree of ambivalence surrounding pregnancy intendedness that some women may experience. Conflicting feelings may result in inconsistent responses given at different times they are asked the same question (Kaufmann et al., 1997). Finally, for pregnancies ending in live births, a common problem is postpartum rationalization. Women are asked to report retrospectively on what were their thoughts about the intendedness status of the pregnancy at the time of conception. Some of them will change their feelings after the child was born and may be reluctant to admit that it was an unintended pregnancy at conception. Therefore, the planning status of pregnancies almost certainly represents a conservative estimate of unintended conceptions.

TABLE 7.3
Percentage of Pregnancies Among Women 15-24 Years of Age Reported as Unintended
By Pregnancy Order By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Total		Pregnancy Order		
	<u>% Unintended Pregnancies</u>	<u>No. of Pregnancies (N=978)</u>	<u>1 (N=523)</u>	<u>2 (N=256)</u>	<u>3+ (N=199)</u>
Total	43.4	978	29.2	50.2	70.1
Pregnancy Outcome					
Live Birth	10.6	487	11.1	8.6	11.5
Current Pregnancy	22.5	72	19.0	28.6	*,*
Miscarriage	28.4	83	24.8	31.8	*,*
Induced Abortion	96.2	336	91.7	99.5	97.1
Residence					
Urban	48.3	321	36.3	61.7	63.5
Rural	38.8	657	22.1	39.6	75.2
Age Group*					
15-19	40.2	451	31.3	55.3	72.3
20-24	45.6	527	26.7	47.3	69.6
Marital Status†					
Married/In Union	40.3	887	22.6	48.4	69.4
Not Married	76.3	91	74.2	78.8	*,*
Education					
Primary	39.3	346	20.7	42.8	72.8
Some High School (HS)	45.1	418	31.2	47.0	70.3
HS Complete& PostHS	45.4	214	34.5	66.3	62.0
Socioeconomic Index					
Low	39.3	685	21.4	40.8	71.9
Middle	46.3	250	33.9	63.6	67.9
High	73.0	43	68.3	*,*	*,*
Ethnicity‡					
Romanian	44.1	841	30.4	49.9	72.5
Hungarian	45.4	42	21.3	*,*	*,*
Gypsy	38.1	83	22.0	54.3	53.8

* Maternal Age at the time of Pregnancy Outcome

, Less than 25 observations in that cell

† Marital Status at the time of Pregnancy Outcome

‡ Excludes twelve pregnancies among women of other ethnicity

In the 1996 YARHS, about half (56%) of all pregnancies among young women were intended whereas 43% were unintended and for one percent the planning status was unknown. [Table 7.3](#) presents the proportion of unintended pregnancies by selected characteristics and by pregnancy order. These data may underscore the need to address the risk of unintended pregnancy differently for various subgroups and by pregnancy experience.

The planning status of pregnancies is strongly correlated with pregnancy outcome. Because of the low occurrence of premarital pregnancies (9%), the high incidence and easy access to abortion, and a traditional fertility pattern of having children shortly after marriage, unintended births among young adults in Romania are rare events (10%). The proportion of unintended pregnancies reported by women currently pregnant was higher than for live births suggesting that some of these pregnancies may end in induced abortion. A relatively high proportion of women whose last pregnancy ended in miscarriage or stillbirth had reported these pregnancies as unintended (28%), almost three times more than the proportion of women with unintended live births. Some of this difference may underscore the association of unintended conception with poor birth outcomes but also may be the result of misreporting (induced abortions reported as spontaneous abortions).

As expected, the majority (96%) of induced abortions were unintended pregnancies. The 4% of induced abortions reported as intended pregnancies may have been intended conceptions which had to be terminated for medical reasons or intended pregnancies which became unintended for different reasons (e.g. marital dissolution or socio-economic reasons).

The percentage of unintended pregnancies was slightly higher among urban than rural residents (48% vs. 39%) and among 20-24 year old women than adolescents (46% vs. 40%) but these differences were not statistically significant. It was significantly higher among unmarried women than among married women (76% vs. 40%). Unlike the pattern in developed countries, the proportion of unintended pregnancies increased directly with education and socioeconomic status (SES), partly because among the most advantaged women the desire for smaller family size is stronger. Due to the small sample size, the differences between the unintendedness rate among women with high or medium education (45%) and low education (39%) were not significant. Women with high SES (73%), however, were significantly more likely than women with medium or low SES to report unintended pregnancies (46% and 39%, respectively). Romanian and Hungarian women were more likely than Gypsies to report unintended pregnancies (44% and 45%, respectively, vs. 38%) but again the differences were not significant due to small sample size.

Regardless of background characteristics, with the exception of pregnancy outcome, the unintendedness rate increases with pregnancy order, from 29% among childless women to 50% among those with one prior pregnancy and 70% among women with two or more prior pregnancies. Consequently, as shown in [Table 7.1.2](#), the proportion of pregnancies ending in induced abortion increases as pregnancy order increases. Because of easy access to abortion after 1989, most unintended pregnancies were probably ended in legally induced abortions and

the level of unintended births remained low, regardless of the pregnancy order. Interestingly, the unintendedness of pregnancies ended in spontaneous abortions increases directly with the pregnancy order, presumably because some of these outcomes may have been, in fact, induced abortions.

Compared to the 1993 RRHS, the level of unintended pregnancies during the three-year period preceding the survey has remained virtually unchanged among 15-19 year olds and decreased slightly (from 54% to 49%) among 20-24 year olds (not shown). Many of these pregnancies could have been prevented with consistent use of modern contraceptive methods. Although in the past three years contraceptive prevalence at first and at most recent sexual intercourse had increased and young adults have experienced fewer pregnancies, the level of unintendedness remained virtually unchanged. Inconsistent use and reliance on less effective methods are the most likely explanations for their failure to avoid unintended pregnancies. Additional factors which may have contributed to the lack of progress in reducing the level of unintended pregnancies among these young women include a higher prevalence of premarital sexual activity, postponement of the first marriage, and an increased desire for smaller family size. To be able to help young couples successfully plan their pregnancies in the future, family planning programs should focus their efforts on better availability and accessibility to more effective methods and on increasing contraceptive education among young adults so that they become consistent and effective users.

7.4 First Pregnancy Experience

In traditional social settings, where premarital sexual activity may be viewed as undesirable, data on premarital conceptions often ending in induced abortion may be under reported. To minimize this bias, information on the woman's relationship with her partner at the time of first conception were checked against the timing of first marriage or consensual union and pregnancies were re-coded as premarital if the date of first union was after the date of first conception. However, some women may have chosen not to report premarital conceptions at all. Thus, we expect that both the proportion of young women who have experienced premarital pregnancies and the proportion of premarital conceptions ending in induced abortion may be somewhat higher than reported.

Among sexually experienced women, 70% reported that they have had at least one pregnancy. About one in four (25%) of these women had not been married or in a consensual union when they got pregnant for the first time. Almost one in two young women whose first pregnancy was conceived before marriage decided to terminate her pregnancy ([Table 7.4.1](#)). Women who were engaged at the time they got pregnant were less likely to abort their pregnancy than women who got pregnant with a boyfriend or a friend (24% vs. 65%). Likewise, women who got married while they were pregnant, were much less likely to obtain an abortion than women who did not marry (21% vs. 70%). Attitude of the father at the time of first premarital

TABLE 7.4.1
Percent of First Premarital Pregnancies Ending in Induced Abortion
By the Relationship with Father, Likelihood to Get Married During the Pregnancy,
and Attitude Toward First Pregnancy
Young Adult Reproductive Health Survey: ROMANIA, 1996

	%	Unweighted No. of Women Whose First Pregnancy Was Premarital
Total*	45.1	132
<u>Relationship to the Father†</u>		
Fiancé	24.4	63
Boyfriend or Friend	65.3	69
<u>Got Married during the Pregnancy</u>		
Yes	20.5	70
No	70.1	62
<u>Attitude of her Partner Toward Pregnancy‡</u>		
Wanted to Marry Her	16.1	74
Wanted Her to Have an Abortion	88.8	50
<u>Attitude of the Woman Toward Pregnancy §</u>		
Accepted the Pregnancy in the First 3 Months	6.3	63
Never Able to Accept It	91.2	61

* Excludes one woman who was unmarried and currently pregnant with her first pregnancy
† Relationship at the Time of Conception
‡ Excludes eight women whose partners never knew about the first pregnancy
§ Excludes eight women who accepted the first pregnancy (ended in live birth) after the first three months of gestation

conception was highly correlated with the pregnancy outcome. Only 16% of women whose partners wanted to marry them had a pregnancy ending in abortion, compared to 89% of women whose partners wanted them to terminate the pregnancy. Almost all women (91%) who were never able to "accept" their first premarital pregnancy decided to end these pregnancies. By contrast, only 6% of women who accepted their premarital pregnancy had an abortion.

[Table 7.4.2](#) shows the percent distribution of young women whose first pregnancy was premarital by how their pregnancies ended, by the relationship with the father, likelihood to get married, and their attitudes toward pregnancy. Overall, one in two women whose first pregnancy

TABLE 7.4.2
Percent Distribution of Women 15-24 Years of Age Whose First Pregnancy Was Premarital
By the Relationship with the Father, Their Likelihood to Get Married During the Pregnancy,
and Their Attitudes Toward the Premarital Pregnancy
By Pregnancy Outcome
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>Total*</u>	<u>Pregnancy Outcome</u>	
		<u>Live Birth</u>	<u>Induced Abortion</u>
<u>Relationship to the Father†</u>			
Fiancé	49.4	72.1	26.8
Boyfriend or Friend	50.6	27.9	73.2
<u>Got Married during the Pregnancy</u>			
Yes	50.4	71.6	22.9
No	49.6	21.2	77.1
<u>Attitude of her Partner Toward Pregnancy</u>			
Wanted to Marry Her	52.5	84.3	18.5
Wanted Her to Have the Child But Not to Get Married	3.5	2.5	1.4
Wanted Her to Have an Abortion	38.0	7.5	74.9
Never Knew About the Pregnancy	6.0	5.7	5.1
<u>Attitude of the Woman Toward Pregnancy</u>			
Accepted the Pregnancy in the First 3 Months	37.2	63.7	4.0
Accepted the Pregnancy After the First 3 Months	10.7	19.5	2.7
Accepted the Pregnancy After the Birth	5.9	13.9	NA
Never Able to Accept It	46.1	2.9	93.3
Total	100.0	100.0	100.0
Unweighted No. of Cases	132	57	60

* Includes 15 women whose first pregnancy ended in miscarriage; excludes one woman who was currently pregnant with her first pregnancy

† Relationship at the Time of Conception

NA Not Applicable

TABLE 7.4.3
Percent Distribution of Women 15-24 Years of Age Whose First Pregnancy Was Marital
By Their and Their Husbands Attitudes Toward Pregnancy By Pregnancy Outcome
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Total*	Pregnancy Outcome		
		Live Birth	Induced Abortion	Miscarriage
<u>Attitude of the Woman Toward Pregnancy</u>				
Accepted the Pregnancy in the First 3 Months	76.4	85.7	15.6	84.3
Accepted the Pregnancy After the First 3 Months	10.7	11.9	3.2	11.0
Accepted the Pregnancy After the Birth	0.7	0.9	NA	NA
Never Able to Accept It	12.2	1.5	81.2	4.7
<u>Attitude of her Husband** Toward Pregnancy</u>				
Accepted the Pregnancy in the First 3 Months	86.3	95.8	23.4	95.3
Accepted the Pregnancy After the First 3 Months	1.4	1.6	1.9	0.0
Accepted the Pregnancy After the Birth	0.5	0.4	NA	NA
Never Able to Accept It	10.9	1.4	71.6	4.7
Do Not Know	0.8	0.5	3.2	0.0
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	349	271	45	33

* Excludes 41 women currently pregnant with their first pregnancy
** Relationship at the Time of Pregnancy Conception
NA Not Applicable

was premarital (51%) got pregnant with her "boyfriend" or "friend" and 49% with their "fiancés". About one in two unmarried women (50%) got married while pregnant; two thirds of those who were already engaged got married during the pregnancy (not shown). Although the most common partner reaction toward paternity was to marry the woman (52%), in many instances the partner preference was to want the pregnancy ended in abortion (38%). Less than 4% accepted the pregnancy but did not want to get married. Six percent of women said that their partner never knew about the pregnancy. Similarly, only about half of women accepted their first premarital pregnancy (54%), including 6% who accepted it only after birth, while 46% said they were never able to accept it.

Relationship between partners and their acceptability of premarital conception often influence a woman's decision about pregnancy resolution. Most women who chose to keep their first premarital pregnancies were already engaged (72%), and most got married before they gave birth (72%). In most of these instances both partners accepted the pregnancy. Only 8% of women said their partners would have wanted the pregnancy ended in abortion while some mothers accepted the pregnancy only after birth (14%) or never accepted the baby (3%).

By contrast, most women who chose to terminate the first premarital pregnancy said the partner was either a boyfriend or a friend (73%) and they did not get married while pregnant (77%). These women's partners were far less agreeable to marry them (19%) and much more likely to want them to abort the pregnancy (75%). Almost all of these women (93%) stated that they were never able to accept the pregnancy.

While unmarried women frequently resort to abortion to delay childbearing (45%), often because they never thought seriously about having a baby, are not in a stable relationship, or are not ready to commit to a relationship, only 1 in 7 married women ended their first pregnancy (13%) with an induced abortion. Most married first time mothers accepted the pregnancy in the first three months (76%), while only 12% were never able to accept it. Likewise, they reported similar levels of agreement about pregnancy among their husbands (86% of husbands accepted the pregnancy in the first trimester and only 11% were never able to accept it).

As expected, most first live births among married couples were wanted pregnancies by both the woman (86%) and her husband (96%). The first birth was seldom reported as unintended either by the woman (2%) or by her husband (1%). Conversely, most first pregnancies that ended in induced abortion were unintended by both partners (81% and 72%, respectively).

CHAPTER VIII

CONTRACEPTIVE USE

One of the greatest challenges for the newly implemented Romanian family planning program is to help women successfully plan their births and reduce the risk of unintended pregnancies and subsequent abortions. In 1993, only 7% of 15-19 year-old women currently in formal or consensual marriage were currently using modern contraception--mainly spermicides and condoms-- and 33% were using withdrawal. Among 20-24 year-olds, the proportion using a modern method was 11%--almost equally divided between pills, condoms and IUD--and 41% were using traditional methods. Among women who were using traditional methods, lack of contraceptive knowledge, fear of side effects, and partner preference were the most common reasons for not using a modern method. Very few sexually active unmarried young women used contraception, mainly because lack of knowledge, of sporadic or unpredictable sexual intercourse. Regardless of marital status, one in five young women had an unmet need for any or more effective contraception and were, therefore, at high risk of unintended pregnancy.

Findings from the YARHS allow examination of the trends in contraceptive behavior among young women and complement the 1993 surveys with information about the contraceptive status of young men. Because of a high prevalence of male-controlled methods (e.g., withdrawal, condoms) among young couples, information from male respondents is essential to understand patterns of contraceptive use, reasons for nonuse, and factors associated with choosing specific methods.

8.1 Contraceptive Use at First Sexual Intercourse

Contraceptive behavior at first sexual intercourse is an important indicator of the risks of unintended pregnancy and STDs. Studies in the United States have shown that the risk of pregnancy among young women is highest in the few months following the first coitus (Zabin LS, et al., 1979), and their chance of acquiring a sexually transmitted disease during a single unprotected intercourse with an infected partner ranges from 1% for HIV to 30% for genital herpes, 40% for chlamydia, and 50% for gonorrhea (Harlap S. et al., 1991). Contraceptive use at first intercourse can also predict future contraceptive behaviors, such as continuation of use and choice of specific methods. Most young people who have used contraception the first time they had sex were also using it at the most recent intercourse (Mauldon J. and Luker K., 1996), and often, with increased time in a relationship, teens will switch to pills instead of male methods (Mosher WD and McNally JW, 1991). Also, nonusers at first intercourse, who adopt a

method soon after, will usually chose oral contraceptives instead of condoms as the first method (Kahn J. et al., 1990).

For these reasons, it was important to know whether the 46% of young women and 66% of young men who reported sexual experience had used a contraceptive method at the time of their first intercourse and whether, for young females, there was any improvement in use since 1993. Since, in 1993, the use of contraception varied directly with the age at first sexual intercourse, data presented here are correlated with the age of first sex. Also, because contraceptive behavior is very different depending on whether the onset of sexual activity precedes marriage, contraceptive use is reported separately according to whether first intercourse was premarital or marital.

TABLE 8.1.1A
Contraceptive Status At Time of First Sexual Intercourse,
By Method and Age at First Intercourse
Women 15-24 Years of Age Whose First Sexual Intercourse Was Premarital
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

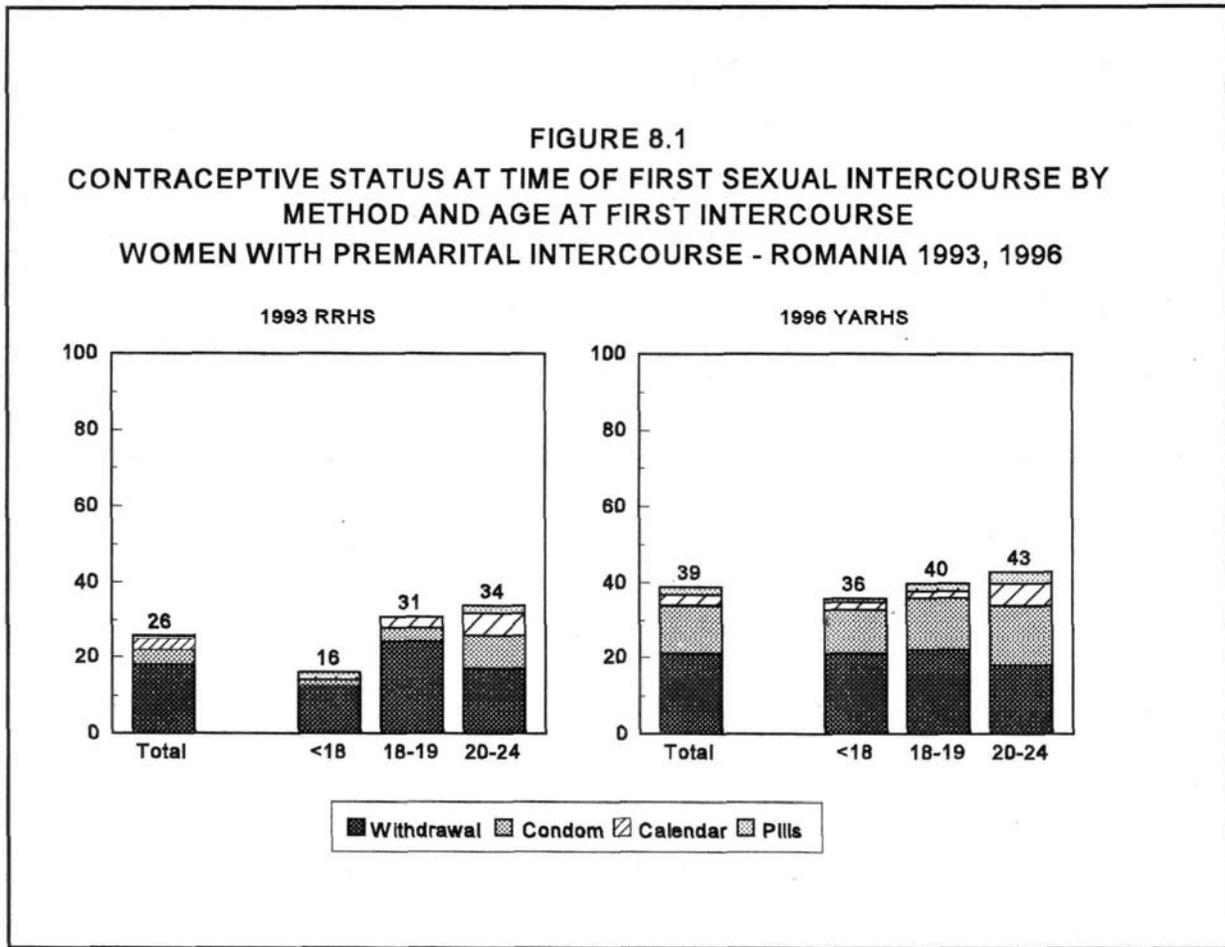
Contraceptive Method	1993 RRHS				1996 YARHS			
	Total	Age at First Intercourse			Total	Age at First Intercourse		
		<18	18-19	20-24		<18	18-19	20-24
Any Method	25.5	15.9	31.0	33.8	39.0	36.2	39.7	42.9
Withdrawal	17.4	13.0	23.7	17.1	20.8	21.0	22.0	18.6
Condom	4.0	1.1	3.7	8.7	13.4	11.5	13.9	15.8
Calendar	3.3	1.3	3.6	6.0	3.2	2.3	2.8	5.7
Pills	0.8	0.5	0.0	2.0	1.4	0.9	1.0	2.8
Other Modern	0.0	0.0	0.0	0.0	0.2	0.5	0.0	0.0
No Method	74.5	84.0	69.0	66.2	61.0	63.8	60.3	57.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	431	165	139	127	425	188	150	87

Data collected in both the 1993 RRHS and 1996 YARHS show low prevalence of contraceptive use at first intercourse and heavy reliance on withdrawal and to a much lesser

extent on condoms (Tables 8.1.1A and 8.1.2A). However, among sexually experienced young women who reported premarital intercourse (see Table 8.1.1A and Figure 8.1), the proportion using a method had increased from 26% in 1993 to 39% in 1996.

Almost all of the increase in use was the result of the increased popularity of condoms, whose prevalence more than tripled--from 4% to 13%. Thus, among users, condom use at first intercourse rose from 16% to 34%. Withdrawal was the leading method at first intercourse in both surveys and although its use had increased recently--from 17% to 21%--its prevalence among users actually declined (from 67% to 55%). There were no significant changes in the use of oral contraceptives or the calendar method.

In both surveys, the likelihood of using a method at first intercourse was positively correlated with age at first sexual experience, but the differences had become negligible by 1996. For example, the proportion of users was twice as high in 1993 if the onset of sexual activity was postponed until after age 18 compared to a difference in use of only 11 % in 1996. This is due to different patterns of change in contraceptive use by age at first sex. The biggest increase in use was among women who started intercourse early (before age 18), narrowing



the previous difference by age at first sex. By 1996, this proportion more than doubled --from 16% to 36%-- while those aged 18-19 or over age 19 at first intercourse experienced a lower (29% and 26%, respectively) but still important increase in overall use --from a prevalence of 31% to 40%, and from 34% to 43%, respectively.

The pattern of change in contraceptive method mix was also related to age at first intercourse. While the most prevalent method continues to be withdrawal, regardless of when first intercourse had occurred, the proportion of condom users increased 10 times among women with early intercourse, four times among those with first intercourse between ages 18-19, and almost doubled for women age 20-24 at first sex.

Conversely, the contraceptive behavior of young women whose first intercourse was marital changed very little and, for some, in the opposite direction ([Table 8.1.2A](#)). The overall contraceptive use--mainly withdrawal and to a lesser extent condoms--remained basically unchanged (15% in 1993 and 14% in 1996). Pills use had doubled but remained very low (only 1% in 1996) whereas the use of the calendar method had fallen to less than one percent.

TABLE 8.1.2A
Contraceptive Status At Time of First Sexual Intercourse,
By Method and Age at First Intercourse
Women 15-24 Years of Age Whose First Sexual Intercourse Was Marital
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Contraceptive Method</u>	<u>1993 RRHS</u>				<u>1996 YARHS</u>			
	<u>Total</u>	<u>Age at First Intercourse</u>			<u>Total</u>	<u>Age at First Intercourse</u>		
		<u><18</u>	<u>18-19</u>	<u>20-24</u>		<u><18</u>	<u>18-19</u>	<u>20-24</u>
Any Method	15.2	8.4	14.8	21.8	13.6	12.3	14.4	14.0
Withdrawal	10.9	6.8	10.3	15.3	10.2	12.3	10.4	7.0
Condom	2.3	1.6	3.1	1.9	1.7	0.0	1.1	4.9
Calendar	1.6	0.0	1.4	3.4	0.7	0.0	1.1	1.0
Pills	0.4	0.0	0.0	1.2	1.0	0.0	1.7	1.0
No Method	84.8	91.5	85.3	78.2	86.4	87.7	85.6	86.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	387	106	146	135	363	151	137	75

TABLE 8.1.2B
Contraceptive Status At Time of First Sexual Intercourse,
By Method and Age at First Intercourse
Men 15-24 Years of Age Whose First Intercourse Was Premarital
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Contraceptive Method</u>	<u>Total</u>	<u>Age at First Intercourse</u>		
		<u><18</u>	<u>18-19</u>	<u>20-24</u>
<u>Any Method</u>	<u>34.5</u>	<u>33.0</u>	<u>37.4</u>	<u>43.1</u>
Condom	15.9	14.8	17.5	24.3
Withdrawal	15.2	15.3	20.6	13.2
Calendar	2.2	1.9	2.8	4.2
Pills	1.0	0.8	1.5	1.3
Other Modern	0.2	0.2	0.3	0.0
No Method	65.5	67.0	62.6	56.9
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	1208	914	221	73

Contraceptive use at first intercourse before age 18 had increased by 50% but the entire increase is attributable to higher prevalence of withdrawal and no respondent reported condom use. Among women who married and started sexual activity at ages 18 or later, contraceptive use remained unchanged; although contraceptive use had fallen from 22% to 14% among women who initiated coitus after age 19, the difference is not statistically significant.

Similar to the contraceptive use among women with premarital intercourse, reported use at first sex among young men was also rather low (35%). Only one in three young men had used a method and the use consisted predominantly of condoms (16%) and withdrawal (15%). Female methods, such as oral contraceptives (1%) and the calendar (2%), accounted for less than ten percent of use (3% for pills and 6% for calendar method). The use of condoms increased sharply with the postponement of first intercourse, from 15% at first sex before age 18 to 24% at intercourse after age 19. Consequently, overall use was higher if the first intercourse was delayed.

These findings indicate that male involvement has been of growing importance in decisions about contraceptive use at first intercourse. Several factors may have contributed to this role. First, the older age of male partners may give them more influence in contraceptive decision-making; the YARHS show that many young women with premarital intercourse had older partners at first intercourse (52%) whereas the majority of young men (83%) were one or more years older than to their first partners. Second, communication and agreements may be difficult to achieve for young women; only 22% of sexually active women had dared to ever ask a partner to wear a condom and only 4% had been successful in their requests. Third, improved condom use at first intercourse may suggest greater concern with preventing STDs, but also may be due to greater availability of and accessibility to an over-the-counter method.

Since young couples in Romania rely overwhelmingly on male-controlled methods, more efforts should be made to educate young men to adopt more effective methods of contraception. Furthermore, education messages should seek to improve negotiation skills and assertiveness among young women, to enable them to play an active role in contraceptive decision-making.

8.2 Reasons for Not Using Contraception At the Time of First Sexual Intercourse

As shown in [Table 8.2](#), among young women who had premarital intercourse, the most common reason for not using a method at first coitus was lack of concern about contraception (26%), followed closely by unexpected sexual intercourse (21%), personal opposition to contraceptive methods (20%), and little knowledge about contraception (19%). Partner opposition played a minor role in the decision of not to use contraception (2%). Personal desire to get pregnant at first intercourse was mentioned by only 9 % of these women.

Among young men (see [Table 8.1.3B](#)), the leading reasons were unexpected sexual intercourse (39%), little knowledge about contraception (25%), lack of concern about contraceptive methods (22%), and personal opposition to contraception (9%). Only one percent of the young men did not use contraception because they sought to get their partner pregnant.

Interestingly, for both women and men, the cost associated with contraceptive methods was not mentioned as a barrier to their use and very few men stated that birth control methods are not easily available (1 %).

These results have important implications for the development of interventions. They make clear that many young adults are not concerned about the risk of unprotected intercourse and do not have accurate information on contraception. These youth could benefit tremendously from comprehensive sex education programs in schools. In addition, for those who actually oppose contraception, programs will need to emphasize other benefits of contraceptive use, such as protection against HIV and other STDs.

TABLE 8.2
Reasons for Not Using Contraception At the Time of First Sexual Intercourse,
By Age at First Intercourse By Gender
Young Adults 15-24 Years of Age Whose First Sexual Intercourse Was Premarital
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

WOMEN	Total	Age at First Intercourse	
		<18	18-24
Reason for Not Using Contraception			
She Did Not Think About Using a Method	25.7	26.0	25.6
Sexual Intercourse Was Unexpected	21.0	17.9	23.2
She Did Not Want to Use Contraception	19.9	12.2	25.5
She Did Not Know About Contraception	19.0	28.6	12.0
She Wanted to Get Pregnant	9.3	12.0	7.4
He Did Not Want to Use Contraception	2.0	1.5	2.3
Sex Was Safe According to the Calendar	1.6	0.0	2.8
Other	1.4	1.7	1.2
Total	100.0	100.0	100.0
Unweighted No. of Cases	238	105	133
MEN	Total	Age at First Intercourse	
		<16	16-17
Reason for Not Using Contraception			
Sexual Intercourse Was Unexpected	39.3	36.2	45.9
He Did Not Know About Contraception	24.8	32.5	18.7
He Did Not Think About Using a Method	22.0	20.6	21.3
He Did Not Want to Use Contraception	9.0	7.3	9.8
He Trust His Partner (To Use a Method)	1.4	0.7	1.5
Contraceptive Methods Are Hard to Find	1.1	1.0	1.7
He Wanted to Get Her Pregnant	1.0	0.0	0.2
She Did Not Want to Use Contraception	0.7	0.8	0.6
Other	0.8	0.9	0.3
Total	100.0	100.0	100.0
Unweighted No. of Cases	753	320	267

8.3 Contraceptive Use at Most Recent Sexual Intercourse

Not all young adults who have ever had intercourse were currently sexually active and in need of contraception. Particularly among those who were not currently married or in consensual union, current contraceptive use was very low (see [Figure 8.4.1](#)). Since most young adults not involved in a marital or cohabitation relationship may be temporarily sexually inactive for varying lengths of time, their current contraceptive status is difficult to assess accurately. Instead, a better measure of their ability to protect against unintended pregnancy and STDs is contraceptive use at most recent sexual intercourse.

As shown in [Figure 8.3](#) and [Table 8.3](#), among sexually experienced young adults, regardless of the timing of their last sexual intercourse, contraceptive prevalence on that occasion was relatively high (67% for females and 66% for males). Furthermore, both females and males were more likely to use a modern method than a traditional method. The ratio of traditional to modern methods use was 0.9:1 for females and 0.5:1 for males.

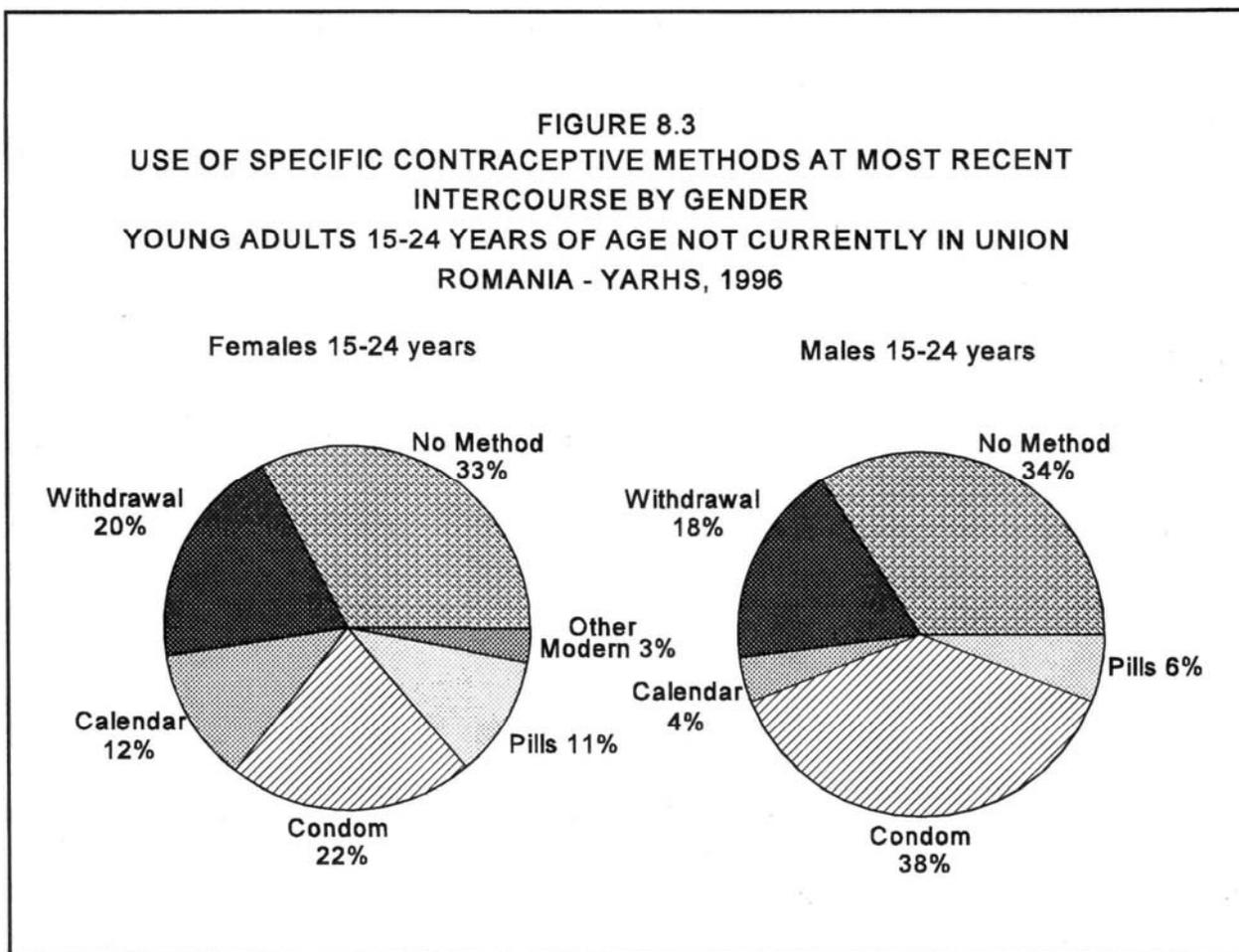


TABLE 8.3
Use of Specific Contraceptive Methods at Most Recent Sexual Intercourse
By Age Group And Gender
Sexually Experienced Young Adults Who Were Not Currently Married or In Consensual Union
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

	Women			Men		
	Total	15-19	20-24	Total	15-19	20-24
Any Method	67.0	62.1	69.1	65.8	63.2	67.5
<u>Modern Methods</u>	<u>35.5</u>	<u>32.4</u>	<u>36.4</u>	<u>42.9</u>	<u>43.1</u>	<u>42.9</u>
Condom	22.2	16.7	25.6	36.7	40.8	34.2
Pills	10.6	12.9	8.2	5.5	2.1	7.6
Other Modern	2.7	2.8	2.6	0.7	0.2	1.1
<u>Traditional Methods</u>	<u>31.5</u>	<u>29.7</u>	<u>32.7</u>	<u>22.8</u>	<u>20.1</u>	<u>23.6</u>
Withdrawal	19.9	19.7	20.1	18.3	16.3	19.6
Calendar	11.6	10.0	12.6	4.5	3.8	5.0
No Method	33.0	37.9	29.9	34.2	36.8	32.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	257	117	140	1,062	524	538

For both females or males, the most prevalent method was the condom, used by 22% of females and 37% of males, followed by withdrawal (20% and 18%, respectively) and oral contraceptives (11% and 6%, respectively).

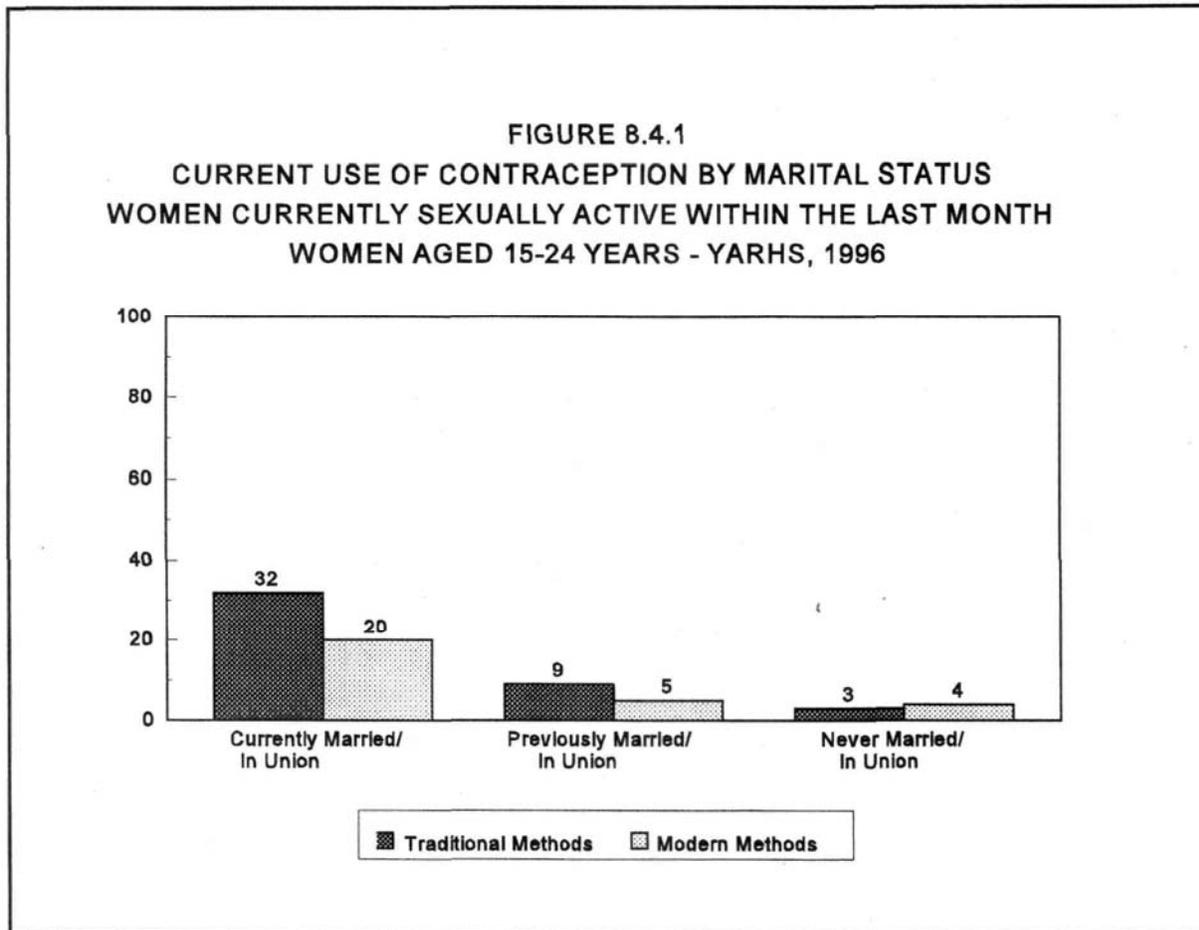
Patterns of contraceptive use at last intercourse varied directly with the respondent's age but the differences were not very striking. The use had increased modestly, from 62% and

63%, respectively, among 15-19 year-old females and males, to 69% and 68% among 20-24 year-olds. However, the increase in use among older women was the result of proportionally higher usage of modern and traditional methods, whereas among older men it was mainly the result of more reliance on traditional methods whereas modern method use remained unchanged.

8.4 Current Contraceptive Use Among Married Women

This section focuses only on young women in union since they represent two-thirds of sexually experienced women, have greater frequency of intercourse, have higher fertility and accidental pregnancies at the beginning of their marriages, and constitute the common denominator for other national and international studies of contraceptive prevalence. In the 1993 RRHS, current contraceptive status was measured as of the month of the interview. To be able to compare the trends in contraceptive practice we maintain the same definition of current contraceptive status among women married or in consensual unions.

As shown in [Figure 8.4.1](#) and similar to the findings of the 1993 survey, current contraceptive use was much higher among women in union (52%) than among previously



married and never-married women (13% and 7%, respectively). However, comparisons of contraceptive prevalence are strongly affected by the proportion of women who have never had sexual intercourse or who have sporadic sexual activity. Since the majority of never married women were not sexually experienced (83%), and most previously married women had not had intercourse within the last month (61 %), they are not currently at risk of getting pregnant and therefore they do not use contraception. If the study of current contraceptive use is restricted to the 38% of women sexually active within the last month (not shown), the prevalence among never or previously married women is in fact higher than among women in union (67% vs. 56%) and their preference for modern methods is stronger (33% vs. 21%). Contraceptive use by current reproductive status will be included in the final report.

At the time of the survey 52 % of young women currently in union reported using a contraceptive method-20% using modern contraceptives and 32% using traditional methods (see [Figure 8.4.2](#) and [Table 8.4](#)). Among the remaining 48% of women not currently using a contraceptive method, almost half were either pregnant (12%), postpartum (4%), or trying to become pregnant (7%); about 10% did not have intercourse during the last month; almost 7% had personal objections to contraception and 4% had little knowledge about contraception; only one percent were not sure if the couple could conceive or mentioned medical reasons which prevented them from using a method; the remaining 3% mentioned partner objections or other reasons.

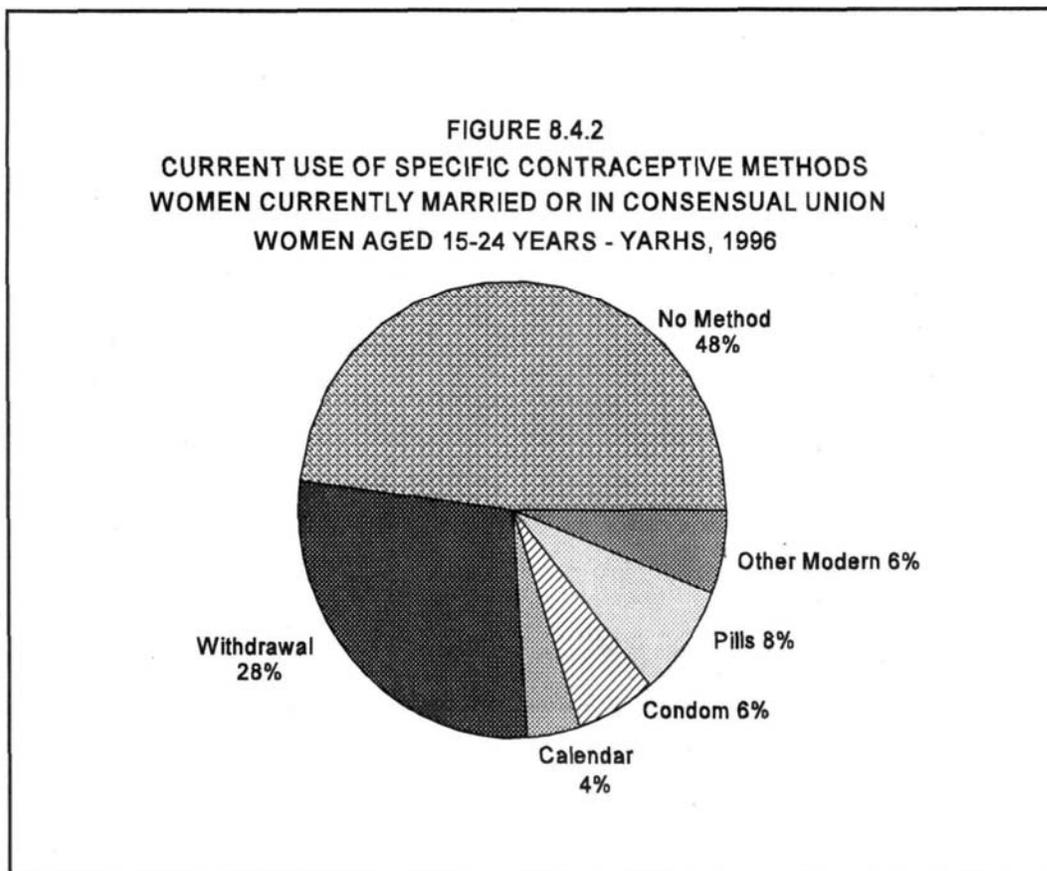
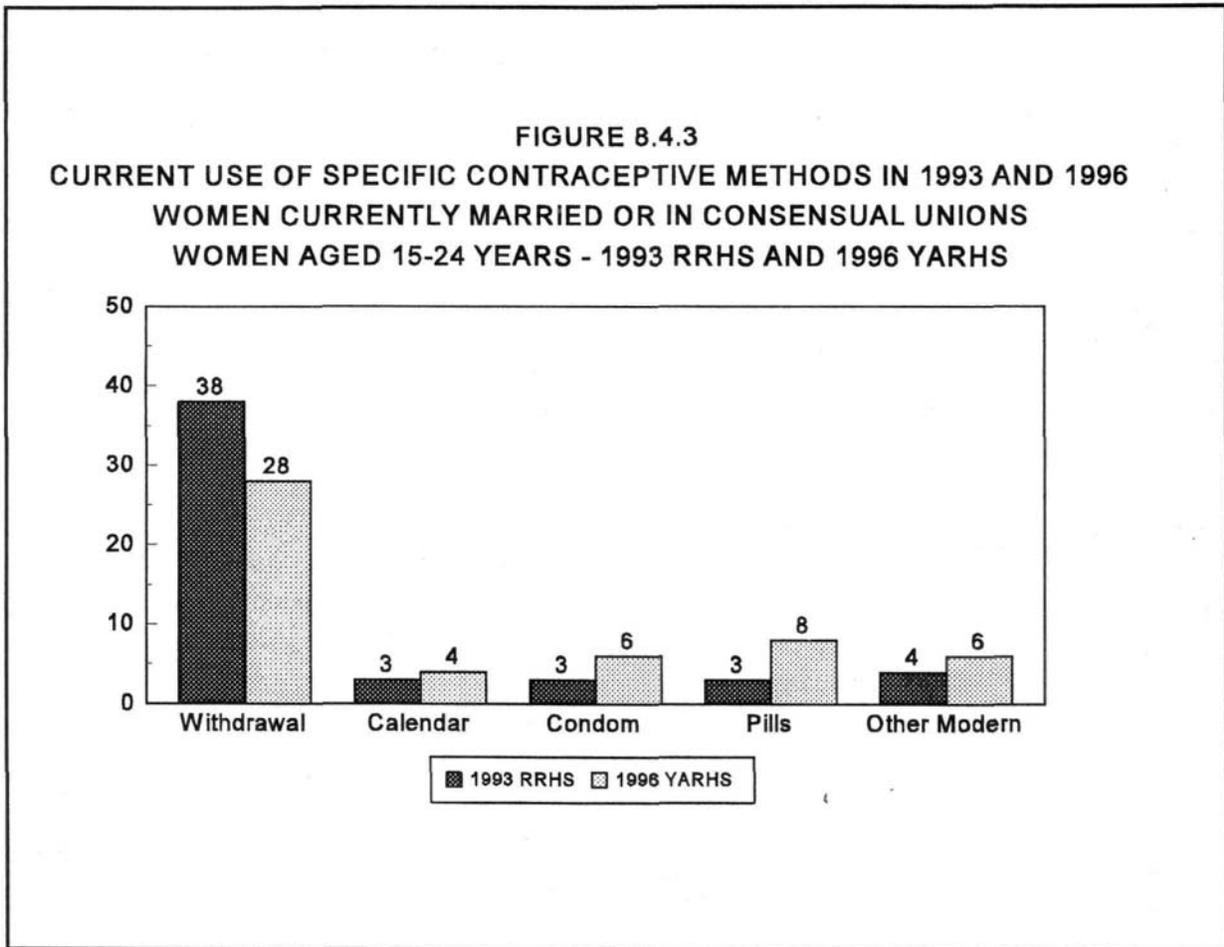


TABLE 8.4
Current Use of Specific Contraceptive Methods by Age Group
Women in Union Aged 15-24-ROMANIA 1993 and 1996
Reproductive Health Survey and Young Adult Reproductive Health Survey
(Percent Distribution)

	1993 Reproductive Health Survey			1996 Young Adults Reproductive Health Survey		
	<u>Total</u>	<u>15-19</u>	<u>20-24</u>	<u>Total</u>	<u>15-19</u>	<u>20-24</u>
Currently Using						
Any Method	50.4	39.9	52.8	51.5	42.5	53.3
<u>Modern Methods</u>	<u>10.4</u>	<u>6.5</u>	<u>11.4</u>	<u>19.7</u>	<u>8.5</u>	<u>22.1</u>
Pills	3.2	1.2	3.6	7.5	2.9	8.4
Condom	2.8	0.8	3.3	5.8	4.4	6.1
IUD	2.8	0.0	3.4	3.3	0.0	4.0
Spermicides	1.4	4.5	0.8	2.2	1.2	2.4
Tubal Ligation	0.0	0.0	0.0	0.8	0.0	1.0
Injectables	0.1	0.0	0.1	0.1	0.0	0.2
Other Modern	0.1	0.0	0.2	0.0	0.0	0.0
<u>Traditional Methods</u>	<u>40.0</u>	<u>33.4</u>	<u>41.4</u>	<u>31.8</u>	<u>34.0</u>	<u>31.2</u>
Withdrawal	36.7	33.4	37.4	27.6	31.8	26.7
Calendar	3.3	0.0	4.0	4.2	2.2	4.5
No Method	49.6	60.1	47.2	48.5	57.5	46.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	(674)	(105)	(569)	(531)	(124)	(407)

Among women in union, the most prevalent birth control method continued to be withdrawal (28%), followed by oral contraceptives (8%) and condoms (6%). The other methods, in rank order, were IUD (3%), spermicides (2%) and tubal ligation (1%). Among users, the ratio of traditional to modern methods use was 1.6:1.

The patterns of contraceptive use differed greatly between age groups. Women in union age 15-19 were less likely than women 20-24 years-old to use contraceptives (43% vs. 53%), especially modern methods (9% vs.22%). Although traditional methods prevailed in both age groups, the ratio of traditional methods to modern methods use decreased significantly with the increase in respondents' age, from 4:1 to 1.4:1. For women aged 15-19 the second most commonly used method after withdrawal, was the condom. Among 20-24 year-olds, the second most prevalent method was the pill.



Comparison with the 1993 RRHS reveals several important changes in contraceptive method mix (see [Table 8.4](#) and [Figure 8.4.3](#)). The most striking findings were a two-fold increase in the proportion of women using a modern method (from 10% to 20%) paralleled by a

20% decrease in the prevalence of traditional methods. These changes brought the ratio of traditional to modern method users down from 4:1 to 1.6:1. Virtually all the increase in the use of modern methods was the result of increased reliance on pills and condoms.

Although overall contraceptive prevalence by age group did not increase significantly, the contraceptive method mix has seen dramatic changes. Between the two surveys, the proportion of women aged 15-19 relying on condoms increased six times and the proportion using pills more than doubled, while the proportion using traditional methods remained unchanged. Among women aged 20-24, while the use of pills and condoms essentially doubled, reliance on traditional methods diminished.

8.5 Source of Contraception and Their Costs

In order to assess sources of contraceptive methods for young couples, the YARHS included questions about the place where current users of supplied contraceptive methods obtain their methods, similar to questions asked in 1993. Since the family planning program was only recently instituted by the government and nongovernmental organizations, and since a nationwide contraceptive logistics system is still under development, information regarding sources of contraception continue to be of great interest.

Similar to the 1993 findings, the YARHS indicated that pharmacies, either public or private, were the most important source of contraception; among current users, they provided 41% of women and 64% of men with a modern method of contraception. Because pharmacies are the subject of a rapid process of privatization, it is very difficult to differentiate between public, private and mixed ownership status. Other commercial sales outlets ("drogherii") provided 2% of women and 6% of men with over-the-counter condoms. The second most important source for women, supplying 19% of current users, was the public sector through 'contraceptive cabinets' set up mainly in hospitals, but also in polyclinics and dispensaries. The private medical sector, also supplied 19% of female users. In addition to private medical offices and clinics, this source includes also the principal family planning nongovernmental organization, the Sexual Education and Contraception Society (SECS), accounting for methods distributed to 4% of women, an increase from 1% in 1993. For men, the second most important source was a street market or vendor, supplying 14% of users, followed by the public medical sector which supplied 7% of male users. Other sources, such as partners, supplied 15% of female users and 3% of male users, whereas friends and relatives supplied 4% of male users but none of the female users (see [Table 8.5](#)).

Sources varied greatly according to the particular contraceptive method used. Pharmacies were the principal provider for condoms, supplying 52% of women whose partners use condoms and 75% of male users. However, 39% of women who used condoms stated that

TABLE 8.5
Current Users of Modern Contraceptive Methods by Main Source of Supply
By Specific Methods
Young Adults Reproductive Health Survey-ROMANIA, 1996
(Percent Distribution)

Source of Supply	Women				Men*		
	Any Method	Pills	Condom	Other**	Any Method	Pills	Condom
Commercial Sales	43.7	37.0	51.5	41.4	70.3	62.1	74.6
Pharmacy	41.4	37.0	45.6	41.4	64.1	62.1	66.3
Other Shops†	2.3	0.0	5.9	0.0	6.2	0.0	8.3
Public Medical Sector	18.9	30.2	0.0	31.6	7.2	22.0	0.3
•Dispensary	0.7	1.9	0.0	0.0	2.7	11.3	0.3
•Polyclinic	3.3	7.5	0.0	2.3	1.8	5.7	0.0
•Hospital	14.9	20.8	0.0	29.3	2.7	5.0	0.0
Private Medical Sector	18.8	31.8	1.3	27.0	2.4	7.8	0.9
•Private office	14.5	20.0	1.3	27.0	2.0	6.0	0.9
•SECS	4.3	11.8	0.0	0.0	0.4	1.8	0.0
Street Market/Vendors	3.2	0.0	8.4	0.0	13.6	2.1	17.8
Partner	15.3	1.0	38.8	0.0	3.0	6.0	1.7
Friends or Relatives	0.0	0.0	0.0	0.0	3.5	0.0	4.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	147	55	57	35	231	44	180
Mean Cost of Contraception‡ (in Lei§)	5,200	3,400	1,000	16,000/5,500§	1,900	6,200	916

* Seven men whose partners were using IUDs or spermicides are included only in the total

** 14 IUD users, 16 users of spermicides, 4 users of contraceptive sterilization, and one user of Depo-Provera

† 'drogherii' which sell over-the-counter health products

‡ Excludes 27 women and 32 men who either did not pay for the method or had partners who paid for contraception

§ (3,000 Lei=\$US 1.00 at the time of the survey)

§ Mean cost for IUD users (16,000 Lei) and users of local spermicides (5,500 Lei)

their partner was providing the supplies. Pharmacies also supplied most of the pill users (38% and 64%, respectively). The government's family planning network was as likely as the private medical sector to provide women with oral contraceptives (30% vs. 31%) but almost three times more likely to distribute them to young men whose partners were using pills (22% vs. 8%).

Unregulated street sales were providing almost one in five males with their condoms but very few females (8%). Other methods, mainly spermicides and IUD, were provided principally through pharmacies (spermicides) and medical sector, public or private (IUDs).

Compared to the 1993 survey, substantially fewer women reported contraceptive purchases from unregulated vendors and more reported as the main source of birth control their partners. The proportion reporting a medical setting (public or private) as the primary source remained basically unchanged. The lack of use of these sources is understandable because most currently sexually active young couples relied on over-the-counter methods (mainly condoms). However, it is important for young adults to visit a doctor or a clinic more often to obtain contraceptive counseling and more effective methods for preventing pregnancy. While such visits could stress the use of these methods (e.g., pills or injectables), they could also provide an opportunity to screen for and eventually treat possible STDs.

Information about the cost of modern methods were obtained from 72% of female users. Nine percent obtained their methods free of charge and 19% either did not remember or did not know the price, since their partner provided the method (24% of condom users, 10% of IUD and pills users). Conversely, fewer men obtained their method free of charge (4%) or did not know their costs because they were purchased by partners (12%).

For women who paid for a modern method, the average cost was 3,400 lei for a cycle of pills, 1,000 lei for a pack of condoms (usually three condoms), 16,000 lei for IUD, and 5,500 for spermicides (3,000 lei=\$US 1.00 at the time of the survey). The cost varies according to the source of supply but given the small number of cases the differences were not significant.

CHAPTER IX

ATTITUDES AND OPINIONS ABOUT CONTRACEPTION

In the years since abortion and contraception have been legalized and pro-natalist laws repealed, most women who considered themselves to be at risk of pregnancy have largely chosen traditional methods or no method of birth control. As shown earlier (Chapter VIII), the use of contraception among currently sexually active young women in union was 52 % and 32% were using traditional, less effective methods. Although the contraceptive behavior of these young women had changed rapidly between 1993 and 1996, with increased use of modern methods (from 10% to 20%) and decreased use of withdrawal (from 37% to 28%), there are still several serious constraints to widespread use of modern contraceptives. The 1993 RRHS showed that low use of modern methods was associated with limited access to a full range of high-quality contraceptive supplies, providers' biases toward various modern methods, lack of counseling, and considerable level of misinformation and lack of knowledge about contraception. Thanks to recent efforts by a number of international donors, the MOH, and Romanian NGOs, both the access to a wider range of modern methods and the delivery of adequate information on modern contraception seem to be improving. As such, it is important to know how contraceptive knowledge and attitudes have evolved among youth in recent years and to study the factors that contribute to contraceptive preferences and decision making for a population with a growing demand of family planning in Romania.

The YARHS included a series of questions to explore young adults' knowledge, attitudes, and opinions on several aspects of reproduction and contraception, including perceptions of their role in decision making about sex, family planning, and fertility. In this chapter we present data on opinions about the best and second best methods to prevent pregnancy, opinions and attitudes about condom use, knowledge and attitudes toward the use of pills, and opinions about IUDs.

9.1 Opinions About the Best Method to Prevent Pregnancy

Opinions about the best and second best method to prevent pregnancy were assessed among all respondents by showing them cards which listed all contraceptive methods and recording their answers on the questionnaires.

Although opinions about the best method to prevent unintended pregnancy differed by respondents' gender and background characteristics, most young adults (69% of females and 78% of males) believed that a modern method, particularly the condom or the pill, would be

the best contraceptive to prevent pregnancy. Condoms were considered the most effective contraceptive by 30% of young women and 60% of young men, while oral contraceptives were recognized as the best contraceptive by 15% of women and 10% of men (see [Figure 9.1](#)). Apparently, women were more willing to accept male-controlled methods for preventing pregnancy, whereas males were less willing to approve methods they could not control.

Interestingly, withdrawal and the calendar method were believed to be the best method to prevent pregnancy by only 9% of females and males, although most young adults had used them at first intercourse, and many continue to rely on them. Among young women, withdrawal and calendar were thought to be the most effective methods by only 6% and 3%, respectively, and among men by only 8% and 2%, respectively. It is important to emphasize that a sizable proportion of young adults did not have enough knowledge to express any opinion about the best method of contraception (20% of women and 12% of men). Less than one percent of females and males stated that no method is good enough to prevent pregnancy.

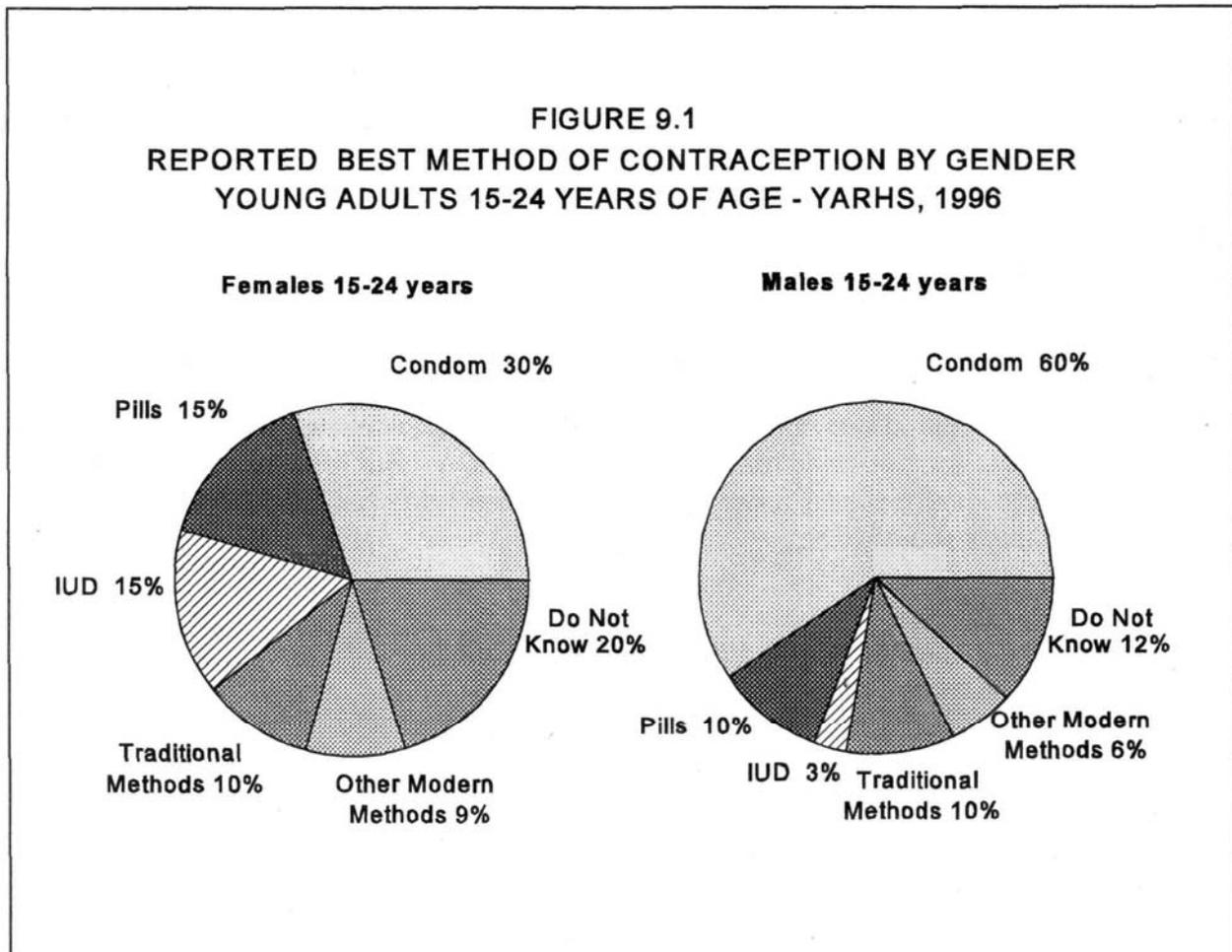


TABLE 9.1.1
Young Adult Beliefs About the Best Method to Prevent Pregnancy
By Method By Marital Status And Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Best</u> <u>Contraceptive Method</u>	<u>Women</u>			<u>Men</u>		
	<u>Total</u>	<u>Ever</u> <u>Married</u>	<u>Never</u> <u>Married</u>	<u>Total</u>	<u>Ever</u> <u>Married</u>	<u>Never</u> <u>Married</u>
Condom	30.1	16.8	37.4	59.7	51.0	61.3
Pills	15.4	14.5	15.9	10.0	8.8	10.2
IUD	14.8	23.3	10.0	2.9	5.1	2.5
Other Modern	8.6	9.9	7.9	5.6	5.3	5.6
Withdrawal	5.5	11.3	2.3	7.6	12.4	6.7
Calendar	3.4	5.2	2.4	1.7	4.5	1.2
Douching	1.1	1.5	0.9	0.3	0.5	0.3
None	0.7	0.7	0.8	0.6	0.8	0.6
Don't Know	20.4	16.8	22.4	11.6	11.6	11.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,025	570	1,455	2,047	156	1,891

Striking differences were found between ever and never married young adults concerning their opinions about the best contraceptive method ([Table 9.1.1](#)). Ever married women were more likely to rank the IUD as the most effective method to prevent pregnancy (23%), followed by condoms (17%) and pills (15%) whereas never married women were more likely to think that condoms are the most effective (37%), before pills (16%) and the IUD (10%). Among males, the ranking of modern methods by their efficacy was not substantially influenced by marital experience. However, more never married than ever married men maintained that the condom is the best method (61% vs. 51%), followed by pills (10% vs. 9%). The belief that withdrawal is the best method, was much more prevalent among ever married than never married young adults (11% vs. 2% among women and 12% vs. 7% among men).

TABLE 9.1.2
Young Adult Beliefs About the Best Method to Prevent Pregnancy
By Method By Age Group And Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Best</u> <u>Contraceptive Method</u>	<u>Women</u>				<u>Men</u>			
	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>	<u>Total</u>	<u>15-17</u>	<u>18-19</u>	<u>20-24</u>
Condom	30.1	37.2	37.1	22.6	59.7	64.0	62.3	55.9
Pills	15.4	13.7	15.7	16.3	10.0	8.7	9.4	11.1
IUD	14.8	7.2	9.5	21.7	2.9	1.5	3.7	3.5
Other Modern	8.6	5.8	6.6	11.2	5.6	2.3	5.3	7.7
Withdrawal	5.5	2.1	4.9	7.8	7.6	2.8	8.1	10.4
Calendar	3.4	1.7	3.0	4.7	1.7	0.5	1.3	2.7
Douching	1.1	0.5	2.1	1.0	0.3	0.1	0.2	0.5
None	0.7	0.8	0.8	0.6	0.6	0.9	0.4	0.5
Don't Know	20.4	30.8	20.1	14.0	11.6	19.1	9.2	7.7
Total	100.0							
Unweighted No. of Cases	2,025	738	501	786	2,047	805	517	725

Belief that modern contraception is more effective in preventing pregnancy varied directly with the respondents' age among females but did not show any age pattern among males (Table 9.1.2). Opinions about which specific modern method is the best in preventing pregnancy were affected by the respondents' age, regardless of their gender. Teenagers (15-19 years of age) were more likely than 20-24 year-olds to believe that is best to use condoms to prevent pregnancy (37% vs. 23% among women and 63% vs. 56% among men), whereas 20-24 year old women held more trust in the IUD being as effective as condoms. Beliefs that traditional methods are the best methods increased directly with the increase in respondents' age. Also, the likelihood to name a certain method as the best contraception increased by age. Almost one-third of 15-17 year-old females and one-fifth of 15-17 year-old males were not able to express an opinion about the efficacy of contraceptive methods, whereas only 14% and 8% of 20-24 year-olds could not do so.

TABLE 9.1.3
Young Adult Beliefs About the Best Method to Prevent Pregnancy
By Method By Education And Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Best Contraceptive Method</u>	<u>Women</u>				<u>Men</u>			
	<u>Total</u>	<u>Primary</u>	<u>Some HS*</u>	<u>HSD& PostHS**</u>	<u>Total</u>	<u>Primary</u>	<u>Some HS*</u>	<u>HSD& PostHS**</u>
Condom	30.1	16.0	33.4	34.1	59.7	50.9	65.9	54.8
Pills	15.4	9.9	14.4	19.6	10.0	4.5	9.4	15.4
IUD	14.8	12.4	13.0	18.3	2.9	0.9	2.7	4.8
Other Modern	8.6	4.0	8.7	11.1	5.6	0.6	3.3	13.5
Withdrawal	5.5	5.4	6.0	5.0	7.6	11.5	7.2	5.4
Calendar	3.4	3.0	2.8	4.4	1.7	1.0	1.6	2.3
Douching	1.1	1.7	1.4	0.4	0.3	0.3	0.3	0.5
None	0.7	0.9	0.4	1.1	0.6	1.1	0.6	0.4
Don't Know	20.4	47.0	19.9	5.9	11.6	29.1	9.0	3.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	2,025	460	917	648	2,047	473	1,065	509

* Some High School

** High School Graduates (with Diploma) and Post High-School Education

Differences in opinions about the efficacy of contraceptive methods were dramatically influenced by the respondents' level of education (Table 9.1.3). Very high proportions of young women (47%) and young men (29%) with the lowest education level were not able to say what was, in their opinion, the best method of contraception. Conversely, among young adults with the highest educational attainment, virtually all could name a method. Beliefs that condoms, pills and IUD are the most effective method increased by education but the trust in traditional methods did not vary substantially. However, among women with primary education who could express an opinion about the best contraceptive method, the belief that a traditional method is the most effective method was 50% more prevalent than among women with better levels of education who had an opinion about the best method. Similarly, among men with primary education who were able to name a best method, the belief in traditional methods' efficacy was twice as high as among men with higher educational levels.

TABLE 9.1.4
Beliefs About the Second Best Method to Prevent Pregnancy
By Method By Best Method And Gender
Young Adults 15-24 Years of Age Who Named a First Best Method to Prevent Pregnancy
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

<u>Second Best Contraceptive Method</u>	<u>Best Contraceptive Method</u>					
	<u>Total*</u>	<u>Condom</u>	<u>Pills</u>	<u>IUD</u>	<u>Other Modern</u>	<u>Withdrawal/ Calendar</u>
FEMALES						
Condom	19.2	0.5	51.1	30.9	32.0	33.3
Pills	18.6	37.0	0.0	33.7	16.5	9.1
IUD	12.2	16.7	27.5	0.3	22.7	11.0
Other Modern	5.8	7.7	3.7	8.3	16.7	1.6
Withdrawal	6.1	7.9	5.0	10.2	3.2	7.4
Calendar	6.2	11.4	5.3	6.3	5.0	5.2
Douching	2.9	2.4	2.6	2.3	1.8	13.6
None	1.5	1.6	0.7	1.0	0.6	2.3
Don't Know	27.5	14.8	4.0	6.9	1.5	16.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	1,553	627	308	257	162	163
MALES						
Pills	21.8	33.1	0.0	27.5	12.1	5.9
Condom	18.3	0.0	84.9	49.0	29.8	70.3
Withdrawal	16.5	25.6	2.7	13.2	1.8	3.4
Other Modern	6.0	4.4	6.1	4.9	45.4	1.1
IUD	5.6	7.1	4.5	0.0	9.3	3.9
Calendar	5.4	8.1	1.2	5.4	1.0	3.1
Douching	1.1	1.5	0.0	0.0	0.0	2.8
None	1.8	1.5	0.5	0.0	0.0	2.4
Don't Know	23.5	11.6	0.0	0.0	0.6	7.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	1,784	198	1,240	55	105	166

* / Includes 36 females and 20 males who cited as best method either douching or no method

[Table 9.1.4](#) shows beliefs about the second best method to prevent pregnancy. Again, beliefs that the second best option to prevent pregnancy is to use a modern method prevailed among both women or men. As might be expected, these beliefs were stronger among those who named a modern method as the first best method of contraception. Furthermore, the opinions about the best modern method influenced the choice of the second best method. Among women who chose condoms as the best method, 37% ranked the pill as the second best method but an additional 19% said a traditional method would be the second best method. Among men who said condoms are the best, the likelihood to rank traditional contraception as the second best way to prevent pregnancy equaled that of naming pills as the best method (33%).

Among women, opinions which favored pills as best contraceptives, were associated with higher likelihood to opt for condoms or IUD as the second best method (51% and 28%, respectively), whereas beliefs that the IUD is the most effective method were associated with approximately equal probability to opt for pills as the second best method. Among men, beliefs that pills were the best method triggered almost always the selection of condoms as the second best method (85%), whereas those which credited the IUD as the best method were followed by strong preferences for condoms (49%) and for pills (28%).

9.2 Opinions About Condoms

According to the YARHS, significant proportions of young women do not know or have incorrect perceptions about the effectiveness of condoms in preventing pregnancy (see [Table 9.2.1A](#)) or protecting against STDs (see [Table 9.2.2A](#)). Overall, 14% of young females believed that condoms are not very effective, 10% said they are not at all effective, and 22% did not have enough knowledge to assess the efficacy of condoms for preventing pregnancy. Furthermore, 12% did not think that condoms are very effective and 6% believe that they are not at all effective in preventing STDs; 22% did not know whether are effective or not. Rural residence, very young age (15-17 years), primary education, low socioeconomic status (SES), and lack of experience with condoms, were associated with lack of knowledge or beliefs that condoms are not very effective or not at all effective for preventing pregnancy and protecting against STDs. As may be expected, the perceived effectiveness of condoms in preventing pregnancy and STDs was the highest among women who have ever used a condom (over 80%).

Young men, however, were much more likely than females to know that correct condom use is effective in preventing pregnancy ([Table 9.2.1B](#)) and protecting against STDs ([Table 9.2.2B](#)). Equally high proportions of males believed that properly used condoms could effectively prevent pregnancy and STDs (79% and 78%) whereas only about 10% were not able to give an answer to either question. Knowledge and beliefs on condom effectiveness were less strong among the same subgroups as in the female sample. Again, the highest levels of perceived effectiveness were reported by males who have ever used condoms (over 90%).

TABLE 9.2.1A
Beliefs About the Effectiveness of Condoms for Preventing Pregnancy
By Selected Characteristics --Women 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

	How Effective is a Properly Used Condom in Preventing A Woman from Becoming Pregnant?					<u>Total</u>	Unweighted <u>No. of Cases</u>
	<u>Very Effective</u>	<u>Somewhat Effective</u>	<u>Not Very Effective</u>	<u>Not at all Effective</u>	<u>Don't Know/ Not Sure</u>		
Total	19.8	34.6	13.7	9.9	22.0	100.0	2,025
Residence							
Urban	24.8	38.2	16.4	8.9	11.6	100.0	983
Rural	13.4	29.9	10.3	11.0	35.3	100.0	1,042
Age Group							
15-17	14.4	32.4	13.4	13.4	26.6	100.0	738
18-19	26.1	33.1	12.7	9.3	18.8	100.0	501
20-24	20.6	36.6	14.4	7.9	20.5	100.0	786
Marital Status							
Ever Married/In Union	17.1	33.3	14.5	8.5	26.7	100.0	570
Never Married	21.4	35.3	13.3	10.6	19.4	100.0	1,455
Education							
Primary	8.3	20.5	11.8	12.0	47.5	100.0	460
Some High School (HS)	17.0	37.2	13.8	10.7	21.4	100.0	917
HS Complete or More	29.9	39.5	14.8	7.7	8.3	100.0	648
Socioeconomic Index							
Low	13.1	28.2	11.7	10.7	36.3	100.0	917
Middle	24.5	38.9	14.6	9.1	13.0	100.0	876
High	26.0	40.5	17.4	9.9	6.2	100.0	232
Condom Experience							
Used for Contraception	39.3	46.0	9.5	3.8	1.5	100.0	132
Used for STD Protection	**	**	**	**	**	100.0	5
Used for Both Reasons	42.4	38.1	14.5	5.0	0.0	100.0	101
Never Used	16.2	33.1	14.0	10.9	25.8	100.0	1,787

./ Estimate based on less than 25 unweighted observations in the cell and has been suppressed

TABLE 9.2.2A
Beliefs About the Effectiveness of Condoms for Protection Against STDs
By Selected Characteristics --Women 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

	How Effective is a Properly Used Condom in Protecting Against STDs?					Total	Unweighted No. of Cases
	Very Effective	Somewhat Effective	Not Very Effective	Not at all Effective	Don't Know/ Not Sure		
Total	23.8	36.5	11.7	5.5	22.5	100.0	2,025
Residence							
Urban	30.8	38.3	13.6	5.1	12.1	100.0	983
Rural	14.8	34.3	9.1	6.1	35.8	100.0	1,042
Age Group							
15-17	14.9	34.8	14.1	6.9	29.4	100.0	738
18-19	28.1	34.3	11.3	6.8	19.6	100.0	501
20-24	27.5	38.6	10.3	4.1	19.5	100.0	786
Marital Status							
Ever Married/In Union	23.1	34.8	10.8	5.8	25.5	100.0	570
Never Married	24.2	37.5	12.1	5.4	20.8	100.0	1,455
Education							
Primary	7.4	23.4	11.9	6.2	51.1	100.0	460
Some High School (HS)	19.9	38.7	13.3	6.3	21.7	100.0	917
HS Complete or More	37.8	41.3	9.4	4.3	7.1	100.0	648
Socioeconomic Index							
Low	15.0	31.8	9.8	5.4	38.1	100.0	917
Middle	29.4	40.0	12.8	5.6	12.2	100.0	876
High	4.1	4.9	1.7	0.7	0.9	100.0	232
Condom Experience							
Used for Contraception	41.8	44.6	7.6	3.6	2.3	100.0	132
Used for STD Protection	*.*	*.*	*.*	*.*	*.*	100.0	5
Used for Both Reasons	50.1	36.3	10.6	0.0	3.0	100.0	101
Never Used	20.0	35.7	12.1	6.1	26.0	100.0	1,787

./ Estimate based on less than 25 unweighted observations in the cell and has been suppressed

TABLE 9.2.1B
Beliefs About the Effectiveness of Condoms for Preventing Pregnancy
By Selected Characteristics --Men 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

	How Effective is a Properly Used Condom in Preventing A Woman from Becoming Pregnant?					Total	Unweighted No. of Cases
	Very Effective	Somewhat Effective	Not Very Effective	Not at all Effective	Don't Know/ Not Sure		
Total	43.6	35.1	7.8	4.5	9.1	100.0	2,047
Residence							
Urban	46.1	37.3	8.3	3.0	5.3	100.0	1,075
Rural	40.5	32.4	7.2	6.2	13.7	100.0	972
Age Group							
15-17	39.5	32.0	9.7	3.9	15.0	100.0	805
18-19	41.1	40.3	7.2	4.1	7.4	100.0	517
20-24	47.3	34.9	6.9	5.0	6.0	100.0	725
Marital Status							
Ever Married/In Union	48.3	35.6	3.4	4.4	8.4	100.0	156
Never Married	42.7	35.0	8.6	4.5	9.2	100.0	1,891
Education							
Primary	30.5	29.9	8.8	5.8	25.0	100.0	473
Some High School (HS)	45.6	35.8	7.6	4.8	6.2	100.0	1,065
HS Complete or More	49.8	37.7	7.5	2.7	2.3	100.0	509
Socioeconomic Index							
Low	37.3	33.1	6.7	7.1	15.9	100.0	786
Middle	46.1	36.3	8.7	3.4	5.5	100.0	943
High	52.0	36.3	8.1	1.0	2.6	100.0	318
Condom Experience							
Used for Contraception	53.2	36.9	5.5	2.5	1.9	100.0	148
Used for STD Protection	52.7	38.2	5.3	3.8	0.0	100.0	92
Used for Both Reasons	54.5	37.0	5.8	2.4	0.2	100.0	543
Never Used	35.8	33.5	9.4	5.8	15.5	100.0	1,264

TABLE 9.2.2B
Beliefs About the Effectiveness of Condoms for Protection Against STDs
By Selected Characteristics --Men 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

	How Effective is a Properly Used Condom in Protecting Against STDs?					Total	Unweighted No. of Cases
	Very Effective	Somewhat Effective	Not Very Effective	Not at all Effective	Don't Know/ Not Sure		
Total	45.3	32.9	9.3	2.9	9.7	100.0	2,047
Residence							
Urban	48.7	35.8	8.3	2.0	5.1	100.0	1,075
Rural	41.1	29.4	10.5	3.9	15.2	100.0	972
Age Group							
15-17	37.5	34.5	9.5	2.7	15.8	100.0	805
18-19	44.1	37.1	8.5	3.0	7.3	100.0	517
20-24	50.8	30.2	9.5	2.9	6.7	100.0	725
Marital Status							
Ever Married/In Union	46.9	32.8	7.9	3.4	9.0	100.0	156
Never Married	45.0	33.0	9.6	2.7	9.8	100.0	1,891
Education							
Primary	28.9	29.6	10.6	3.9	27.1	100.0	473
Some High School (HS)	46.7	34.6	9.0	3.2	6.5	100.0	1,065
HS Complete or More	55.0	32.4	8.9	1.4	2.3	100.0	509
Socioeconomic Index							
Low	37.5	31.6	9.3	3.9	17.6	100.0	786
Middle	48.1	33.4	10.2	2.6	5.7	100.0	943
High	56.2	34.7	6.6	1.0	1.5	100.0	318
Condom Experience							
Used for Contraception	52.1	31.3	12.0	1.7	3.0	100.0	148
Used for STD Protection	64.0	26.4	6.3	2.3	1.1	100.0	92
Used for Both Reasons	60.7	30.6	7.3	0.6	0.8	100.0	543
Never Used	34.7	34.9	10.2	4.2	16.0	100.0	1,264

TABLE 9.2.3A
Beliefs About Condoms and Condom Use Among Women 15-24 Years of Age
By Condom Experience
Young Adult Reproductive Health Survey: ROMANIA, 1996

Statements About Condoms:	Ever Users (N=238)			Never Users (N=1,787)		
	Agree	Disagree	Don't Know	Agree	Disagree	Don't Know
Condoms Reduce Sexual Pleasure	46.3	51.6	2.1	14.8	13.3	71.9
Condoms Are Messy to Use	42.8	55.5	1.7	15.4	13.0	71.6
Condoms Require One's Partner to Have Self Control	47.0	45.0	8.0	21.1	9.7	69.1
One Can Use a Condom More than Once	0.6	99.4	0.0	1.6	78.4	20.0
People Who Use Condoms Sleep Around a Lot	11.1	72.7	16.2	15.9	41.7	42.4
It Is Embarrassing to Buy Condoms in Pharmacy or Store	21.9	75.8	2.3	26.2	56.8	17.0
It Is Embarrassing to Ask for Condoms in FP Clinics	12.7	84.3	3.0	20.1	61.4	18.5
Most Women Don't Like to Use Condoms	61.4	19.6	19.0	34.1	9.5	56.4
Most Men Don't Like to Use Condoms	61.2	18.6	20.2	35.2	8.5	56.4
Using Condoms with a New Partner Is a Good Idea	95.6	1.2	3.2	66.3	5.9	27.8
If You Know Your Partner It's Not Necessary to Use Condoms	43.0	54.7	2.3	29.1	41.5	29.4
Women Should Ask Their Partners to Use Condoms	81.1	13.3	5.7	51.4	15.9	32.7
It is Easy to Discuss Condom Use with a Prospective Partner	65.3	24.4	10.3	29.6	30.0	40.4

In addition to the perceived effectiveness of condoms, other attitudes and beliefs associated with condom use among young adults were explored (see [Table 9.2.3A](#) and [9.2.3B](#)). These associations were explored by asking young adults, regardless of their sexual experience or condom experience, whether they agree or disagree with selected statements about condoms. These results should be interpreted bearing in mind that substantial proportions of young adults who have never used condoms had no opinion about certain statements, whereas almost all young adults with condom experience could give an answer.

Ever users, regardless of their gender, appear to be significantly more likely than never users to agree that "condom (use) reduces sexual pleasure" (46% vs. 15% among young women and 60% vs. 35% among young men). They also are more likely than never users to believe that "condoms are messy to use" (43% vs. 15% and 50% vs. 30%, respectively).

TABLE 9.2.3B
Beliefs About Condoms and Condom Use Among Men 15-24 Years of Age
By Condom Experience
Young Adult Reproductive Health Survey: ROMANIA, 1996

Statements About Condoms:	Ever Users (N=783)			Never Users (N=1,264)		
	Agree	Disagree	Don't Know	Agree	Disagree	Don't Know
Condoms Reduce Sexual Pleasure	60.0	38.8	1.2	34.6	13.5	51.9
Condoms Are Messy to Use	50.4	48.5	1.1	30.4	15.5	54.2
Condoms Require One's Partner to Have Self Control	38.3	59.5	2.2	31.8	21.5	46.7
One Can Use a Condom More than Once	1.8	97.9	0.3	4.2	84.8	11.0
People Who Use Condoms Sleep Around a Lot	14.1	79.9	6.0	21.1	50.9	28.0
It Is Embarrassing to Buy Condoms in a Pharmacy or Store	10.5	89.5	0.0	24.0	64.7	11.3
It Is Embarrassing to Ask for Condoms in FP Clinics	11.3	87.9	0.9	24.9	62.7	12.4
Most Women Don't Like to Use Condoms	60.3	18.4	21.3	36.3	10.9	52.9
Most Men Don't Like to Use Condoms	79.4	9.9	10.7	51.0	9.8	39.2
Using Condoms with a New Partner Is a Good Idea	97.3	2.1	0.6	77.1	7.3	15.5
If You Know Your Partner It's Not Necessary to Use Condoms	56.1	38.6	5.3	54.2	26.1	19.7
Women Should Ask Their Partners to Use Condoms	75.5	19.4	5.1	57.3	18.9	23.8
It is Easy to Discuss Condom Use with a Prospective Partner	73.8	20.3	5.9	41.1	32.8	26.1

Similarly, perceptions that using condoms "requires one's partner to have self control", were more than two times higher among ever user women than never users (47% vs. 21%). Young males, however, did not differ significantly from never users in their agreement with this statement.

Questions asked to explore beliefs concerning embarrassment in purchasing or obtaining condoms from clinics, showed females and males who have ever used condoms were significantly more likely than never users to disagree that "it is embarrassing to buy condoms in a pharmacy or store" (76% vs. 57% and 90% vs. 65%, respectively) or "to ask for condoms in a family planning clinic" (84% vs. 61% and 88% vs. 63%, respectively).

It is worth noting that virtually all young females or males with condom experience (99% and 98%) and the majority of those who have never used condoms (78% and 85%, respectively), did not agree that condoms could be reused. Women and men who have ever used condoms were more likely than never users to disagree that "people who use condoms sleep around a lot", (73% and 80% vs. 42% and 51%).

Questions which explored perceptions about the social acceptance of condoms among women and men showed that more than half of ever users agreed that "most women don't like to use condoms" (61% and 60%, respectively), or that "most men don't like to use condoms" (61% and 79%, respectively). Most never users, regardless their gender, did not know if women like or not to use condoms (56% of women and 53% of men) whereas half of never user males believed that men dislike the use of condoms.

Virtually all users and nonusers, who vouched an opinion, agreed that "using condom with a new partner is a good idea". Apparently, men were more willing than women to agree that "if you know your partner is not necessary to use condoms", regardless of their condom experience.

TABLE 9.2.4
Interpersonal Impact of Condom Use
By Condom Experience and Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

How Would the Respondents Feel If a Partner Wanted to Use a Condom When Having Sex:	Females			Males		
	<u>Total</u>	<u>Ever Users</u>	<u>Never Users</u>	<u>Total</u>	<u>Ever Users</u>	<u>Never Users</u>
Embarrassed	13.0	11.9	13.2	**	**	**
Angry	9.2	3.8	10.2	9.3	9.2	9.4
Safe From Getting (Somebody) Pregnant	43.6	97.1	34.0	59.9	92.7	35.1
Safe From Getting HIV	43.3	96.4	33.8	59.5	91.3	35.5
Safe From Getting STDs	42.6	97.1	32.8	60.6	93.9	35.5
Like You Had Done Something Wrong	6.7	3.9	7.2	3.5	3.8	3.3
Unweighted No. of Cases	2,025	238	1,787	2,047	783	1,264

** This question was not answered by male respondents

Agreement that women "should ask their partners to use condoms" and that "it is easy to discuss condom use with prospective partners" was much higher for ever users of condoms. Young adults who have ever used condoms were more likely to agree with these statements than nonusers. As may be expected, women, regardless of their condom experience, were more likely than men to agree that women should ask their partners to use condoms and less likely to believe that it is easy to talk about condoms with prospective partners.

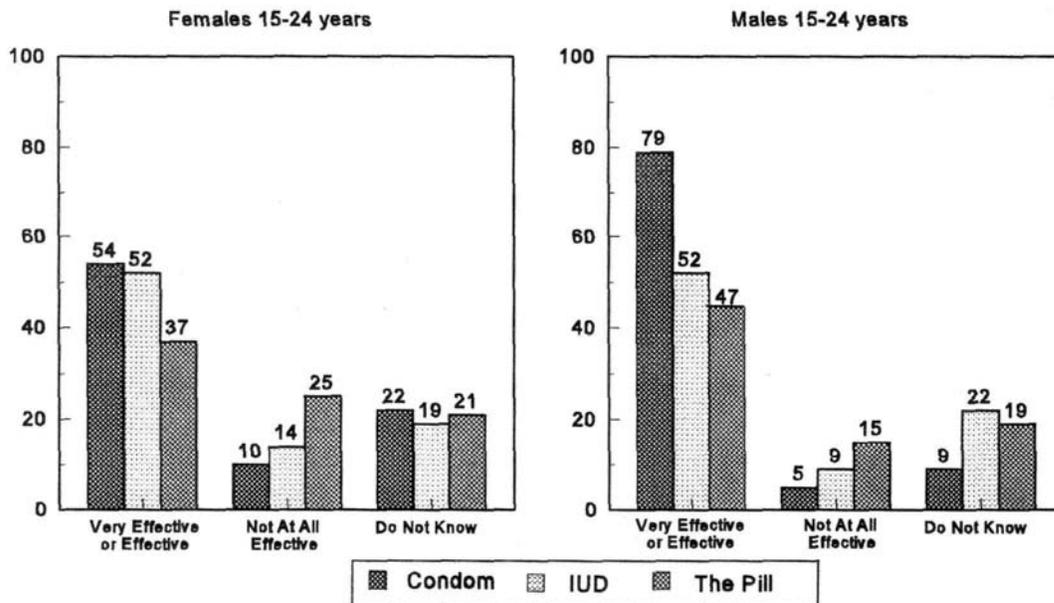
Many young adults, and most of those who have ever used condoms, expressed positive feelings (i.e., feeling of being protected from pregnancy and STDs, including AIDS) if their partners would want to use condoms (see [Table 9.2.4](#)). Very few women and men would have negative feelings about partners' desire to use condoms, such as embarrassment (13%), anger (9%) or guilt (7% and 4%, respectively).

9.3 Opinions About Effectiveness and Safety of Oral Contraceptives and IUDs

Young men and women's perceptions and opinions about the effectiveness and safety of the most commonly used modern contraceptive methods may often result from and reflect in their contraceptive behavior. For example, the 1993 RRHS revealed a very low prevalence of pill and IUD use (3% and 4%, respectively) combined with a general distrust or lack of knowledge about the safety and effectiveness of these methods that explained in part the heavy reliance on withdrawal and rhythm, traditional methods practiced historically in Romania. Despite high levels of awareness about the pill and the IUD (80%), the majority of sexually active women who were using a traditional method or no method at all did not believe that these modern methods are either safe or effective for preventing unintended pregnancy. Almost two-thirds of traditional-method users believed that their method was as effective as or more effective than the pill or the IUD (Serbanescu et al., 1995). Young women aged 15-24 were the least likely to rate the pill and the IUD safe or effective and the most likely to not know how to rate them. The survey findings suggested that women's lack of knowledge and misperceptions about modern contraceptives, with their subsequent low usage, may help explain why the country's rate of unintended pregnancy and induced abortion are among the highest in the world.

The young men and women interviewed in the 1996 YARHS continue to lack confidence in the contraceptive effectiveness of the pill and IUD. Furthermore, their view of higher effectiveness of condoms compared to the pill and the IUD contradict the actual failure rates of these methods. As shown in [Figure 9.3.1](#), condoms are perceived as "very effective" or "effective" by the highest proportion of young men and women in Romania. With 54% of women and 79% of men indicating that condoms are effective in preventing pregnancy, this method is perceived to be slightly more effective than the IUD (considered effective by 52% of men and women) and substantially more effective than the pill (identified as effective by only 37% of women and 47% of men).

FIGURE 9.3.1
OPINIONS ABOUT CONTRACEPTIVE EFFECTIVENESS
BY SPECIFIC METHODS AND GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



A possible explanation for this confusion may be found in greater levels of media coverage about contraceptive benefits of condoms without comparable coverage about other modern methods. Additionally, since educational campaigns about condoms have emphasized equally its contraceptive benefits and its role in preventing STDs, some respondents may have overestimated condom's protection against pregnancy influenced by condom's effectiveness against STD transmission.

As shown in [Figure 9.3.1](#), alarming proportions of respondents believe that pills and IUDs are not at all effective in preventing pregnancy, even though these methods are among the most reliable contraceptives, with one year failure rates of 3% and 1%, respectively (Robert A. Hatcher et al. 1994). Despite a much higher failure rate (18% during the first year of use), fewer youth believe that condoms are not effective at all (e.g. the proportions who distrust the pill as being protective against pregnancy was 2.5 to 3 times higher). As with the case of condoms' reliability, women were more likely than men to distrust pills (25% vs. 15%) and IUDs (14% vs. 9%). In addition, one in five young women or men, despite their awareness of pills and IUDs,

were not sure or did not know whether these methods could prevent pregnancy when used correctly. Their distrust in pills and IUDs may result from and affect their contraceptive behaviors. About half of young women and men who were currently using a traditional method stated that their method confers a higher or equal protection against pregnancy as the use of the pill or the IUD (not shown).

Lack of knowledge about pills' reliability vary with respondents' background characteristics ([Table 9.3.1A](#) and [9.3.1B](#)). Generally, among both women and men, adolescents, those with low level of education or low SES, and those who have never had sexual intercourse, were the least likely to rate the pill as very effective or effective. Youth who have ever used the pill, although very few, were much more likely to be aware of pill's effectiveness (78% of women and 70% of men) than their non-user counterparts.

Although the respondents' perceptions about the IUD's effectiveness for preventing pregnancy were slightly more accurate than those about the pill, almost one in three youth believed the method is not at all reliable or did not know if it is reliable or not ([Table 9.3.2A](#) and [9.3.2B](#)). The proportions lacking confidence or knowledge in the IUD's effectiveness were higher among rural residents (37%), young adolescents (40% of women and 41% of men), and among those with primary education (43% of women and 36% of men) or with low SES (38%). The very few young adults or their partners who have ever used the IUD were the most likely to rate it as a reliable method (77% of women and 62% of men).

As shown in [Tables 9.3.3A](#) and [9.3.3B](#), fewer young than one third of women and men believed that pills are safe for a woman's health (31%). Pills were considered unsafe by almost one in two young adults whereas one in four women and one in five men did not know if they are safe or not. The proportions of young adults who qualified the pill as safe were even lower among rural residents (25% of women and 27% of men), among the very young women (24%), among those with primary education (28% of women and 23% of men) or with low SES (27% of women and 24% of men), and among those without sexual experience (27% of women and 28% of men). Again, young adults who have ever used the pill were the only group who showed significantly greater assurance in the pill's safety. However, even among those women and men, a sizable proportion considered the pill as unsafe (35% and 40%, respectively).

Similarly, the majority of young adults did not know or do not believe that the IUD is safe for a woman's health ([Tables 9.3.4A](#) and [9.3.4B](#)). Only 41% of women and 36% of men considered the IUD as a very safe, safe or somewhat safe method, with the rest of them either believing it is an unsafe method (30% of women and 37% of men), or not knowing if it is safe or not (30% of women and 26% of men). However, compared to the pill, fewer youth thought that the IUD is completely unsafe. Rural residence, younger age, lower education or SES, lack of sexual experience (women only), and lack of IUD experience, were associated with lack of knowledge or misinformation about the method's safety.

TABLE 9.3.1A
Percent of Young Women Who Believe That It is Very Sure, Sure, Somewhat Sure, or Not at All Sure
That a Woman Would Not Become Pregnant if Using Oral Contraceptives Correctly
By Selected Characteristics --Women 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Sure Can a Woman Be That She Will Not Become Pregnant if She Takes the Pill Correctly?"					<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>Very Sure</u>	<u>Sure</u>	<u>Somewhat Sure</u>	<u>Not at all Sure</u>	<u>Don't Know</u>		
Total	11.4	26.0	16.2	25.4	21.1	100.0	1,608
Residence							
Urban	10.0	28.1	18.4	25.4	18.1	100.0	901
Rural	13.6	22.4	12.4	25.5	26.0	100.0	707
Age Group							
15-17	7.5	24.1	15.6	28.4	24.4	100.0	520
18-19	12.1	23.0	19.9	26.8	18.2	100.0	400
20-24	13.0	28.1	14.9	23.4	20.5	100.0	688
Marital Status							
Ever Married/In Union	13.6	23.5	13.4	27.2	22.4	100.0	440
Never Married/In Union	10.1	27.3	17.7	24.5	20.3	100.0	1168
Education							
Primary	11.7	15.2	13.2	23.8	36.1	100.0	218
Some High School (HS)	9.2	24.0	15.3	27.0	24.5	100.0	763
HS Complete or More	13.6	31.3	18.0	24.3	12.9	100.0	627
Socioeconomic Index							
Low	12.1	21.2	12.7	27.0	26.9	100.0	574
Middle	11.0	28.1	16.4	25.5	18.9	100.0	806
High	10.9	29.1	23.3	21.5	15.2	100.0	228
Sexual Experience							
Never Had Intercourse	8.4	25.6	16.6	27.0	22.4	100.0	955
Ever Had Intercourse	14.5	26.3	15.7	23.8	19.6	100.0	653
Pill Experience							
Never Used Pills	8.7	24.6	16.5	27.5	22.7	100.0	1,489
Ever Used Pills	38.3	39.4	13.1	5.1	4.0	100.0	119

* / Excludes 417 women who said they never heard of the pill

TABLE 9.3.1B
Percent of Young Men Who Believe That It is Very Sure, Sure, Somewhat Sure, or Not at All Sure
That a Woman Would Not Become Pregnant if Using Oral Contraceptives Correctly
By Selected Characteristics --Men 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Sure Can a Woman Be That She Will Not Become Pregnant if She Takes the Pill Correctly?"					Total	Unweighted No. of Cases
	Very Sure	Sure	Somewhat Sure	Not at all Sure	Don't Know		
Total	13.6	32.9	20.2	14.5	18.9	100.0	1,301
Residence							
Urban	15.6	34.5	21.1	12.6	16.3	100.0	809
Rural	10.0	30.1	18.8	17.8	23.3	100.0	492
Age Group							
15-17	10.1	34.1	18.0	14.5	23.3	100.0	409
18-19	13.6	32.3	24.1	15.3	14.8	100.0	335
20-24	15.1	32.6	19.8	14.2	18.4	100.0	557
Marital Status							
Ever Married/In Union	14.9	25.4	20.5	15.5	23.6	100.0	102
Never Married/In Union	13.3	34.4	20.2	14.3	17.9	100.0	1,199
Education							
Primary	6.5	25.3	18.0	17.7	32.5	100.0	131
Some High School (HS)	10.4	32.4	19.6	16.3	21.3	100.0	695
HS Complete or More	19.5	35.3	21.6	11.3	12.3	100.0	475
Socioeconomic Index							
Low	10.0	27.1	16.3	17.2	29.3	100.0	317
Middle	14.7	33.0	22.3	14.2	15.7	100.0	703
High	15.2	39.7	19.7	11.8	13.7	100.0	281
Sexual Experience							
Never Had Intercourse	8.8	33.2	18.2	15.5	24.4	100.0	385
Ever Had Intercourse	15.1	32.8	20.8	14.2	17.1	100.0	916
Pill Experience (Partner)							
Never Used Pills	10.0	32.4	20.6	15.8	21.3	100.0	1,130
Ever Used Pills	34.6	35.6	18.1	7.1	4.7	100.0	171

*/ Excludes 746 men who said they never heard of the pill

TABLE 9.3.2A
Percent of Young Women Who Believe That It is Very Sure, Sure, Somewhat Sure, or Not at All Sure
That a Woman Would Not Become Pregnant if Using the IUD Correctly
By Selected Characteristics --Women 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Sure Can a Woman Be That She Will Not Become Pregnant if She Uses the IUD Correctly?"					Total	Unweighted No. of Cases
	Very Sure	Sure	Somewhat Sure	Not at all Sure	Don't Know		
Total	21.5	30.5	15.4	13.9	18.7	100.0	1,309
Residence							
Urban	22.1	30.3	17.3	12.8	17.5	100.0	723
Rural	20.5	30.6	12.3	15.7	20.8	100.0	586
Age Group							
15-17	17.1	26.7	16.0	15.5	24.7	100.0	320
18-19	18.5	30.2	19.2	12.7	19.4	100.0	338
20-24	24.0	31.8	13.9	13.8	16.5	100.0	651
Marital Status							
Ever Married/In Union	23.1	31.9	12.2	16.3	16.5	100.0	439
Never Married/In Union	20.4	29.4	17.7	12.2	20.3	100.0	870
Education							
Primary	24.1	25.6	7.8	15.2	27.4	100.0	178
Some High School (HS)	20.0	29.7	13.3	16.1	20.9	100.0	566
HS Complete or More	22.1	32.5	19.4	11.7	14.4	100.0	565
Socioeconomic Index							
Low	22.5	28.7	11.2	17.0	20.7	100.0	482
Middle	21.5	31.6	16.2	12.4	18.4	100.0	634
High	19.4	30.9	22.4	12.2	15.2	100.0	193
Sexual Experience							
Never Had Intercourse	18.3	28.9	17.6	13.9	21.4	100.0	676
Ever Had Intercourse	24.0	31.7	13.7	14.0	16.6	100.0	633
IUD Experience							
Never Used IUD	20.4	30.6	15.7	13.9	19.3	100.0	1,279
Ever Used IUD	51.5	25.5	6.4	14.4	2.2	100.0	30

*/ Excludes 716 women who said they never heard of the IUD

TABLE 9.3.2B
Percent of Young Men Who Believe That It is Very Sure, Sure, or Somewhat Sure
That a Woman Would Not Become Pregnant if Using the IUD Correctly
By Selected Characteristics --Men 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>“How Sure Can a Woman Be That She Will Not Become Pregnant if She Uses the IUD Correctly ?”</u>					<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>Very Sure</u>	<u>Sure</u>	<u>Somewhat Sure</u>	<u>Not at all Sure</u>	<u>Don't Know</u>		
Total	21.0	31.4	17.0	9.1	21.5	100.0	724
Residence							
Urban	23.1	31.2	17.9	7.5	20.3	100.0	475
Rural	16.6	31.6	15.2	12.6	24.0	100.0	249
Age Group							
15-17	13.1	32.0	13.9	6.3	34.7	100.0	172
18-19	19.9	36.1	14.4	13.1	16.5	100.0	190
20-24	23.6	29.7	18.7	8.7	19.4	100.0	362
Marital Status							
Ever Married/In Union	24.4	29.5	20.6	8.3	17.2	100.0	80
Never Married/In Union	20.0	31.9	16.0	9.4	22.8	100.0	644
Education							
Primary	5.2	29.1	29.6	12.5	23.6	100.0	50
Some High School (HS)	21.6	30.0	14.3	7.3	26.8	100.0	330
HS Complete or More	22.5	32.9	17.9	10.4	16.4	100.0	344
Socioeconomic Index							
Low	19.3	27.9	14.8	11.1	27.0	100.0	150
Middle	18.8	32.4	17.5	8.2	23.1	100.0	397
High	27.5	32.0	18.0	9.7	12.8	100.0	177
Sexual Experience							
Never Had Intercourse	12.4	28.0	15.6	10.6	33.4	100.0	158
Ever Had Intercourse	22.7	32.0	17.3	8.8	19.1	100.0	566
IUD Experience (Partner)							
Never Used IUD	20.4	31.6	16.8	9.1	22.0	100.0	699
Ever Used IUD	36.9	24.7	22.3	9.1	6.9	100.0	25

*/ 1,323 men who said they never heard of the IUD were not included

TABLE 9.3.3A
Beliefs About the Safety of Oral Contraceptives in Regard to Women's Health
By Selected Characteristics --Women 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Safe are Oral Contraceptives For a Woman's Health?"					Total	Unweighted No. of Cases
	Very Safe	Safe	Somewhat Safe	Not at all Safe	Don't Know/ Not Sure		
Total	2.1	14.9	13.6	45.8	23.6	100.0	1,608
Residence							
Urban	2.1	16.2	15.5	46.3	19.9	100.0	901
Rural	2.0	12.8	10.6	44.9	29.8	100.0	707
Age Group							
15-17	1.0	11.3	12.2	46.6	28.9	100.0	520
18-19	1.9	14.6	14.4	49.0	20.1	100.0	400
20-24	2.6	16.9	14.1	44.1	22.3	100.0	688
Marital Status							
Ever Married/In Union	2.4	18.0	11.7	45.6	22.3	100.0	440
Never Married/In Union	1.8	13.2	14.7	45.9	24.4	100.0	1,168
Education							
Primary	1.8	16.3	10.2	34.5	37.2	100.0	218
Some High School (HS)	1.7	13.1	10.7	47.4	27.0	100.0	763
HS Complete or More	2.5	16.4	17.8	47.4	15.9	100.0	627
Socioeconomic Index							
Low	2.2	13.7	11.0	43.2	29.9	100.0	574
Middle	2.1	14.1	14.6	48.1	21.1	100.0	806
High	1.6	20.5	16.3	43.6	18.0	100.0	228
Sexual Experience							
Never Had Intercourse	1.5	12.8	12.6	46.4	26.7	100.0	955
Ever Had Intercourse	2.7	17.2	14.7	45.2	20.2	100.0	653
Pills Experience							
Never Used Pills	1.4	13.1	13.0	46.8	25.7	100.0	1,489
Ever Used Pills	8.8	33.8	20.1	35.2	2.2	100.0	119

*/ Excludes 417 women who said they never heard of the pill

TABLE 9.3.3B
Beliefs About the Safety of Oral Contraceptives in Regard to Women's Health
By Selected Characteristics --Men 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Safe are Oral Contraceptives for a Woman's Health?"					Total	Unweighted No. of Cases
	Very Safe	Safe	Somewhat Safe	Not at all Safe	Don't Know/ Not Sure		
Total	1.1	13.4	16.5	48.7	20.4	100.0	1,301
Residence							
Urban	1.4	13.6	18.4	48.0	18.7	100.0	809
Rural	0.7	13.1	13.2	49.8	23.2	100.0	492
Age Group							
15-17	1.7	12.8	15.1	42.2	28.3	100.0	409
18-19	2.7	16.7	15.7	48.5	16.4	100.0	335
20-24	0.3	12.5	17.3	51.6	18.3	100.0	557
Marital Status							
Ever Married/In Union	0.0	9.8	9.2	60.7	20.4	100.0	102
Never Married/In Union	1.3	14.1	17.9	46.3	20.4	100.0	1,199
Education							
Primary	2.5	9.0	11.6	47.3	29.6	100.0	131
Some High School (HS)	0.8	11.7	15.5	50.3	21.8	100.0	695
HS Complete or More	1.2	16.8	19.0	46.9	16.2	100.0	475
Socioeconomic Index							
Low	1.1	14.3	9.2	52.7	22.8	100.0	317
Middle	1.3	12.6	17.8	48.7	19.6	100.0	703
High	0.6	14.3	22.2	43.7	19.2	100.0	281
Sexual Experience							
Never Had Intercourse	1.5	12.9	13.8	45.0	26.8	100.0	385
Ever Had Intercourse	1.0	13.6	17.3	49.8	18.3	100.0	916
Pill Experience (Partner)							
Never Used Pills	0.9	12.2	14.8	50.1	22.0	100.0	1,130
Ever Used Pills	2.2	20.7	26.3	40.1	10.8	100.0	171

*/ Excludes 746 men who said they never heard of the pill

TABLE 9.3.4A
Beliefs About the IUDs' Safety in Regard to Women's Health
By Selected Characteristics --Women 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	"How Safe are the IUDs for a Woman's Health?"					Total	Unweighted No. of Cases
	Very Safe	Safe	Somewhat Safe	Not at all Safe	Don't Know/ Not Sure		
Total	3.8	21.5	15.4	29.7	29.6	100.0	1,309
Residence							
Urban	3.7	22.5	17.3	28.3	28.2	100.0	723
Rural	4.0	19.9	12.3	31.9	31.9	100.0	586
Age Group							
15-17	2.5	17.8	10.8	29.6	39.4	100.0	320
18-19	3.4	14.8	17.6	34.7	29.6	100.0	338
20-24	4.4	25.1	16.2	27.9	26.4	100.0	651
Marital Status							
Ever Married/In Union	4.2	26.1	14.2	29.2	26.3	100.0	439
Never Married/In Union	3.6	18.2	16.3	30.0	32.0	100.0	870
Education							
Primary	3.1	20.2	12.8	27.0	36.9	100.0	178
Some High School (HS)	4.2	21.4	12.2	29.5	32.7	100.0	566
HS Complete or More	3.7	22.0	19.0	30.5	24.9	100.0	565
Socioeconomic Index							
Low	3.8	22.4	13.8	30.5	29.6	100.0	482
Middle	3.2	20.9	16.4	29.5	30.0	100.0	634
High	6.1	21.5	15.7	28.2	28.5	100.0	193
Sexual Experience							
Never Had Intercourse	3.6	17.7	14.9	30.8	33.0	100.0	676
Ever Had Intercourse	4.0	24.5	15.9	28.7	26.9	100.0	633
IUD Experience							
Never Used IUD	20.4	30.6	15.7	13.9	19.3	100.0	1,279
Ever Used IUD	51.5	25.5	6.4	14.4	2.2	100.0	30

*/ Excludes 716 women who said they never heard of the IUD

TABLE 9.3.4B
Beliefs About the IUDs' Safety in Regard to Women's Health
By Selected Characteristics --Men 15-24 Years of Age*
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>"How Safe are the IUDs for a Woman's Health?"</u>					<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>Very Safe</u>	<u>Safe</u>	<u>Somewhat Safe</u>	<u>Not at all Safe</u>	<u>Don't Know/ Not Sure</u>		
Total	2.6	18.6	15.0	37.4	26.4	100.0	724
Residence							
Urban	2.7	20.1	15.2	35.9	26.1	100.0	475
Rural	2.4	15.5	14.8	40.4	26.9	100.0	249
Age Group							
15-17	4.0	19.5	11.6	26.5	38.4	100.0	172
18-19	3.1	23.2	12.6	36.3	24.9	100.0	190
20-24	2.1	17.0	16.7	40.7	23.5	100.0	362
Marital Status							
Ever Married/In Union	2.8	21.6	13.8	43.8	18.1	100.0	80
Never Married/In Union	2.6	17.8	15.4	35.5	28.8	100.0	644
Education							
Primary	1.7	18.5	7.2	43.4	29.2	100.0	50
Some High School (HS)	4.0	19.3	13.9	35.1	27.7	100.0	330
HS Complete or More	1.5	18.0	17.0	38.7	24.8	100.0	344
Socioeconomic Index							
Low	1.3	18.2	15.1	37.5	27.9	100.0	150
Middle	3.0	17.3	12.7	37.8	29.2	100.0	397
High	2.9	22.0	20.2	36.4	18.5	100.0	177
Sexual Experience							
Never Had Intercourse	3.9	18.6	13.1	27.2	37.2	100.0	158
Ever Had Intercourse	2.4	18.6	15.4	39.4	24.2	100.0	566
IUD Experience (Partner)							
Never Used IUD	2.7	17.8	15.1	37.4	27.0	100.0	699
Ever Used IUD	0.0	41.9	12.3	38.2	7.6	100.0	25

*/ 1,323 men who said they never heard of the IUD were not included

Despite a significant amount of mistrust and skepticism about modern methods, which continue to pose a heavy burden on contraceptive decisions of young Romanian couples (e.g. to use less effective methods of contraception or no methods at all), young women appear to have had some important changes in their attitudes toward the pill and the IUD in a short period of time. Compared to the 1993 survey findings, young Romanian women seemed to have acquired more trust regarding both the reliability and the safety of oral contraceptives (Figure 9.3.2 and Tables 9.3.5 and 9.3.6). Between the two surveys, their confidence in the pill's contraceptive effectiveness grew by 33% (from 28% of women who rated the pill as very reliable or reliable in 1993 to 37% in 1996) and their trust about the method as being safe or somewhat safe increased by 30% (from 24% to 31%). Particularly encouraging are the changes in some women's perceptions about pills being very effective or effective in preventing pregnancy. For example, 50% more women in rural areas held that belief in 1996 compared to 1993 (36% vs. 24%). Similar increases in confidence about pills' reliability were notable among lower educated women, those with low SES, and women with sexual experience. Along with increased access to oral contraceptives and the availability of a wider variety of pills, these changes may have accounted for the substantial increase in the proportion of pill's users. The prevalence of use among women in union in 1996 (7.5%) was 2.3 times that of the 1993 prevalence (3.2%). Additionally, one in ten women not currently in union had used pills at most recent sexual intercourse (see Chapter 8).

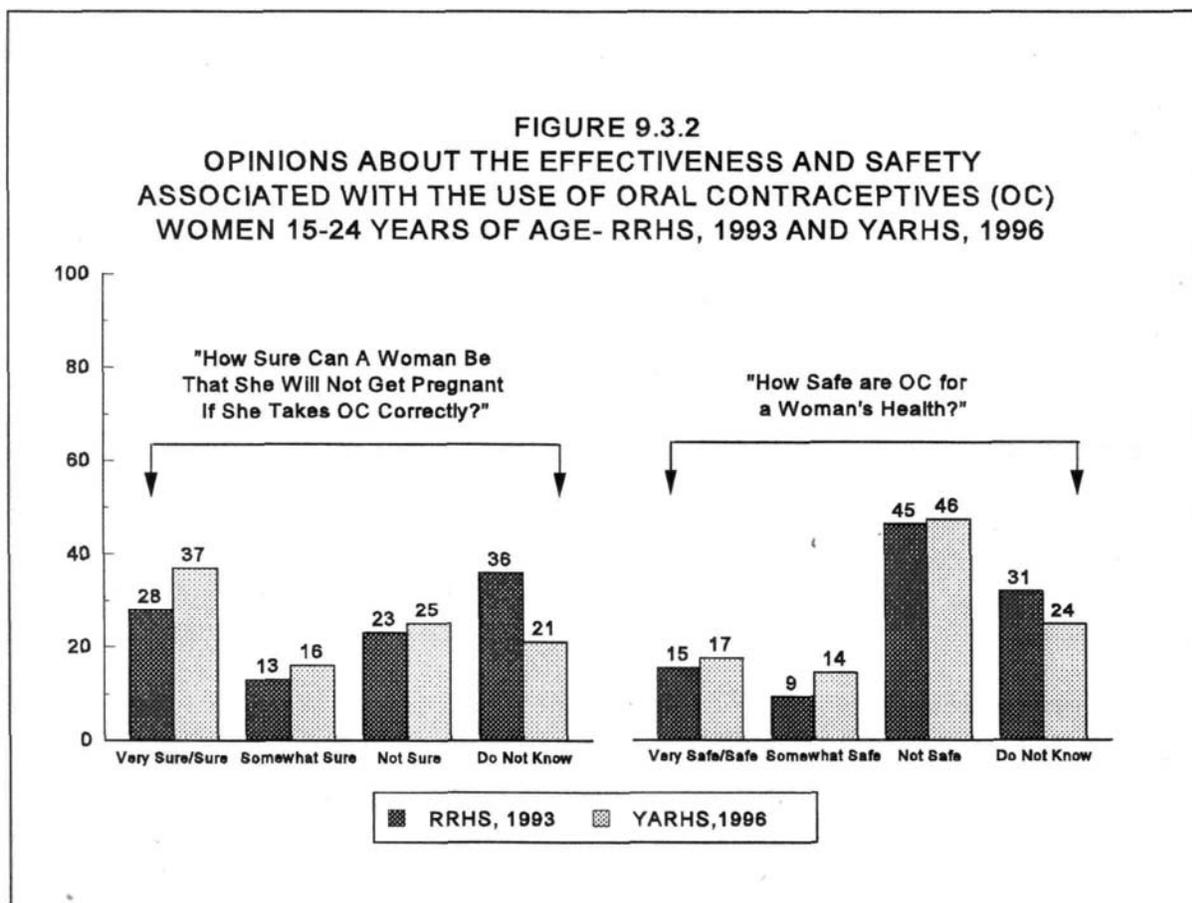


TABLE 9.3.5
Percent of Young Women Who Believe That It is Very Sure or Sure, or Somewhat Sure
That a Woman Would Not Become Pregnant if Using Oral Contraceptives Correctly
By Selected Characteristics --Women 15-24 Years of Age
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	"How Sure Can a Woman Be That She Will Not Become Pregnant If She Takes the Pill Correctly?"					
	1993 Romanian Reproductive Health Survey*			1996 Young Adult Reproductive Health Survey*		
	Very Sure or Sure	Somewhat Sure	Unweighted No. of Cases	Very Sure or Sure	Somewhat Sure	Unweighted No. of Cases
Total	28.2	12.7	1,232	37.4	16.2	1,608
Residence						
Urban	30.9	14.6	794	38.1	18.4	901
Rural	23.8	9.3	438	36.0	12.4	707
Age Group						
15-17	26.4	9.1	279	31.6	15.6	520
18-19	25.8	16.3	225	35.1	19.9	400
20-24	30.3	13.2	728	41.2	14.9	688
Education						
Primary	18.6	7.5	123	26.9	13.2	218
Some High School (HS)	22.8	9.0	469	33.2	15.3	763
HS Complete	30.5	16.2	484	43.4	17.0	436
Post HS	51.1	18.7	156	48.2	20.0	191
Socioeconomic Index						
Low	22.3	10.7	446	33.3	12.7	574
Middle	32.2	12.4	639	39.1	16.4	806
High	28.5	19.7	147	40.0	23.3	228
Sexual Experience						
Never Had Intercourse	28.9	13.9	606	34.0	16.6	955
Ever Had Intercourse	27.3	10.9	626	40.8	15.7	653
Pill Experience						
Never Used Pills	26.5	12.8	1,168	33.3	16.5	1,489
Ever Used Pills	68.9	7.5	64	77.7	13.1	119

*/ 409 women in 1993 and 417 women in 1996 who said they never heard of the Pill were not included

TABLE 9.3.6
Percent of Young Women Who Believe That Oral Contraceptives Are Very Safe or Safe,
or Somewhat Safe for a Woman's Health
By Selected Characteristics --Women 15-24 Years of Age
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	"How Safe are Oral Contraceptives for a Woman's Health?"					
	1993 Romanian Reproductive Health Survey*			1996 Young Adult Reproductive Health Survey*		
	Very Safe or Safe	Somewhat Safe	Unweighted No. of Cases	Very Safe or Safe	Somewhat Safe	Unweighted No. of Cases
Total	14.8	8.9	1,232	17.0	13.6	1,608
Residence						
Urban	16.3	9.6	794	18.3	15.5	901
Rural	12.2	8.0	438	14.8	10.6	707
Age Group						
15-17	11.9	6.0	279	12.3	12.2	520
18-19	12.4	12.0	225	16.5	14.4	400
20-24	17.3	9.5	728	19.6	14.1	688
Education						
Primary	8.9	3.3	123	18.1	10.2	218
Some High School (HS)	11.9	5.7	469	14.8	10.7	763
HS Complete	15.6	10.3	484	17.4	17.4	436
Post HS	29.1	22.7	156	22.3	18.7	191
Socioeconomic Index						
Low	13.1	7.0	446	15.9	11.0	574
Middle	16.4	9.5	639	16.2	14.6	806
High	12.1	13.3	147	22.1	16.3	228
Sexual Experience						
Never Had Intercourse	14.1	10.1	606	14.3	12.6	955
Ever Had Intercourse	15.7	7.4	626	19.9	14.7	653
Pill Experience						
Never Used Pills	14.0	8.9	1,168	14.5	13.0	1,489
Ever Used Pills	35.5	11.2	64	42.6	20.1	119

*/ 409 women in 1993 and 417 women in 1996 who said they never heard of the Pill were not included

However, widespread concerns about potential adverse health effects of oral contraceptives continue to be an important deterrent to their use. As shown in [Figure 9.3.2](#), in both surveys a majority of young women either perceived the pill as an unsafe method of contraception (45% in 1993 and 46% in 1996) or had no knowledge about its safety (31% in 1993 and 24% in 1996). Generally, improvements in perceived safety of oral contraceptives have occurred mostly among those women who lack knowledge about the method rather than among those with fears and concerns of side effects (not shown). For example, among women with primary education, the proportion who believed that pills are either safe or somewhat safe had more than doubled between the two studies (from 12% in 1993 to 28% in 1996).

Changes in misperceptions about the IUD's reliability and safety were less substantial ([Figure 9.3.3](#) and [Tables 9.3.7](#) and [9.3.8](#)). The proportion of young women who trusted the IUD's effectiveness (answers "very sure", "sure" or "somewhat sure") increased by 23% (from 55% in 1993 to 78% in 1996) whereas the proportion who believed the method is safe or somewhat safe increased by only 13% (from 36% to 49%). Some groups had changed their misperceptions more dramatically than others. The most notable example is constituted by women with primary education who were much more likely to believe that the IUD is effective in 1996 compared to their counterparts in 1993 (58% vs.33%). They were also the group whose trust in the IUD's safety more than double between the two surveys (from 17% in 1993 to 36% in 1996).

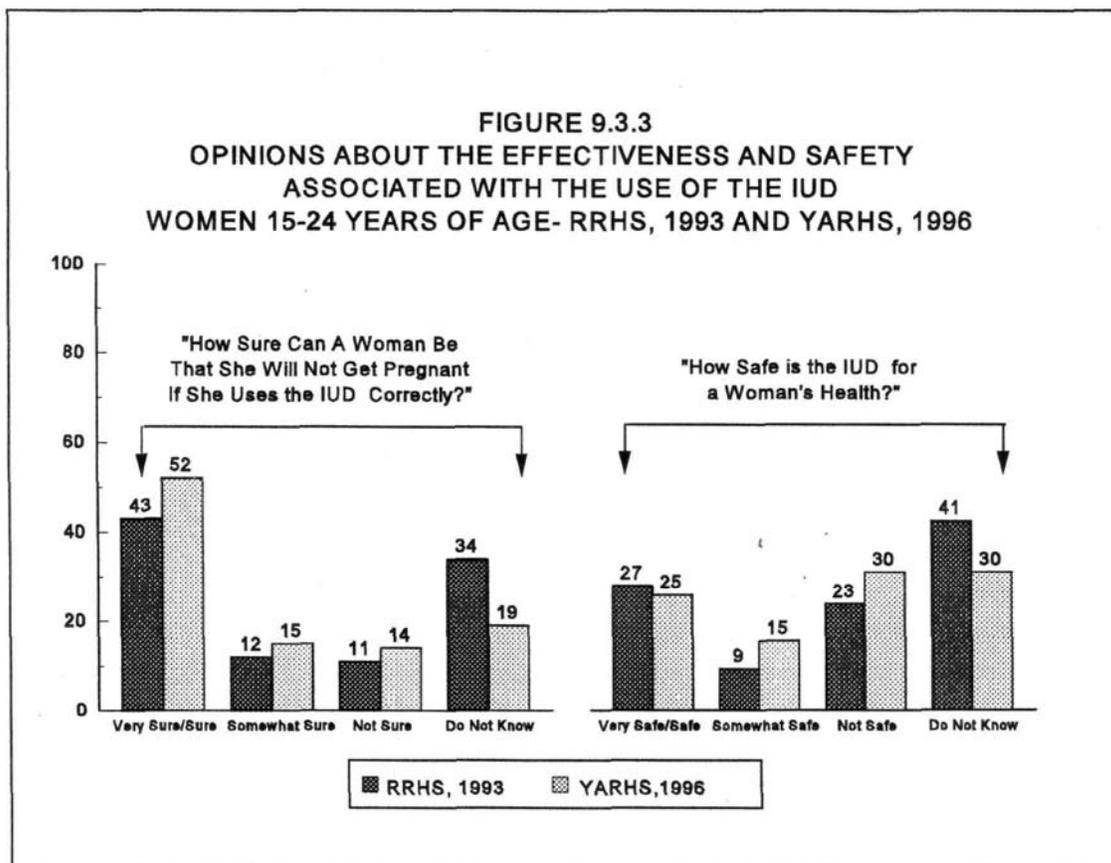


TABLE 9.3.7
Percent of Young Women Who Believe That It is Very Sure or Sure, or Somewhat Sure
That a Woman Would Not Become Pregnant if Using the IUD Correctly
By Selected Characteristics --Women 15-24 Years of Age
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	"How Sure Can a Woman Be That She Will Not Become Pregnant If She Uses the IUD Correctly?"					
	1993 Romanian Reproductive Health Survey*			1996 Young Adult Reproductive Health Survey*		
	Very Sure or Sure	Somewhat Sure	Unweighted No. of Cases	Very Sure or Sure	Somewhat Sure	Unweighted No. of Cases
Total	43.0	11.9	1,027	52.0	15.4	1,309
Residence						
Urban	46.2	12.3	663	52.4	17.3	723
Rural	37.3	11.2	364	51.2	12.3	586
Age Group						
15-17	34.0	13.8	142	43.7	16.0	320
18-19	52.6	9.1	175	48.7	19.2	338
20-24	42.6	12.3	710	55.8	13.9	651
Education						
Primary	26.2	7.5	109	49.7	7.8	178
Some High School (HS)	35.5	10.7	333	49.7	13.3	566
HS Complete	48.3	12.5	437	56.1	19.2	382
Post HS	60.1	17.5	148	51.4	19.6	183
Socioeconomic Index						
Low	37.6	11.8	370	51.2	11.2	482
Middle	45.1	11.5	528	53.0	16.2	634
High	47.3	14.0	129	50.3	22.4	193
Sexual Experience						
Never Had Intercourse	44.2	13.8	399	47.2	17.6	676
Ever Had Intercourse	41.9	10.4	628	55.7	13.7	633
IUD Experience						
Never Used the IUD	42.3	11.9	999	51.1	15.7	1,279
Ever Used the IUD	75.7	11.8	28	77.0	6.4	30

*/ 614 women in 1993 and 716 women in 1996 who said they never heard of the IUD were not included

TABLE 9.3.8
Percent of Young Women Who Believe That the IUD is Very Safe or Safe,
or Somewhat Safe for a Woman's Health
By Selected Characteristics --Women 15-24 Years of Age
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	"How Safe is the IUD for a Woman's Health?"					
	1993 Romanian Reproductive Health Survey*			1996 Young Adult Reproductive Health Survey*		
	Very Safe or Safe	Somewhat Safe	Unweighted No. of Cases	Very Safe or Safe	Somewhat Safe	Unweighted No. of Cases
Total	27.2	8.8	1,027	25.3	15.4	1,309
Residence						
Urban	28.2	9.2	663	26.2	17.3	723
Rural	25.4	8.1	364	23.9	12.3	586
Age Group						
15-17	21.9	6.4	142	20.2	10.8	320
18-19	30.7	8.6	175	18.2	17.6	338
20-24	27.5	9.4	710	29.5	16.2	651
Education						
Primary	14.2	2.8	109	23.3	12.8	178
Some High School (HS)	20.8	8.5	333	25.6	12.2	566
HS Complete	31.4	9.4	437	25.0	17.6	382
Post HS	41.8	13.0	148	26.9	21.8	183
Socioeconomic Index						
Low	25.7	6.9	370	26.1	13.8	482
Middle	27.3	9.8	528	24.1	16.4	634
High	30.0	9.3	129	27.7	15.7	193
Sexual Experience						
Never Had Intercourse	31.8	7.7	399	21.3	14.9	676
Ever Had Intercourse	23.3	9.7	628	28.5	15.9	633
IUD Experience						
Never Used the IUD	26.3	8.9	999	24.5	15.3	1,279
Ever Used the IUD	69.4	3.9	28	48.8	19.3	30

*/ 614 women in 1993 and 716 women in 1996 who said they never heard of the IUD were not included

9.4 Opinions About Oral Contraceptives' Risks and Benefits

The current low-dose pills are an effective and safe method of birth control that could be used by most women of reproductive age. Lack of knowledge or misinformation about the pill's reliability and safety constitutes a major deterrent of using the method by young Romanian women. Other major reasons for nonuse are the method-related fear of side effects and the lack of awareness about its health benefits, which include lower risks of ovarian and endometrial cancers, benign breast disease, pelvic inflammatory disease, ectopic pregnancy, iron-deficiency anemia, dysmenorrhea (painful menses), and lower incidence of premenstrual syndrome, heavy menstrual blood loss, and irregular bleeding.

Widely inconsistent with the scientific evidence, taking the pill continues to be considered unsafe for a woman's health by almost one in two young women ([Table 9.3.2A](#) and [Figure 9.3.2](#)). Both reproductive health surveys in Romania included additional questions to explore the extent of the women's misconceptions regarding specific method-related health risks and the status of their awareness of non-contraceptive benefits associated with its use. In both surveys, however, it is clear that women's mistrust in oral contraceptives had been shaped by a general lack of knowledge about the method rather than an awareness of health side-effects and benefits. As shown in [Table 9.4.1](#), most women did not know how to answer the majority of questions about the pill's health risks and few were aware of the pill's advantages.

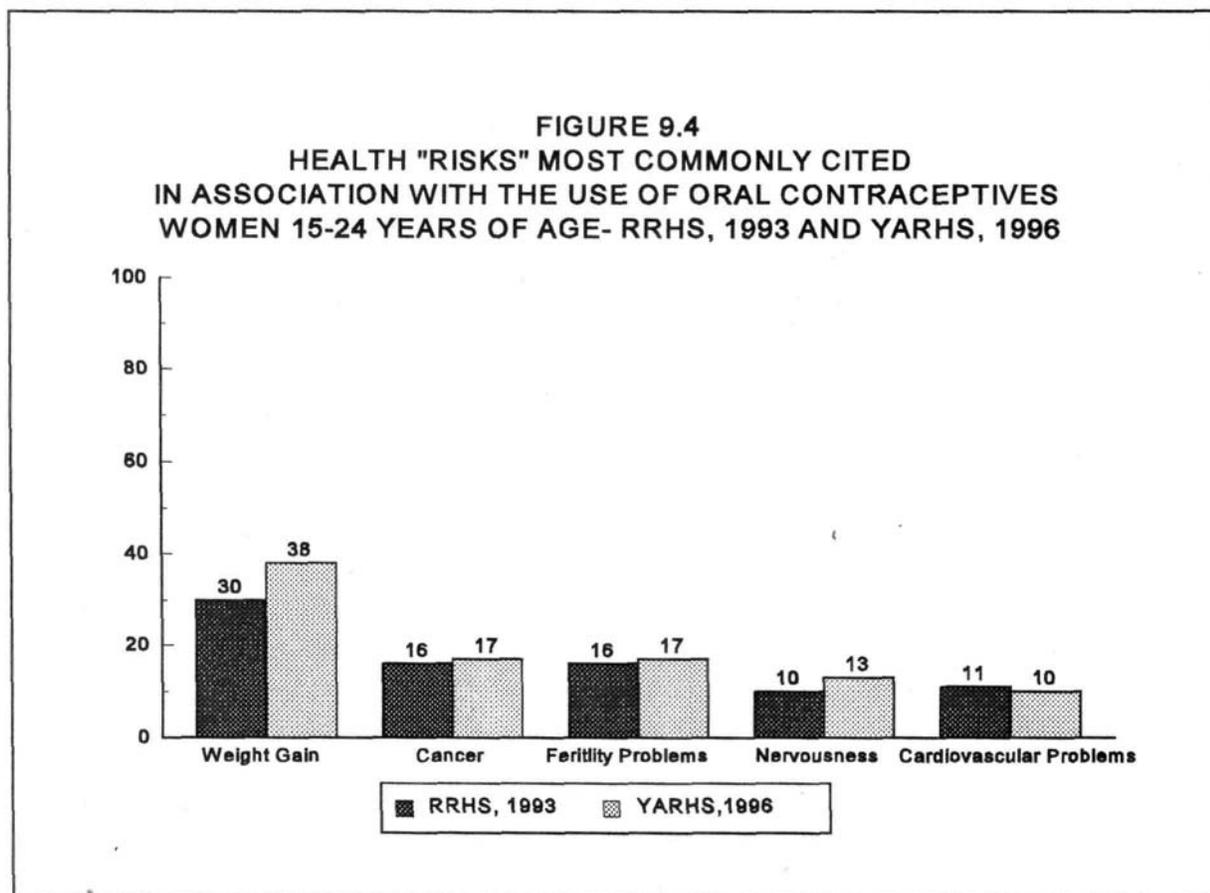


TABLE 9.4.1
Percent Distribution of Young Women By Their Agreement with Selected Statements
Concerning Health Risks and Benefits Associated With The Use of Oral Contraceptives
Women 15-24 Years of Age*
RRHS and YARHS: ROMANIA, 1993 and 1996

Statements About Oral Contraceptives	Agreement with Statement							
	Agree		Disagree		Do Not Know		Total	
	1993	1996	1993	1996	1993	1996	1993	1996
Easy to Use Method	59.7	64.2	3.0	5.2	37.3	30.6	100.0	100.0
Remove the Fear of Getting Pregnant	41.3	54.7	16.4	16.5	42.3	28.8	100.0	100.0
Make Menstrual Periods More Regular	17.1	27.8	10.7	9.4	72.2	62.8	100.0	100.0
Are Bothersome to Use Because You Have to Take Them Daily	25.9	29.3	40.9	44.6	33.2	26.1	100.0	100.0
Increase the Risk of Getting Cancer	15.9	16.7	11.3	16.3	72.7	67.0	100.0	100.0
Increase Nervousness	10.0	12.6	11.7	16.4	78.4	71.0	100.0	100.0
Increase the Risk of Infertility After Long Periods of Use	15.6	17.0	12.9	23.5	71.5	59.5	100.0	100.0
Cause Weight Gain	30.0	38.4	16.0	18.0	54.0	43.6	100.0	100.0
Increase the Risk of Cardiovascular Problems	10.5	10.0	8.8	12.8	80.7	77.2	100.0	100.0

*/409 women in 1993 and 417 women in 1996 who said they never heard of the Pill were not included.

TABLE 9.4.2
Percent of Young Women Who Agreed with Selected Statements About Side Effects
Sometimes Associated With The Use of Oral Contraceptives
By Selected Characteristics --Women 15-24 Years of Age*
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Increase the Risk of Getting Cancer		Increase Nervousness		After Long Periods of Use Can Cause Infertility		Cause Weight Gain		Increase the Risk of Cardiovascular Problems		Unweighted Number of Cases	
	1993	1996	1993	1996	1993	1996	1993	1996	1993	1996	1993	1996
Total	15.9	16.7	10.0	12.6	15.6	17.0	30.0	38.4	10.5	10.0	1,232	1,608
Residence												
Urban	15.9	17.4	9.6	13.4	16.8	17.2	32.1	40.7	10.4	10.8	794	901
Rural	12.2	15.6	8.0	11.4	13.5	16.7	26.6	34.5	10.7	8.7	438	707
Age Group												
15-17	12.0	15.4	9.7	11.7	12.4	13.5	19.4	26.1	11.6	10.7	279	520
18-19	19.5	16.9	13.7	9.4	19.4	17.0	32.4	41.5	11.6	9.7	225	400
20-24	16.7	17.3	8.7	14.4	15.9	18.8	35.0	43.4	9.5	9.7	728	688
Education												
Primary	8.9	11.7	3.3	12.1	14.5	13.7	19.8	29.6	5.4	9.2	123	218
Some HS	11.9	14.7	5.7	11.1	13.4	15.0	25.1	32.8	10.5	7.8	469	763
HS Complete	15.6	19.0	10.3	19.0	16.5	20.4	36.8	48.0	11.0	11.2	484	436
Post HS	29.1	23.4	22.7	23.4	21.8	19.6	35.0	44.7	13.8	15.6	156	191
Socioeconomic Index												
Low	17.0	14.8	12.2	11.0	13.6	15.0	24.4	33.9	10.9	7.9	416	574
Middle	15.1	17.2	8.2	14.3	15.1	18.0	31.5	39.1	10.0	11.2	642	806
High	16.6	19.6	11.3	10.4	22.8	18.5	38.5	46.0	11.3	10.7	174	228
Sex Education In School†												
Never Had	‡	16.0	‡	12.2	‡	16.5	‡	37.0	‡	9.4	‡	1,135
Ever Had	‡	18.7	‡	13.7	‡	18.3	‡	42.0	‡	11.6	‡	473
Pill Experience												
Never Used Pills	16.0	17.2	9.0	12.2	15.3	17.2	30.1	39.1	10.5	10.3	1,168	1,489
Ever Used Pills	12.2	11.7	31.6	16.7	22.0	14.9	29.5	31.4	11.4	6.8	64	119

* 409 women in 1993 and 417 women in 1996 who said they never heard of the Pill were not included

† Sex education about Methods of Birth Control

‡ Questions about sex education were not asked in the 1993 survey

TABLE 9.4.3
Percent of Young Women Who Agreed with Selected Statements About
Benefits Associated With The Use of Oral Contraceptives
By Selected Characteristics --Women 15-24 Years of Age*
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Easy to Use Method		Remove Fear of Getting Pregnant		Make Menstrual Periods More Regular		Unweighted Number of Cases	
	1993	1996	1993	1996	1993	1996	1993	1996
Total	59.7	64.2	41.3	54.7	17.1	27.8	1,232	1,608
Residence								
Urban	64.1	68.3	45.5	57.5	19.2	30.9	794	901
Rural	52.3	57.4	34.2	50.0	13.5	22.5	438	707
Age Group								
15-17	49.2	53.5	31.8	46.8	9.0	15.9	279	520
18-19	63.1	69.5	40.9	60.0	13.8	28.7	225	400
20-24	64.2	67.7	46.7	56.7	22.8	33.5	728	688
Education								
Primary	36.6	50.1	22.8	42.9	11.9	19.5	123	218
Some HS	53.7	57.1	34.7	49.1	11.9	19.2	469	763
HS Complete	65.3	74.0	48.2	60.9	18.8	37.3	484	436
Post HS	85.9	80.6	60.5	71.7	36.2	44.1	156	191
Socioeconomic Index								
Low	49.6	56.2	37.0	47.2	13.3	23.0	416	574
Middle	63.2	66.3	42.2	56.4	18.2	29.3	642	806
High	70.5	75.4	48.4	66.1	21.9	33.4	174	228
Sex Education in School[†]								
Never Had	‡	62.4	‡	53.4	‡	27.2	‡	1,135
Ever Had	‡	68.9	‡	58.2	‡	29.3	‡	473
Pill Experience								
Never Used Pills	58.2	61.0	39.5	51.1	14.8	22.4	1,168	1,489
Ever Used Pills	95.2	96.6	82.8	90.9	71.1	82.1	64	119

* 409 women in 1993 and 417 women in 1996 who said they never heard of the Pill were not included

† Sex education about Methods of Birth Control

‡ Questions about sex education were not asked in the 1993 survey

For example, between 44% (the risk of gaining weight) and 77% (the risk of cardiovascular problems) of respondents in 1996 had no opinion about potential side effects associated with using the pill. With that many women not knowing either risks or benefits associated with the use of pills, it is hard to interpret the answers of those who ventured a response. It is worth noting, however, that in 1996 slightly fewer women had no opinion about specific risks (e.g. weight gain, the risk of fertility problems) and more were in agreement with the statements about the benefits of the pill's use. Also, almost half of them disagreed that it would be "bothersome to take the pill daily", an improvement of 10% in the three-year period.

[Tables 9.4.2](#) and [9.4.3](#) include only women who agreed with selected statements about health risks and benefits of oral contraceptives. Although almost 50% of young women considered that pills are "not safe at all" for a woman's health, the majority of them did not recognize potential adverse health effects associated with taking the pill. As shown in [Table 9.4.2](#), in both the 1993 and 1996 surveys, weight gain was the most common concern (30% and 38%, respectively); it was followed by concerns about an increased risk of cancer (16% and 17%) and fertility problems after long periods of use (16% and 17%). Very few women agreed that using pills is associated with increased nervousness (10% and 13%, respectively) and only one in ten believed that oral contraceptives could be "bad for blood circulation".

Although about two-thirds of women believed that the pill is "easy to use" and one in two agreed that it could "remove the fear of getting pregnant", only few women (17% in 1993 and 28% in 1996) were aware of the benefits of oral contraceptives in making menstrual cycle more regular (see [Table 9.4.3](#)).

Generally, the likelihood to agree with statements about both risks and benefits of oral contraceptives was directly correlated with age, education, and SES, and was slightly higher among urban residents and those who have had sexual education about contraception in school.

9.5 Information About Contraceptive Methods

The majority of young women (82%) and men (80%) would like to have more information about contraceptive methods. The desire for more information is slightly higher in urban areas and is directly correlated with education (including sexual education) and SES. Also it is higher among youth not currently married than among those married or in consensual union (see [Tables 9.5A](#) and [9.5B](#)).

Most youth who would like to know more about contraception, perceived that a doctor or other health provider would be the most reliable source of information (68% of women and 61% of men). Young women named as the second most reliable source of information their mothers (10%) whereas young men named mass-media (14%) which is rated by women the third most important source (8%). Less mentioned sources for both women and men were: a friend, including a partner (8% and 7%, respectively), somebody who uses a contraceptive method (4% and 8%, respectively), the school (1% and 3%), and other relatives, including fathers (1% and 4%, respectively).

Table 9.5A
Percent of Young Women Who Want to Have More Information About Contraceptive Methods,
And Percent Distribution of These Women By Their Self-perceived Most Reliable Source of
Information About Contraception
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	% Who Want More Information	No. Of Cases	Percent Distribution of Young Women Who Want More Information								
			Total	Health Provider	Mother	Mass-Media	Friend/Partner	FP User	School	Other Relative	Don't Know
All Women	81.5	2,025	100.0	67.7	9.9	7.7	6.6	4.2	0.9	0.7	2.3
Residence											
Urban	85.7	983	100.0	68.9	10.8	8.5	5.1	3.9	1.0	0.3	1.5
Rural	76.1	1,042	100.0	66.0	8.5	6.5	8.7	4.7	0.8	1.3	3.5
Age Group											
15-17	79.6	738	100.0	54.0	21.9	6.0	7.5	5.2	2.2	0.8	2.4
18-19	85.3	501	100.0	67.8	10.1	5.9	8.6	4.3	0.7	0.7	1.8
20-24	81.1	786	100.0	76.1	2.4	9.5	5.1	3.6	0.3	0.7	2.5
Marital Status											
Ever Married	77.3	570	100.0	79.3	1.8	6.7	4.9	3.2	0.0	1.2	3.0
Never Married	83.8	1,455	100.0	61.8	14.0	8.1	7.4	4.7	1.4	0.5	2.0
Education											
Primary	65.7	460	100.0	54.8	14.3	4.0	10.1	7.3	0.3	1.6	7.5
HS Incomplete	82.7	917	100.0	65.3	14.0	6.1	6.8	4.3	1.4	0.8	1.3
HSC/PostHS	89.0	648	100.0	75.9	3.4	10.9	4.8	2.8	0.6	0.2	1.3
SES											
Low	72.6	917	100.0	64.2	9.4	5.4	9.0	5.9	0.7	1.2	4.2
Medium	87.2	876	100.0	69.0	10.4	9.3	5.6	2.9	1.0	0.5	1.2
High	91.1	232	100.0	72.6	9.6	8.2	3.3	4.1	1.2	0.0	0.9
Sexual Experience											
No	81.8	1,237	100.0	58.6	16.5	7.5	8.4	5.0	1.6	0.6	1.8
Yes	81.1	788	100.0	78.5	2.1	7.9	4.4	3.2	0.1	0.9	2.9
Had SE in School											
No	78.9	1,521	100.0	66.6	9.1	7.9	7.2	5.0	0.9	0.9	2.5
Yes	89.6	504	100.0	70.8	12.2	6.9	4.9	2.1	1.1	0.2	1.8

Table 9.5B
Percent of Young Men Who Want to Have More Information About Contraceptive Methods,
And Percent Distribution of These Men By Their Self-perceived Most Reliable Source of Information
About Contraception
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	% Who Want More Information	No. Of Cases	Percent Distribution of Young Men Who Want More Information								
			Total	Health Provider	Mass- Media	Friend/ Partner	FP User	Other Relative	School	Mother	Don't Know
All Women	80.3	2,047	100.0	60.6	13.9	8.4	7.7	3.6	3.1	1.6	1.2
Residence											
Urban	80.2	1,075	100.0	59.6	15.8	6.8	8.8	3.5	2.6	2.2	0.7
Rural	80.4	972	100.0	61.7	11.5	10.3	6.3	3.9	3.6	0.9	1.9
Age Group											
15-17	82.8	805	100.0	53.5	12.8	10.0	6.6	5.8	6.0	3.4	1.9
18-19	80.7	517	100.0	59.2	11.5	11.4	8.0	4.0	3.5	1.0	1.3
20-24	78.5	725	100.0	65.9	15.5	6.0	8.3	2.0	0.9	0.6	0.8
Marital Status											
Ever Married	72.5	156	100.0	72.7	15.2	2.3	7.3	2.5	0.0	0.0	0.0
Never Married	81.8	1,891	100.0	58.6	13.6	9.4	7.7	3.8	3.6	1.8	1.4
Education											
Primary	70.9	473	100.0	49.9	10.8	15.4	9.8	7.6	3.9	1.1	1.4
HS Incomplete	82.3	1,065	100.0	62.9	12.4	7.1	7.0	3.8	3.4	1.8	1.6
HSC/PostHS	83.7	509	100.0	63.1	18.5	6.2	7.6	0.8	1.9	1.5	0.5
SES											
Low	74.6	786	100.0	58.0	12.9	10.5	9.0	4.5	2.9	0.9	1.2
Medium	83.5	943	100.0	62.4	14.5	7.6	6.4	2.9	3.0	1.8	1.4
High	84.8	318	100.0	60.8	14.0	5.8	8.4	3.9	3.8	2.6	0.8
Sexual Experience											
No	78.9	839	100.0	56.1	12.6	8.6	6.5	6.3	4.9	2.7	2.2
Yes	81.0	1,208	100.0	62.7	14.5	8.2	8.3	2.4	2.2	1.0	0.8
Had SE in School											
No	78.5	1,529	100.0	58.1	14.6	9.0	8.1	3.9	3.6	1.3	1.4
Yes	84.6	518	100.0	67.3	11.8	6.7	6.6	2.8	1.7	2.3	0.7

CHAPTER X

REPRODUCTIVE HEALTH ATTITUDES

Prior to 1990, in the Romanian climate of strong moralistic principles vigorously promoted by the recently ended communist regime, sex education in school was prohibited, sexuality was a taboo topic, knowledge of reproductive health issues was discouraged for the purpose of population growth, fertility control practices were limited to the use of traditional methods, and access to induced abortion was severely restricted. Furthermore, sexual relations before marriage were openly criticized, many children born out of wedlock and those exceeding the desired family size were abandoned in overcrowded orphanages, husband-wife communication on sexual issues and contraception was basically non-existent, and child-care was largely viewed as a woman's duty. Details of the Romanian pronatalist policy and its legacy have been widely reported since 1989 when the communist regime was overturned (David HP., 1990; Hord C. et al., 1991; Serbanescu F. et al., 1995a and 1995b).

In the years since abortion and contraception have been legalized and pronatalist laws repealed, most women who considered themselves to be at risk of pregnancy have largely chosen traditional methods or have not used any method of birth control. The 1993 RRHS showed an overwhelming desire to limit family size, a high level of unmet need for modern contraception (49%), very high rates of induced abortion, widespread lack of knowledge and misconceptions about the pill and the IUD, and limited understanding of reproduction and sexuality. Not surprisingly, the survey revealed high acceptability of induced abortion as an option for pregnancy resolution (72%) and universal consensus for the use of abortion under specific conditions: when the fetus has serious birth defects (98%), if the woman's life or health are endangered by pregnancy (97% and 96%, respectively), if the pregnancy resulted from rape (96%), if the woman is unmarried (90%), and when the family cannot afford the child (89%).

In addition to exploring the attitudes about family size and induced abortion among young women and men, the 1996 YARHS aimed also at understanding the attitudes that surround reproductive decision-making, pregnancy resolution, and gender roles in Romania. The results of questions on these topics should prove useful for developing and modifying elements of reproductive health education programs and curriculums.

10.1 Ideal Family Size

Respondents were asked what they thought was the ideal number of children for a young family in Romania. This question is meant to explore respondents' general attitudes and not their personal decisions about the ideal family size. However, some respondents may have been

TABLE 10.1
Ideal Number of Children for a Young Family in Romania
By Gender, By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Women		Men	
	<u>Ideal No. Of Children</u>	<u>No. Of Cases*</u>	<u>Ideal No. Of Children</u>	<u>No. Of Cases*</u>
Total	2.7	1,969	2.6	2,018
Residence				
Urban	2.5	968	2.4	1,065
Rural	2.8	1,001	2.8	953
Age Group				
15-17	2.8	712	2.7	789
18-19	2.6	488	2.6	512
20-24	2.6	769	2.5	717
Marital Status				
Ever Married&In Union	2.7	561	2.6	156
Never Married	2.7	1,408	2.6	1,862
Education				
Primary	2.9	440	2.8	454
Some High School (HS)	2.7	888	2.6	1,059
HS Complete& PostHS	2.5	641	2.4	505
Socioeconomic Index				
Low	2.9	876	2.8	768
Middle	2.5	863	2.5	935
High	2.4	230	2.3	315
Ethnicity**				
Romanian	2.6	1,775	2.6	1,801
Hungarian	2.6	96	2.7	108
Gypsy	3.2	66	3.1	70
Number of Living Children				
None	2.6	1,602	2.6	1,946
One or more	2.8	367	2.8	72

*/Excludes 56 women and 29 men who answered "How many God wants "and other non-numeric responses

**/Excludes 32 women and 39 men of other ethnicity

influenced in their general opinion about the ideal number of children by their personal experience (actual number of children). Since the majority of young female respondents (77%) and male respondents (93%) were childless, the ideal number or mean desired number of children in Romania is probably not affected to any great extent by the actual fertility.

[Table 10.1](#) presents the mean ideal number of children by gender and selected background characteristics. Overall, young adults, regardless of their gender, had similar views about ideal family size (2.7 children for women and 2.6 for men). The effect of gender was negligible regardless of the respondents background characteristics. With the exception of the Gypsy ethnic group, the mean ideal number of children varies from 2.3 to 2.9. The mean ideal number of children was higher for women and men in rural areas than in urban areas (2.8 vs. 2.5 and 2.4, respectively) and it was inversely correlated with age (higher mean ideal number for the youngest group). Lower means were reported by young adults with high educational attainment (2.5 and 2.4 children) and high socioeconomic index (2.4 and 2.3 children). Young people with one or more living children reported slightly higher ideal number of children than childless young adults. Young women and men of Romani ethnicity (gypsies) reported the highest mean ideal number of children (3 or more children) compared to young adults of Romanian or Hungarian ethnicity (2.6 children).

10.2 Attitudes Toward Abortion

As in most Eastern-European countries, Romania has a long history of reliance on abortion which, in combination with traditional methods of contraception, was responsible for the rapid decline in fertility in the 1950s. Even before the first legalization of abortion in 1957, clandestine abortions, provided by either medical providers or traditional practitioners, were widely used to avert unwanted births. Legally induced abortion was the main method of fertility control in Romania between 1957-1965. During 1966-1989, when most abortions were strictly prohibited and contraception was banned, illegal pregnancy terminations continued to be performed in spite of rigorously enforced legal restrictions and severe health consequences. After the December 1989 revolution, abortion performed in the first trimester again became available "on request" when the restrictive legislation was revoked under public pressure on the interim government. Romania rapidly became the country with the highest abortion rate in Europe with 3.2 abortions for every live birth in 1990. In spite of a gradual decrease in recent years (from 198 abortions per 1000 women aged 15-44 in 1990 to 107/1000 in 1995), abortion rates in Romania remain very high.

This long tradition of relying on abortion to control fertility, combined with the economic difficulties which pressure couples to limit or delay childbearing and the lack of widespread availability of modern contraception, are largely responsible for the continued high rates of abortion and its high acceptability in Romania.

A series of attitudinal questions about abortion asked in the 1996 YARHS maintained the same wording and sequence as in the 1993 survey. Therefore, it is possible to monitor changes in attitudes over the three-year period of time. The respondents' positions on abortion were explored by asking whether "a woman should always have the right to make personal decisions about her pregnancy, including obtaining an abortion" and, for those who disagree that induced abortion should be an option for pregnancy resolution under any circumstance, whether an abortion should be permitted only under six specified circumstances: if "the woman's life is endangered by the pregnancy", if "the fetus has malformations", if "the pregnancy occurred as a result of rape", if "the woman's health is affected by pregnancy", if "the woman is not married", and if "the couple has a low income and cannot afford the child".

Overall, the proportion of respondents agreeing that a woman should always have the right to decide about her pregnancy, including resorting to abortion, was 67% among young women and 53% among men (Figure 10.2.1 and Table 10.2.1). Although young men were significantly less likely than women to agree with abortion as always being an option for pregnancy resolution, they were much more likely to accept abortion as an option under certain circumstances (43% vs. 29%).

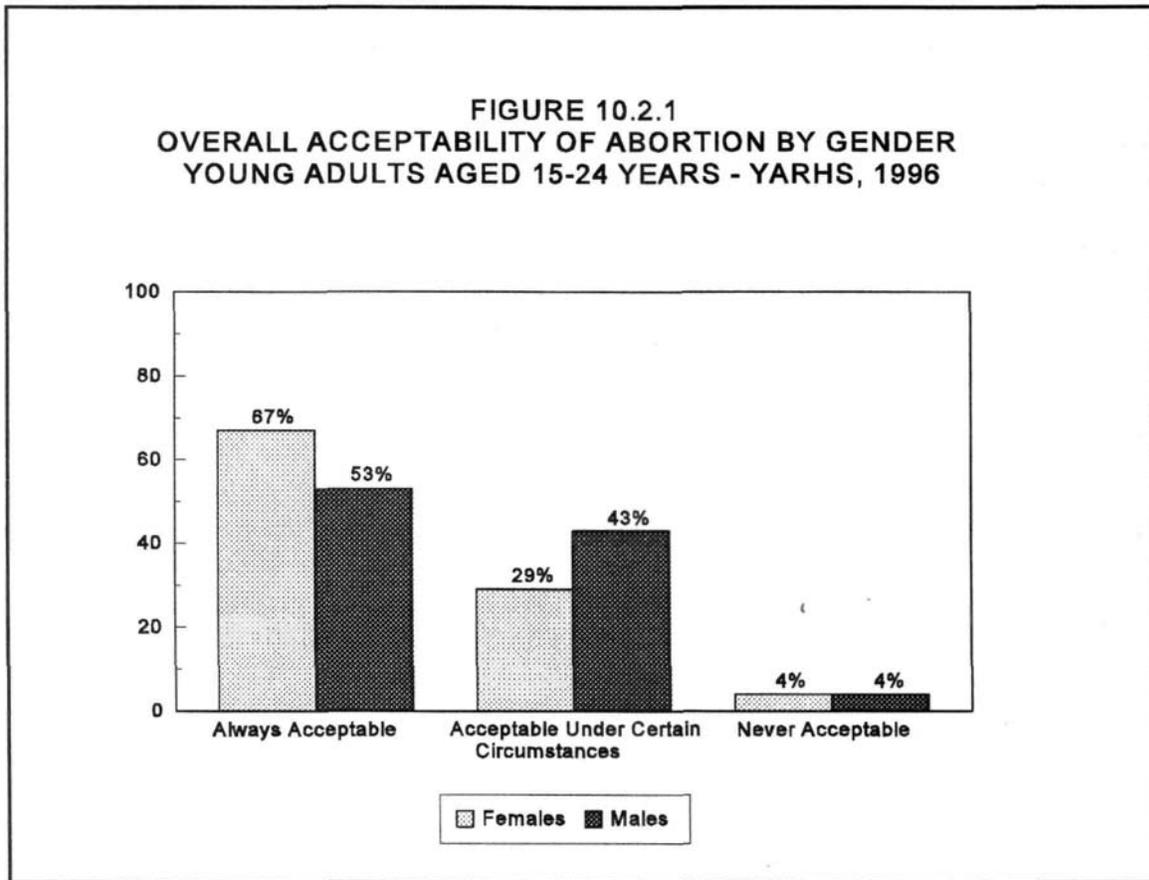


TABLE 10.2.1
Percent Distribution of Young Adults Aged 15-24 By Their Opinion On Acceptability of Abortion
By Gender By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Women			Men			No. of Cases		
	Always Acceptable	Under Certain Circumstances	Never Acceptable	Always Acceptable	Under Certain Circumstances	Never Acceptable	Total	Women	Men
Total	67.3	28.5	4.2	52.8	43.3	4.0	100.0	2,025	2,047
Residence									
Urban	70.3	27.4	2.3	52.9	44.1	3.0	100.0	983	1,075
Rural	63.4	29.8	6.7	52.6	42.3	5.1	100.0	1,042	972
Age Group									
15-17	64.2	30.4	5.4	57.8	38.6	3.5	100.0	738	805
18-19	64.5	30.5	4.9	54.9	40.6	4.5	100.0	501	517
20-24	70.3	26.4	3.3	48.6	47.4	4.0	100.0	786	725
Marital Status									
Ever Married/In Union	69.8	26.7	3.5	39.3	56.0	4.7	100.0	570	156
Never Married	65.9	29.5	4.6	55.3	40.9	3.8	100.0	1,455	1,891
Education									
Primary	63.4	29.2	7.4	57.0	36.3	6.7	100.0	460	473
Some High School	65.3	30.0	4.7	51.0	45.0	4.0	100.0	917	1,065
HS Complete&PostHS	71.9	26.2	1.9	52.8	45.4	1.8	100.0	648	509
Socioeconomic Index									
Low	63.4	29.2	7.4	51.7	42.9	5.3	100.0	917	786
Middle	68.6	29.5	2.0	54.8	41.6	3.6	100.0	876	943
High	75.6	22.5	1.9	49.4	49.1	1.5	100.0	232	318
Religion*									
Orthodox	67.9	28.6	3.5	54.2	42.7	3.1	100.0	1,778	1,827
Other Religion	60.6	29.5	9.9	40.1	48.4	11.5	100.0	225	211
Religiosity									
Every Week	54.0	35.0	11.0	41.7	46.6	11.7	100.0	499	222
Once per Mth. Or Less	69.1	27.3	3.6	49.9	45.6	4.4	100.0	642	484
Certain Occasions	71.4	27.3	1.3	55.9	41.6	2.5	100.0	783	1,269
Never	82.1	15.5	1.4	47.5	47.6	4.8	100.0	101	72
Ideal No. Of Children									
None	88.9	11.1	0.0	50.9	49.1	0.0	100.0	26	35
1-2	69.6	26.7	3.6	55.5	43.2	1.4	100.0	445	534
2	70.0	27.5	2.5	53.6	43.9	2.5	100.0	1,089	1,037
2-3	57.6	34.4	8.0	50.3	42.3	7.4	100.0	242	233
3+	56.0	33.6	10.4	43.4	42.5	14.1	100.0	196	186

* Excludes 22 women and nine men who refused to declare their religious affiliation.

Only 4% of young adults disapprove of abortion any circumstance. Thus, while men may hold more ambivalent attitudes than women about unrestricted abortion, they are more comfortable with the idea of abortion being used for certain reasons and there is no gender difference on the availability of abortion, with only 4 % of youth opposing it for any reason.

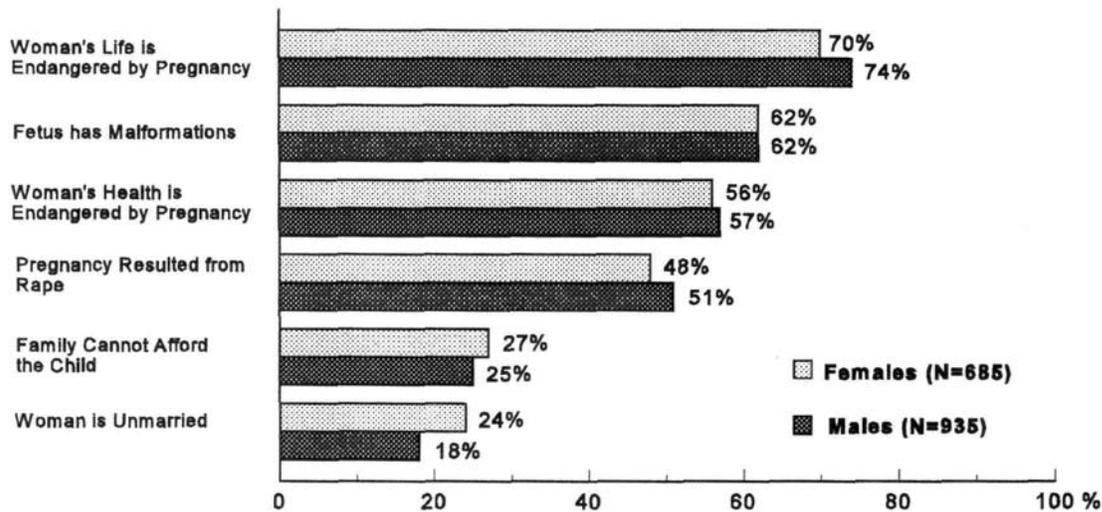
Between 1993 and 1996, the acceptability of abortion under any circumstance among young women 15-24 years of age declined from 73% to 67% (data not shown). However, their agreement that an abortion could be obtained under specific circumstances rose from 25% to 29% and their complete disagreement with abortion availability did not significantly change (from 3% to 4%).

Attitudes toward abortion varied by respondents' demographic characteristics, their religion and religiosity, and other attitudinal variables ([Table 10.2.1](#)). Female rural residents were less approving of abortion being used for any reason and more likely to never accept abortion. Younger age for women was associated with slightly lower acceptance of abortion whereas for men age was inversely correlated with approval of abortion. Marital status was not associated with significant attitudinal differences among women; young married men, however, were less likely than those who have never been married to accept abortion for any reason but more likely to approve it for certain reasons. For both women and men, education and socioeconomic status (SES) were inversely related with disapproval of abortion; the higher the level of educational attainment and SES, the lower was the likelihood to oppose abortion.

Respondents associated with other than the Orthodox church (mostly Catholics and Protestants), were less approving of abortion under any circumstance (61% of women and 40% of men) and more likely to believe that abortion is never acceptable (10% of women and 12% of men). When religiosity was measured by frequency of church attendance, young women and men who attended church services every week were considerably more opposed to abortion than those with less frequent attendance (11% of women and 12% of men) and less likely to approve abortion for any reason (54% and 42%, respectively). Not surprisingly, acceptability of abortion was strongly influenced by the ideal family size. The very few respondents who believed that young families in Romania should not have children also said that abortion is always acceptable, either for any reason (89% of women and 51% of men) or for certain reasons (11% of women and 49% of men).

Approval of abortion was inversely correlated with the ideal family size; the higher the number of children believed as ideal, the lower the acceptance of abortion, culminating with 10% of women and 14% of men who believed that young families should have at least three children saying that abortion is never acceptable. For both women and men, abortion acceptability was directly correlated with sexual permissiveness measured by opinions on the timing of first sexual intercourse in relation to marriage: only after marriage or engagement, if the couple is in love regardless of marital plans, and if the couple is dating, regardless of their feelings and marital plans (not shown). Women and men who disapprove of sexual initiation prior to marriage/engagement were also more likely to not accept abortion (7% of women and

FIGURE 10.2.2
ACCEPTABILITY OF ABORTION UNDER CERTAIN CIRCUMSTANCES
AMONG YOUNG WOMEN AND MEN WHO SAID THAT
ABORTION IS NOT ALWAYS ACCEPTABLE- YARHS, 1996



9% of men) and less likely to approve of abortion for any reason (59% of women and 46% of men). Conversely, those who believed it is all right for young people to have sex before marriage, even if they are not in love, hold the highest approval for abortions under any circumstance (81% of women and 61% of men).

[Figure 10.2.2](#) and [Table 10.2.2](#) show the levels of approval for abortion under certain circumstances among those who said that abortion is not always acceptable. Overall, young adults demonstrated various levels of acceptance under given circumstances that might motivate a pregnant woman to consider abortion. However, their opinions seem to polarize around a higher level of abortion acceptability when physical or mental health complications are related to the continuation of pregnancy (health problems of the mother, physical deformities of the fetus, pregnancy resulted from rape) and a lower acceptability for socio-economic reasons (out of wedlock pregnancy and low family income). For each specific circumstance, young adults' level of approval was not significantly different by gender. Moreover, ranking of the specified circumstances for abortion was identical for women and men. The approval for health reasons ranged from 48% (pregnancy resulted from rape) to 70% (pregnancy which endangers the

TABLE 10.2.2
Percent Distribution of Young Adults Aged 15-24 By Their Agreement or Disagreement
With the Acceptability of Abortion Under Selected Circumstances
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Circumstance</u>	<u>Women</u>				<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>Acceptability of Abortion</u>					
	<u>Acceptable</u>	<u>Depends</u>	<u>Not Acceptable</u>	<u>Do Not Know</u>		
If the Woman's Life is Endangered by Pregnancy	70.2	5.5	20.8	3.5	100.0	685
If the Child Might be Born Deformed	62.4	6.5	26.0	5.2	100.0	685
If Pregnancy has Resulted from Rape	55.6	8.0	30.7	5.7	100.0	685
If the Woman's Health is Endangered by Pregnancy	47.9	9.8	35.7	6.5	100.0	685
If Family Cannot Afford to Support the Child	27.0	7.3	60.0	5.7	100.0	685
If the Woman is not Married	24.1	11.0	61.5	3.4	100.0	685
 Men 						
	<u>Acceptability of Abortion</u>				<u>Total</u>	<u>Unweighted No. of Cases</u>
	<u>Acceptability of Abortion</u>					
	<u>Acceptable</u>	<u>Depends</u>	<u>Not Acceptable</u>	<u>Do Not Know</u>		
If the Woman's Life is Endangered by Pregnancy	73.9	6.5	14.7	4.9	100.0	935
If the Child Might be Born Deformed	62.1	7.8	23.1	7.0	100.0	935
If Pregnancy has Resulted from Rape	57.3	20.2	16.9	5.5	100.0	935
If the Woman's Health is Endangered by Pregnancy	50.5	16.5	27.5	5.5	100.0	935
If Family Cannot Afford to Support the Child	24.7	23.7	46.6	5.0	100.0	935
If the Woman is not Married	17.9	28.2	49.3	4.5	100.0	935

TABLE 10.2.3A
Percentage of Young Women Who Disagree That Abortion Is Acceptable for Any Reason
By Their Agreement With Certain Circumstances for Abortion
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Circumstance						No. of Cases
	Woman's Life in Danger	Fetus Deformed	Woman's Health in Danger	Pregnant From Rape	Financial Problems	Woman is Unmarried	
Total	70.2	62.4	55.6	47.9	27.0	24.1	685
Residence							
Urban	75.0	68.7	60.3	51.4	31.8	23.8	298
Rural	65.3	55.8	50.6	44.3	22.0	24.4	387
Age Group							
15-17	69.2	60.9	53.3	46.0	24.3	17.8	267
18-19	69.0	61.4	56.5	50.3	28.8	28.3	181
20-24	71.6	63.9	56.8	48.2	28.0	26.6	237
Marital Status							
Ever Married/In Union	70.8	66.8	60.8	49.9	29.5	29.5	180
Never Married/In Union	69.9	60.2	53.0	47.0	25.7	21.4	505
Education							
Primary	56.0	48.2	51.4	47.7	27.9	31.0	174
Some High School	72.1	62.9	55.8	44.3	24.9	20.6	323
HS Complete&PostHS	77.9	72.0	58.2	53.6	29.3	24.1	188
Socioeconomic Index							
Low	65.2	52.6	52.5	41.6	20.0	23.5	343
Middle	75.7	70.3	58.3	54.9	33.4	25.3	284
High	69.9	74.6	58.5	47.1	32.2	20.9	58
Religiosity*							
Every Week	59.9	49.7	45.0	38.7	20.4	18.5	230
Once per Mth. Or Less	73.6	60.1	62.0	49.8	27.8	23.6	206
Certain Occasions	77.8	76.2	58.9	53.3	32.3	27.8	231
Ideal No. Of Children†							
1-2	71.1	68.0	60.0	56.6	32.1	28.6	140
2	73.8	68.4	60.2	52.4	32.0	27.1	341
2-3	63.1	47.2	45.3	33.7	11.9	15.1	103
3+	62.4	48.8	43.3	36.8	15.5	15.2	85

* Excludes 18 women who said they do not attend church.

† Excludes 16 women who either had no opinion about the ideal family size or said a couple should not have children.

TABLE 10.2.3B
Percentage of Young Men Who Disagree That Abortion Is Acceptable for Any Reason
By Their Agreement With Certain Circumstances for Abortion
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Circumstance						No. of Cases
	Woman's Life in Danger	Fetus Deformed	Woman's Health in Danger	Pregnant From Rape	Financial Problems	Woman is Unmarried	
Total	73.9	62.1	57.3	50.5	24.7	17.9	935
Residence							
Urban	79.0	65.2	62.9	55.9	26.5	19.1	479
Rural	67.6	58.5	50.6	43.9	22.5	16.5	456
Age Group							
15-17	75.7	60.1	52.1	44.6	25.8	19.3	342
18-19	73.0	56.4	53.7	46.9	20.9	19.7	233
20-24	73.2	65.3	61.4	54.9	25.5	16.5	360
Marital Status							
Ever Married/In Union	66.3	68.2	62.2	66.5	29.6	18.9	92
Never Married/In Union	75.8	60.6	56.1	46.5	23.5	17.7	843
Education							
Primary	64.3	54.5	53.5	44.2	27.5	22.5	205
Some High School	72.5	63.5	53.7	48.7	22.6	16.0	493
HS Complete&PostHS	83.2	64.8	67.0	58.3	26.8	18.4	237
Socioeconomic Index							
Low	66.3	56.8	49.6	44.5	24.5	18.7	367
Middle	75.7	66.0	62.0	53.6	21.9	16.9	409
High	86.9	64.6	63.5	56.6	32.5	18.8	159
Religiosity*							
Every Week	58.0	50.8	40.0	30.8	15.5	12.5	230
Once per Mth. Or Less	80.4	66.0	60.3	52.2	20.7	16.0	206
Certain Occasions	75.5	63.2	60.1	55.2	27.8	19.4	231
Ideal No. Of Children†							
1-2	80.8	66.2	67.3	57.7	29.8	18.3	225
2	76.5	64.6	59.3	50.1	23.6	20.1	465
2-3	65.1	52.1	39.7	44.4	18.7	15.0	114
3+	59.1	54.5	49.2	41.6	18.2	13.1	105

* Excludes 37 men who said they do not attend church.

† Excludes 26 men who either had no opinion about the ideal number of children or said a couple should not have children.

mother's life) for young women and from 51% to 74%, respectively, for young men. The approval for socio-economic reasons was significantly lower with only 24% of women and 18% of men agreeing with abortion if the woman is unmarried and with 27% of women and 25 % of men accepting abortion as an option if a family cannot afford the child. However, if young women and men whose abortion acceptability depended on additional information (answers "it depends") were counted as having favorable opinions, the approval for health reasons ranged from 60% to 76% and 67% to 80%, respectively, and for socioeconomic reasons was 35% for women and 46%-48% for men.

[Tables 10.2.3A](#) and [10.2.3B](#) show differentials in acceptance of each specific abortion circumstance by background characteristics. Generally, youth in rural areas, in lower educational and socio-economic categories, those who are highly religious (weekly church attendance), or those whose ideal family size is over two children were slightly less likely to approve of abortion for health reasons. In the last two circumstances (woman is unmarried, financial problems), youth aged 15-17, those who have never been married, those with low SES, youth who attend church weekly, or those with high ideal number of children were less likely to accept abortion for socioeconomic reasons.

All respondents were asked if a woman who has an unintended pregnancy should "keep the baby", "give the baby for adoption", or "have an abortion"(data not shown). Interestingly, young women were more ambivalent about abortion and their opinions more susceptible to context variations than young men. Significantly fewer women (47%) agreed with abortion when a third alternative, that of giving the baby up for adoption, was offered. However, young men's attitude under this pregnancy scenario remained essentially unchanged.

10.3 Attitudes Toward Marital and Reproductive Norms

Adherence to traditional marital and reproductive norms for women and men can influence their reproductive and contraceptive decisions. [Table 10.3](#) shows that slightly less than half of young adults (48% of women and 39% of men) hold conservative values about sexual experience prior to marriage. Regardless of their gender, rural residents, especially females, 15-17 year olds, those who have ever been married or in union, those with low educational attainment (primary education) or low SES, and those of Romani ethnicity, were more likely to agree that "women should be virgins when they marry".

Not surprisingly, young women and men who have reported premarital sexual experience were less likely to value postponement of sexual experience until after marriage (21% of women and 33% of men). However, these results indicate that one-fifth of young women and one third of young men have sexual behaviors that do not match their norms.

TABLE 10.3
Agreement with Statements Concerning Reproductive Norms
By Gender By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Women Should Be a Virgin When They Marry		All People Should Marry		Women Should Have As Many Children As God Gives Them		Child Care is a Woman's Job	
	Women	Men	Women	Men	Women	Men	Women	Men
Total	47.8	39.2	44.5	54.4	36.0	33.1	16.0	16.0
Residence								
Urban	35.7	32.0	35.6	45.8	29.1	27.3	10.6	12.3
Rural	63.2	48.0	56.0	64.9	44.9	40.2	22.9	20.5
Age Group								
15-17	56.7	45.3	42.8	56.1	44.6	40.7	16.7	18.9
18-19	45.2	41.7	41.5	51.6	36.3	31.5	17.1	14.9
20-24	43.3	34.2	46.9	54.4	30.6	28.9	15.1	14.6
Marital Status								
Ever Married/In Union	52.8	44.8	56.7	63.5	33.2	30.3	23.0	15.9
Never Married/In Union	45.0	38.1	37.8	52.7	37.6	33.6	12.1	16.0
Education								
Primary	74.0	54.6	63.5	69.6	48.5	45.3	37.0	28.8
Some High School	51.2	42.6	45.1	57.4	38.6	34.8	14.5	15.7
HS Complete&PostHS	28.6	21.0	33.0	37.0	25.8	20.5	5.9	6.7
Socioeconomic Index								
Low	67.9	52.1	58.4	68.4	47.5	42.3	26.9	23.6
Middle	36.2	33.7	36.6	48.3	30.4	29.6	8.5	11.9
High	21.7	23.1	26.6	37.0	17.4	20.4	6.5	9.3
Ethnicity*								
Romanian	46.5	39.0	43.6	53.3	35.2	32.6	13.9	15.2
Hungarian	38.9	27.0	35.5	52.9	36.7	29.5	16.6	13.5
Gypsy	82.4	58.2	82.4	80.9	53.6	44.2	67.3	34.6
Sexual Experience								
Never Had Intercourse	52.9	50.6	40.5	56.7	40.6	42.1	13.5	18.3
Marital Experience	65.9	**	56.6	**	32.5	**	22.9	**
Premarital Experience	21.3	32.8	36.0	53.0	25.7	28.0	11.6	14.7

* Excludes 30 women and 40 men of other ethnicity.

** Fewer than 25 cases in this cell

About half of the young adults believed that "all people should marry". Interestingly, men were slightly more likely than women to have a favorable attitude toward marriage (54 % vs.45%). Rural residence, having been married, low education, low SES, and Romani ethnicity were associated with higher agreement that "all people should marry". Youth with the highest educational and socioeconomic level and those whose first sexual experience was premarital, were the least likely to believe that all people should marry.

A significant proportion of youth have a fatalistic attitude toward fertility and do not support women's participation in childbearing decisions. About one in three young adults agreed that "women should have as many children as God gives them". This traditional attitude is more prevalent among rural residents than urban residents, among 15-17 year-olds, among lower educated youth and those with low SES, among Gypsies, and among those who have never had sexual intercourse. Only one in six youth believed that "child care is a woman's job", suggesting perhaps a higher desire of sharing child-care responsibilities among the younger generation. The groups with lower acceptance of child-care sharing duties were rural youth, those with low SES or low education, and Gypsies.

10.4 Attitudes Toward Gender Roles

Views about gender roles may be important predictors of young people's sexual and contraceptive behavior. As shown in [Table 10.4.1](#), the majority of youth (72% of women and 79% of men) agreed that "women should talk to their partners about what they like or dislike in sexual relations". This belief was stronger among urban residents, older young adults, those in a marital or cohabitation relationship, and those with high education or SES level (data not shown). Conversely, very few young adults (17% of women and 20% of men) believed that "men are not interested in talking to their partners about sexual needs". This belief was slightly higher among youth whose first sexual relation was marital (24 % of women and 23% of men) and among men living in rural areas or with low SES (data not shown).

Contrary to the belief that most young people are influenced to have sex because their friends have sex, the survey shows that only one third of young women and slightly less than a half of young men agreed with this statement. Communication between partners on family planning issues has been found to be a powerful predictor of increased contraceptive use (Baker S., 1996; Mott FL and Mott S., 1985). Thus, it is also important to explore young adults' opinions and attitudes toward such communication. Although one in three young women and one in five young men did not know how to answer the statements regarding communication about contraception, the majority of those who express an opinion disagreed that men and women "are not interested in talking to their partner/spouse about contraception". Agreement with the statement about men's and women's lack of interest in communication on family planning issues was equally low for women (18% and 12%) and men (23% and 16%). Level of agreement was slightly higher among young women with high

TABLE 10.4.1
Percent Distribution of Young Adults By Their Agreement or Disagreement With
Selected Statements About Gender Roles By Gender
Young Adult Reproductive Health Survey: ROMANIA, 1996

Statements About Gender Roles	WOMEN				MEN			
	Agree	Disagree	Do Not Know	Total	Agree	Disagree	Do Not Know	Total
Women Should Talk to Their Partners About What They Like or Dislike In Sexual Relations	71.8	7.2	21.0	100.0	79.1	8.3	12.6	100.0
Many Youth Have Sex Because Their Friends Have Sex	33.8	43.5	22.8	100.0	44.1	44.1	11.8	100.0
Men Are Not Interested in Talking to the Partner/Spouse About Contraception	17.7	51.9	30.4	100.0	23.1	58.4	18.6	100.0
Men Are Not Interested in Talking to the Partner/Spouse About Their Sexual Needs	16.9	52.5	30.7	100.0	19.8	61.3	18.9	100.0
Women Are Not Interested in Talking to the Partner/Spouse About Contraception	11.5	59.6	29.0	100.0	16.1	63.0	20.9	100.0

SES (23% and 15%), those whose sexual initiation was marital (24% and 15%), and those who have ever used a birth control method (21% and 14%). Among men, agreement was not significantly influenced by background characteristics (data not shown).

Along with views about gender roles, the 1996 YARHS also explored attitudes about procreative responsibility, measured in terms of men's and women's responsibility toward contraception ([Table 10.4.2](#)) and family size ([Table 10.4.3](#)). The majority of young adults (86% of women and 80% of men) agreed that both partners should be responsible for avoiding unintended pregnancies and for deciding how many children the couple would have (96% of women and 94% of men). Regardless of their gender, opinions of shared contraceptive responsibility were stronger among urban than among rural residents, among never married than among ever married, and were directly correlated with educational attainment and SES. Gypsy (Romani) women and men were the least likely to agree upon shared contraceptive responsibility (60%) and the most likely to think that avoiding unintended pregnancies is the woman's responsibility (26% of women and 23% of men). Although contraceptive experience did not influence youth attitudes about shared contraceptive responsibility, men and women who have ever used contraception were slightly more likely than never users to consider that the man should be responsible for contraception, probably because of high prevalence of male dependent methods among ever users.

The attitudes toward family size decision-making followed a similar pattern ([Table 10.4.3](#)). Although the opinion of shared decision-making was universal, youth with low SES

TABLE 10.4.2
Perceived Responsibility of Avoiding Unintended Pregnancy
By Gender By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	"In Your Opinion, Who Do You Think Should Be Responsible for Avoiding Unintended Pregnancy?"						Total	Number of Cases*	
	The Woman		The Man		Both			Women	Men
	Women	Men	Women	Men	Women	Men			
Total	8.2	9.5	6.0	9.2	85.8	79.7	100.0	1,914	2,033
Residence									
Urban	6.7	7.8	5.3	8.2	87.9	83.2	100.0	963	1,068
Rural	10.2	11.5	6.8	10.5	83.0	75.5	100.0	951	965
Age Group									
15-17	10.6	9.5	4.2	9.1	85.2	78.5	100.0	674	795
18-19	7.0	9.8	6.4	8.9	86.6	79.8	100.0	481	514
20-24	7.3	9.4	6.8	9.5	85.9	80.5	100.0	759	724
Marital Status									
Ever Married/In Union	8.7	12.8	9.6	9.2	81.7	76.9	100.0	541	156
Never Married/In Union	7.9	8.9	4.0	9.2	88.2	80.3	100.0	1,373	1,877
Education									
Primary	16.6	16.2	7.9	12.7	75.5	66.7	100.0	408	465
Some High School	6.8	8.9	5.7	9.2	87.5	80.7	100.0	872	1,061
HS Complete&PostHS	5.4	5.5	5.3	6.7	89.2	87.7	100.0	634	507
Socioeconomic Index									
Low	11.3	12.7	8.3	12.0	80.4	72.7	100.0	832	780
Middle	5.7	8.4	5.1	8.0	89.2	82.5	100.0	853	936
High	7.1	4.5	1.8	6.1	91.1	89.0	100.0	229	317
Ethnicity†									
Romanian	7.8	9.1	4.9	8.8	87.3	80.7	100.0	1,727	1,814
Hungarian	4.7	9.3	17.0	10.6	78.3	78.9	100.0	97	108
Gypsy	26.2	23.0	13.6	11.5	60.2	60.9	100.0	59	70
Contraceptive Use									
Never Used	8.8	10.7	5.1	7.4	86.1	79.1	100.0	1,301	985
Ever Used	7.2	8.7	7.3	10.5	85.4	80.2	100.0	613	1,048

* Excludes 111 women and 14 men who had no opinion about the responsibility of avoiding unintended pregnancy.

† Excludes 31 women and 41 men of other ethnicity.

TABLE 10.4.3
Perceived Responsibility for the Decision Regarding the Number of Children in a Family
By Gender By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	“In Your Opinion, Who Do You Think Should Decide How Many Children a Couple Should Have?”						Total	Number of Cases*	
	The Woman		The Man		Both			Women	Men
	Women	Men	Women	Men	Women	Men			
Total	3.0	1.9	1.3	3.7	95.6	94.4	100.0	1,989	2,033
Residence									
Urban	2.0	1.3	1.6	1.9	96.3	96.9	100.0	971	1,068
Rural	4.3	2.8	1.0	5.9	94.7	91.4	100.0	1,018	965
Age Group									
15-17	4.4	1.6	1.6	4.0	94.0	94.4	100.0	714	795
18-19	3.2	3.3	1.9	4.7	95.0	92.0	100.0	496	514
20-24	2.2	1.6	0.9	3.0	96.9	95.4	100.0	779	724
Education									
Primary	7.4	4.6	5.2	9.0	87.4	86.4	100.0	453	465
Some High School	2.7	1.7	0.5	2.8	96.8	95.6	100.0	896	1,061
HS Complete&PostHS	1.0	0.4	0.1	1.4	98.9	98.2	100.0	640	507
Socioeconomic Index									
Low	4.7	3.3	2.6	6.3	92.6	90.4	100.0	896	780
Middle	1.8	1.4	0.4	2.4	97.8	96.2	100.0	863	936
High	1.9	0.3	0.4	0.9	97.7	98.8	100.0	230	317
Ethnicity†									
Romanian	2.6	1.6	0.9	3.4	96.5	95.0	100.0	1,791	1,814
Hungarian	6.2	5.4	0.6	1.4	93.1	93.2	100.0	98	108
Gypsy	11.4	4.2	10.8	15.5	77.8	80.3	100.0	69	70
Perceived Responsibility for Avoiding Unintended Pregnancy‡									
The Woman	19.2	9.7	3.4	13.1	77.3	77.1	100.0	167	191
The Man	5.4	5.5	9.7	13.9	84.9	80.6	100.0	108	186
Both	1.3	0.6	0.6	1.3	98.1	98.1	100.0	1,634	1,618

* Excludes 36 women and 14 men who had no opinion about who should decide the number of children in a family.

† Excludes 31 women and 41 men of other ethnicity.

‡ Excludes 80 women and 38 men who had no opinion about who should be responsible of avoiding unintended pregnancy.

or low education, Gypsies, and those who perceive that avoiding unintended pregnancies should be entirely the woman's responsibility, were less likely to agree that the number of children in a family should be a joint decision.

The multitude of factors that influence sexual and contraceptive behaviors of young people also includes attitudes, beliefs, and perceived norms regarding sexual behaviors. [Table 10.4.4](#) shows young adults' opinions of the acceptability of the first sexual experience in different relationship scenarios (marriage, engagement, love affair, and dating).

Generally, women hold less permissive attitudes toward premarital sex than men. Twice as many women as men believed that first sexual intercourse should take place only after marriage or engagement (48% vs 21%). Furthermore, fewer than one percent of women agreed that sexual intercourse with a date would be acceptable if the couple is not in love whereas one in five men said so. However, about half of young women and men agreed that first intercourse may happen before marriage if the couple is in love (51% of women and 59% of men).

Lower acceptance of premarital sex was more prevalent among residents in rural areas than in urban areas, especially for women. Almost two in three women and one in four men believed that first intercourse should be postponed until marriage or engagement whereas only one in three women and one in six men in urban areas said so. Postponement of sexual involvement as the norm was inversely correlated with age, education and SES. However, older youth, those with higher level of education or with higher SES were more likely to hold permissive attitudes toward sex if the couple is in love whereas their attitudes toward sexual intercourse in a dating relationship were not significantly different from their younger, less educated or less socioeconomic advantaged counterparts. Gypsy women were significantly more likely than Romanian and Hungarian youth to believe that sexual initiation would be permissible only after marriage/engagement (88% vs. 47% and 37%, respectively). Gypsy men, however, do not hold significantly different attitudes than men of other ethnicity. Not surprisingly, women and men with premarital sexual experience were the least likely to believe that first intercourse should be postponed until after marriage/engagement (20% of women and 12% of men). Correspondingly, women with premarital experience were more likely than sexually inexperienced women or those with marital experience to agree with sexual initiation if the couple is romantically involved (79% vs. 44% and 36%, respectively) whereas men with premarital experience were more likely than sexually inexperienced men to agree with sexual involvement with a date (23% vs. 15%).

Conservative norms about sexual intercourse prior to marriage were also associated with other conservative beliefs. For example, youth who believe that sexual initiation would be permissible only after marriage/engagement were significantly less likely than those who do not believe in postponement of sexual involvement to accept that women should talk to their partners about sexual needs and more likely to think that "a woman should be virgin when she marries", and that "a woman should have as many children as God gives". Furthermore, they were more likely to think that abortion is never acceptable (data not shown).

TABLE 10.4.4
Acceptability of the Timing of First Sexual Intercourse
By Gender By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

Characteristics	"When Do You Think Youth Should First Have Sexual Intercourse?"						Total	Number of Cases*	
	After Marriage or Engagement		If They are In Love, Regardless of Their Plans to Marry		If They Date, Even If They Are Not in Love			Women	Men
	Women	Men	Women	Men	Women	Men			
Total	48.4	21.1	50.9	58.7	0.7	20.2	100.0	1,980	1,996
Residence									
Urban	37.8	16.1	61.3	65.6	1.0	18.3	100.0	968	1,050
Rural	62.1	27.2	37.4	50.3	0.5	22.5	100.0	1,012	946
Age Group									
15-17	59.4	28.1	39.8	52.9	0.8	19.0	100.0	714	773
18-19	45.2	21.8	53.5	56.6	1.3	21.6	100.0	493	506
20-24	43.0	16.4	56.6	63.2	0.4	20.4	100.0	773	717
Education									
Primary	71.5	34.3	27.5	41.6	1.1	24.1	100.0	442	452
Some High School	51.4	21.7	48.1	58.9	0.5	19.5	100.0	897	1,039
HS Complete&PostHS	32.0	10.2	67.2	71.1	0.8	18.7	100.0	641	505
Socioeconomic Index									
Low	66.2	29.7	33.5	46.8	0.3	23.5	100.0	890	764
Middle	38.7	18.0	60.3	63.6	1.0	18.4	100.0	859	921
High	24.1	8.5	74.7	73.9	1.2	17.6	100.0	231	311
Ethnicity†									
Romanian	47.1	20.5	52.1	59.1	0.8	20.4	100.0	1,788	1,778
Hungarian	36.6	14.9	63.4	71.0	0.0	14.2	100.0	96	108
Gypsy	88.1	35.6	11.9	35.1	0.0	29.4	100.0	66	70
Sexual Experience									
Never Had Intercourse	55.3	38.8	43.8	46.3	0.8	14.8	100.0	1,204	804
Marital Experience	64.5	**	35.5	**	0.0	**	100.0	356	10
Premarital Experience	20.0	11.7	78.9	65.3	1.1	23.0	100.0	420	1,182

** Fewer than 25 observations in this cell

* Excludes 45 women and 51 men who had no opinion about the timing of first sexual intercourse.

† Excludes 30 women and 40 men of other ethnicity.

CHAPTER XI

HEALTH BEHAVIORS

11.1 Cigarette Smoking

According to the 1996 Report of the Preventive Services Task Force, "smoking accounts for one out of five deaths in the United States (United States Preventive Services Task Force: Guide to Clinical Preventive Services, 1996). It is the most important modifiable cause of death, responsible annually for an estimated five million years of potential life lost." Tobacco is a potent human carcinogen which has been shown to be related to a significant number of cancers of the respiratory and digestive tracts, bladder, cervix and kidney. Cigarette smoking accounts for 87 percent of lung cancer deaths, and 30 percent of all cancer deaths. Smoking is also a risk factor for atherosclerosis — the clogging of the blood vessels with fat and cholesterol - which is a major risk factor for heart attacks, strokes and blood clots of the legs and lungs. Smoking also contributes to the large number of people with asthma, emphysema, pneumonia, and osteoporosis. Maternal smoking had been linked to low birth weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome (SIDS), and respiratory problems of infants exposed to "passive smoking". The U.S. Preventive Services Task Force reports that "estimated smoking-attributable costs for medical care in 1993 were \$50 billion, and excess lifetime medical expenditures for the current cohort of smokers may be as high as \$500 billion dollars." One of the national health objectives related to smoking in the United States is to reduce smoking to a general prevalence of no more than 15% among people 20 years of age or older and 12% among women of reproductive age. Another objective is to decrease initiation of smoking to no more than 15 % among youth under 20 years of age.

Tobacco use in Eastern Europe has increased to alarming proportions since 1990, owing mostly to the transition toward a market economy and the arrival of the international tobacco industry whose costly promotional campaigns of advertising tobacco products have thrived in the absence of legislative regulations. In Romania, tobacco products were advertised in almost every corner of the country, through television and other mass media, on billboards, buses, street-cars, in supermarkets, restaurants, parks, and even fitness clubs. Consequently, cigarette sales have increased and more young people have been at risk of starting to smoke.

According to the 1993 Romanian Reproductive Health Survey, 29% of women of reproductive age have ever smoked (including 22% of young adults) and 22% were currently smoking (including 15% of women aged 15-24). Smoking prevalence was higher for urban than rural women, for ever married women, for high school and post high school graduates, for women with high socioeconomic status (SES), and for those currently working.

TABLE 11.1.1A
Percentage of Young Women Who Used Tobacco By Selected Characteristics
Women 15-24 Years of Age
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Cigarette Use				Unweighted	
	% Ever Smoked		% Current Smokers		No. of Cases	
	1993	1996	1993	1996	1993	1996
Total	22.3	24.9	15.4	19.8	1,640	2,025
Residence						
Urban	27.5	31.0	19.9	25.1	943	983
Rural	15.7	17.0	9.6	12.9	697	1,042
Age Group						
15-17	10.6	12.4	7.4	8.9	451	738
18-19	17.7	24.6	9.7	18.7	293	501
20-24	32.7	32.7	23.6	27.0	896	786
Marital Status						
Married&In Union	34.0	33.1	23.8	27.1	716	570
Unmarried	15.8	20.3	10.8	15.7	924	1,455
Education						
Primary	23.4	21.5	16.5	19.2	280	460
Some High School (HS)	17.3	22.7	12.9	18.0	654	917
HS Complete	26.6	28.1	17.2	21.7	544	454
Postsecondary&University	28.8	32.4	18.2	23.2	162	194
Socioeconomic Index						
Low	18.8	21.7	12.6	18.0	687	917
Middle	25.4	26.6	18.4	20.9	760	876
High	21.8	29.4	12.5	21.8	193	232
Current Employment						
Employed	30.7	35.0	21.1	30.6	446	396
Unemployed	19.7	21.8	13.6	16.5	1,194	1,629
Sexual Experience						
Never Had	11.9	13.8	7.6	10.5	823	1,237
Ever Had	37.1	37.7	26.5	30.5	817	788

TABLE 11.1.1B
Percentage of Young Men 15-24 Years of Age Who Used Tobacco and
Percentage Currently Smoking By Number of Cigarettes Smoked Daily
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Cigarette Use			Number of Cigarettes Smoked Daily			Total	No. Of Cases
	% Ever Smoked	% Currently Smoking	No. Of Cases	1-5	6-10	11+		
Total	55.8	46.7	2,047	29.2	30.5	40.4	100.0	964
Residence								
Urban	55.0	47.7	1,075	29.0	31.2	39.8	100.0	499
Rural	56.7	45.5	972	29.4	29.6	41.0	100.0	465
Age Group								
15-17	27.7	21.3	805	48.5	29.4	22.1	100.0	206
18-19	57.7	47.0	517	33.8	32.9	33.3	100.0	273
20-24	73.0	62.9	725	23.1	29.9	46.9	100.0	485
Marital Status								
Married&In Union	83.5	76.2	156	12.7	29.6	57.6	100.0	117
Unmarried	50.6	41.2	1,891	34.2	30.7	35.1	100.0	847
Education								
Primary	52.8	45.5	473	25.8	29.9	44.3	100.0	210
Some High School (HS)	54.2	44.3	1,065	29.6	31.1	39.3	100.0	475
HS Complete	63.3	54.6	344	33.2	28.4	38.4	100.0	195
Postsecondary&University	56.7	46.8	165	25.4	32.7	41.9	100.0	84
Socioeconomic Index								
Low	59.9	49.9	786	26.4	31.0	42.6	100.0	391
Middle	54.9	46.0	943	31.7	29.9	38.4	100.0	448
High	48.1	40.4	318	29.1	30.6	40.3	100.0	125
Current Employment								
Employed	71.8	62.1	641	24.1	27.8	48.1	100.0	412
Unemployed	46.1	37.4	1,406	34.0	33.0	33.0	100.0	552
Sexual Experience								
Never Had	25.7	18.8	839	48.9	27.8	23.4	100.0	194
Ever Had	71.0	60.7	1,208	25.6	30.9	43.4	100.0	770

As shown in [Tables 11.1A](#) and [11.1B](#), in 1996, one fourth of young women and more than half of young men have smoked at least 100 cigarettes during their lifetimes (ever smokers). One in five women and 47% of men have smoked daily during the 30 days preceding the survey (current cigarette smokers). In addition, 3% of women and 5% of men reported smoking within the past 30 days but less than every day (not shown). Compared to the last survey, cigarette use among women 15-24 years of age has increased by 14% for ever use of tobacco and 29% for current use. Young women residing in urban areas were almost twice as likely as rural young women to have ever smoked and to be current smokers. Conversely, the rate of past and current smoking among young men was similar, regardless their residence.

For youth of both sexes, smoking experience was directly correlated with age, with the prevalence of smoking being three times higher among those aged 20-24 years than among 15-17 year-olds. Currently married young adults were much more likely than those unmarried to have ever smoked (33% vs. 20% among women and 84% vs. 51% among men) or to smoke currently (27% vs. 16% and 76% vs. 41%, respectively). Smoking did not vary significantly by educational attendance for either women or men but it was slightly more prevalent among young men with low SES. Young adults who were currently employed (presumably older too) were nearly twice as likely as those not employed (and probably still in school) to have ever smoked and to be current smokers. Youth with sexual experience were about three times as likely as young adults who have never had sex to be either past or current smokers.

One in two women and the majority of young men (71 %) who were currently smoking were using six or more cigarettes daily, including 20% of women and 40% of men who were using more than a half of pack daily ([Tables 11.1B](#) and [11.1.2](#)). Among male respondents, current heavy smoking (eleven or more cigarettes per day) was significantly higher for 20-24 year-olds than for those aged 18-19 and 15-17 years (47% vs. 33% and 22%, respectively). It was also higher for youth married or in consensual union than for those not in union (58% vs. 35%), for those sexually experienced (43% vs. 23%), and for those employed (48% vs. 33%). Women respondents who were currently smoking 11 or more cigarettes per day were slightly more likely to live in urban areas than in rural areas (22% vs. 16%), to be older (24% among 20-24 year-olds), currently married women than not married (26% vs. 15%), and currently employed (31% vs. 15%).

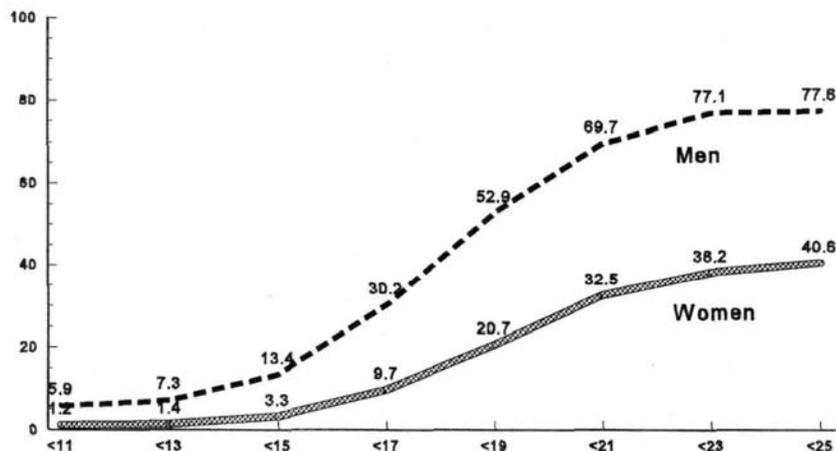
Compared to the 1993 survey more young women overall were smoking 1-5 cigarettes daily (an increase of 12%) or over 11 cigarettes daily (an increase of 22%) whereas the proportion smoking 6-10 cigarettes had declined. Between the two surveys, several changes in the number of cigarettes smoked daily had occurred. In 1996, more women in urban areas reported an increase in their daily number of cigarettes from 6-10 cigarettes to over 11 cigarettes whereas more rural residents reported a decrease, from 6-10 to 1-5 cigarettes daily. A higher proportion of women 20-24 years of age reported heavy smoking in 1996 compared to 1993 (24% vs. 18%). Also unmarried women reported a 50% increase in smoking 11 or

TABLE 11.1.2
Percentage of Young Women Currently Smoking
By Number of Cigarettes Smoked Daily By Selected Characteristics
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Number of Cigarettes Smoked Daily						Unweighted		
	1-5 Cigarettes		6-10 Cigarettes		11+ Cigarettes		Total	No. of Cases	
	1993	1996	1993	1996	1993	1996		1993	1996
Total	43.5	48.6	40.1	31.4	16.4	20.1	100.0	283	402
Residence									
Urban	42.7	43.5	40.5	34.7	16.8	21.8	100.0	212	256
Rural	45.7	60.9	39.1	23.3	15.2	15.8	100.0	71	146
Age Group									
15-19	55.8	53.3	32.2	34.1	12.0	12.6	100.0	70	170
20-24	38.6	46.0	43.3	29.9	18.1	24.1	100.0	213	225
Marital Status									
Married&In Union	38.7	44.4	39.8	29.8	21.5	25.8	100.0	172	150
Unmarried	49.3	52.3	40.6	32.8	10.2	14.9	100.0	111	252
Education									
Primary	38.8	48.8	37.0	29.5	24.2	21.7	100.0	50	83
Some High School (HS)	46.3	43.7	33.2	37.8	20.5	18.6	100.0	95	160
HS Complete&PostHS	43.4	53.3	47.1	25.9	9.5	20.8	100.0	138	159
Socioeconomic Index									
Low	38.7	50.8	42.4	31.1	18.9	18.1	100.0	92	163
Middle& High	46.0	47.2	39.0	31.6	15.0	21.3	100.0	191	239
Current Employment									
Employed	42.2	36.5	48.0	32.9	9.8	30.6	100.0	105	120
Unemployed	44.1	54.5	36.4	30.6	19.5	14.8	100.0	178	282

more cigarettes daily compared to their 1993 counterparts (15% vs.10%). The most notable changes had been reported by women with medium or high level of education, whose prevalence of heavy use of tobacco in 1996 was twice as high as the 1993 prevalence (21 % vs. 10%), by employed women whose reported heavy smoking was three times as high as in 1993 (31 % vs. 10%) and by those with medium or high SES, who reported a 63% increase in heavy

FIGURE 11.1
PERCENT OF YOUNG ADULTS WHO HAVE EVER SMOKED REGULARLY
BEFORE GIVEN AGES - LIFE TABLE ESTIMATES
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



smoking (21% vs. 15%). Although sample size for this subgroup of smokers was not great enough to detect statistically significant differences, the overall consistent pattern of increase in heavy smoking is an alarming finding.

Compared to young women, young men were much more likely to have smoked regularly at any give ages, but the differences are higher if smoking was initiated at an earlier age ([Figure 11.1](#)). For example, the cumulative life-table probability of initiating constant smoking by age 13 is 1 % for women and 7% for men, by age 15 is 3% vs. 13%, and by age 15, is 10% vs. 30%. If smoking was not initiated before age 17, the probabilities of starting smoking regularly range from 21% by age 19 to 41% by age 25 for young women and 53% to 78%, respectively, for men.

For young men, the probabilities of initiating smoking regularly by younger ages (before the 13th anniversary) were twice as high in rural areas than in urban areas (10% vs. 5%), and in low educated or low SES youth than among those with medium or high education or SES (11% vs. 6%). Among young women (data not shown), probabilities of initiating smoking before age 17 were higher for urban than for rural residents (12% vs. 7%), for 15-19 year-olds than for 20-24 year-olds (12% vs. 7%), and for youth with primary education (14%) than for those with high school (5%) or post- high school education (4%).

11.2 Alcohol Use

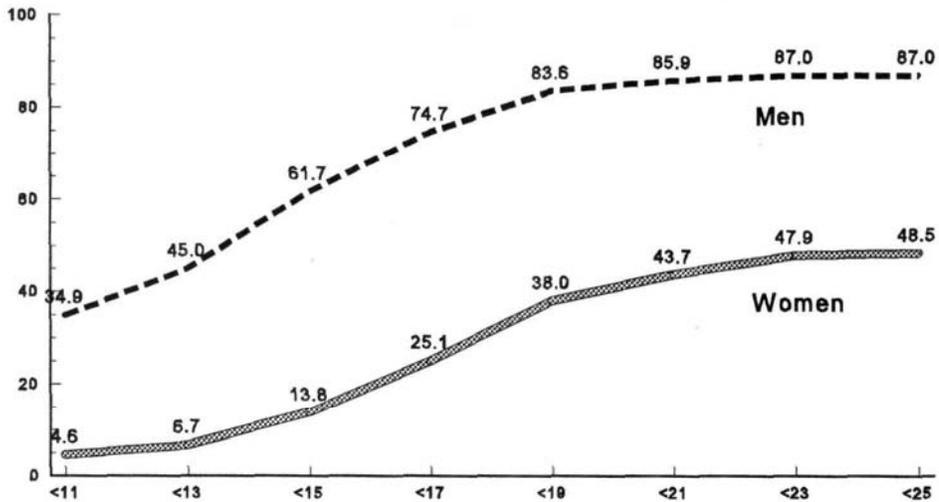
Alcohol use among young adults has been shown to be related to risky sexual behaviors, violence, and academic problems (DJ Hanson and RC Engs, 1992). Episodic heavy drinking has been shown to be strongly correlated to serious injuries, particularly fatal motor vehicle crashes. Alcohol abuse among women of reproductive age has significance beyond its potential harm to the individual because of the potential damage to their fetus or children. No one knows how much alcohol it takes to harm a fetus, or if any mothers can drink safely. However, it is known that the more alcohol a pregnant woman drinks, the greater the chances of birth defects (fetal alcohol syndrome). Even "social drinking" may cause minor developmental problems in an otherwise normal baby.

Although alcohol consumption is perceived to be high in Romania, no other studies have assessed alcohol use among national samples of women and men. The 1996 YRHS is the first representative study to address this issue in a subgroup of the general population. Alcohol use was measured by asking each respondent at what age did they first drink an alcoholic beverage, how many drinks did they have at any given occasion during the past three months, and how often did they drink that amount. Respondents who have had at least one drink within the last three months were considered "current drinkers", those who had at least one drink every day or almost every day were defined as "current frequent drinkers", and those who consumed 5 or more drinks in a row (4 or more for female respondents) at any given time during the three months preceding the survey were defined as "episodic heavy drinkers".

As shown in [Figure 11.2](#), consuming alcohol begins at early ages for males but not for females. About one third of men (35%) but only 5% of young women have started drinking alcohol before age 11. Men were much more likely than women to have consumed alcohol before any given age. For both men and women, probabilities of initiating the use of alcohol rose rapidly with each year of age before age 19 leveling off gradually after this age. Probabilities range from 45% before age 13 to 84% before age 19 for men, and from 7% to 38%, respectively, for women.

Survey results show that, while approximately two-thirds of young women report no drinking, the majority of men (86%) have used alcohol ([Tables 11.2A](#) and [11.2B](#)). Among all youth, 16% of women and 65% of men have had at least one drink in the past three months. Women were also much less likely than men to be current frequent users (2% vs. 19%). For young men, current use and current frequent use were slightly higher among rural than among urban residents (70% and 23% vs. 61% and 16%), were directly correlated with age (with 77% and 28%, respectively, of 20-24 year-olds reporting current use and current frequent use), did not vary by educational attainment, and were inversely correlated with SES, with the highest levels reported by men with low SES (72% and 21 %, respectively). Also, current use and frequent use were higher among married men (79% and 31%) and those with reported sexual experience (76% and 24%).

FIGURE 11.2
PERCENT OF YOUNG ADULTS WHO DRANK ALCOHOL
BEFORE GIVEN AGES - LIFE TABLE ESTIMATES
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



Since young women reported much lower levels of use of alcohol, differences in current and current frequent use between different subgroups were largely not significant; however, some of these differences mirror the same patterns observed for young men (increase in the use of alcohol with the increase in age, and higher prevalence of alcohol use among married women and women with sexual experience. Other trends were opposite to the trends found for men (e.g. higher prevalence of current and frequent use among women with high SES than those with low or medium SES).

About one-fourth of men (27%) reported current episodic heavy drinking (five or more drinks of alcohol on at least one occasion within the last three months) and approximately one in ten youth consumed ten drinks of alcohol at least once during the three months preceding the survey (not shown). Conversely, young women seldom drank several drinks in a row and current episodic heavy drinking was reported by only one percent.

TABLE 11.2.1A
Percentage of Young Women Who Used Alcohol By Selected Characteristics
Women 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Alcohol Use				Unweighted No. of Cases
	% Ever Drank	% Current Drinkers	% Current Frequent Drinkers	% Current Episodic Heavy Drinking	
Total	40.1	15.6	1.8	0.9	2,025
Residence					
Urban	44.2	16.8	2.1	1.3	983
Rural	34.9	14.1	1.5	0.4	1,042
Age Group					
15-17	32.7	12.3	1.3	1.3	738
18-19	42.6	15.4	1.4	1.3	501
20-24	43.7	17.7	2.3	0.5	786
Marital Status					
Married&In Union	40.9	16.8	2.9	0.4	570
Unmarried	39.7	14.9	1.3	1.2	1,455
Education					
Primary	28.9	14.0	1.2	1.1	460
Some High School (HS)	40.0	14.7	2.0	1.1	917
HS Complete&PostHS	46.7	17.6	2.0	0.6	648
Socioeconomic Index					
Low	36.2	14.5	1.9	0.6	917
Middle	41.2	15.1	1.4	1.1	876
High	49.6	21.2	3.1	1.1	232
Current Employment					
Employed	46.2	17.7	1.9	0.8	396
Unemployed	38.3	15.0	1.8	0.9	1,629
Sexual Experience					
Never Had	34.9	11.6	1.0	0.7	1,237
Ever Had	46.2	20.2	2.8	1.2	788

TABLE 11.2.1B
Percentage of Young Men Who Used Alcohol By Selected Characteristics
Men 15-24 Years of Age
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Alcohol Use				Unweighted No. of Cases
	<u>% Ever Drank</u>	<u>% Current Drinkers</u>	<u>% Current Frequent Drinkers</u>	<u>% Current Episodic Heavy Drinking</u>	
Total	85.7	65.1	18.9	26.6	2,047
Residence					
Urban	84.3	61.1	15.6	22.7	1,075
Rural	87.5	69.9	22.9	31.4	972
Age Group					
15-17	75.9	46.1	8.4	11.5	805
18-19	85.5	66.3	13.8	25.1	517
20-24	92.1	76.8	27.7	37.0	725
Marital Status					
Married&In Union	91.0	79.0	31.4	37.0	156
Unmarried	84.7	62.5	16.6	24.7	1,891
Education					
Primary	80.7	62.8	19.0	28.5	473
Some High School (HS)	86.1	64.4	18.6	25.7	1,065
HS Complete&PostHS	88.9	68.0	19.2	27.0	509
Socioeconomic Index					
Low	86.4	71.7	21.2	30.6	786
Middle	86.1	62.8	18.4	26.4	943
High	83.0	55.1	14.5	17.3	318
Current Employment					
Employed	91.4	76.5	24.1	32.1	641
Unemployed	82.3	58.2	15.8	23.3	1,406
Sexual Experience					
Never Had	73.0	44.1	8.8	9.8	839
Ever Had	92.2	75.6	24.0	35.1	1,208

Episodic heavy drinking was consistent with the pattern for current frequent drinking . It was significantly higher among men in rural than urban areas (31 % vs. 23%) and among 20-24 year-old than those aged 15-17 or 18-19 years, (37% vs. 12% and 25%, respectively). Also, it was higher among married youth than those unmarried (37% vs. 25%), among those with sexual experience than those without (35% vs. 10%), and among youth currently employed than those unemployed (32% vs. 23%). Young males with low or middle SES were significantly more likely to report episodic heavy drinking than those with high SES. Heavy drinking did not vary by education.

11.3 Prevalence of Routine Gynecologic Visits Among Young Women

Patient attitudes and behaviors regarding health care visits are important determinants of whether they receive routine screening, including cervical and breast cancer screening. Important barriers that can prevent individual accessibility to routine health visits include: perceived lack of susceptibility to disease, no knowledge about benefits of screening, perceived discomfort of screening, fear of positive results, fatalistic attitudes toward illness and fear of potential treatment. Lack of knowledge of health related issues, noncompliance with doctor's recommendations, miscommunication between patient and provider, and socio-economic and geographic factors are also other potential barriers. Other factors limiting access to preventive health care visits include limited resources within the health system, inadequate and/or maldistribution of health providers, and physician barriers (knowledge, attitudes and beliefs regarding routine screening, lack of time or expertise, restrictive hours of service availability).

The 1993 RRHS clearly demonstrated that routine gynecological examinations are not customary in Romania (only one in four women had had a gynecologic exam every year and 44% have never been examined) and cervical cancer screening coverage is very low (27% among sexually experienced women aged 15-44). Young women, those living in rural areas, never married women, and women with low education attainment or low SES were the least likely to have had routine gynecological visits and cancer screening.

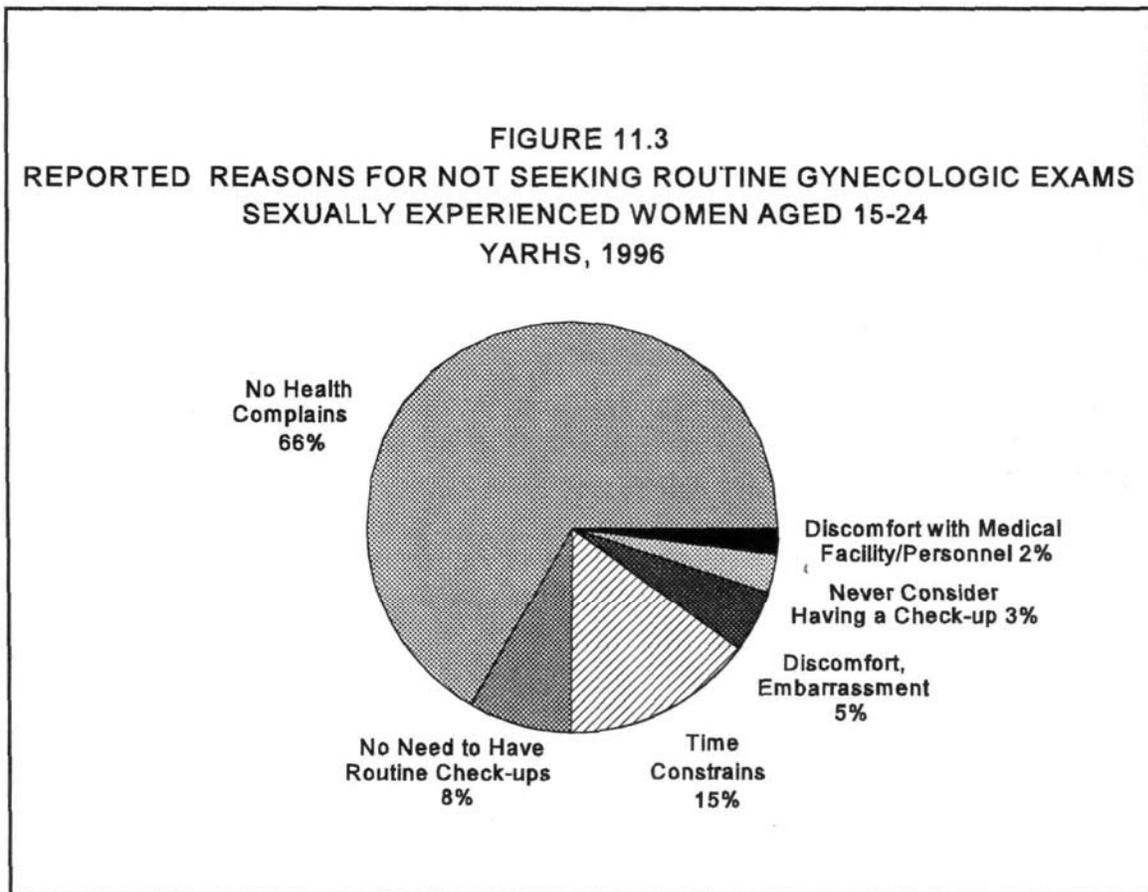
Unfortunately, low coverage of gynecological screening continues to persist in Romania. The 1996 survey ([Table 11.3](#)) shows that only 25% of sexually experienced young women have been examined annually by a gynecologist and 61% have never had a gynecologic exam in their life. Rural residents, younger women, less-educated women and those with low SES were more likely to have never received preventive gynecologic exams or to have screening less often. Rural women were 2.4 times less likely than urban women to receive annual exams (14% vs. 35%); women 15-17 were much less likely than 18-19 and 20-24 year-olds to have such visits (11% vs 28% and 26%, respectively). Women with primary education were 3 times less likely than women with secondary or post-secondary education to have had annual exams (12% vs. 37%) and women with low SES were 2.5 times less likely than women with higher SES to have routine visits (14% vs. 34% and 40%, respectively).

TABLE 11.3
Frequency of Routine Gynecologic Exams Among Young Women By Selected Characteristics
Women 15-24 Years of Age Who Have Ever Had Sexual Intercourse
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Frequency of Routine Gynecologic Exams						Total	Unweighted Number of Cases	
	Every Year		Less Than Every Year		Never Had			1993	1996
	1993	1996	1993	1996	1993	1996		1993	1996
Total	19.3	25.4	17.0	13.6	63.7	61.0	100.0	817	788
Residence									
Urban	25.9	35.2	17.4	13.7	56.7	51.1	100.0	436	337
Rural	12.7	13.6	16.5	13.4	70.8	73.0	100.0	381	451
Age Group									
15-17	5.6	10.8	14.1	7.0	80.3	82.3	100.0	39	63
18-19	12.1	28.1	15.0	9.6	72.9	62.3	100.0	106	178
20-24	21.8	26.0	17.6	14.9	60.7	59.1	100.0	672	547
Marital Status									
Married&In Union	19.9	23.4	17.2	13.0	62.8	63.6	100.0	714	570
Unmarried	15.7	32.3	15.6	15.7	68.7	52.1	100.0	103	218
Education									
Primary	13.6	11.9	15.6	15.1	70.8	73.0	100.0	158	212
Some High School (HS)	18.4	20.3	15.3	14.1	66.4	65.5	100.0	272	276
HS Complete&PostHS	22.9	37.3	18.9	12.2	58.2	50.5	100.0	387.0	300
Socioeconomic Index									
Low	13.4	14.0	16.7	11.6	69.9	74.4	100.0	392	407
Middle	25.6	34.4	17.1	14.8	57.2	50.9	100.0	355	297
High	22.3	39.5	18.0	17.1	59.7	43.4	100.0	70	84
Current Employment									
Employed	22.9	34.0	16.7	12.5	60.4	53.5	100.0	295	209
Unemployed	17.6	21.6	17.1	14.1	65.2	64.3	100.0	522	579

Although young women in the 1996 survey reported a 32% increase in routine gynecologic exams (annual visits) than their counterparts in 1993, the proportion of women who get these exams is rather small and the overall difference is not statistically significant. Compared to 1993, significant improvements were noted only among 18-19 year-olds (12% vs. 28%) and among the best educated women (23% vs. 37%).

The reasons for not seeking routine gynecologic exams are important to study because they may uncover potential barriers to the use of preventive health services. The majority of young women (75%) who have never had a routine exam believed they do not need one because they are healthy or have no health complains. These women are probably lacking general health education and are unaware of the screening procedures and/or the health benefits of screening. The second most often mentioned reason was lack of enough commitment or time to have a check-up (15%), followed by fear of discomfort including pain and embarrassment associated with gynecologic check-ups (5%). Few women said they never thought to go to such visits (3%) and very few claimed that the medical facilities or health providers were unpleasant. These findings demonstrate that, to achieve effective preventive health services for reproductive age women, more efforts should be made to modify general health beliefs and attitudes and to educate women about screening procedures and disease prevention.



11.4 Cervical Cancer Screening

Cervical cancer is the second most common cancer among women with almost 450,000 new cases diagnosed each year in the world (World Health Organization, 1993). However, it is the most frequent cancer of women in developing countries where 80% of cervical cancers are diagnosed (Parkin DM, et al., 1993). Age-adjusted incidence rates range from 5-42 cases per 100,000 women, with high rates in Latin America, Africa, Southeast Asia and lower rates in North America, Western Europe, Australia, and Israel. The 1993 crude incidence rate of 24.7 per 100,000 females reported in Romania (Romanian Ministry of Health, 1995) was higher than the Eastern-European average (21.6 per 100,000) and well over the Western European average of 15 per 100,000. Mortality due to cancer of the cervix constitute the third cause of death among women in Romania, while in Poland, Hungary, Ukraine, Czech Republic, Russian Federation, and Bulgaria it ranked the 5th, 8th, 11th, 12th, 16th, and 23th, respectively (Parker SL et al., 1996). Mortality rates from cervical cancer in Romania has increased from 12 per 100,000 in 1990 to 14 per 100,000 in 1993.

In developed countries the incidence of in situ cervical cancer is increasing whereas invasive cancer and cervical cancer mortality are declining. Much of the decline in mortality has been attributed to widespread use of cervical cancer screening (Papanicolau smear test). The decrease in mortality results from detection of cancer at an earlier and therefore more curable stage and the detection and treatment of premalignant lesions. Data from large screening programs have shown that annual Pap smear screening reduces the probability of developing invasive cancer by 93.3%, whereas screening every 3 years reduces the probability by 91.2%, and screening every 5 years by 83.6% (Miller AB, 1986). Based on these estimates, most experts recommend that women who are sexually active or 18 years of age or older should have a Pap test annually or every three years, followed by the option of reducing the frequency of screening in women over age 65 who have been regularly screened with normal results.

Risk factors for cervical cancer include history of multiple sexual partners, early onset of sexual intercourse, smoking, infection with the human immunodeficiency virus and infection with certain serotype of the human papilloma virus.

Although the validity of self-reported rates of Pap testing cannot be established without examining medical records, survey results are often used to estimate the extent of cervical screening in the general population. The YARHS included a series of questions for female respondents regarding Pap tests history: "Have you ever had a cervical smear test (Papanicolau screening test)?" and "When did you have your last cervical smear test?" .

Overall, only 13% of sexually experienced women aged 15-24 reported that they had ever had a Pap smear ([Table 11.4](#)) and only 4% had more than one test. Because of such a low prevalence, frequency of cervical screening was not analyzed. Although low, the proportion of

TABLE 11.4
Cervical Cancer Screening History of Young Women By Selected Characteristics
Women 15-24 Years of Age Who Have Ever Had Sexual Intercourse
RRHS and YARHS: ROMANIA, 1993 and 1996

Characteristics	Cervical Cancer Screening Test						Unweighted Number of Cases*	
	Ever Had		Never Had		Total		1993	1996
	1993	1996	1993	1996	1993	1996	1993	1996
Total	9.1	12.7	90.9	87.3	100.0	100.0	795	785
Residence								
Urban	11.5	18.0	88.5	82.0	100.0	100.0	421	337
Rural	6.7	6.2	93.3	93.8	100.0	100.0	374	448
Age Group								
15-17	0.0	5.1	100.0	94.9	100.0	100.0	39	63
18-19	6.3	4.8	93.7	95.2	100.0	100.0	103	177
20-24	10.3	14.9	89.7	85.1	100.0	100.0	653	545
Education								
Primary	4.3	5.7	95.7	94.3	100.0	100.0	149	211
Some High School (HS)	9.9	13.1	90.1	86.9	100.0	100.0	265	274
HS Complete	10.0	14.8	90.0	82.8	100.0	100.0	303	204
Postsecondary&University	13.8	18.9	86.2	78.7	100.0	100.0	78	96
Socioeconomic Index								
Low	6.4	6.4	93.6	93.6	100.0	100.0	380	405
Middle	11.5	17.2	88.5	82.8	100.0	100.0	346	296
High	12.4	21.3	87.6	78.7	100.0	100.0	69	84
Current Employment								
Employed	10.8	16.3	89.2	83.7	100.0	100.0	288	207
Unemployed	8.2	11.1	91.8	88.9	100.0	100.0	507	578
Frequency of Gynecologic Exams								
Never	2.6	4.1	97.4	95.9	100.0	100.0	495	503
Less than Once per Year	10.4	18.3	89.6	81.7	100.0	100.0	141	104
Once per Year	30.6	30.2	69.4	69.8	100.0	100.0	159	178

*/ Excludes 22 women in 1993 and 3 women in 1996 who said they did not know if they had or did not have a Pap smear.

women who have had a Pap test was three times higher in urban areas than in rural areas. This finding indicates that rural women have even lower access to cancer screening than urban women due probably to lower education and lower income, uneven distribution of primary health care providers, unavailability of local screening facilities, geographical location, transportation, and/or cultural barriers.

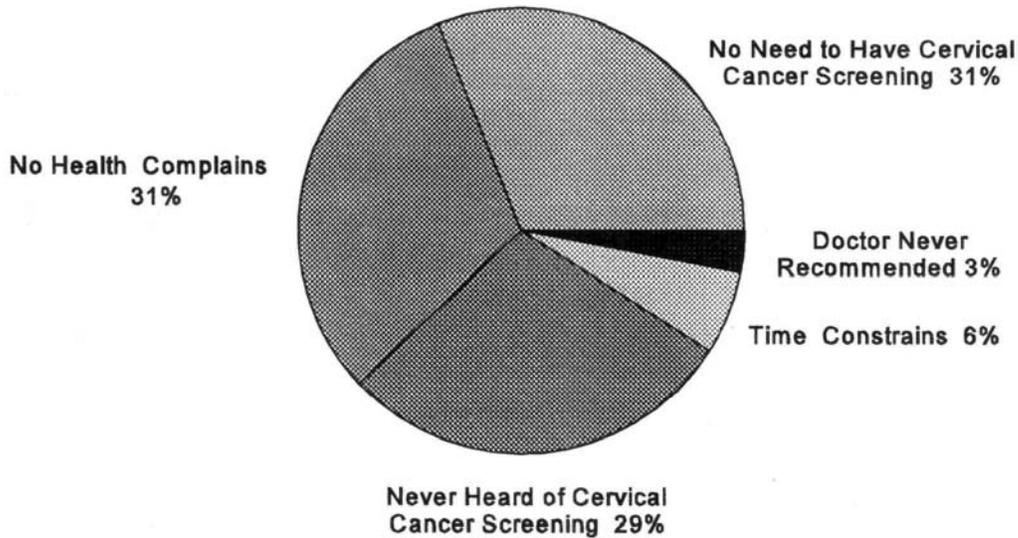
Prevalence of cervical cancer screening was directly correlated with age (three times higher among 20-24 year-olds than among 15-19 year olds) and with educational attainment, ranging from 6% among women with primary education to 19% among those with postgraduate education. The proportion of respondents having a Pap test increased with SES, from 6% among those with low SES to 17% and 21%, respectively, among women with medium or high SES. Women who had reported multiple sexual partners (not shown) had a higher prevalence of Pap smear screening than those with only one lifetime partner (19% vs. 11%).

Prevalence of Pap smear tests was directly correlated with frequency of gynecologic exams, ranging from 4% among women who have never had a routine exam to 30% among those with annual visits. It is worth noting, however, that only a third of women seeking routine gynecologic exams were screened for cervical cancer, in spite of their eligibility (age over 15 and sexually experienced). Gynecologic routine visits should be viewed as opportunities to educate patients about healthy lifestyle choices and to promote appropriate screening for preventable diseases such as cervical cancer. Lack of time and of financial incentives, lack of provider knowledge and interest in preventive care, lack of patient knowledge, and a poorly developed screening system are major contributors to the low coverage of cervical cancer screening. As long as health care providers do not engage actively in the delivery of preventive care in Romania, screening for cervical cancer will remain unsatisfactory, with costly consequences for an already burdened health delivery system.

The findings of the YARHS were largely consistent with the 1993 survey examining demographic and other indicators associated with utilization of cervical cancer screening ([Table 11.4](#)). Overall, the proportion of sexually experienced women aged 15-24 reporting at least one Pap smear test was higher in 1996 than in 1993 (13% vs. 9%) but the difference was not significant. Nor were the differences reported by certain subgroups who had an increased prevalence in 1996 compared to 1993 (urban women, women 20-24 year of age, best educated women, women with medium or high income, and women currently employed).

[Figure 11.4](#) presents the most important reasons for not having a cervical cancer screening test. As with the case of routine gynecologic exams, the majority of women who have never had a Pap smear either believe they do not need to have one (31 %) or consider that screening is not necessary if they not have health problems (31 %). Interestingly, the third most often mentioned reason was lack of knowledge of such a screening; 29% of women have never heard of Pap test. About 6 % of respondents reported that the most important reason they have not had screening was that they could not find time to visit the physician, and 3 % said that the doctor did not recommend the test.

FIGURE 11.4
REPORTED REASONS FOR NOT SEEKING CERVICAL CANCER SCREENING
SEXUALLY EXPERIENCED WOMEN AGED 15-24
YARHS, 1996



These findings reiterate the lack of knowledge about cervical cancer and screening procedures among young women in Romanian with no significant improvement in the three-year period from 1993 to 1996. The need for an intensive health education campaign for both young women and the general population is obvious.

11.5 Prevalence of Selected Health Problems Among Young Women

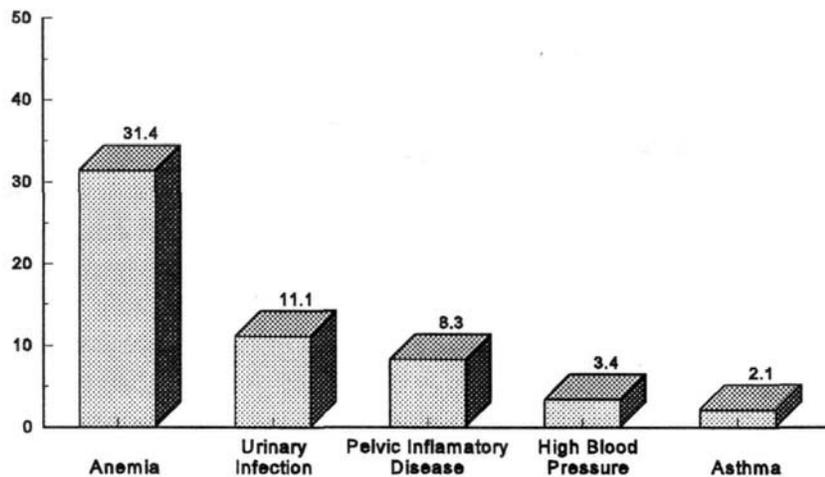
All female respondents were asked "Has a doctor ever told you that you have had (selected health problems)?". These problems were: anemia, urinary infection, infection of the tubes or uterus, high blood pressure, asthma, and diabetes. [Table 11.5](#) and [Figure 11.5](#) show the percentage of young women who have ever been told by a doctor that they have had these specific health problems. Given that less than one percent of young women have ever been told that they have diabetes and no significant differences in prevalence were found among various subgroups, this illness was not included in the analysis.

TABLE 11.5
Percentage of Young Women 15-24 Years of Age Who Have Been Told By A Doctor
That They Have Selected Health Problems
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

Characteristics	Selected Health Problems					Unweighted No. of Cases
	Anemia	Urinary Infection	Pelvic Inflammatory Disease	High Blood Pressure	Asthma	
Total	31.4	11.1	8.3	3.4	2.1	2,025
Residence						
Urban	37.1	12.8	9.6	3.9	2.3	983
Rural	24.1	8.8	6.6	2.9	1.8	1,042
Age Group						
15-17	21.3	6.1	1.1	1.8	2.6	738
18-19	32.7	9.5	7.0	2.5	2.8	501
20-24	37.1	14.8	13.4	4.9	1.4	786
Marital Status						
Married&In Union	39.0	16.0	14.5	5.1	1.5	570
Unmarried	27.2	8.3	4.9	2.5	2.3	1,455
Education						
Primary	21	7.5	6.2	3.3	2.8	460
Some High School (HS)	29.5	9.3	5.8	3.6	2.2	917
HS Complete	39.7	15.3	12.5	3.3	1.5	648
Sexual Experience						
Never Had	25.4	7.0	2.8	1.9	2.5	1,237
Ever Had	38.4	15.7	15.0	5.2	1.5	788
Pregnancy Experience*						
Never Been Pregnant	27.2	8.5	5.2	2.2	2.1	1,502
Had Only Birth(s)	40.4	14.4	8.9	3.6	2.8	231
Had Birth(s) and Abortion(s)	42.2	18.4	19.1	9.2	1.5	145
Had Only Abortion(s)	43.3	17.9	19.7	6.4	0.8	105

*/ Excludes 42 women who were currently pregnant at the time of the interview and had no previous pregnancy.

FIGURE 11.5
PERCENTAGE OF WOMEN WHO HAVE BEEN TOLD BY A
DOCTOR THAT THEY HAVE SELECTED HEALTH PROBLEMS
YOUNG WOMEN AGED 15-24 YEARS - YARHS, 1996



Obviously, these results are minimum estimates of the true prevalence of these health problems in the population of young women. They probably under-represent the real prevalence since self-reporting of health conditions implies that young women had access to health care facilities, had visited these facilities, and had been told by physicians about their health. Thus, the self-reported occurrence of health problems among different subgroups should be interpreted with caution because background characteristics may affect both the access to health care system and reporting. Furthermore, these are lifetime estimates and do not reflect current health status and cannot be temporally associated with other events. For example, a direct link between anemia and the pregnancy experience cannot be established since it is impossible to determine if anemia was a prior condition or had developed during the pregnancy. For all these reasons, the survey data about health problems among young women may serve only as proxy estimates of their true prevalence in the absence of official statistics based on medical records or hospital discharge data.

Overall, almost one in every three young women reported that she was told by a doctor that she had anemia. The proportion of women with anemia was significantly higher in urban areas than in rural areas (37% vs. 24%) and increased directly with age, from 21% among 15-17 year-olds, to 33% among women aged 18-19, and 37% among 20-24 year-olds. Prevalence of anemia was significantly higher among married women than among unmarried (39% vs.

27%) and it was positively correlated with educational level, ranging from 21% among women with primary education, to 30% among women with some high-school, and 40% among the best educated women. Anemia was reported more often by women with sexual experience than by those without (38% vs. 25%). Perhaps the most striking finding is the higher prevalence among young women with pregnancy experience (40-43%) compared to the levels reported by women who have never had a pregnancy (27%).

There is strong evidence to suggest that the majority of cases of anemia among young women in Romania are secondary to iron deficiency. A previous national nutrition survey which tested blood for hemoglobin (Yip R. et al., 1993), showed the prevalence of anemia to be as high as 50% among younger children. Iron deficiency is primarily due to an unbalanced diet, with inadequate consumption of food with high content of iron, vitamins and micronutrients which stimulate iron absorption and a high intake of foods of non-animal origin which are low in iron content. Iron deficiency could be exacerbated during periods of rapid growth and during pregnancy, when considerable amount of maternal iron is transferred to the fetus. When iron deficiency is highly prevalent in a population, pregnant women, who have a physiologic hemodilution and also higher iron requirements, are at greater risk of developing anemia than nonpregnant women. However, it is possible that the higher prevalence of anemia among women with pregnancy experience might also reflect differences in reporting, since pregnant women are more likely to find out about their anemia during prenatal care visits compared to women who have never been pregnant and may not have had any blood test. Other common causes of anemia among young women include blood loss and acute infections. Anemia associated with abortion is more likely the result of excessive blood loss and/or infection at the time of pregnancy termination because of both hemodilution and iron depletion begin after the first 10 weeks of gestation.

Overall, one in ten young women had been told by a doctor that they have or have had urinary infection. The percentage of respondents reporting urinary infections were higher in urban areas than in rural areas (13% vs. 9%), was directly correlated with age and educational level, and was two times higher among married than among unmarried women (16% vs. 8%). Women with sexual experience were also two times more likely than women who have never had sexual intercourse to report urinary tract infections (16% vs. 7%). Also, women with abortion experience were the most likely to have been told by a doctor about having urinary infections (18%), whereas those who have never been pregnant were the least likely (9%).

The prevalence of pelvic inflammatory disease (PID) was determined by asking women if they had ever been told that they had an infection of the fallopian tubes (salpingitis) or infection of the uterus (endometritis). Overall, 8% of young women reported PID. The most likely to report PID, were women aged 20-24 years (13%), women with postgraduate education (13%), married women (15%), women with sexual experience (15%), and women with abortion experience (19%). Prevalence of chronic diseases such as high blood pressure and asthma were very low (3% and 2%, respectively) with significant variations by background characteristics.

CHAPTER XII

KNOWLEDGE OF AIDS TRANSMISSION AND PREVENTION

Of the estimated 4.5 million cases of acquired immunodeficiency syndrome (AIDS) in the world, only 4% have been reported in Europe (World Health Organization, 1995). However, according to WHO estimates, over 500,000 persons in Europe are infected with the human immunodeficiency virus (HIV) that causes AIDS. In 1995, there were 148,358 cases of AIDS in Europe (European Centre for the Epidemiological Monitoring of AIDS, 1995), of which only a few more than 5,000 cases were reported from Central and Eastern Europe.

HIV infection is potentially a major health problem in Romania as it has proven to be in other European countries. As of September, 1995, a total of 3,601 AIDS cases resulting in 1,262 deaths had been reported to the Romanian Ministry of Health (since 1985 when the country reported the first AIDS case). AIDS cases in Romania are concentrated among pediatric patients (Hersh, et al., 1991), especially among abandoned children living in public institutions, owing primarily to nosocomial transmission-through non-sterile needles and syringes or through transfusions of contaminated blood. Almost 3,300 cases of those reported by September 1995 (91 %) were among children under 13 years of age, accounting for over 50% of the pediatric cases reported in Europe. Although the number of AIDS cases in children continues to rise as more infected children begun to have symptoms, few cases have been reported among the cohorts born after 1990 concurrent with the intensive efforts undertaken by the national program of HIV/AIDS prevention and control developed and implemented by the MOH in late 1990 with assistance from WHO and other international organizations. This program is aimed particularly at curbing nosocomial or common source transmission (testing the blood supply for HIV-antibodies, proper indications for blood transfusions and parenteral therapy, widespread use of disposable needles and syringes).

Of equal concern for public health authorities is the rise in adult AIDS cases, which, in the wake of the post-revolution surge in prostitution, has been mainly attributed to the sexual transmission of HIV. Of the 322 AIDS cases reported among adults, 209 have a known source of transmission and 170 (81%) were caused by sexual transmission--145 among heterosexual men and women, and 25 among homosexual or bisexual men (MOH, Department of Preventive Medicine, 1995). At the same time, as in other Eastern-European countries, Romania has experienced an alarming increase in other sexually transmitted diseases (STDs), especially in primary and secondary syphilis. The reported syphilis rate (new cases) increased by almost 5 times between 1986 and 1996, from 7.1 to 32.2 per 100,000 inhabitants (MOH, Center for Health Information, 1997). These figured are based on the current national statistics reflecting only cases reported to the public health authorities. In Romania, reporting of HIV, syphilis, and gonorrhea is mandatory by law but these statistics reflect only patients who seek medical care and underreport persons who avoid visiting a medical care provider and use self-treatment, those with

asymptomatic STDs, and those with limited access to medical care. Furthermore, other STDs are not reported and the laboratory facilities are limited and often lack the ability to perform basic tests (e.g Chlamydia is diagnosed only in a few laboratories).

Another critical issue in the epidemiology of STDs is the synergistic effect they may have on each other. From the beginning of AIDS epidemic, it has become clear that HIV and other STDs could often be found in the same patients. Although these concurrent infections share common sexual risk factors, epidemiologic and biologic evidence show that classic STDs can exacerbate HIV transmission, while HIV infection and related immunodeficiency may enhance susceptibility to other STDs (Laga et al., 1991, Wasserheit, 1992).

In the past, primary prevention for STDs had been largely neglected, but with the emergence of HIV the public health community started to give increasing attention to the promotion of safer sexual behaviors through educational messages and increasing condom availability. In recent years, both the national HIV/AIDS prevention program and several newly founded NGOs, such as the Romanian Association Against SIDA (ARAS), made educating the general public about the HIV infection threat and means of transmission a priority, along with promotion of safer sex and risk reduction practices. While increasing the level of knowledge about HIV and its transmission can successfully prevent the spread of the disease among those at risk, efforts should also be made to insure high awareness about other STDs. However, it is also critical that information does not convey needless threats among those having very low risk of becoming infected.

In order to effectively target these educational efforts, it is important to examine periodically the STDs-related knowledge among various population groups and define population subgroups in greater need of primary prevention messages, to identify factors that influence correct knowledge, and to better understand misconceptions surrounding HIV transmission. Worldwide, data on STD levels and behaviors related to STDs' risk have demonstrated that a high priority should be given to educational efforts targeting adolescents and young adults. More information is needed to increase self-perceived susceptibility for STDs among youths, to correct misperceptions, and to promote protective behaviors.

As in the 1993 Romanian Reproductive Health Survey, the 1996 YARHS included a module designed to assess the general level of HIV/AIDS awareness, the level and accuracy of knowledge about HIV transmission and prevention of HIV infection, and the self-perceived risk of HIV infection. In addition, in the 1996 survey respondents who have heard about HIV/AIDS were asked their main source of information about the disease and if they ever heard of other selected STDs.

12.1 Knowledge of AIDS and Other STDs

Survey findings showed that awareness of HIV/AIDS is generally high in Romania, but the ability of young adults to identify other STDs is limited. As shown in [Tables 12.1A](#) and

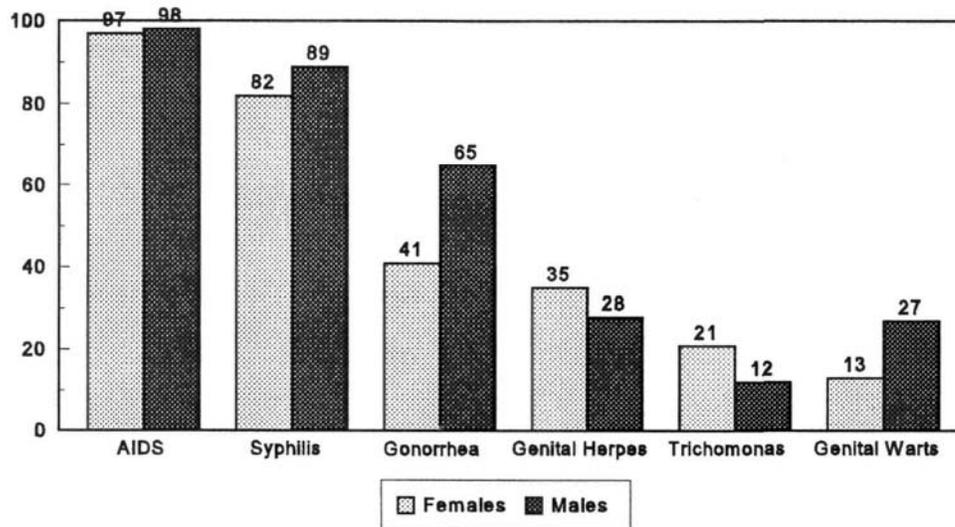
TABLE 12.1A
Percent of Young Women Who Have Heard of Specified Sexually Transmitted Diseases
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>AIDS</u>	<u>Syphilis</u>	<u>Gonorrhea</u>	<u>Genital Herpes</u>	<u>Trichomonas</u>	<u>Genital Warts</u>	<u>Number of Cases</u>
Total	96.7	81.7	40.7	35.4	20.7	13.0	2,025
Residence							
Urban	98.0	90.1	49.5	45.2	26.1	16.8	983
Rural	95.1	70.9	29.5	22.9	13.9	8.1	1,042
Age Group							
15-17	95.8	73.3	21.6	26.1	8.4	6.2	738
18-19	96.8	83.3	44.0	39.2	19.5	13.4	501
20-24	97.2	86.3	51.3	39.6	28.9	17.1	786
Education							
Primary	87.1	50.6	19.0	10.4	7.0	3.5	460
HS Incomplete	99.1	84.0	31.2	28.1	12.2	7.8	917
HS Complete & PostHS	99.3	96.7	64.7	58.6	38.9	24.8	648
Socioeconomic Index							
Low	92.9	66.6	27.5	15.3	9.9	5.9	917
Medium	99.4	92.0	48.4	47.3	26.9	17.2	876
High	100.0	95.5	58.0	60.1	35.2	21.9	232
Sexual Experience							
No Sexual Experience	97.4	79.7	33.1	34.3	15.4	10.0	1,237
Sexually Experienced	95.9	84.0	49.6	36.7	26.9	16.6	788
No. of Lifetime Partners							
0	97.4	79.7	33.1	34.3	15.4	10.0	1,237
1	95.6	81.8	46.6	33.5	23.8	14.4	636
2+	97.6	93.9	62.9	51.2	40.9	25.1	146
Formal Sex Education							
Never Had	95.1	76.4	36.7	28.7	17.2	9.7	1,292
Ever Had	99.6	91.6	48.2	47.7	27.2	19.1	733
Parental Sex Education							
Never Had	95.8	77.9	37.2	29.5	17.8	10.2	1,467
Ever Had	99.1	91.6	49.9	50.7	28.3	20.4	558

Table 12.1B
Percent of Young Men Who Have Heard of Specified Sexually Transmitted Diseases
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	AIDS	Syphilis	Gonorrhea	Genital Herpes	Genital Warts	Trichomonas	Number of Cases
Total	97.6	89.2	64.6	28.4	27.3	11.5	2,047
Residence							
Urban	99.1	95.1	67.0	38.1	32.5	13.2	1,075
Rural	95.9	81.9	61.8	16.6	20.9	9.4	972
Age Group							
15-17	97.2	79.2	49.0	17.6	15.7	4.9	805
18-19	97.5	89.1	64.7	30.7	25.6	9.0	517
20-24	97.9	95.7	74.7	34.4	35.6	16.7	725
Education							
Primary	90.4	67.4	46.7	6.3	14.0	3.5	473
HS Incomplete	99.3	92.5	64.0	24.3	25.1	10.5	1,065
HS Complete & PostHS	100.0	99.7	79.5	52.9	41.6	19.4	509
Socioeconomic Index							
Low	94.8	79.7	55.6	12.7	20.5	8.2	786
Medium	99.3	94.3	69.2	33.0	30.9	12.1	943
High	100.0	97.9	73.7	54.0	33.6	17.9	318
Sexual Experience							
Not Sexually Experienced	95.5	76.2	47.6	16.3	15.5	4.6	839
Sexually Experienced	98.7	95.7	73.2	34.5	33.3	14.9	1,208
No. of Lifetime Partners							
0	95.5	76.2	47.6	16.3	15.5	4.6	839
1	95.6	89.6	67.4	23.5	23.2	9.2	164
2+	99.3	96.8	74.0	35.9	34.6	15.4	1,021
Formal Sex Education							
Never Had	96.5	86.5	59.9	21.3	24.8	8.6	1,234
Ever Had	99.5	93.5	72.3	39.8	31.4	16.1	813
Parental Sex Education							
Never Had	97.2	87.3	62.2	23.7	24.5	9.4	1,623
Ever Had	99.5	96.7	74.4	46.7	38.3	19.6	424

FIGURE 12.1
AWARENESS OF SEXUALLY TRANSMITTED DISEASES (STDs)
BY SPECIFIC STDs, BY GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



12. 1B and Figure 12.1, almost all young adults in Romania had heard of AIDS (97% of women and 98% of men) and of syphilis (82% of women and 89% of men) but fewer were aware of other common STDs. Overall, young adults demonstrated moderate levels of awareness of gonorrhea (41% of females and 65 % of males) and low levels of knowledge about the names of several other diseases which are transmitted through sexual contact; only 35 % of women and 28 % of men recognized that genital herpes is a disease transmitted sexually, whereas 21 % of women and 12% of men positively identified trichomoniasis as an STD and 13% of women and 27% of men have heard of genital warts. Only 20% of females and 38% of males have heard of four or more STDs out of six STDs mentioned in the questionnaire.

Although the level of awareness about AIDS was almost universal across various population subgroups, those with better education and exposure to AIDS education in school or at home had slightly higher awareness. However, for other STDs, the level of awareness varied substantially by respondents characteristics. Generally, among both women and men, urban residence, older age, high socioeconomic status, higher education attainment (including exposure to sex education about STDs), being sexually experienced, and having two or more lifetime sexual

TABLE 12.1.2
Percent of Young Adults Who Have Heard Of AIDS
And Who Believe A Person Can Be Infected With HIV Without Showing Symptoms
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	WOMEN				MEN			
	Have Heard of HIV/AIDS		Believe Infection Can Be Asymptomatic		Have Heard of HIV/AIDS		Believe Infection Can Be Asymptomatic	
	%	n	%	n	%	n	%	n
Total	96.7	2,025	61.8	1,955	97.6	2,047	73.0	1,995
Residence								
Urban	98.0	983	70.3	968	99.1	1,075	80.1	1,067
Rural	95.1	1,042	50.7	987	95.9	972	64.1	928
Age Group								
15-17	95.8	738	58.5	706	97.2	805	66.9	781
18-19	96.8	501	64.1	484	97.5	517	77.9	503
20-24	97.2	786	62.9	765	97.9	725	74.9	711
Education								
Primary	87.1	460	33.5	403	90.4	473	54.4	429
HS Incomplete	99.1	917	58.7	908	99.3	1,065	72.5	1,057
HS Complete & PostHS	99.3	648	79.8	644	100.0	509	86.9	509
Sexual Experience								
Not Sexually Experienced	97.4	1,237	62.4	1,202	95.5	839	66.5	799
Sexually Experienced	95.9	788	61.2	753	98.7	1,208	76.2	1,196
Formal Sex Education								
Never Had	95.1	1,292	55.7	1,138	96.5	1,234	68.8	1,210
Ever Had	99.6	733	71.2	817	99.5	813	80.3	785
Parental Sex Education								
Never Had	95.8	1,467	56.9	1,387	97.2	1,623	70.8	1,652
Ever Had	99.1	558	73.9	568	99.5	424	84.4	343

partners were associated with significantly higher levels of awareness of specific STDs. For the least known STDs, such as genital herpes, trichomoniasis, and genital warts, the awareness among these subgroups of young adults was two or even three fold higher compared to rural residents,

younger age, primary education, low socioeconomic status, lack of sexual experience and no sex education, respectively.

The questionnaire did explore AIDS knowledge in greater depth. As in the 1993 survey, the findings of YARHS underscored that simple awareness is not always an indication of knowing basic facts concerning AIDS. Awareness of AIDS, and by implication of other STDs, appears to be weakly associated with correct knowledge in many cases. For example, only 62% of women and 73% of men who had heard of AIDS (see [Table 12.1.2](#)) knew that HIV infection could be symptomless and a person could be infected without being sick. This finding is particularly alarming because: (1) the number of HIV-positive individuals living among a largely unsuspecting population is much higher than the number of individuals with AIDS symptoms, (2) Romania, apart from blood donors and institutionalized children, has not implemented extensive routine HIV testing, (3) the sexual transmission of HIV has accounted for an increasing number of AIDS cases, and (4) the consistent use of condoms among young adults remains low (see Chapter 8).

Furthermore, although awareness of AIDS was almost universal among various subgroups, there are great variations in the levels of correct AIDS knowledge by sociodemographic characteristics. As previously mentioned, young males were more likely to know that a person could be infected with HIV and have no symptoms than young females. Only 51% of young women and 64% of young men residing in rural areas knew that HIV infection could be asymptomatic, compared with 70% of women and 89% of men in urban areas. Adolescent women and men were only marginally less knowledgeable than 20-24 year-olds. Only 34% of women and 54% of men with primary education knew that someone could be infected and have no symptoms, compared to 80% women and 87% men with complete secondary or post-secondary education. Knowledge that the infection could be symptomless was slightly higher among sexually experienced men (76% vs. 67%) but not among women. Exposure to sex education in school about HIV/AIDS and discussion with parents about this topic were positively correlated with better knowledge both among women and men.

12.2 Source of Information About HIV/AIDS

As shown in [Table 12.2](#), the most important source of HIV information (for 62 % of men and 57% of women) were announcements on television or radio. Among men, the proportion who mention seeing or hearing AIDS announcements as the first source of information did not differ significantly by sociodemographic characteristics, whereas among women it was higher for rural residents, those aged 20 or more, ever married, and with lower education. Also, young women who knew that HIV infection could be asymptomatic were less likely to cite TV and radio as their most important source than women who did not have this knowledge (52% vs. 65%).

The second most important source for women, mentioned by 17%, was a school lecture whereas for men it was word of mouth (a relative or a friend). Reading AIDS pamphlets, brochures, or newspaper information were mentioned as the most important source by 13% of

Table 12.2
Percent Distribution of Young Adults Who Have Heard of HIV/AIDS
By Their Most Important Source of Information about AIDS By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>TV/Radio</u>		<u>School</u>		<u>Magazines Brochures/ Pamphlets</u>		<u>A Relative and/or a Friend</u>		<u>Health Professional</u>		<u>Total</u>	<u>No. of Cases*</u>	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men		Women	Men
Total	57.0	62.4	17.3	10.2	13.2	12.3	8.3	12.9	4.2	2.2	100.0	1,954	1,991
Know that HIV Infection Can be Asymptomatic													
Yes	52.0	63.4	20.1	10.4	17.2	13.8	6.5	10.0	4.2	2.5	100.0	1,182	1,445
No	65.1	60.0	12.8	9.5	6.6	8.4	11.2	20.8	4.3	1.4	100.0	772	546
Residence													
Urban	53.0	63.5	19.2	10.3	15.7	14.6	7.9	9.4	4.2	2.1	100.0	968	1,065
Rural	62.4	61.1	14.9	10.0	9.9	9.4	8.7	17.3	4.2	2.2	100.0	986	926
Age Group													
15-17	49.8	61.6	27.1	16.9	11.0	5.6	8.6	13.6	3.5	2.3	100.0	706	780
18-19	55.3	57.8	20.0	11.5	12.4	11.8	7.6	15.3	4.8	3.5	100.0	483	502
20-24	62.2	64.9	10.2	5.3	14.8	16.9	8.3	11.5	4.5	1.5	100.0	765	709
Marital Status													
Ever Married	69.1	65.6	5.6	3.0	10.5	19.1	9.9	11.1	4.9	1.1	100.0	537	150
Never Married	50.5	61.8	23.7	11.5	14.6	11.1	7.4	13.2	3.9	2.4	100.0	1,417	1,841
Education													
Primary	68.2	61.3	8.6	5.2	5.2	4.6	13.9	27.8	4.1	1.1	100.0	402	429
HS Incomplete	56.5	64.9	19.9	12.1	10.8	9.9	8.5	10.9	4.3	2.3	100.0	908	1,056
HS Complete/PostHS	52.1	58.6	18.6	10.1	20.0	22.3	5.1	6.3	4.2	2.7	100.0	644	506
Sexual Experience													
No Sexual Experience	51.7	62.9	24.6	15.2	12.8	6.8	7.4	12.7	3.5	2.4	100.0	1,201	798
Sexually Experienced	63.3	62.2	8.8	7.7	13.6	15.0	9.2	13.0	5.1	2.1	100.0	753	1,193
No. Lifetime Partners													
0	51.7	62.9	24.6	15.2	12.8	6.8	7.4	12.7	3.5	2.4	100.0	1,201	798
1	65.3	59.8	7.8	11.5	12.9	13.2	9.4	12.3	4.7	3.2	100.0	607	160
2+	55.4	62.6	13.3	7.1	15.7	15.2	8.3	13.2	7.3	1.9	100.0	141	1,012

* Excludes one woman and four men who mentioned other sources of information about HIV/AIDS

women and 12% of men. The proportion mentioning this source as the most important increased with age and education, and was higher among urban residents, sexually experienced males, and those with two or more lifetime sexual partners. Young women and men who knew that HIV infection could be asymptomatic tended to get their information (most important source) more often from school or from written materials (magazines, brochures or pamphlets) compared to those who did not know HIV infection could be symptomless. Conversely, both men and women without this knowledge were more likely to report a relative or friend as their most important source of information than those who know that HIV could be symptomatic, a possible indication of lower quality of information coming from these sources.

The proportion who mentioned a health-care worker as the most important source was negligible for both men and women (2% and 4%, respectively) underscoring the need of engaging the medical community in counseling and health education efforts.

12.3 Knowledge About HIV/AIDS Transmission

The level of knowledge about AIDS transmission was assessed by asking the respondents whether selected statements (12 statements) about transmission were true or false. The respondents were classified as lacking knowledge if they reported that a specific activity could not cause HIV transmission when, on the contrary, it could (answers "No") or they did not know if the means of transmission could cause infection (answers "Do not Know"). If respondents identified activities which in fact cannot cause HIV infection as potential ways of transmission (answers "Yes"), they were classified as having "misinformation". For this latter group, however, those who answered "No" and "Do not Know" were grouped together as not having misinformation.

Overall, the level of knowledge of common modes of AIDS transmission was high, with 74% of females and 82% of men identifying correctly the four major activities which could transmit HIV infection: sexual intercourse (heterosexual or homosexual), using non-sterile needles, and receiving blood transfusions. In addition, 18% of women and 15 % of men gave only one wrong answer. Only two percent of women and less than one percent of men did not know whether any of these four means of transmission could spread the virus. [Tables 12.3.1A](#) and [12.3.1B](#) and [Figure 12.3.1](#) show the percent of women and men with lack of knowledge about these four modes of transmission.

Heterosexual transmission has accounted for the highest proportion of adult AIDS cases in Romania (45%), followed by blood transfusions and homo/bisexual transmission (8%). Almost all young adults reported correctly that HIV can be transmitted by heterosexual intercourse. Only 3 % of women and 2% of men reported that a person could not be infected this way. Younger age, rural residence, lower education, low socio-economic index, and no sexual experience were associated with higher levels of lack of knowledge about heterosexual transmission.

TABLE 12.3.1A
Percent of Young Women With Lack of Knowledge About Specified Means of AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Heterosexual Intercourse	Using Non-Sterile Needles	Receiving Blood Transfusions	Homosexual Intercourse	Unweighted Number of Cases
Total	3.3	5.1	8.8	21.0	1,955
Residence					
Urban	1.7	2.5	4.2	13.9	968
Rural	5.3	8.5	15.0	30.4	987
Age Group					
15-17	4.7	6.4	10.1	25.0	706
18-19	3.0	5.8	7.8	19.5	484
20-24	2.5	4.0	8.5	19.2	765
Education					
Primary	11.0	15.4	20.2	36.0	403
HS Incomplete	2.4	3.5	9.6	22.6	908
HS Complete & PostHS	0.4	1.9	2.2	11.7	644
Socioeconomic Index					
Low	5.7	9.9	16.2	30.0	853
Medium	1.6	1.8	4.2	15.6	870
High	1.6	2.0	2.2	12.4	232
No. of Lifetime Partners					
0	3.6	5.8	8.1	21.9	1,202
1	2.9	4.9	9.8	21.0	607
2+	2.8	2.0	9.3	16.0	141
Formal Sex Education					
Never Had	4.7	7.0	11.9	23.7	1,138
Ever Had	1.2	2.2	4.1	16.9	817
Parental Sex Education					
Never Had	4.0	6.3	11.5	23.0	1,387
Ever Had	1.6	2.1	2.2	16.2	568

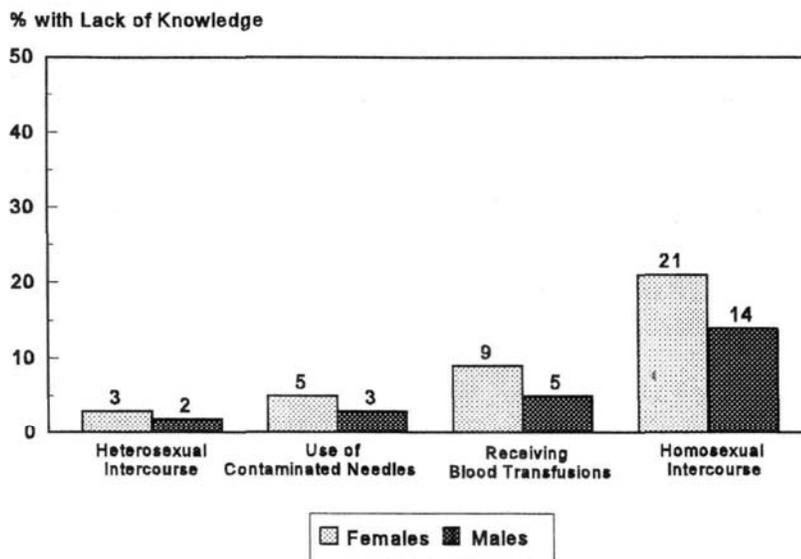
TABLE 12.3.1B
Percent of Young Men With Lack of Knowledge About Specified Means of AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Heterosexual Intercourse	Using Non-Sterile Needles	Receiving Blood Transfusions	Homosexual Intercourse	Unweighted Number of Cases
Total	1.9	3.1	4.9	13.5	1,995
Residence					
Urban	1.5	2.3	4.0	9.9	1,067
Rural	2.4	4.1	6.1	18.1	928
Age Group					
15-17	2.6	3.3	6.6	18.7	781
18-19	1.1	3.3	4.6	9.2	503
20-24	1.7	2.9	3.9	11.9	711
Education					
Primary	3.5	8.4	10.4	21.9	429
HS Incomplete	1.8	2.2	4.9	14.4	1,057
HS Complete & PostHS	0.9	1.2	1.0	6.0	509
Socioeconomic Index					
Low	2.2	5.2	7.9	18.5	742
Medium	1.7	2.2	3.3	11.6	935
High	1.7	0.9	2.4	7.4	318
No. of Lifetime Partners					
0	2.4	4.0	7.7	18.2	799
1	1.7	2.2	2.8	12.8	160
2+	1.5	2.8	3.6	10.9	1,014
Formal Sex Education					
Never Had	2.6	3.9	6.4	14.9	1,210
Ever Had	0.5	1.9	2.2	11.1	785
Parental Sex Education					
Never Had	2.1	3.5	5.4	14.3	1,652
Ever Had	0.6	1.2	2.3	9.5	343

Transmission through contaminated needles had been the major contributor to the AIDS epidemic in Romania, but no adult cases have been directly attributed to it. About 36% of the pediatric cases were caused by inappropriate re-use of needles and syringes in medical settings. So far, no cases had been linked to therapeutic injections among the adult population or to the use of non-sterile hypodermic needles among intravenous drug users. The use of contaminated needles was highly publicized as a major public health concern in Romania; the national AIDS prevention programme concentrated its efforts to stop the spread of HIV through injections and to educate the general population about this risk. Overall, only 5% of women and 3% of men were not aware of this mode of transmission. Again, knowledge of needle transmission was positively associated with urban residence, age over 20, education, socioeconomic status, exposure to sex education about AIDS (in school or at home), and sexual experience.

HIV infection from blood transfusions is another documented source of AIDS transmission in Romania. About 24% of children cases and 13% of adult cases owe their disease to a transfusion of infected blood or blood products. In the most recent comparison of the incidence

FIGURE 12.3.1
LACK OF KNOWLEDGE ABOUT HIV TRANSMISSION
BY SPECIFIED MEANS OF TRANSMISSION AND GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



rates of AIDS cases among transfusion recipients in European countries (Franceschi et al., 1995) and the United States, Romania had the highest rate of blood borne AIDS cases in children and the second highest (after France) in adults. Since the implementation of blood control procedures in 1990, Romania has experienced a substantial decline in the blood borne AIDS cases. There is widespread knowledge among Romanians that HIV infection could be transmitted through blood transfusions. Only 9% of women and 5% of men did not recognize this mode of transmission.

Homosexual intercourse is another important mode of spreading HIV infection, more prevalent in Western Europe and the U.S. In Romania, only 8% of AIDS cases occurred among homo-/bisexual men. Knowledge about this risk was less prevalent than knowledge on other means of transmission, regardless of the gender of the respondents. About one in five women and 14% of men thought that homosexual intercourse could not spread the AIDS virus. The differences in knowledge were notable by place of residence. In rural areas, 30% of young women and 18% of young men were not aware that homosexual intercourse could result in HIV transmission. For both sexes, misinformation about homosexual transmission was inversely correlated with age, education, socio-economic index, and number of lifetime partners. Misinformation about this type of HIV transmission was slightly lower among those with formal sex education and discussions with a parent for both females and males.

[Tables 12.3.2A](#) and [12.3.2B](#) show the percent of young adults who have misinformation about HIV/AIDS transmission (agreed with means of transmission which cannot result in HIV spread) by background characteristics. Eight statements were used to assess misinformations about HIV/AIDS transmission and are listed in ascending order, from the least common to the most prevalent. Generally, the same groups that were the least likely to know valid means of HIV transmission (see [Tables 12.3.1A](#) and [B](#)) were also the most likely to have unfounded concerns.

Overall, most young adults have some misperceptions about HIV/AIDS transmission, even though many identified correctly several behaviors which could result in HIV spread. When the number of incorrect responses were totaled for each individual, only 7% of women and 5% of men answered correctly to all eight statements, with most young adults (66% of women and 59% of men) giving three or more wrong answers, and 10% young adults giving 6-8 erroneous responses ([Figure 12.3.2](#)).

Generally, shaking hands was rarely regarded as a route of HIV transmission (6% of women and 7% of men). In contrast, using public baths (douches and/or bathtubs) and sharing objects with a person with HIV infection were erroneously viewed as means of HIV transmission by a sizable proportion. Almost one in four young adults thought that using public baths carries the risk of contracting HIV and one in three believed that sharing objects with HIV-infected people could be a valid means of transmission. Rural residence, lower education and socioeconomic index, and lack of sex education were associated with higher level of misbeliefs that HIV could be transmitted through these kind of casual contacts.

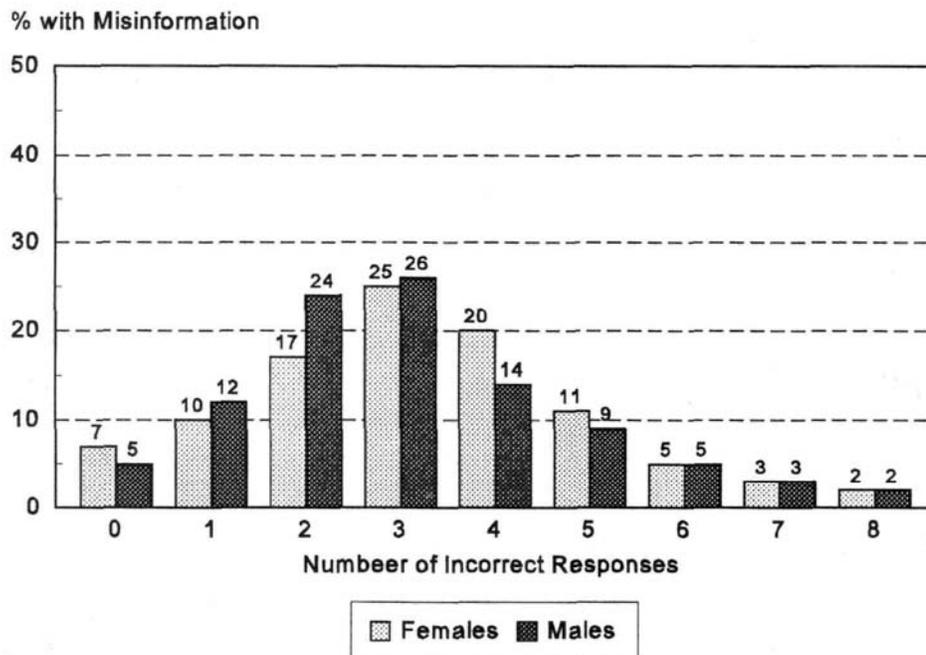
TABLE 12.3.2A
Percent of Young Women With Misinformation about HIV/AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Shaking Hands	Kissing	Being Bitten by Mosquitos	Using Public Baths	Sharing Objects with an Infected Person	Going to Barber or Nail Parlors	Donating Blood	Getting Surgical or Dental Treatment	Number of Cases
Total	5.9	22.0	23.4	27.9	37.0	61.7	68.9	75.0	1,955
Residence									
Urban	2.5	17.3	22.5	24.6	31.3	68.6	71.9	80.6	968
Rural	10.5	28.3	24.7	32.2	44.6	52.7	65.0	67.6	987
Age Group									
15-17	5.9	23.1	22.0	27.6	39.0	55.4	68.9	69.4	706
18-19	6.0	20.3	23.3	28.1	34.7	63.5	69.2	76.6	484
20-24	6.0	22.1	24.3	27.9	36.8	64.8	68.8	77.8	765
Education									
Primary	14.9	33.0	24.3	35.2	48.0	43.7	61.3	62.1	403
HS Incomplete	4.9	22.9	24.0	32.3	40.2	58.5	68.8	72.2	908
HS Complete/PostHS	2.7	15.5	22.2	18.8	27.8	74.6	72.7	85.0	644
Marital Status									
Ever Married	8.5	26.5	28.7	33.4	41.3	59.2	66.1	75.4	537
Never Married	4.6	19.6	20.6	24.9	34.7	63.1	70.4	74.8	1,418
Socioeconomic Index									
Low	10.3	29.7	25.0	33.6	45.1	51.9	65.3	66.2	853
Medium	3.2	17.1	22.6	24.7	33.0	66.5	70.5	80.8	870
High	2.4	15.7	21.3	21.3	26.1	75.4	74.4	82.1	232
No. Lifetime Partners									
0	5.4	20.4	19.8	26.2	37.0	60.7	69.8	72.7	1,202
1	7.6	25.2	27.6	30.3	38.0	61.4	67.6	76.4	607
2+	2.9	18.4	28.6	28.0	32.8	70.0	69.0	84.6	141
Formal Sex Education									
Never Had	7.1	24.2	24.1	30.4	37.5	57.9	67.2	71.0	1,138
Ever Had	4.2	18.8	22.4	24.0	36.3	67.5	71.6	81.1	817
Parental Sex Education									
Never Had	7.0	24.0	24.1	29.1	39.7	59.4	66.6	72.8	1,387
Ever Had	3.2	17.1	21.8	24.7	30.5	67.6	80.6	74.6	568

TABLE 12.3.2B
Percent of Young Men With Misinformation about HIV/AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Shaking Hands	Using Public Baths	Being Bitten by Mosquitos	Kissing	Sharing Objects with an Infected Person	Going to Barber or Nail Parlors	Getting Surgical or Dental Treatment	Donating Blood	Number of Cases
Total	6.7	23.8	25.7	26.8	33.0	40.7	71.8	77.2	1,995
Residence									
Urban	3.2	18.1	21.9	19.6	27.0	45.6	75.4	75.9	1,067
Rural	11.0	30.9	30.6	35.8	40.5	34.4	67.3	78.9	928
Age Group									
15-17	7.2	24.8	28.1	27.7	35.0	34.9	66.7	76.3	781
18-19	5.1	23.1	23.9	24.6	32.3	41.9	73.9	77.8	503
20-24	7.0	23.4	24.9	27.1	32.0	43.9	74.3	77.6	711
Education									
Primary	14.7	44.4	41.2	47.8	55.9	37.9	67.7	77.1	429
HS Incomplete	6.1	22.1	24.0	26.0	31.2	36.9	69.3	77.8	1,057
HS Complete/PostHS	2.3	12.7	18.2	13.7	20.6	49.6	79.4	76.1	509
Socioeconomic Index									
Low	11.9	34.2	32.9	40.7	44.6	34.0	66.1	76.3	742
Medium	3.6	19.5	22.6	21.2	28.9	42.5	73.2	78.1	935
High	3.2	11.7	17.9	10.3	17.6	51.1	81.3	76.8	318
No. Lifetime Partners									
0	8.4	24.7	28.2	29.5	36.0	34.1	64.7	74.8	799
1	8.1	22.6	24.1	30.7	26.8	32.9	68.1	80.9	160
2+	5.4	23.7	24.8	24.9	32.6	45.3	76.5	78.1	1,014
Formal Sex Education									
Never Had	7.7	27.6	28.6	30.7	38.5	38.8	70.4	76.1	1,210
Ever Had	4.8	17.3	20.9	20.1	23.7	43.9	74.2	79.0	785
Parental Sex Education									
Never Had	7.3	25.2	26.2	28.5	34.7	39.2	71.2	76.5	1,652
Ever Had	3.1	16.7	23.2	17.7	24.3	48.3	75.2	80.8	343

**FIGURE 12.3.2
MISINFORMATION ABOUT HIV TRANSMISSION
BY NUMBER OF INCORRECT RESPONSES, BY GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996**



Young adults also hold a relatively high level of concern about HIV transmission through saliva (kissing) or insect bites. About one in five young women and one in four young men thought that HIV could be transmitted by kissing or mosquito bites. Again, rural residents, those with lower education and socioeconomic levels, and young adults who had not had either formal or parental education about AIDS, were more likely to have these misconceptions.

Many young adults also believe that HIV transmission is common in nail parlors and barber shops (62% of women and 41 % of men) and have misconceptions about donating blood (69% of women and 77% of men), and having surgery or dental treatments (75 % of women and 72% of men). These concerns share a common misbelief that HIV is spread by sharp instruments or needles contaminated with blood from an infected person and reused without proper sterilization. They may be interpreted as an exaggerated response to the fear of nosocomial transmission which accounted for most AIDS cases in Romania. Contrary to the patterns found for lack of knowledge and other misinformation mentioned above, these misconceptions were more prevalent among urban residents, respondents with higher education and socioeconomic

levels, and those who had AIDS education in school. Unwarranted concerns could have major public health consequences by deterring young people from donating blood and from seeking medical care. Educational campaigns should emphasize that donating blood is safe and that infection-control procedures are in place in all medical facilities. Furthermore, the public should be informed that no AIDS cases had been attributed to these means of transmission.

For young women, the 1993 survey findings were used as a baseline for studying trends in HIV/AIDS knowledge of transmission and misinformation about the spread of HIV infection ([Tables 12.3.3](#) and [12.3.4](#)). The 1996 findings show a significant increase in knowledge of transmission by contaminated needles, blood transfusion, and homosexual or bisexual intercourse, adding to the already widespread knowledge of the sexual and nosocomial transmission of AIDS documented in 1993. Since mis improvement was consistent in all subgroups, the knowledge gap between rural-urban, low-high education, and low-high socioeconomic level has not changed posing a continuing challenge for educational efforts.

However, misinformation about HIV transmission continues to be common among young women. Compared to 1993, fewer women mistook kissing as a route of AIDS transmission but a higher proportion believed that sharing objects with a HIV-infected person or using public baths could transmit the disease. Most alarming, concerns about medical care became more prevalent, with 75% of women (compared with 44% in 1993) reporting that AIDS could be transmitted by surgical and dental treatments.

In both surveys, misinformation about transmission were more common among rural residents, never married women, and those with lower education and lower socioeconomic index with the one notable exception of misperceptions about medical care. Concerns about getting AIDS through surgical or dental treatments were associated in both surveys with urban residence, older age, higher education and socioeconomic level, and being sexually experienced.

12.4 Knowledge About HIV/AIDS Prevention

Young adults who have heard about AIDS were also asked what a person could do to reduce the risk of getting AIDS. The percentages spontaneously mentioning means of preventing HIV transmission are shown in [Tables 12.4.1A](#) and [12.4.1B](#). If any of these eight common means of prevention were not mentioned spontaneously, each one was individually probed by the interviewer. The probed answers were particularly useful in estimating the proportion of young people who have absolutely no awareness about ways to prevent HIV infection ([Table 12.4.2](#) and [Figure 12.4](#)).

Thirty-one percent of women and 21 % of men were not able to spontaneously mention any means to avoid HIV/AIDS transmission (not shown). The average number of methods of prevention reported spontaneously was only 1.3 for women and 1.8 for men. Methods most frequently mentioned were: using condoms (52% of women and 65% of men), using sterile

TABLE 12.3.3
Percent of Young Women With Lack of Knowledge About Specified Means of AIDS Transmission
By Selected Characteristics
Reproductive Health Survey: ROMANIA, 1993

	<u>Heterosexual Intercourse</u>	<u>Using Contaminated Needles</u>	<u>Receiving Blood Transfusions</u>	<u>Homosexual Intercourse</u>	<u>Unweighted Number of Cases</u>
Total	4.2	9.5	12.9	29.1	1,571
Residence					
Urban	2.8	6.2	8.1	21.7	931
Rural	6.0	14.0	19.3	39.1	640
Age Group					
15-17	5.8	13.8	14.4	34.2	425
18-19	2.6	7.6	11.6	27.8	284
20-24	3.7	7.1	12.3	25.9	862
Marital Status					
Ever Married	4.9	10.1	15.8	31.4	685
Never Married	3.8	9.1	11.3	27.9	886
Education					
Primary	11.1	21.3	26.1	41.2	244
HS Incomplete	3.8	9.9	13.3	33.1	629
HS Complete	1.9	4.8	8.2	22.6	537
PostHS/University	0.3	0.6	1.2	8.7	161
Socioeconomic Index					
Low	7.9	15.7	21.0	39.9	625
Medium	2.1	5.6	8.8	24.1	753
High	0.2	4.6	2.6	12.9	193
Sexual Experience					
No Sexual Experience	3.7	9.5	11.7	29.2	785
Sexually Experienced	4.8	9.5	14.5	29.0	786

TABLE 12.3.4
Percent of Young Women With Misinformation about HIV/AIDS Transmission
By Selected Characteristics
Reproductive Health Survey: ROMANIA, 1993

	<u>Shaking Hands</u>	<u>Kissing</u>	<u>Being Bitten by Mosquitos</u>	<u>Using Public Baths</u>	<u>Sharing Objects with an Infected Person</u>	<u>Getting Surgical or Dental Treatment</u>	<u>Number of Cases</u>
Total	7.8	28.7	21.7	27.9	33.0	44.2	1,571
Residence							
Urban	4.8	24.1	20.9	24.8	27.6	48.2	931
Rural	11.8	34.9	22.9	32.1	40.5	38.7	640
Age Group							
15-17	8.2	26.1	20.4	28.3	34.7	35.8	425
18-19	6.6	24.5	20.5	27.2	33.1	44.4	284
20-24	8.0	32.2	23.2	27.9	31.8	50.2	862
Marital Status							
Ever Married	12.7	37.5	26.3	35.4	39.4	45.2	685
Never Married	5.1	23.9	19.2	23.9	29.6	43.6	886
Education							
Primary	16.0	37.8	22.7	37.2	44.1	35.5	244
HS Incomplete	8.1	28.7	24.0	30.2	35.9	38.1	629
HS Complete	5.0	26.8	19.5	23.2	27.5	52.4	537
PostHS&University	0.0	16.3	16.8	15.2	16.8	61.1	161
Socioeconomic Index							
Low	12.9	34.6	22.3	33.3	41.8	39.4	625
Medium	4.7	25.8	22.8	25.1	27.2	45.5	753
High	3.7	20.4	14.6	21.1	28.0	55.5	193
Sexual Experience							
No Sexual Experience	5.6	24.0	18.7	24.2	30.0	41.9	785
Sexually Experienced	10.9	35.4	26.1	33.2	37.4	47.4	786

TABLE 12.4.1A
Percent of Young Women Who Have Heard About HIV/AIDS
Who Spontaneously Mentioned Possible Means of Preventing HIV/AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Using Condoms	Using Clean Needles	Being Mono- gamous	Avoiding Sex With Prostitutes	Avoiding Sex With Homo-/ Bisexuals	Asking the Partner to be Tested for HIV	Avoiding Injections	Abstaining From Sexual Intercourse	No. of Cases
Total	52.3	27.1	15.9	11.0	8.3	4.3	3.5	2.2	1,955
Residence									
Urban	64.8	33.9	17.3	13.4	11.0	5.0	4.5	1.8	968
Rural	35.8	18.0	14.2	7.7	4.7	3.3	2.2	2.7	987
Age Group									
15-17	47.8	25.3	10.8	9.0	5.8	5.7	3.2	3.2	706
18-19	51.9	26.3	14.9	9.5	8.2	4.6	4.1	2.3	484
20-24	55.2	28.5	19.6	12.8	9.9	3.2	3.4	1.5	765
Education									
Primary	25.7	11.6	9.0	5.1	3.0	1.4	1.3	4.5	403
HS Incomplete	49.6	23.9	14.0	9.3	7.7	4.3	4.4	2.0	908
HS Complete/PostHS	68.9	38.6	21.8	15.9	11.6	5.6	3.4	1.3	644
Socioeconomic Index									
Low	33.1	16.3	14.5	7.0	5.4	3.4	2.5	2.6	853
Medium	62.5	31.8	16.1	13.4	9.7	4.2	4.5	2.0	870
High	76.0	43.9	19.9	14.3	12.3	7.2	2.6	1.8	232
No. Lifetime Partners									
0	51.6	28.0	14.1	10.1	6.7	5.3	4.0	2.7	1,202
1	50.9	25.0	18.5	10.9	10.4	3.0	3.0	1.7	607
2+	63.5	29.9	17.3	16.4	9.1	3.5	2.4	1.6	141
School Sex Education									
Never Had	47.3	21.6	15.6	9.1	7.8	2.7	3.3	2.1	1,138
Ever Had	59.9	35.5	16.5	13.8	9.0	6.7	3.7	2.4	817
Parental Sex Education									
Never Had	47.6	24.2	15.9	10.2	7.6	3.2	3.7	2.0	1,387
Ever Had	63.9	34.0	16.0	12.8	10.1	6.9	3.0	2.7	568

TABLE 12.4.1B
Percent of Young Men Who Have Heard About HIV/AIDS
Who Spontaneously Mentioned Possible Means of Preventing HIV/AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Using Condoms	Using Clean Needles	Being Mono- gamous	Avoiding Sex With Prostitutes	Avoiding Sex With Homo-/ Bisexuals	Asking the Partner to be Tested for HIV	Avoiding Injections	Abstaining From Sexual Intercourse	No. of Cases
Total	65.2	28.3	16.7	28.1	17.8	2.8	8.0	3.6	1,995
Residence									
Urban	75.3	33.6	19.3	27.8	18.5	2.9	9.4	4.0	1,067
Rural	52.3	21.6	13.6	28.4	17.0	2.7	6.3	3.1	928
Age Group									
15-17	59.8	25.9	10.6	21.4	13.2	2.5	5.6	4.5	781
18-19	71.4	27.8	15.6	29.8	19.6	3.9	8.8	2.6	503
20-24	66.0	30.1	21.1	31.7	20.1	2.6	9.3	3.4	711
Education									
Primary	38.1	13.4	8.8	17.4	10.6	2.2	2.3	2.7	429
HS Incomplete	66.1	27.0	14.2	27.6	17.3	2.9	7.4	3.3	1,057
HS Complete/PostHS	82.2	41.1	27.0	36.3	23.8	3.0	13.2	4.8	509
Socioeconomic Index									
Low	47.0	15.6	14.0	22.5	14.5	1.8	3.9	2.7	742
Medium	73.7	33.4	17.3	30.9	18.7	3.3	9.9	4.2	935
High	83.2	43.7	21.5	33.2	23.3	3.9	12.3	3.8	318
No. Lifetime Partners									
0	54.8	25.3	12.2	24.3	16.7	2.7	5.7	4.8	799
1	63.6	30.6	29.3	31.3	18.1	3.3	12.9	5.1	160
2+	71.2	29.4	17.8	29.9	18.3	2.8	8.6	2.8	1,014
School Sex Education									
Never Had	58.6	21.8	14.7	24.6	14.6	2.3	6.1	3.1	1,210
Ever Had	76.3	39.4	20.1	34.0	23.3	3.7	11.4	4.5	785
Parental Sex Education									
Never Had	61.7	26.6	16.5	27.8	17.0	2.2	7.3	3.6	1,652
Ever Had	82.9	37.2	17.8	29.3	22.4	5.9	11.9	3.5	343

TABLE 12.4.2
Percent of Young Women and Men Who Have Heard about HIV/AIDS
Who Were Not Aware of Specified Means of Preventing HIV/AIDS Transmission
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	<u>Asking the Partner to be Tested for HIV</u>	<u>Being Monogamous</u>	<u>Using Condoms</u>	<u>Avoiding Sex With Homo-/Bisexuals</u>	<u>Avoiding Sex With Prostitutes</u>	<u>Using Sterile Needles</u>	<u>No. of Cases</u>
WOMEN							
Total	22.8	21.3	11.4	11.3	6.3	5.5	1,955
<u>Residence</u>							
Urban	18.4	22.6	5.2	7.3	3.5	3.0	968
Rural	28.6	19.6	19.5	16.5	10.0	8.8	987
<u>Education</u>							
Primary	35.5	23.4	25.4	26.0	17.4	17.5	403
HS Incomplete	20.5	20.8	12.1	11.1	5.7	4.3	908
HS Complete/PostHS	19.2	20.9	3.6	4.1	1.4	1.0	644
<u>No. Lifetime Partners</u>							
0	19.9	24.3	11.3	11.8	6.9	5.8	1,202
1	26.3	14.7	12.9	10.5	5.5	5.9	607
2+	25.5	30.6	5.2	10.9	5.3	2.7	141
<u>School Sex Education</u>							
Never Had	26.4	20.5	14.0	13.5	7.9	7.6	1,138
Ever Had	17.3	22.5	7.4	7.9	3.9	2.4	817
MEN							
Total	24.0	21.5	5.8	8.0	6.8	4.7	1,995
<u>Residence</u>							
Urban	24.5	23.6	3.2	6.4	6.0	4.0	1,067
Rural	23.4	19.0	9.2	10.1	7.9	5.7	928
<u>Education</u>							
Primary	32.3	23.6	13.9	13.5	9.7	8.5	429
HS Incomplete	22.3	21.2	3.9	6.7	5.7	4.1	1,057
HS Complete/PostHS	21.5	20.7	3.8	6.7	7.0	3.3	509
<u>No. Lifetime Partners</u>							
0	23.0	20.3	9.5	8.6	6.8	5.6	799
1	20.5	8.4	5.2	9.6	6.2	3.4	160
2+	24.9	23.3	3.8	7.4	6.8	4.2	1,014
<u>School Sex Education</u>							
Never Had	25.6	22.3	7.7	8.6	8.4	5.5	1,210
Ever Had	21.4	20.2	2.8	7.0	4.2	3.4	785

needles (27% of women and 28% of men), having monogamous relationships (16% of women and 17% of men), and avoiding sex with prostitutes (11 % of women and 28 % of men) or with homo-/bisexuals (8% of women and 18% of men). Other behaviors were mentioned by 8% or fewer.

The lack of awareness about HIV testing as an important element in AIDS prevention by detecting HIV carriers is a special cause of concern since most HIV-infected individuals are asymptomatic; only 4 % of women and 3 % of men mentioned spontaneously that a possible way to avoid HIV infection is to ask a partner to be tested for HIV. Among other responses, some misconceptions about HIV prevention were notable; better hygiene, regular medical check-ups, and the use of oral contraceptives or local spermicides were considered valid means of prevention by a minority of young adults.

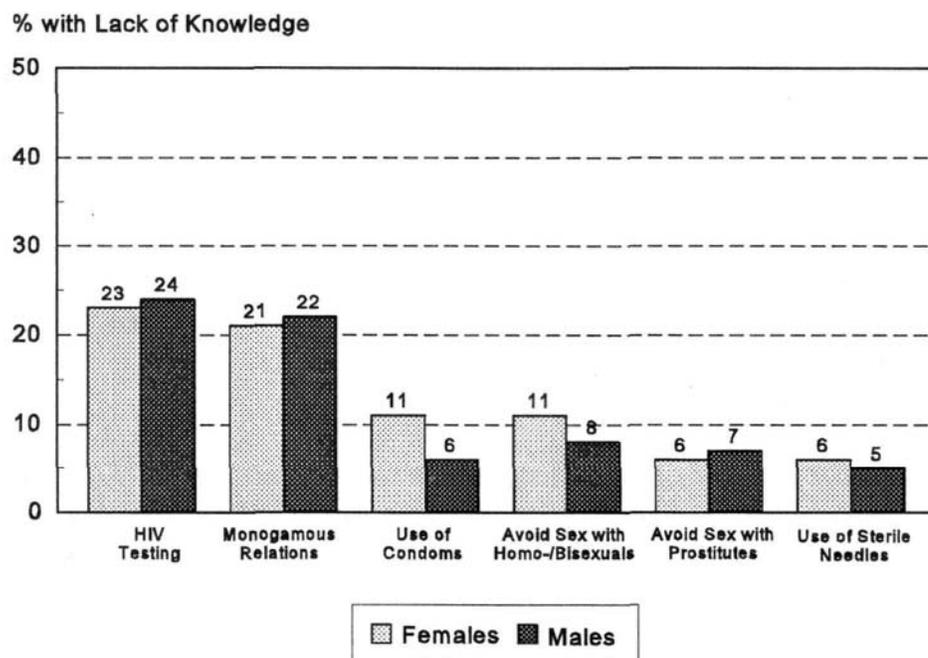
Certain subgroups had more extensive knowledge about methods of preventing HIV transmission. Generally, knowledge about effective means of prevention was higher among urban than rural respondents, especially women, and positively correlated with education and socioeconomic levels. It was also generally more prevalent among young adults with sex education in school or at home, and among sexually experienced men and women, especially those who had had two or more lifetime sexual partners.

Similar levels of knowledge about HIV prevention were reported by young women in the 1993 survey. The only significant change was in the percent of women who spontaneously mentioned that using condom is an effective way of preventing AIDS which increased by 25 % (from 43% to 52%).

Awareness of HIV prevention improved substantially after probing. Virtually all young adults identified at least one behavior as an effective means of prevention (96% of women and 99% of men). Counting both spontaneous and probed answers, women were able to correctly identify an average of 5.9 means of preventing AIDS transmission whereas men identified 6.3 means.

However, although a minority, some young adults remained unaware of effective protective behaviors ([Table 12.4.2](#) and [Figure 12.4](#)). Almost one in four were not aware that knowledge of one's HIV status through testing could contribute to preventive behaviors. Lack of knowledge about HIV testing was especially common among women residing in rural areas (29%) and men and women with primary education (32% and 36%, respectively). About one in five young adults did not agree that commitment to a steady, monogamous relationship with an uninfected partner could protect against HIV infection. This misbelief varied little by residence and education level but was the lowest among those with only one lifetime partner. Eleven percent of young women and eight percent of young men were not aware that you can protect against AIDS by avoiding unprotected sex with homosexuals or bisexuals. Again, rural residents and those with primary education were the least knowledgeable. Also, 11 % of women and 6% of men did not know that using condoms can protect against HIV infection. Rural residence, lower education, lack of sex education about AIDS, and lack of sexual experience (for young

FIGURE 12.4
LACK OF KNOWLEDGE ABOUT PREVENTING HIV TRANSMISSION
BY SPECIFIED MEANS OF PREVENTION, BY GENDER
YOUNG ADULTS AGED 15-24 YEARS - YARHS, 1996



men) were associated with lower levels of knowledge about the role of condoms in HIV prevention. Less than 7 % of women and men were not aware that avoiding sex with prostitutes could lower the risk of contracting AIDS and fewer than 6% did not know that the use of sterile needles could prevent HIV transmission. Women residing in rural areas and with primary education were consistently the least knowledgeable about HIV prevention.

Educational messages targeting youths should emphasize that the surest way to protect yourself against HIV sexual transmission (and against other STDs) is to abstain from sex or, if sexually active, to have sex with a steady partner; messages should also convey that casual sexual relationships could potentially result in HIV or other STD transmission but using condoms every time protects against STDs. Efforts should also be made to increase awareness of the availability of testing for HIV antibodies and authorities should be prepared to provide counseling opportunities for those who seek elective tests.

12.5 Beliefs About Risk of HIV/AIDS Among Selected Groups and Self-Perceived Risk of HIV/AIDS

Respondents were also asked about their perception of risk for persons in the selected groups shown in [Table 12.5.1](#). Knowledge about groups at higher risk of contracting HIV is relevant for both women and men because it underscores the importance of knowing their sexual partners and may prevent them from engaging in risky sexual behaviors.

Based on current scientific knowledge about HIV transmission, some health behaviors could place some individuals at higher risk of contracting HIV than others. Individuals practicing high risk behaviors include those engaging in unprotected sexual intercourse with several partners, including men having sex with men, those who trade sex for money or drugs, and drug users who share intravenous needles (U.S. Department of Health and Human Services, 1994). Generally, these groups of people were correctly identified as being at higher risk of HIV infection by most young adults. An overwhelming majority (90%) believed that prostitutes have a high risk of getting infected with the AIDS virus. Drug users and homosexual men were also identified correctly as having high risk of AIDS by most women (79% and 69%, respectively) and men (83% and 72%, respectively). Few young adults, regardless their gender, were not aware of the high risk of HIV associated with prostitution (6%), injecting drugs intravenously (15% of women and 10% of men), and homosexual intercourse among men (23% of women and 16% of men). Generally, rural residence, lower education and lack of sex education were associated with lower awareness of higher risk of HIV infection among prostitutes, drug users and homosexual men.

However, misconceptions in identifying groups with high-risk of HIV infection were not uncommon. Unfounded beliefs about homosexual women as being at higher risk of AIDS were prevalent among both female and male respondents (61 % and 49%, respectively). Also, the high-risk attributed to sexually experienced unmarried men and women, regardless their behaviors, contrasted with the low risk associated to married individuals. Over 60% of women and one in two men believe that unmarried people have a high risk of getting AIDS whereas an alarming number of young people believed that married women and men could not get AIDS or they did not know if these groups have any risk for the disease (42% of women and 37% of men). Only 22-29% of respondents reported the risk for unmarried or married persons depends, presumably referring to whether or not they have unprotected sex, multiple partners, and extramarital relations with high risk individuals.

Incorrect knowledge about AIDS risk for homosexual women was associated with rural residence, lower education, and lack of sexual experience (only among mele respondents). Misperceptions about the risk of sexually active men and women was more common among better educated women (including exposure to sex education in school or in family) and those without sexual experience; conversely, in men it was associated with rural residence, lower education and having two or more lifetime sexual partners. Misperceptions about the risk among married individuals was higher among rural respondents, those with lower education, and respondents who had never had sex education about AIDS topics.

TABLE 12.5.1
Young Adults' Beliefs About the Degree of Risk of Contracting HIV/AIDS
Among Selected Groups
Young Adult Reproductive Health Survey: ROMANIA, 1996
(Percent Distribution)

WOMEN							
<u>Mode of Transmission</u>	<u>High Risk</u>	<u>Low Risk</u>	<u>No Risk</u>	<u>Depends</u>	<u>Do Not Know</u>	<u>Total</u>	<u>No. of Cases</u>
Prostitutes	90.3	0.8	0.2	2.4	6.3	100.0	1,955
Drug Users	79.2	2.3	0.7	3.5	14.2	100.0	1,955
Homosexual Men	69.3	3.7	0.9	4.0	22.1	100.0	1,955
Unmarried Men with Sexual Experience	61.8	8.5	0.8	21.7	7.2	100.0	1,955
Homosexual Women	61.3	4.6	2.6	4.1	27.5	100.0	1,955
Unmarried Women with Sexual Experience	61.2	8.9	0.8	21.9	7.1	100.0	1,955
Married Men	15.5	37.7	12.4	26.0	8.3	100.0	1,955
Married Women	9.7	43.0	15.0	24.9	7.4	100.0	1,955
MEN							
<u>Mode of Transmission</u>	<u>High Risk</u>	<u>Low Risk</u>	<u>No Risk</u>	<u>Depends</u>	<u>Do Not Know</u>	<u>Total</u>	<u>No. of Cases</u>
Prostitutes	90.1	1.6	0.5	2.8	5.0	100.0	1,995
Drug Users	82.7	3.3	1.4	4.5	8.2	100.0	1,995
Homosexual Men	71.7	6.1	1.5	5.9	14.8	100.0	1,995
Unmarried Men with Sexual Experience	50.6	13.6	7.8	7.3	20.7	100.0	1,995
Homosexual Women	49.0	17.9	1.0	26.8	5.4	100.0	1,995
Unmarried Women with Sexual Experience	48.8	18.5	1.1	26.1	5.5	100.0	1,995
Married Men	13.6	40.3	11.2	29.2	5.7	100.0	1,995
Married Women	11.0	40.6	13.8	28.9	5.7	100.0	1,995

TABLE 12.5.2A
Percent Distribution of Young Women Who Have Heard About HIV/AIDS Infection
By Self Perceived Risk of Contracting HIV/AIDS
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

	Self Perceived Risk of Contracting HIV/AIDS					Total	No. of Cases
	No Risk	Low Risk	Some Risk*	High Risk	Do Not Know		
Total	58.5	18.5	2.7	4.4	15.9	100.0	1,955
Residence							
Urban	57.7	22.8	2.7	5.6	11.2	100.0	968
Rural	59.6	12.9	2.6	2.8	22.1	100.0	987
Education							
Primary	60.0	9.1	2.4	4.2	24.3	100.0	403
HS Incomplete	60.9	16.6	2.7	3.7	16.1	100.0	908
HS Complete/PostHS	54.9	25.6	2.8	5.4	11.3	100.0	644
Marital Status/Sexual Experience							
No Sexual Experience	59.2	17.7	3.3	3.8	16.0	100.0	1,202
Currently Married	60.3	15.3	1.1	4.7	18.5	100.0	502
Unmarried with Sexual Experience	50.8	30.0	4.2	6.2	8.8	100.0	251
No. of Lifetime Partners							
0	59.2	17.7	3.3	3.8	16.0	100.0	1,202
1	58.6	17.7	1.7	4.4	17.6	100.0	607
2+	54.4	26.8	2.9	8.3	7.6	100.0	141
School Sex Education							
Never Had	61.5	14.5	2.2	4.0	17.7	100.0	1,138
Ever Had	53.8	24.7	3.4	5.1	13.0	100.0	817
Parental Sex Education							
Never Had	59.5	16.3	2.4	4.0	17.9	100.0	1,387
Ever Had	56.0	24.0	3.5	5.6	10.9	100.0	568

*/ Includes women who considered themselves at risk but could not decide if the risk was low or high

TABLE 12.5.2B
Percent Distribution of Young Men Who Have Heard About HIV/AIDS Infection
By Self Perceived Risk of Contracting HIV/AIDS
By Selected Characteristics
Young Adult Reproductive Health Survey: ROMANIA, 1996

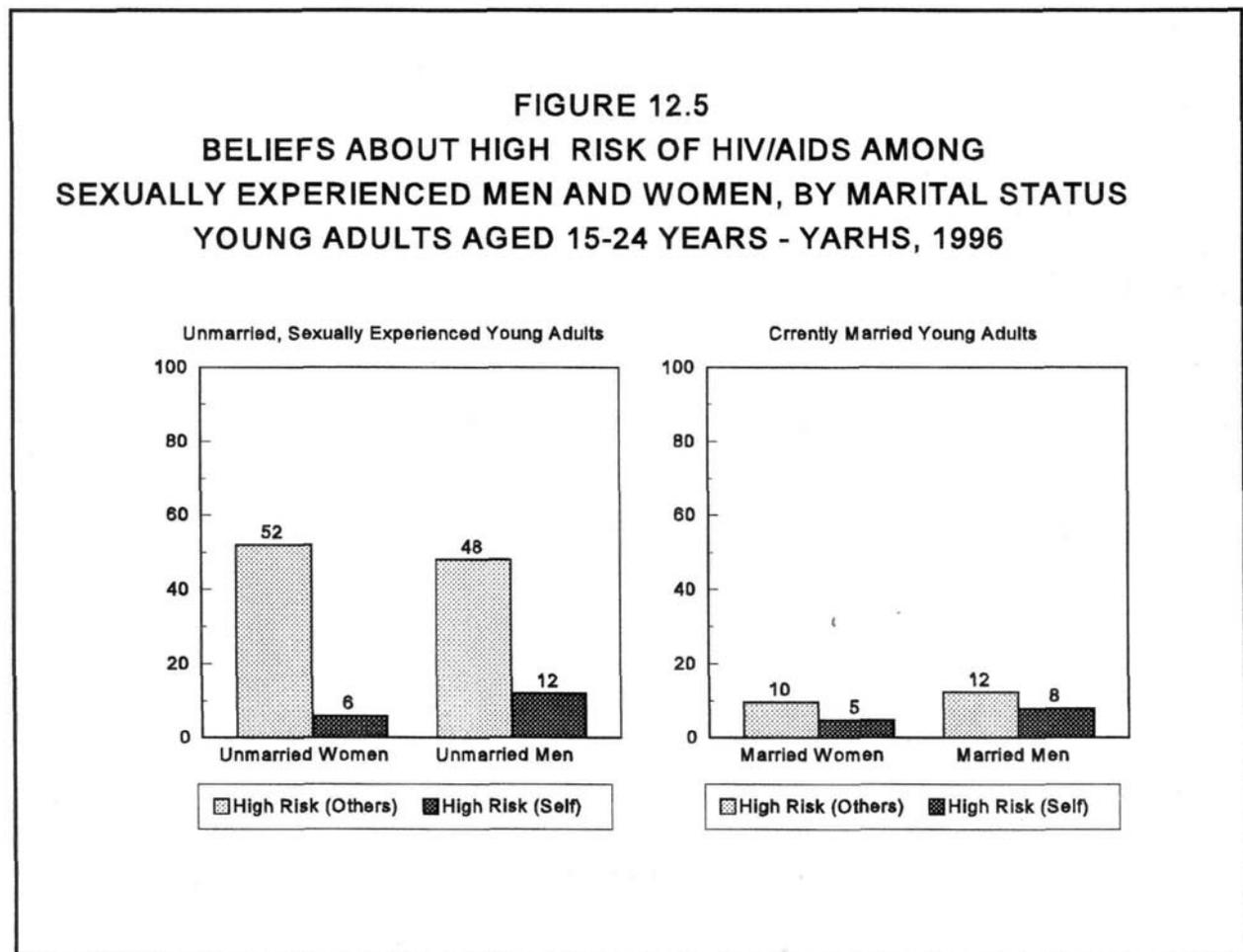
	Self Perceived Risk of Contracting HIV/AIDS					Total	No. of Cases
	No Risk	Little Risk	Some Risk*	High Risk	Do Not Know		
Total	44.6	31.0	5.5	9.9	9.0	100.0	1,995
Residence							
Urban	42.8	35.7	5.0	9.2	7.2	100.0	1,067
Rural	46.7	25.1	6.0	10.9	11.3	100.0	928
Education							
Primary	48.7	21.1	4.2	13.5	12.6	100.0	429
HS Incomplete	45.7	29.9	5.6	9.4	9.4	100.0	1,057
HS Complete/PostHS	39.7	39.9	6.1	8.4	5.9	100.0	509
Marital Status/Sexual Experience							
No Sexual Experience	53.5	23.6	4.9	6.7	11.5	100.0	799
Currently Married	53.6	24.7	4.6	8.3	8.9	100.0	140
Unmarried with Sexual Experience	36.6	37.3	6.1	12.4	7.6	100.0	1,056
No. of Lifetime Partners							
0	53.5	23.6	4.9	6.7	11.5	100.0	799
1	48.1	28.6	4.8	7.0	11.5	100.0	160
2+	39.3	35.3	5.9	12.3	7.3	100.0	1,014
School Sex Education							
Never Had	47.1	27.8	5.6	10.0	9.5	100.0	1,210
Ever Had	40.3	36.5	5.2	9.8	8.3	100.0	785
Parental Sex Education							
Never Had	44.6	29.7	5.8	10.0	9.9	100.0	1,652
Ever Had	44.2	37.7	3.8	9.8	4.6	100.0	343

*/ Includes men who considered themselves at risk but could not decide if the risk was low or high

To assess their self-perceived vulnerability to HIV infection, respondents were also asked if they felt that they had any risk of contracting AIDS and, if so, if they think their risk is low or high. Their responses indicated that only a small percentage of young women and men were seriously concerned about getting AIDS ([Tables 12.5.2A](#) and [12.5.2B](#)).

Overall, female respondents were more likely than male respondents to deny any risk of getting AIDS (59% versus 45%) and were less likely to report high risk. About one in five women and 31 % of men said they had a low risk, 3% of women and 6% of men acknowledged some risk, 4% of women and 10% of men believed they had a high risk of getting AIDS, whereas 16% of women and 9% of men were not able to assess if they have any AIDS risk.

The differences in perception about the risk of getting infected with the AIDS virus were rather small. Denial of HIV risk was slightly more common among respondents with lower education and no sex education, those with no sexual experience or who had had only one partner. Self-perception of risk also varied by background characteristics. The percent of young adults who thought they had low risk or some risk of contracting HIV increased with education and with number of lifetime partners, was higher among urban than rural residents, among unmarried youth



with sexual experience, and among those who had ever had sex education about AIDS. Within the minority who believed they had high risk, the most likely to have this perception, consistent with available evidence, were the young people with two or more lifetime partners (8 % of women and 12% of men). Currently married women and men were the least likely to report high self-perceived risk (1 % and 5%, respectively).

Whether because of denial or underestimation of personal risk, many young adults who perceived high levels of risk of HIV infection among similar population groups were not ready to accept that the same risks may extend to themselves. To illustrate this discrepancy, personal risk perception among sexually experienced young women and men of all marital statuses was compared with their beliefs of HIV-risk for other individuals with similar sexual and marital experience ([Figure 12.5](#)). Clearly, for all sexually experienced unmarried men and women there is a significant gap between the self perceived high risk and their beliefs of high risks attributed to others. The gap is largest for unmarried women whose self-perceived high risk is only one ninth as great as their perceived high risk of HIV infection among other unmarried sexually active women (6% vs. 52%). The gap, although narrower, is equally striking for unmarried men whose estimation of personal high risk is one fourth of their perceived high risk for other sexually experienced unmarried men (12% vs. 48%).

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APPENDIX A

SAMPLE WEIGHTS AND ESTIMATED SAMPLING ERROR

A.1 Sampling Weights

Although the survey response rates were high (93% for the female sample and 87% for the male sample), the sample population included a higher representation of 15-19 year-olds and lower representation of the 20-24 year old group (especially married respondents), than expected (Chapter II). Differential non-response can result in a distorted sample by over-representing easily-reached respondents. The problem may be two-fold: (1) the characteristics of the easily-reached may be different from the hard-to-reach respondents, or (2) given that they have the same characteristics, the behavior of these two groups may be different. One may adjust for the characteristics of the hard-to-reach by appropriate post-survey weighting adjustments as done in this study, but it is not possible to adjust for differences in behavior. However, a recent study indicated that the degree and direction of non-response bias for behavioral variables are largely determined by the background characteristics of respondents (Cardenas C. et al., 1993).

To provide national and regional estimates for this study, all the analyses in this report were weighted to adjust for non-response related to three principal background characteristics: age, marital status, and residence.

Compared to a cohort projection from the 1992 Census, the age composition of the 1996 YARHS sample reflects an over-representation of adolescents 15-19 years of age, in both the female and male samples. (Comisia Nationala pentru Statistica, 1994). As discussed in Chapter II, the sample population is essentially ten percentage points higher for 15-19 year olds and lower than expected in the 20-24 year old age group when compared to the census population. In both urban and rural areas there is a slightly higher over representation of men 15-19 years old, as high as 15 percentage points in rural areas. This is probably due to the greater difficulty in finding 20-24 year old women and men at home, since they are more likely to be at work or attending university level classes. It may also reflect greater mobility of these young adults, both within the country and outside of the country. Also, the comparison with the Census marital distribution showed an under representation of currently married 20-24 year olds. This is probably due to two factors: (1) the sample age composition which is skewed toward younger ages includes fewer married individuals, and (2) married couples living alone, with both wife and husband at work or studying, are more difficult to locate for an interview.

TABLE A.1.1
Percent Distribution of Young Adults by Sex, Age Group, and Marital Status
ROMANIA: 1992 Census Projections and 1996 Young Adult Reproductive Health Survey (YARHS)

Residence/Marital Status	Age Group	Females		Males	
		1992CENSUS	1996 YARHS	1992CENSUS	1996 YARHS
Urban Ever Married	15-19	2.3904	1.3333	0.5043	0.4885
Urban Never Married	15-19	27.4893	29.1358	29.1631	34.001
Urban Ever Married	20-24	15.0445	7.4568	8.1689	2.3449
Urban Never Married	20-24	11.2571	10.6173	17.1218	15.6815
Rural Ever Married	15-19	3.5801	5.5802	0.4570	0.3909
Rural Never Married	15-19	17.8577	25.1358	21.3040	29.702
Rural Ever Married	20-24	14.6371	13.7778	6.5186	4.3967
Rural Never Married	20-24	7.7438	6.963	16.7622	12.9946
TOTAL	15-24	100.00	100.00	100.00	100.00

Based on these findings of non-response differentials, all RESULTS have been weighted with a post-survey adjustment factor to account for the differences in response rates. The nonresponse adjustment factors were calculated by comparing the 1992 Census projections of the Romanian population of females and males by age, residence, and marital status with the sample distribution. The distribution of young adults expected in 1996 based on the 1992 Census projections and in the YARHS is shown in [Table A.1.1](#).

For each subclass listed in [Table A.1.1](#), the post-survey adjustment factor was the ratio of the known national value to the sample estimate of that value. The weighting of these subclasses for differential response rates are shown in [Table A.1.2](#). With these adjustments, the YARHS data are representative nationally and regionally (urban/rural) of Romanian young adults aged 15-24 year old.

TABLE A.1.2
Weighting of Subclasses for Differential Nonresponse Rates
Young Adult Reproductive Health Survey: ROMANIA, 1996

<u>Residence/Marital Status</u>	<u>Age Group</u>	<u>Females</u>	<u>Males</u>
Urban Ever Married	15-19	1.7928	1.0324
Urban Never Married	15-19	0.9435	0.8577
Urban Ever Married	20-24	2.0176	3.4837
Urban Never Married	20-24	1.0603	1.0918
Rural Ever Married	15-19	0.6416	1.1690
Rural Never Married	15-19	0.7104	0.7173
Rural Ever Married	20-24	1.0624	1.4826
Rural Never Married	20-24	1.1121	1.2899

A.2 Sampling Errors

The estimates for a sample survey are affected by two types of errors: (1) non-sampling error and (2) sampling error. Non-sampling error is the result of mistakes made in carrying out data collection and data processing, including the failure to locate and interview the right household, errors in the way questions are asked or understood, and data entry errors. Although intensive quality control efforts were made during the implementation of the YARHS to minimize this type of error, non-sampling errors are impossible to avoid and difficult to evaluate statistically. Sampling error is a measure of the variability between an estimate and the true value of the population parameter intended to be estimated that can be attributed to the fact that a sample rather than a complete enumeration was used to produce it; in other words, sampling error is the difference between the expected value for any variable measured in a survey and the value estimated by the survey. This sample is only one of the many probability samples which could have been selected from the young adult population aged 15-24 using the same sample design and projected sample size. Each of these samples would have yielded slightly different results from the actual sample selected.

Because the statistics presented here are based on a sample, they may differ by chance variations from the statistics that would result if all young adults 15-24 years of age in

Romania would have been interviewed. Sampling error is usually measured in terms of the variance and standard error (square root of the variance) for a particular statistic (mean, proportion, or ratio). The standard error (SE) can be used to calculate confidence intervals (CI) of the estimates within which we can say with a given level of certainty that the true value of population parameter lies. For example, for any given statistic calculated from the survey sample, there is a 95 percent probability that the true value of that statistic will lie within a range of plus or minus two SE of the survey estimate. The chances are about 68 out of 100 (about two out of three) that a sample estimate would fall within one standard error of a statistic based on a complete count of the population.

The estimated sampling errors for 95% confidence intervals ($1.96 \times SE$) for selected proportions and sample sizes are shown in [Table A.2](#). The estimates in [Table A.2](#) can be used to estimate 95% confidence intervals for the estimated proportions shown for each sample size. The sampling error estimates include an average design effect of 1.6 needed because the YARHS did not employ a simple random sample but included clusters of elements in the second stage of the sample selection.

TABLE A.2
Sampling Error Estimates (Expressed in Percentage Points) for 95% Confidence Intervals
For Selected Estimated Proportions and Sample Sizes on Which the Proportions Are Based
Assuming a Design Effect of 1.6

Sample Size	Estimated Proportions (Pi)					
	<u>0.05/0.95</u>	<u>0.10/0.90</u>	<u>0.20/0.80</u>	<u>0.30/0.70</u>	<u>0.40/0.60</u>	<u>0.50/0.50</u>
25	0.108	0.149	0.198	0.227	0.243	0.248
50	0.076	0.105	0.140	0.161	0.172	0.175
100	0.054	0.074	0.099	0.114	0.121	0.124
200	0.038	0.053	0.070	0.080	0.086	0.088
400	0.027	0.037	0.050	0.057	0.061	0.062
800	0.019	0.026	0.035	0.040	0.043	0.044
1000	0.017	0.024	0.031	0.036	0.038	0.039
1500	0.014	0.019	0.026	0.029	0.031	0.032
2000	0.012	0.017	0.022	0.025	0.027	0.028

The selection of clusters is generally characterized by some homogeneity that tends to increase the variance of the sample. Thus, the variance in the YARHS sample is greater than in a simple random sample due to the effect of clustering. The design effect represents the ratio of the two variance estimates: the variance of the complex design using clusters divided by the variance of a simple random sample using the same sample size (Kish L., 1967).

To obtain the 95% CI for proportions or sample sizes not shown in the table, one may interpolate. For example, for a sample size of 200 and a point estimate of 25% (midway between 0.20/0.80 and 0.30/0.70), the 95% CI would be plus or minus 7.5%; for a sample size of 300 and an estimate of 20%, the 95% CI would be plus or minus 6.0%.

Differences between estimates discussed in this report were found to be statistically significant at the 5 percent level using a 2-tailed normal deviate test ($p=0.05$). This means that in repeated samples of the same type and size, a difference as large as the one observed would occur in only 5% of samples if there were, in fact, no differences between the percents in the population.

In this text, terms such as "greater", "less", "increase", or "decrease" indicate that the observed differences were statistically significant at the 0.05 level using a 2-tailed deviate test. Statements using the phrase "the data suggest" indicate that the difference was significant at the 0.10 level but not the 0.05 level. Lack of comment in the text about any two statistics does not mean that the difference was tested and not found to be significant.

The relative standard error of a statistic (also called "coefficient of variation") is the ratio of the standard error (SE) for that statistic to the value of the statistic. It is usually expressed as a percent of the estimate. Estimates with a relative standard error of 30% or more are generally viewed as unreliable by themselves, but they may be combined with other estimates to make comparisons of greater precision. For example, an estimate of 20% based on a sample size of only 50 observations yields a SE of 7% (one half the 95% confidence interval shown in [Table A.2](#)). The relative standard error would be 35% (the ratio of the SE of 7% to the estimate of 20%), too large for the estimate to be reliable.

APPENDIX B

INSTITUTIONAL PARTICIPATION

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PERSONS INVOLVED IN THE 1996 YOUNG ADULT REPRODUCTIVE HEALTH SURVEY OPERATION AND SUPERVISION

- National Director:** • Alin Stanescu, MD, IOMC&IFCF
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**1996 YOUNG ADULT REPRODUCTIVE HEALTH SURVEY
HOUSEHOLD QUESTIONNAIRE**

ID NUMBER _____

JUDET _____

BASIC CENSUS DISTRICT _____

URBAN/RURAL _____

LOCALITY _____

STREET ADDRESS _____

BUILDING/HOUSE NUMBER _____

VISIT RECORD

Visit number	1	2	3	4
	Day Month	Day Month	Day Month	Day Month
Date of visit	____	____	____	____
Result*	_____	_____	_____	_____
Interviewer	____	____	____	____
Supervisor	____	____	____	____

* RESULT CODES

- 1 Household has at least one young adult
- 2 No young adults in household
- 3 Nobody at home
- 4 Household refusal
- 5 Unoccupied household
- 6 Respondent incompetent _____
- 7 Other _____

1. How many people normally live in this household? __ __ people

2 How many females/males between the ages of 15 and 24 live in this household? __ females/males

**IF THERE IS NO WOMAN/MAN 15 TO 24 YEARS OLD, TERMINATE THE INTERVIEW.
IF THERE IS ONE OR MORE WOMEN/MEN 15 TO 24 YEARS OLD, CONTINUE WITH Q3.**

3. For each of these women/men could you give me the following information:

Line	First name	Age	Marital status	Education Level Grade
1	_____	___	___	___
2	_____	___	___	___
3	_____	___	___	___
4	_____	___	___	___
5	_____	___	___	___
6	_____	___	___	___

Marital Status;

Level:

- 1 Married
- 2 Consensual Union
- 3 Separated
- 4 Divorced
- 5 Widowed
- 6 Single
- 9 Don't Know

- 0 No school
- 1 Primary
- 2 Secondary
- 3 Post Secondary
- 4 University
- 9 Don't know

IF YOU ARE NOT SPEAKING TO THE ELIGIBLE RESPONDENT AND SHE/HE IS NOT AVAILABLE, GET HER/HIS FIRST NAME AND SCHEDULE A RETURN VISIT.

Return Date: _____ Time: _____

1996 YOUNG ADULT REPRODUCTIVE HEALTH SURVEY
INDIVIDUAL QUESTIONNAIRE

DAY ___ MONTH ___

RESULT ___

TIME STARTED: ___ : ___

ID NUMBER ___ - ___

I. BACKGROUND CHARACTERISTICS

100. In what month and year were you born?

MONTH ___
YEAR 19 ___

88 DON'T KNOW

101. How old are you (at last birthday)? ___ YEARS OLD 88 DON'T KNOW

MAKE SURE THAT AGE AND DATE OF BIRTH CORRESPOND

102. Are you currently attending regular school or university?

1 YES—> **GO TO 104**

2 NO

103. Why is it that you are not currently attending a school or university?

1. NEVER WENT
2. ALREADY COMPLETED ALL STUDIES
3. GOT MARRIED
4. QUIT DUE TO PREGNANCY
5. HAVE TO PROVIDE CHILD CARE
6. FAMILY PROBLEMS
7. DO NOT LIKE IT/DO NOT WANT TO CONTINUE
8. HEALTH PROBLEMS
9. AM NOT ABLE TO FOR FINANCIAL REASONS
10. HAD TO GET A JOB
20. OTHER (PLEASE SPECIFY) _____

104. What is the highest grade in school you successfully completed, not counting the current grade you are in?

00 NEVER ATTENDED

- | | |
|------------------------------------|----------------|
| 1 ELEMENTARY | 12 3 4 5 6 7 8 |
| 2 HIGH SCHOOL | 123 4 5 + |
| 3 PROFESSIONAL SCHOOL | 123 4 5 + |
| 4 TECHNICAL SCHOOL (POST HS) | 12 3 + |
| 5 UNIVERSITY/FACULTY | 123 4 5 + |
| 6 POST UNIVERSITY/GRADUATE STUDIES | 12 3 4 5 |

IF Q104 = 4 OR MORE GO TO Q106; IF Q104 < 4 CONTINUE

105. Do you have a high school diploma?

- 1 YES
- 2 NO

106. Do you intend to complete any additional years of regular school or university/faculty at any time in the future?

- 1. YES
- 2. PROBABLY YES
- 3. PROBABLY NOT — > **GO TO Q108**
- 4. DEFINITELY NOT — > **GO TO Q108**

107. What is the highest level of education you intend to complete?

- | | | |
|-----------------------------------|-----------------|---|
| 1 ELEMENTARY | 1 2 3 4 5 6 7 8 | 9 |
| 2 HIGH SCHOOL | 12 3 4 5+ | 9 |
| 3 PROFESSIONAL SCHOOL | 123 4 5+ | 9 |
| 4 TECHNICAL SCHOOL (POST HS) | 12 3+ | 9 |
| 5 UNIVERSITY/FACULTY | 123 4 5+ | 9 |
| 6 POST UNIVERSITY/GRADUATE SCHOOL | 123 4 5+ | 9 |
| 88 DON'T KNOW | | |

108. Do you currently work outside of the home (at least 20 hours per week)?

- 1 YES--> **GO TO Q110**
- 2 YES, BUT ON MATERNITY/PREGNANCY LEAVE—> **GO TO Q110**
- 3 NO

109. What is the main reason that you are not working at this time?

1. ATTENDING SCHOOL
2. VACATION
3. LOOKING FOR WORK
4. LAID OFF
5. DOES NOT NEED/WANT/LIKE TO WORK
6. TEMPORARY ILLNESS
7. MATERNITY LEAVE
8. INABILITY TO FIND/AFFORD CHILD CARE
9. HOMEMAKER
10. PERMANENT DISABILITY
20. OTHER (SPECIFY) _____

110. What is it that you most enjoy reading? (**READ 1-7**):

	<u>YES</u>	<u>NO</u>
1. NEWSPAPERS	1	2
2. MAGAZINES	1	2
3. TECHNICAL BOOKS	1	2
4. CLASSICAL LITERATURE	1	2
5. RECREATIONAL LITERATURE	1	2
6. NOVELS ON LOVE AND ADVENTURE STORIES	1	2
7. OTHER (PLEASE SPECIFY) _____	1	2

111. Do you listen to the radio regularly?

1. YES
2. NO

112. More or less how many hours a day do you spend watching television?

- Hours a day ___ ___
- 00 NEVER
 66. NOT EVERY DAY
 77. DOES NOT HAVE TV
 88. DON'T KNOW

113. Are you currently married, not married but living with someone, separated, divorced, widowed, or have you never been married ?

- 1 MARRIED --> **GO TO Q.115**
- 2 NOT MARRIED BUT LIVING WITH A PARTNER --> **GO TO Q.115**
- 3 SEPARATED \--> **GO TO Q.115**
- 4 DIVORCED /
- 5 WIDOWED /
- 6 NEVER MARRIED

114. Have you ever lived with a boyfriend or partner?
- 1 YES
2 NO- >GO TO Q121
115. How many times have you been married or lived with a man?
- ___ TIMES
116. In what month and year did you begin living with your (first) husband/partner?
- MONTH ___ __ YEAR 19 ___ __ 98 DON'T KNOW
117. When you first got married did you wish to have any children?
- 1 YES
2 NO-----> GO TO Q119
3 NOT SURE---->GO TO Q119
118. How many children did you wish to have when you first got married?
- | | |
|--------|-------------------------|
| 1. 1 | 7. 4 |
| 2. 1-2 | 8. 5 or more |
| 3. 2 | 9. As many as God gives |
| 4. 2-3 | 20. Other: _____ |
| 5. 3 | 88. Was not sure |
| 6. 3-4 | |
119. What was the highest grade in school that your (last) husband(wife)/partner completed?
- | | | |
|-------------------------------|-----------------|---|
| 00 NEVER ATTENDED | | |
| 1 ELEMENTARY | 1 2 3 4 5 6 7 8 | 9 |
| 2 HIGH SCHOOL | 1 2 3 4 5+ | 9 |
| 3 PROFESSIONAL SCHOOL | 1 2 3 4 5+ | 9 |
| 4 TECHNICAL SCHOOL (POST HS) | 1 2 3+ | 9 |
| 5 UNIVERSITY/FACULTY | 1 2 3 4 5+ | 9 |
| 88 DON'T REMEMBER/ DON'T KNOW | | |
120. How old is your husband(wife) or partner?
- Age ___ __ (specify age at last birthday) 88. Do not know

Now I wish to ask you about your relationship with your parents:

121. Is your father still alive?
- 1. YES
 - 2. NO —>GO TO Q123
 - 3.1 NEVER KNEW HIM —> GO TO Q128
 - 8. DON'T KNOW —>GO TO Q123

122. Do you live with him?
- 1. YES —>GOTOQ124
 - 2. NO

23. Until what age did you live with your father?
- Age — — 00 NEVER
88 DON'T REMEMBER

IF Q123 < 10 GO TO Q127

124. Were you very close, close or not close to your father when you were between 10 and 15 years of age?
- 1. VERY CLOSE
 - 2. CLOSE
 - 3. NOT CLOSE
 - 4. DID NOT LIVE WITH HIM BETWEEN 10-15 —>GO TO Q127
 - 8. DON'T REMEMBER

125. The following questions are regarding the relationship with your father when you were between 10 and 15 years of age. I am going to read some statements and I want you to tell me if they are true or not?
(READ A-G):

	<u>YES</u>	<u>NO</u>	<u>DK</u>
A. Your father was very interested in you.....	1	2	8
B. Your father was very authoritative	1	2	8
C. The two of you argued a lot.....	1	2	8
D. He was very demanding	1	2	8
E. You were able to talk to him about sexual issues	1	2	8
F. You were able to talk to him about any subject you wanted	1	2	8
G. He allowed you to do whatever you wanted.....	1	2	8

126. During this time did you have any trust in your father? **(READ 1-5):**
- 1. VERY MUCH TRUST
 - 2. MUCH TRUST
 - 3. NEITHER MUCH OR LITTLE TRUST
 - 4. LITTLE TRUST
 - 5. NO TRUST
 - 8. DON'T KNOW

127. What was the highest level of education that your father finished in school or university?

- 00 NEVER ATTENDED
- 1 ELEMENTARY 12 3 4 5 6 7 8 9
- 2 HIGH SCHOOL 12 3 4 5+ 9
- 3 PROFESSIONAL SCHOOL 12 3 4 5+ 9
- 4 TECHNICAL SCHOOL (POST HS) 12 3+ 9
- 5 UNIVERSITY/FACULTY 12 3 4 5+ 9
- 88 DON'T REMEMBER/ DON'T KNOW

128. Is your mother still alive?

- 1. YES
- 2. NO —>GO TO Q130
- 3. I NEVER KNEW HER —>GO TO Q200
- 88. DON'T KNOW —>GO TO Q130

129. Do you live with her?

- 1. YES —>GOTOQ131
- 2. NO

130. Until what age did you live with your mother?

- Age ___ ___ 00 NEVER
88 DON'T REMEMBER

IF Q130 < 10 GO TO Q134; OTHERWISE CONTINUE

131. Were you very close, close or not close to your mother when you were between 10 and 15 years of age?

- 1. VERY CLOSE
- 2. CLOSE
- 3. NOT CLOSE
- 4. DID NOT LIVE WITH HER BETWEEN 10-15 —> GO TO Q134
- 8. DON'T REMEMBER

132. The following questions are regarding the relationship with your mother when you were between 10 and 15 years of age. I am going to read some statements and I want you to tell me if they are true or not.

(READ A-G):

	<u>YES</u>	<u>NO</u>	<u>DK</u>
A. Your mother was very interested in you.....	1	2	8
B. Your mother was very authoritative	1	2	8
C. The two of you argued a lot.....	1	2	8
D. She was very demanding	1	2	8
E. You were able to talk to her about sexual issues	1	2	8
F. You were able to talk to her about any subject you wanted.....	1	2	8
G. She allowed you to do whatever you wanted.....	1	2	8

133. During this time did you have a lot, a little or no trust in your mother? **(READ 1-5)**

- 1. VERY MUCH TRUST
- 2. MUCH TRUST
- 3. NEITHER MUCH OR LITTLE TRUST
- 4. LITTLE TRUST
- 5. NO TRUST
- 8. DON'T KNOW

134. What was the highest level of education that your mother finished in school or university?

00 NEVER ATTENDED

- | | | |
|-------------------------------|-----------------|---|
| 1 ELEMENTARY | 1 2 3 4 5 6 7 8 | 9 |
| 2 HIGH SCHOOL | 1 2 3 4 5+ | 9 |
| 3 PROFESSIONAL SCHOOL | 1 2 3 4 5+ | 9 |
| 4 TECHNICAL SCHOOL (POST HS) | 1 2 3+ | 9 |
| 5 UNIVERSITY/FACULTY | 1 2 3 4 5+ | 9 |
| 88 DON'T REMEMBER/ DON'T KNOW | | |

II. SEX EDUCATION

The next set of questions are about sex education.

200. Before you were 18 years old, did you ever talk with a parent about... (READ A-E)

	<u>YES</u>	<u>NO</u>	<u>DR</u>	<u>NR</u>
A. Menstrual Cycle?.....	1	2	8	9
B. How pregnancy occurs?.....	1	2	8	9
C. Methods of birth control?	1	2	8	9
D. Sexually transmitted diseases?	1	2	8	9
E. HIV/AIDS?.....	1	2	8	9

TOPIC	201. Before you were 18 years old, have you ever been taught at school about...? (READ EACH TOPIC)	202. In what grade were you when you first were taught at school about...?	203. Who taught you at school about...?
A. Menstrual Cycle	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
B. Female Reproductive System	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
C. Male Reproductive System	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
D. How Pregnancy Occurs	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
E. Contraceptive Methods	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
F. Sexually Transmitted Diseases	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER
G. HIV/AIDS	1 YES -> GO TO Q202 2 NO -> GO TO Q201B 8 DK -> GO TO Q201B 9 NR -> GO TO Q201B	— —	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER _____ 8 DON'T REMEMBER

204. Have you ever attended a lesson, course or lecture on sex education outside of school?

- 1. YES
- 2. NO—> **GO TO Q207**
- 8. DON'T REMEMBER—> **GO TO Q207**

205. Where did you get this lesson, course, or lecture on sex education?

- 1. SECS clinic
- 2. FP clinic
- 3. Hospital
- 4. Church
- 5. Community center
- 6. Youth for youth foundation
- 7. Youth organization
- 8. Other organization
- 20. Other _____

88. DR/DK

206. In what month and year did you first attend a lesson, course, or lecture on sex education outside the school?

A. MONTH ___ ___ B. YEAR ___ ___ 98 DR - > How old were you? ___ ___

207. Do you think schools should teach courses about reproductive biology, contraception, and prevention of sexually transmitted diseases?

- 1. YES
- 2. NO --> **GO TO 209**
- 8. DK
- 9. NR -> **GO TO 209**

208. At what year of age should they begin to teach about? (**READ A-C**)

- A. How pregnancy occurs? ___ ___ 77. Should not be taught in school.
- B. Contraception? ___ ___ 88. DK
- C. STD's ___ ___ 99. NR

SKIP TO 300 SERIES

209. Now I want to read some reasons for which one may oppose sex education in school. Please tell me if you agree or don't agree. (**READ A-C**)

	<u>AGREE</u>	<u>DISAGREE</u>	<u>DK</u>	<u>NR</u>
A. Sex education will give adolescents the idea to begin sex earlier.	1	2	8	9
B. Sex education ought to be taught only in the house	1	2	8	9
C. Sex education goes against my religious beliefs	1	2	8	9

III. FERTTLITY/PREGNANCY

300. Are you currently pregnant?
- 1 YES
 - 2 NO- >**GOTOQ305**
 - 3 NOT SURE—> **GOTO Q305**
301. How many months pregnant are you now? ____ MONTHS
302. At the time you became pregnant, did you want to become pregnant?
- 1 YES
 - 2 NO
 - 9 NOT SURE
303. Is this your first pregnancy?
- 1 YES
 - 2 NO----- >**GOTOQ307**
 - 3 NOT SURE
304. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?
- 1 YES----> **GO TO PREGNANCY TABLE**
 - 2 NO -----> **GO TO 319**
305. Have you ever been pregnant?
- 1 YES-----> **GO TO Q307**
 - 2 NO
 - 3 NOT SURE
 - 4 NEVER HAD SEX --> **GO TO MODULE IV**
306. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?
- 1 YES----> **GO TO PREGNANCY TABLE**
 - 2 NO -----> **GO TO MODULE TV**
307. Have you ever had any live-born children?
- 1 YES
 - 2 NO-----> **GO TO PREGNANCY TABLE**
308. How many living children do you have, including those who do not live with you? ____ __ children
309. Have you ever had a child born alive who later died or died right after birth?
1. YES
 2. NO -> **GO TO PREGNANCY TABLE**
310. You said, you had a total of ____ __ live births?

PREGNANCY HISTORY

Now I would like to talk to you about all your pregnancies (not counting the current one). Please, make sure you include all pregnancies, it doesn't matter when they happened or how they ended, whether in a live birth, an abortion, a miscarriage, or a stillbirth. Starting with your most recent pregnancy, please give me the following information:

Q311	Q312	Q313	Q314	Q315	Q316	Q317	Q318
	How did that pregnancy end?	When did that pregnancy end? (month & year) Probe for mth. & yr.	How many weeks or months had you been pregnant when that pregnancy ended?	Just before you got pregnant, did you want to get pregnant or did you not want to get pregnant?	Did you have one or more prenatal care visits? (PROBE: pregnancy check-ups)?	How many weeks pregnant were you at the time of your first Prenatal care visit?	How many prenatal care visits did you have for that pregnancy?
1	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IF Q312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO—> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
2	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IF Q312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO—> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
3	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IF Q312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO—> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR

4	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IFQ312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO —> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
5	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IFQ312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO —> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
6	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IFQ312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO —> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
7	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IFQ312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO —> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR
8	1. LIVE BIRTH (SINGLE) 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. STILLBIRTH (SINGLE) 5. MULTIPLE STILLBIRTH 6. MISCARRIAGE 7. INDUCED ABORTION 8. ECTOPIC PREGNANCY	A. ___ MONTH B. ___ YEAR 98.DK 99.NR	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 998.NR IF D11B < 90 GO TO NEXT LINE.	1. WANTED TO GET PREGNANT 2. DID NOT WANT TO GET PREGNANT 3. NOT SURE IFQ312>5—> GO TO NEXT PREGNANCY	1. YES 2. NO —> GOTO NEXT PREGNANCY	1 ___ WEEKS OR 2 ___ MONTHS 888.DK 999.NR	VISITS ___ 88.DK 99.NR

318A. THE NEXT QUESTION REFERS TO YOUR FIRST PREGNANCY (LAST LINE OF THE PREGNANCY TABLE). HOW DID THAT PREGNANCY END____AND IN WHAT MONTH AND YEAR DID IT END?

318B. MONTH __ __ YEAR __ __ 98 DR 99 REFUSED

319. Which of the following best describes your reaction to your first pregnancy? (READ 1-5)

1. Were you immediately happy about it,
 2. Did you accept it in the first 3 months of pregnancy,
 3. Did you accept it after the first 3 months of pregnancy
 4. Did you accept it eventually after the birth
 5. Were you never able to accept it 8.
- Don't know

320. How old was the father of your child when you became pregnant the first time? __ __ 88 DK 99 REF

321. When you first became pregnant, who were you living with?

- 1 HUSBAND/PARTNER— > **GO TO Q324**
- 2 HUSBAND/PARTNER AND PARENT(S) OR IN LAWS—>**GO TO Q324**
- 3 MOTHER AND FATHER
- 4 MOTHER OR FATHER ONLY
- 5 GRANDPARENTS ONLY
- 6 OTHER RELATIVES
- 7 FRIENDS
- 8 ALONE
- 0 OTHER: _____

322. When you became pregnant the first time, what was your relationship to the fattier of that pregnancy?

- 1 ENGAGED TO BE MARRIED
 - 2 BOYFRIEND
 - 3 FRIEND
 - 4 CASUAL ACQUAINTANCE
 - 5 JUST MET
 - 6 SEXUAL PARTNER
 - 7 RELATIVE
 - 8 WAS RAPED/INCEST-----> **GO TO MODULE IV**
 - 20 OTHER _____
- 88 DR/DN

323. What was his attitude when he learned of that first pregnancy (READ 1-5)?

1. He wanted to marry you
2. Insisted that you get married
3. He accepted the pregnancy but did not want to get married/stay with you
4. Wanted you to get an abortion
5. He did not know about pregnancy
7. Other _____
8. DON'T REMEMBER/REF

GO TO MODULE IV

324. Which of the following best describes your husband/partner's reaction to this first pregnancy?

1. He was immediately happy about it
2. He accepted it in the first 3 months of pregnancy,
3. He accepted it after the first 3 months of pregnancy
4. He accepted it after the birth,
5. He was never able to accept it/refused to become involved,
7. He did not know about pregnancy
8. DON'T REMEMBER/REF

IV. FAMILY PLANNING KNOWLEDGE/ SEXUAL EXPERIENCE

For each of the following methods of preventing pregnancy, please tell me:

METHOD	400. Have you ever heard of it?	401. Do you know how to use it?	402. Have you ever used it?	403. Do you know where to get it?	404. From whom did you hear about it? (SEE CODES BELOW)
A. Pins	1 Yes-->Q401 2 No--->B	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
B. IUD	1 Yes-->Q401 2 No--->C	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
C. Condoms	1 Yes-->Q401 2 No--->D	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
D. Foam/Jelly/ Cream	1 Yes-->Q401 2 No--->E	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
E. Diaphragm	1 Yes-->Q401 2 No--->F	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
F. Female Sterilization	1 Yes-->Q401 2 No--->G	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
G. Vasectomy	1 Yes-->Q401 2 No--->H	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
H. Injectables	1 Yes-->Q401 2 No--->I	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403	1 Yes\ 2 No /Q404	— —
I. Rhythm/Calendar	1 Yes-->Q401 2 No--->J	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403		— —
J. Withdrawal	1 Yes-->Q401 2 No--->K	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403		— —
K. Other _____ _____	1 Yes-->Q401 2 No--->Q405	1 Yes-->Q402 2 No--> Q402	1 Yes\ 2 No /Q403		— —

CODES FOR Q.404:

- | | |
|------------------------|-----------------------------|
| 1. Mother | 9. Doctor |
| 2. Father | 10. Medical Assistant/Nurse |
| 3. Relative | 11. Teacher |
| 4. Boyfriend | 12. Newspaper |
| 5. Friend | 13. TV |
| 6. Co-Worker | 14. Radio |
| 7. Partner/Husband | 20. Other (specify): _____ |
| 8. Someone who uses it | 88. Don't remember |

405. Looking at this CARD, please tell me which do you think is the most effective contraceptive method?

- 1 PILLS
- 2 IUD
- 3 CONDOM
- 4 FOAM/JELLY/CREAM
- 5 DIAPHRAGM
- 6 FEMALE STERILIZATION
- 7 MALE STERILIZATION
- 8 ELECTABLES
- 9 CALENDAR METHOD
- 10 WITHDRAWAL
- 11 DOUCHING AFTER INTERCOURSE
- 20 OTHER: _____
- 77 NONE OF THEM
- 88 DON'T KNOW/NOT SURE

406 And which do you think is die second most effective method?

- 1 PILLS
- 2 IUD
- 3 CONDOM
- 4 FOAM/JELLY/CREAM
- 5 DIAPHRAGM
- 6 FEMALE STERILIZATION
- 7 MALE STERILIZATION
- 8 INJECTABLES
- 9 CALENDAR METHOD
- 10 WITHDRAWAL
- 11 DOUCHING AFTER INTERCOURSE
- 20 OTHER: _____
- 77 NONE OF THEM
- 88 DON'T KNOW/NOT SURE

407. Looking at this card, which do you think is the most appropriate method for young people your age?

- 1 PILLS
- 2 IUD
- 3 CONDOM
- 4 FOAM/JELLY/CREAM
- 5 DIAPHRAGM
- 6 FEMALE STERILIZATION
- 7 MALE STERILIZATION
- 8 INJECTABLES
- 9 CALENDAR METHOD
- 10 WITHDRAWAL
- 11 DOUCHING AFTER INTERCOURSE
- 20 OTHER: _____
- 77 NONE OF THEM
- 88 DON'T KNOW/NOT SURE

408. Now I have some questions about your first sexual intercourse. When did you have sexual intercourse for the first time - in what month and year was that? (**PROBE: Can you tell me what year that was?**)
- A. ___ MONTH B. ___ YEAR 00. NEVER HAD SEXUAL INTERCOURSE
 98. DON'T REMEMBER
 99. REFUSE TO ANSWER
100. How old were you at that time? ___ YEARS 88. DON'T REMEMBER/DON'T KNOW
101. At the time you first had sexual intercourse, what was your relationship with your partner?
1. HUSBAND
 2. FIANCEE, ENGAGED TO BE MARRIED
 3. BOYFRIEND
 4. FRIEND
 5. ACQUAINTANCE
 6. JUST MET
 7. RELATIVE
 8. FORCED INTERCOURSE / RAPE — > **GO TO Q418**
 20. OTHER (SPECIFY) _____
 88. DON'T REMEMBER
411. How old was the person with whom you had intercourse for the first time?
- ___ YEARS 88. DK/DR
412. How long were you and your first partner dating when you first had sexual relations?
1. ___ Days OR 2. ___ Weeks OR 3. ___ Months OR 4. ___ Years
- 000=First time we met
 888=Don't remember
 999=No response
 777=Other _____
413. Before you had sex for the first time, did you and your partner talk about using contraception?
1. LYES
 2. NO
 8. DON'T REMEMBER
414. At the time you had first sexual intercourse, did you or your partner use any birth control method?
1. YES
 2. NO ---->**GO TO Q417**
 8. DK —>**GO TO Q418**
 9. REF—>**GO TO Q418**

415. Which birth control method did you or your partner use at the first intercourse?

- 1 PILLS
- 2 IUD
- 3 CONDOM
- 4 FOAM/JELLY/CREAM/VAGINAL FILMS
- 5 DIAPHRAGM
- 6 FEMALE STERILIZATION
- 7 MALE STERILIZATION
- 8 INJECTABLES
- 9 CALENDAR METHOD
- 10 WITHDRAWAL
- 11 DOUCHE
- 20 OTHER: _____
- 77 NONE
- 88 DON'T KNOW/DON'T REMEMBER

416. Who made then decision to use contraception at that time? (**READ 1-3**)

- 1. You
- 2. Your partner
- 3. Both you and your partner 8.
- Don't remember

GO TO Q418

417. What was the main reason for not using a method of birth control at that time?

- 1 SEX WAS NOT EXPECTED
- 2 THOUGHT IT WAS A SAFE TIME OF THE MONTH
- 3 A METHOD WAS UNAVAILABLE
- 4 RESPONDENT DISLIKED METHOD
- 5 PARTNER DISLIKED METHOD
- 6 DID NOT KNOW ABOUT CONTRACEPTION
- 7 WANTED TO GET PREGNANT
- 8 DID NOT WANT TO USE A METHOD
- 9 COULD NOT FIND A CONTRACEPTIVE METHOD
- 10 NEGLIGENCE
- 20 OTHER (SPECIFY) _____
- 88 DON'T REMEMBER/DON'T KNOW

418. During the past month have you had sexual intercourse?

- 1. YES
- 2. NO — **>GO TO Q420**
- 9. REF — **>GO TO Q420**

425. Last time when you had intercourse, did you or your partner use any birth control method?
1. YES
 2. NO —>GO TO Q427
 9. REF—>GO TO Q427
426. Which birth control method did you or your partner use the last intercourse? (PROBE: With condoms did you use spermicide?)
1. PILLS
 2. IUD
 3. CONDOM
 4. FOAM/JELLY/CREAM/VAGINAL FILMS
 5. DIAPHRAGM
 6. FEMALE STERILIZATION
 7. MALE STERILIZATION
 8. INJECTABLES
 9. CALENDAR METHOD
 10. WITHDRAWAL
 11. DOUCHE
 20. OTHER: _____
 77. NONE
 88. DON'T KNOW/DON'T REMEMBER

GO TO Q428

427. What was the main reason for not using a birth control method at your last intercourse?
1. SEX WAS NOT EXPECTED
 2. THOUGHT IT WAS A SAFE TIME OF THE MONTH
 3. A METHOD WAS UNAVAILABLE
 4. RESPONDENT DISLIKED METHOD
 5. PARTNER DISLIKED METHOD
 6. DID NOT KNOW ABOUT CONTRACEPTION
 7. WANTED TO GET PREGNANT
 8. DID NOT WANT TO USE A METHOD
 9. DID NOT THINK ABOUT IT
 10. SHE WAS PREGNANT
 11. BREASTFEEDING
 12. NEGLIGENCE
 20. OTHER (SPECIFY) _____
 88. DK/DR
428. Last time when you had intercourse, did you have any alcoholic drinks prior to intercourse?
1. YES
 2. NO
 8. DR

V. CURRENT AND PAST CONTRACEPTIVE USE

The next section of the interview is about contraceptives or family planning methods you or a partner may have used together.

501. RECORD WHETHER RESPONDENT REPORTS HAVING USED ANY METHOD (ANY Q402=1)

- 1 NEVER USED (NO Q402=1)
- 2 EVER USED (ANY Q402=1)— > **GO TO Q503**

502. So, you said you or any of your partners have never used any method to prevent pregnancy?

- 1 NEVER USED—> **GOTO Q518**
- 2 EVER USED— > **CORRECT Q402 AND/OR Q415, AND/OR Q426, THEN CONTINUE**

503. Are you (or your partner) currently using (in the last month) any method or doing anything to prevent pregnancy?

- 1 YES
- 2 NO—>**GO TO Q518**
- 3 NO SEXUAL RELATION IN THE LAST 30 DAYS— > **GO TO Q519**

504. What method are you currently using?

1. PILLS
2. IUD
3. FOAM/JELLY/CREAM/VAGINAL FILM
4. DIAPHRAGM
5. FEMALE STERILIZATION
6. VASECTOMY
7. INJECTABLES
8. CONDOM—>**GOTO Q506**
9. CONDOM AND SPERMICIDE— > **GO TO Q506**
10. CONDOM AND WITHDRAWAL— > **GO TO Q506**
11. CONDOM AND CALENDAR— > **GO TO Q506**
12. CALENDAR
13. WITHDRAWAL
14. WITHDRAWAL AND CALENDAR
15. OTHER TRADITIONAL METHODS
16. DOUCHE
77. OTHER: _____
88. NOT SURE

505. In the last 30 days, did you and your partner ever use a condom in addition to the method you are using?

- 1 YES
- 2 NO

506. In the last 30 days did you or your partner use - (method from Q504) - _____ every time you have sexual intercourse?

- 1 YES
- 2 NO

BOX1

IF Q504 = 1-11, CONTINUE; IF Q504 = 11-77, GO TO Q510; IF Q504 = 88, GO TO Q519

507. Where do (did) you or your partner get your family planning method?

- | | |
|--------------------------------|---------------------------|
| 1 REGIONAL/DISTRICT DISPENSARY | 7 OPEN MARKET |
| 2 POLYCLINIC | 8 STORE/DRUGSTORE |
| 3 HOSPITAL | 9 PARTNER |
| 4 PRIVATE PHYSICIAN/FP CLINIC | 10 FRIEND |
| 5 PHARMACY | 11 RELATIVE |
| 6 SECS CLINIC | 20 OTHER (SPECIFY): _____ |
| | 88 DON'T KNOW |

508. Do (Did) you pay for this method?

- 1 YES
- 2 NO----->**GO TO Q510**
- 3 PARTNER GETS THE METHOD -----> **GO TO Q510**

509. How much did you pay? ___ ___ ___ ___ ___ Lei 88888 = DOES NOT REMEMBER

510. Would you prefer to use a different method of family planning from the one you are currently using?

- 1 YES
- 2 NO - > **GO TO BOX2, MODULE V**

511. What method would you prefer to use?

- 1. PILLS
- 2. IUD
- 3. FOAM/JELLY/CREAM/VAGINAL FILM
- 4. DIAPHRAGM
- 5. FEMALE STERILIZATION
- 6. VASECTOMY
- 7. ELECTABLES
- 8. CONDOM—>**GOTO Q506**
- 9. CONDOM AND SPERMICIDE—> **GO TO Q506**
- 10. CONDOM AND WITHDRAWAL—> **GO TO Q506**
- 11. CONDOM AND CALENDAR—> **GO TO Q506**
- 12. CALENDAR
- 13. WITHDRAWAL
- 14. WITHDRAWAL AND CALENDAR
- 15. OTHER TRADITIONAL METHODS
- 16. DOUCHE
- 77. OTHER: _____
- 88. NOT SURE

512. What is the most important reason that you do not use that method?

- 1 DOCTOR WILL NOT PRESCRIBE IT
- 2 COST
- 3 NOT AVAILABLE/UNRELIABLE SUPPLIES/DIFFICULT ACCESS
- 4 TOO FAR AWAY
- 5 DO NOT KNOW HOW TO OBTAIN IT
- 6 HUSBAND/PARTNER OBJECTS TO IT
- 7 RELIGIOUS REASONS
- 8 FEAR OF SIDE EFFECTS
- 9 HAS NOT YET MADE UP HER MIND
- 20 OTHER _____
- 88 DON'T KNOW

BOX 2, MODULE V

IF USING NATURAL/TRADITIONAL METHOD (Q504=12-16), CONTINUE; IF MODERN METHOD USER (Q504=1-11), GO TO Q516; IF Q504=77 OR =88, GO TO Q519

514. You said that you are now using _____ (FILL IN THE METHOD USED) to avoid becoming pregnant, rather than a method you might obtain from a doctor, health facility, or pharmacy. Please tell me whether each of the following was very important, somewhat important, or not important at all in your decision to use this method:

	<u>Very Important</u>	<u>Somewhat Important</u>	<u>Not Important</u>	<u>Not Sure</u>
A. Difficult to get these methods	1	2	3	8
B. Cost of these methods	1	2	3	8
C. Little knowledge of these methods	1	2	3	8
D. Health/Side effects	1	2	3	8
E. Husband/Partner preference	1	2	3	8
F. Religious beliefs	1	2	3	8
G. Doctor's recommendation	1	2	3	8

515. How effective at preventing pregnancies do you think _____ (FILL IN THE METHOD USED) is compared to modern methods, like the pill or the IUD? (**READ 1-3**)

- 1 Current method more effective
- 2 About equally effective
- 3 Current method less effective
- 8 DON'T KNOW/NOT SURE

516. Do you have any problems or concerns with using _____ (**FILL IN THE METHOD USED**)?

- 1 YES
- 2 NO—>**GOTOQ519**

517. What is the most important problem?

- 1 SIDE EFFECTS
- 2 HEALTH CONCERNS
- 3 ACCESS/AVAILABILITY
- 4 COST
- 5 SOMETIMES FORGET TO USE
- 6 SOMETIMES DIFFICULT/INCONVENIENT TO USE
- 7 HUSBAND/PARTNER DISAPPROVES
- 8 LESS EFFECTIVE METHOD
- 20 OTHER _____
- 88 DK/DR

GO TO Q519

518. What is the main reason that you or your partner are not currently using a contraceptive method?

1. DOES NOT LIKE SIDE EFFECTS
2. BIRTH CONTROL IS TOO DIFFICULT TO USE
3. LOVEMAKING WOULD BE INTERRUPTED
4. BIRTH CONTROL IS TOO MESSY
5. CONCERNED ABOUT LONG TERM HEALTH PROBLEMS
6. PARTNER OBJECTS TO USING METHOD
7. DOES NOT KNOW WHERE TO GET METHOD
8. DOES NOT KNOW HOW TO USE THEM
9. MEDICAL PROBLEM
10. CANNOT AFFORD BIRTH CONTROL
11. OBJECTS DUE TO RELIGIOUS REASONS
12. NOT SURE IF RESPONDENT OR COUPLE CAN GET PREGNANT
13. PREGNANCY IS WANTED
14. POSTPARTUM NURSING
15. DIDN'T THINK ABOUT IT
16. BIRTH CONTROL ARE NOT (VERY) EFFECTIVE
17. NOT SEXUALLY ACTIVE IN THE LAST MONTH
18. DOES NOT CURRENTLY HAVE A PARTNER
19. CURRENTLY PREGNANT
20. OTHER (SPECIFY) _____
88. DK

519. Some people use condoms for reasons other than birth control, for instance because they are concerned about getting diseases that can result from sexual intercourse. Have you ever used condoms with a partner only for birth control, only to prevent diseases, or have you used them for both reasons?

1. Birth control only ----- > **GO TO Q521**
2. Disease prevention only—>**GO TO Q521**
3. Both----->**GO TO Q521**
4. Never used condom
8. Other _____

520. Why have you and your partner(s) never used condoms?

1. PREVENTING PREGNANCY IS WOMAN'S RESPONSIBILITY
2. PARTNER(S) OBJECTED TO USE CONDOMS
3. HAVE ONLY ONE PARTNER
4. THEY ARE ONLY FOR USE WITH PROSTITUTES
5. THEY ARE ONLY FOR USE OUTSIDE MARRIAGE(COUPLE)
6. CONDOMS DIMINISH PLEASURE/SPONTANEITY
7. CONDOMS ARE NOT EFFECTIVE IN PREVENTING PREGNANCY
8. CONDOMS ARE BAD FOR YOUR HEALTH?
9. CONDOMS ARE TOO DIFFICULT TO USE
10. LOVEMAKING WOULD BE INTERRUPTED
11. CONDOM USE IS TOO MESSY
12. CONDOMS ARE EXPENSIVE
13. SHE HAS NEVER THOUGHT ABOUT IT
14. PSYCHOLOGICAL RESISTANCE
15. PREFERS WITHDRAWAL
20. OTHER _____
88. DON'T KNOW

521. Have you ever asked a partner to wear a condom?

1. YES
2. NO ----> **GO TO BOX 3, MODULE V**
8. DK ----> **GO TO BOX 3, MODULE V**
9. REF ----> **GO TO BOX 3, MODULE V**

522. Has any of the following ever happened because you asked a partner to wear a condom: **(READ 1-5)**

	<u>YES</u>	<u>NO</u>	<u>DK</u>	<u>EEE</u>
1. Did a partner ever refuse to wear a condom?	1	2	8	9
2. Did a partner ever refuse to have sexual intercourse with you?	1	2	8	9
3. Did a partner ever yell or threaten to hurt you?	1	2	8	9
4. Did a partner ever physically hurt you?	1	2	8	9
5. Did a partner ever make you have sex anyway without a condom? . .	1	2	8	9

BOX 3, MODULE V

IF NO METHOD HAS BEEN USED SINCE JANUARY 1991 THEN ASK ONLY THE FIRST COLUMN AND WRITE "0" AT THE BEGINNING AND THE END OF THE SECOND COLUMN

523. CONTRACEPTIVE METHODS USED/PREGNANCY OUTCOMES CALENDAR

COLUMN 1

PREGNANCY OUTCOME

- 1 Pregnant
- 2 Live birth
- 3 Stillbirth
- 4 Induced abortion
- 5 Miscarriage
- 6 Ectopic pregnancy

COLUMN 2

METHOD USED

- 0 No method
- 1 Pills
- 2 IUD
- 3 Condoms
- 4 Local spermicides
- 5 Diaphragm
- 6 Tubal Ligation
- 7 Vasectomy
- 8 Injectables
- 9 Calendar method
- 10 Withdrawal
- 12 Condoms + local spermicides
- 20 Other _____
- 88 Don't remember

COLUMN 3

REASON SHE STOPPED USE

- 1 Became pregnant on method
- 2 Stopped to become pregnant
- 3 Husband no longer agreed
- 4 Side effects
- 5 Fear of developing side effects
- 6 Stopped to "rest the body"
- 7 Doctor's advice
- 8 Method no longer available
- 9 Inconvenient to use
- 10 Split up with husband/partner
- 11 Wanted to use another method
- 20 Other _____

DATE	1	2	3		DATE	1	2	3
1991					1994			
Jan 1					Jan 1			
Feb 2					Feb 2			
Mar 3					Mar 3			
Apr 4					Apr 4			
May 5					May 5			
Jun 6					Jun 6			
Jul 7					Jul 7			
Aug 8					Aug 8			
Sep 9					Sep 9			
Oct 10					Oct 10			
Nov 11					Nov 11			
Dec 12					Dec 12			
1992					1995			
Jan 1					Jan 1			
Feb 2					Feb 2			
Mar 3					Mar 3			
Apr 4					Apr 4			
May 5					May 5			
Jun 6					Jun 6			
Jul 7					Jul 7			
Aug 8					Aug 8			
Sep 9					Sep 9			
Oct 10					Oct 10			
Nov 11					Nov 11			
Dec 12					Dec 12			
1993					1996			
Jan 1					Jan 1			
Feb 2					Feb 2			
Mar 3					Mar 3			
Apr 4					Apr 4			
May 5					May 5			
Jun 6					Jun 6			
Jul 7					Jul 7			
Aug 8					Aug 8			
Sep 9					Sep 9			
Oct 10					Oct 10			
Nov 11					Nov 11			
Dec 12					Dec 12			

IF NOT USING A CONTRACEPTIVE METHOD IN JANUARY 1991, GO TO BOX 4

524. You said you were using _____ in January of 1991. When did you start using that method?

A. MONTH ___ ___

B. YEAR 19 ___ ___

98.DK

99.REF

BOX 4--MODULE V

IF A CONTRACEPTIVE METHOD WAS USED IN THE LAST MONTH (LAST CELL EST COLUMN 2 IS NOT "0") THEN GO TO Q527; ELSE CONTINUE WITH Q525
--

525. Do you think you are physically able to get pregnant at the present time?

1 Yes—> **GO TO Q527**

2 No

3 Not sure

4 Currently pregnant— > **GO TO Q527**

526. What is the main reason why you think you cannot get pregnant?

1. OVARIAN CYSTS

2. CURRENTLY BREAST-FEEDING /POSTPARTUM

3. SEXUALLY TRANSMITTED DISEASE (PID)

4. PARTNER HAD A MEDICAL OPERATION

5. PARTNER IS INFERTILE

6. RESPONDENT HAD A MEDICAL OPERATION THAT MAKES PREGNANCY IMPOSSIBLE

7. HAS BEEN USING BIRTH CONTROL

8. RESPONDENT IS NOT SEXUALLY ACTIVE

9. HAS TRIED TO GET PREGNANT IN THE PAST 2 YEARS AND DID NOT SUCCEED

77. OTHER (SPECIFY) _____

88. DK

99. REF

527. In the past 12 months have you ever tried to get/obtain birth control pills?

1 YES

2 NO ----->**GO TO Q531**

528. In the past 12 months, did you succeed in getting/obtaining birth control pills?

1. YES—>**GO TO Q531**

2. NO

3. DID NOT KNOW WERE I CAN GET PILLS —> **GO TO Q531**

529. What was the reason you were unable to get them?
1. NEED RX AND DID NOT HAVE ONE
 2. PILLS UNAVAILABLE/OUT OF STOCK —>**GO TO Q531**
 3. COST —> **GO TO Q531**
 4. HARD TO FIND/DID NOT HAVE TIME TO LOOK FOR THEM —> **GO TO Q531**
 5. EMBARRASSED TO ASK FOR THEM IN A PHARMACY/FP CLINIC—> **GO TO Q531**
 7. OTHER (SPECIFY)_____ —>**GO TO Q531**
 8. DON'T REMEMBER —>**GO TO Q531**
530. Why did you not have a prescription?
- 1 PHYSICIAN REFUSED BECAUSE OF HEALTH/SIDE EFFECTS
 - 2 PHYSICIAN REFUSED BECAUSE OF AGE
 - 3 PHYSICIAN REFUSED BECAUSE OF MARITAL STATUS
 4. NEVER THOUGHT TO ASK FOR ONE
 5. NEVER HAVE TIME TO GET ONE
 6. TOO EMBARRASSED TO ASK FOR ONE
 7. OTHER _____
531. In the past 12 months have you ever wanted to get/obtain condoms?
- 1 YES
 - 2 NO----->**GO TO Q534**
 3. DID NOT KNOW WERE I CAN GET CONDOMS —> **GO TO Q534**
532. In the past 12 months, did you succeed in getting/obtaining condoms?
- 1 YES—>**GO TO Q534**
 - 2 NO
533. What was the reason you were unable to get condoms?
1. CONDOMS UNAVAILABLE/OUT OF STOCK
 2. COST
 3. HARD TO FIND/DID NOT HAVE TIME TO LOOK FOR THEM
 4. EMBARRASSED TO ASK FOR THEM IN A PHARMACY/FP CLINIC
 7. OTHER (SPECIFY) _____
 8. DON'T REMEMBER

<p>IF RESPONDENT IS CURRENTLY PREGNANT (Q300=1) GO TO Q535</p>

534. Looking to the future, do you yourself intend to have (a/another) baby at some time?

1. WANT A BABY — > **GO TO Q536**
2. DO NOT WANT A BABY — > **GO TO 600 SERIES**
3. RESPONDENT AND PARTNER DISAGREE — > **GO TO 600 SERIES**
8. DK —> **GO TO 600 SERIES**

535. Looking to the future, do you yourself intend to have another baby after this pregnancy?

- LYES**
2. NO ---> **GO TO 600 SERIES**
 3. RESPONDENT AND PARTNER DISAGREE —> **GO TO 600 SERIES**
 8. DK — > **GO TO 600 SERIES**

536. When do you, yourself, actually want to get pregnant (again).. .(READ 1-5)

1. you want to get pregnant now,
2. within the next 12 months,
3. In 1-2 years,
4. In 3-5 years,
5. or after 5 years?
8. DK

VI. WOMEN'S HEALTH

600. How old were you at the time of your first menstruation?

- ___ ___ YEARS 00. NOT HAVE YET
 88. DO NOT REMEMBER
 99. REFUSE

601. At the time you had your first menstruation, did you know what menstruation is?

1. YES
2. NO
8. NOT SURE

602. Have you ever had a gynecologic exam?

1. YES—>**GO TO Q604**
2. NO
9. NR

603. What is the principle reason that you have not had a routine gynecologic exam?

- 1 DOES NOT NEED TO GO TO GYNECOLOGIC EXAM
2 SHE IS HEALTHY AND HAS NOT GYNECOLOGIC PROBLEMS
3 THERE IS NOT TIME TO GO FOR EXAM
4 SHE FORGETS ABOUT IT
5 SHE DOES NOT LIKE GYNECOLOGIC EXAM
6 IT IS DIFFICULT TO GET APPOINTMENT
7 DOES NOT LIKE PLACE/FACILITY
8 DOES NOT LIKE THE STAFF
9 WAITING TIME IS TOO LONG
10 DOCTOR DID NOT RECOMMEND
11 SHE IS EMBARRASSED TO HAVE GYNECOLOGIC EXAM
12 NEVER THOUGHT ABOUT IT
13 NOT SEXUALLY ACTIVE
20 OTHER _____
88 DK
99 NR

GO TO Q605

604. How often do you go for regular (not pregnancy related) gynecologic exams? (**READ 1-4**)

- 1 At least once per year
2 Every 1-2 years
3 Every 3-5 years
4 Less than every 5 years
8 DK/DR

605. Have you ever had a Pap smear? (PROBE: A pap smear is a test that takes a sample of cells from the cervix, or opening to the uterus, to detect cancer)

1. YES—>**GO TO Q607**
2. NO
8. DK
9. REF

606. What is the main reason you have never had a Pap smear?

0. NEVER HEARD OF IT
1. SHE DOES NOT FEEL TEST IS NECESSARY
2. SHE IS HEALTHY AND HAS NO GYNECOLOGIC PROBLEMS
3. DOES NOT HAVE TIME TO GO FOR A TEST
4. SHE FORGETS ABOUT IT
5. IT IS DIFFICULT TO GET APPOINTMENT
6. DOCTOR HAS NOT RECOMMENDED IT
7. I'M TOO EMBARRASSED TO GET THE TEST OR A PELVIC EXAM.
8. I AM AFRAID OF THE RESULTS
9. NEVER THOUGHT OF IT
10. NOT SEXUALLY ACTIVE
11. SHE HAD NO PARTNER
12. SHE IS AFRAID IT COULD BE PAINFUL
20. OTHER (SPECIFY): _____
88. DON'T KNOW
99. NR

GO TO Q608

607. When did you have your last Pap smear? Was it... (**READ 1-4**)

1. within the last year,(0 TO 11 MONTHS AGO)
2. 1 to 2 years ago,(12 TO 23 MONTHS AGO)
3. 2-3 years ago,(24 to 35 MONTHS AGO)
4. more than 3 years ago? (36+MONTHS AGO)
8. DK

608. Have you ever tried cigarette smoking, even one or two puffs?

1. YES
2. NO—> **GO TO 615**

609. How old were you when you smoked a cigarette for the first time? ___ ___ years

88. DK
99.NR

616. Now, I have some questions about drinking alcohol. We count a drink as one can or bottle of beer, one glass of wine, or one cocktail or shot of liquor. How old were you when you had your first drink of alcohol other than a few sips?

__ __ Years

00. NEVER HAD A DRINK OTHER THAN A FEW SIPS— > **GO TO Q700**

88. DK 99. REF

618. In the past 3 months, on the days that you drank alcohol, how many drinks did you usually have?

__ __ # OF DRINKS

00. NO DRINKS—> **GO TO Q624**

88. DK— > **GO TO Q623**

99. REF—> **GO TO Q623**

619. How often did you drink that amount? (PROBE: How many times a week, a month)

1. EVERYDAY
2. ALMOST EVERY DAY
3. 3-4 TIMES A WEEK
4. 1-2 TIMES A WEEK
5. 2-3 TIMES A MONTH
6. ONCE A MONTH
7. 1-2 TIMES IN THREE MONTHS

VII REPRODUCTIVE HEALTH KNOWLEDGE/ATTITUDES

700. What do you think is the ideal number of children for a young family in Romania

- 0 0 children
- 1 1 child
- 2 1-2
- 3 2
- 4 2-3
- 5 3
- 6 3-4
- 7 4
- 8 5 or more
- 9 God knows
- 77 As many as possible
- 88 Don't know

701. When is it most likely for a woman to become pregnant (**READ 1-5**)?

- 1 A week before menstruation starts
- 2 During menstruation
- 3 A week after menstruation starts
- 4 Halfway between her periods
- 5 It doesn't matter, all times alike
- 7 Other (SPECIFY) _____
- 8 DON'T KNOW

702. Do you think that a woman always has the right to decide about her pregnancy, including whether to have an abortion?

- 1 Yes—> **GO TO Q704**
- 2 No

703. Under which of the following conditions is it all right for a woman to have an abortion (**READ A-F**)?

	<u>YES</u>	<u>NO</u>	<u>DEP.</u>	<u>DK</u>
A. Her life is endangered by pregnancy	1	2	3	8
B. The fetus has a physical deformity	1	2	3	8
C. The pregnancy has resulted from rape	1	2	3	8
D. Her health is endangered by pregnancy	1	2	3	8
E. She is unmarried	1	2	3	8
F. The couple cannot afford to have a child	1	2	3	8

704. If a woman had a unwanted pregnancy what should she do? **(READ 1-3):**

- 1 Have the baby and keep it
- 2 Have the baby and give it up for adoption
- 3 Have an abortion
- 8 DON'T KNOW

705. I would like to know if you are in agreement with the following statements **(READ A-K):**

	<u>AGREE</u>	<u>AGREE</u>	<u>DK</u>
A. A woman can become pregnant the first time			
she has sexual intercourse	1	2	8
B. All people should get married	1	2	8
C. Many people have sex because their friends are sexually active	1	2	8
D. Men are not interested in discussing contraception with their partner/wives ...	1	2	8
E. Females are not interested in discussing contraception with their partner/hus. ...	1	2	8
F. Men are not interested in the emotional and sexual needs of their partner/wife .	1	2	8
G. Women should tell their partners/husbands what they like or don't like to do			
during sex	1	2	8
H. A woman must have the children that GOD gives her	1	2	8
I. Child care is a woman job	1	2	8
J. A woman should be a virgin when she marries	1	2	8
K. A man who has an operation in order not to have			
more children loses his manhood	1	2	8

706. When do you think young women /men should first have sexual intercourse **(READ 1-4)?**

- 1. Only after they get married
- 2. Only if the couple plans to get married
- 3. If the couple is in love regardless plans of marriage
- 4. If the couple date each other but are not in love
- 8 DON'T KNOW

707. Who do you think should decide how many children a couple should have **(READ 1-3)?**

- 1. The woman,
- 2. The man, or
- 3. Both?
- 8 DON'T KNOW

708. Who do you think should be responsible to avoid pregnancy (**READ 1-3**)?
1. The woman,
 2. The man, or
 3. Both?
 8. DON'T KNOW
709. How effective do you think correctly taken pills are in preventing a woman from becoming pregnant? (**READ 1-4**)
1. Very Effective
 2. Somewhat effective
 3. Not very effective
 4. Not at all effective
 8. DON'T KNOW

710. How safe for a woman's health is the pill (**READ 1-4**)?
- 1 Very safe
 - 2 Safe
 - 3 Fairly safe or,
 - 4 Unsafe
 - 8 DON'T KNOW

711. Please indicate whether you agree or disagree with the following statements about the pill.

	<u>AGREE</u>	<u>DISAGREE</u>	<u>DK</u>
A. The pill makes a woman gain weight	1	2	8
B. Having to remember to take the pill every day causes stress	1	2	8
C. The pill makes periods more regular	1	2	8
D. The pill makes a woman nervous	1	2	8
E. Taking the pill for too long can cause infertility	1	2	8
F. Women who take the pill have a higher risk of getting cancer	1	2	8
G. The pill removes the fear of getting pregnant	1	2	8
H. The pill is easy to use	1	2	8
I. The pill is bad for blood circulation	1	2	8

712. How effective do you think a properly fitted IUD is in preventing a woman to become pregnant? **(READ 1-4)**
1. Very Effective
 2. Somewhat effective
 3. Not very effective
 4. Not at all effective
 8. Don't know
713. How safe for a woman's health is the IUD? **(READ 1-4)**
- 1 Very safe
 - 2 Safe
 - 3 Fairly safe
 - 4 Unsafe
 - 8 DON'T KNOW
714. How effective do you think douching after sexual intercourse is in preventing a woman from getting pregnant? **(READ 1-4)**
1. Very Effective
 2. Somewhat effective
 3. Not very effective
 4. Not at all effective
 8. DON'T KNOW
715. How effective do you think a properly used condom is to prevent a woman to become pregnant? **(READ 1-4)**
1. Very Effective
 2. Somewhat effective
 3. Not very effective
 4. Not at all effective
 8. DON'T KNOW
716. Some people use condoms to keep from getting sexual transmitted diseases. How effective do you think is a properly used condom is for this purpose? **(READ 1-4)**
1. Very Effective
 2. Somewhat effective
 3. Not very effective
 4. Not at all effective
 8. DON'T KNOW
717. Have you ever talked to a partner about him using a condom?
- LYES
 2. NO
 3. NEVER HAD A PARTNER—> **GO TO Q719**
 8. DON'T REMEMBER

718. If your partner/husband would want to use a condom when having sex with you, would you feel:
(READ A-F)

	<u>AGREE</u>	<u>DISAGREE</u>	<u>DK</u>
A. Embarrassed?	1	2	8
B. Angry?	1	2	8
C. Safe from getting pregnant?	1	2	8
D. Safe from getting HIV?	1	2	8
E. Like you had done something wrong?	1	2	8
F. Safe from getting STD?	1	2	8

719. Please indicate whether you agree or disagree with the following statements about condoms.

	<u>AGREE</u>	<u>DISAGREE</u>	<u>DK</u>
A. Condoms reduce (takes away?) the pleasure of sex	1	2	8
B. Condoms are messy (repulsive) to use.....	1	2	8
C. Condoms requires one's partner to have self control.....	1	2	8
D. One can use a condom more than once	1	2	8
E. People who use condoms sleep around a lot	1	2	8
F. It is embarrassing to buy condoms in pharmacy or store	1	2	8
G. It is embarrassing to ask condoms in FP clinics.....	1	2	8
H. Most women don't like to use condoms	1	2	8
I. Most men don't like to use condoms	1	2	8
J. Using condoms with a new partner is a good idea	1	2	8
K. Using condoms is not necessary if you know your partner.....	1	2	8
L. Women should ask their partners to use condoms	1	2	8
M. Discussing condom use with prospective partner is easy.....	1	2	8

720. Do you want to have more information about contraceptive methods?

- 1 Yes
- 2 No ----- > **GO TO Q722**
- 8 DK—> **GO TO Q722**

721. Who do you consider the most reliable person to give you this information?

- 1 DOCTOR
- 2 NURSE/MIDWIFE
- 3 USER OF CONTRACEPTION
- 4 GIRL FRIEND(S)
- 5 HUSBAND/PARTNER
- 6 MOTHER
- 7 FATHER
- 8 RELATIVE
- 9 MASS MEDIA
- 20 OTHER: _____
- 98 DON'T KNOW

722. Now I am going to read you a series of statements. After I read each statement, please tell me whether you agree with the statement, disagree with it, or have no opinion one way or the other (don't know).
(READ A-G)

	<u>AGREE</u>	<u>DISAGREE</u>	<u>DK</u>
A. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad luck.	1	2	8
B. I have often found that what is going to happen will happen, whether I want it to or not.	1	2	8
C. My life is chiefly controlled by people with more power than me.	1	2	8
D. In order to get what I want, I have to conform to the wishes of others.	1	2	8
E. What others in the family want should always come first before what I want.	1	2	8
F. I can generally determine what will happen in my own life.	1	2	8
G. When I get what I want, it's usually because I've worked hard for it.	1	2	8

VIII. SOCIOECONOMIC CHARACTERISTICS

800. Please tell me whether this household or any member of it has the following items: **(READ A-H):**

	<u>Yes</u>	<u>No</u>
A. Flush Toilet	1	2
B. Central heating	1	2
C. Vacuum cleaner	1	2
D. Color television	1	2
E. Automobile	1	2
F. VCR	1	2
G. Telephone	1	2
H. Vacation home	1	2

801. How many rooms does this house/flat have (not including bathrooms and kitchen)? _____ rooms

802. Which of these best describes this house/flat? **(READ 1-4)**

- 1 Own home/apartment
- 2 Rental, from private owner
- 3 Rental, state owned
4. Living with other family/relatives

803. What is your ethnic background?

- 1 Romanian
- 2 Hungarian
- 3 Romy (Gipsies)
- 4 German
- 8 Other (specify): _____
- 9 Refused/Not stated

804. What is your religion?

- 1 Orthodox
- 2 Romano-Catholic
3. Lutheran
4. Baptist
5. Pentecostal
6. Greco-Catholic
7. Other Protestant
8. Other (specify): _____
9. No Religion----- > **GO TO Q900**
99. Undeclared— > **GO TO Q900**

805. About how often do you usually attend religious services? **(READ 1-5)**

- 1 At least once a week
- 2 At least once a month, but less than once a week
- 3 Less than once a month
- 4 Only on holidays
- 5 Never

IX. KNOWLEDGE OF AIDS

900. The next questions refer to sexually transmitted diseases. Please tell me if you have ever heard about: **(READ A-G)**

	<u>Yes</u>	<u>No</u>	<u>DK</u>
A. Syphilis	1	2	8
B. Gonorrhea	1	2	8
C. Tricinoma	1	2	8
D. Condyloma	1	2	8
E. Vaginal yeast infection	1	2	8
F. Genital herpes	1	2	8
G. HIV infection (AIDS)	1	2	8

IF THEY HAVE NEVER HEARD OF HIV/AIDS (Q900G = 2 OR = 8), END INTERVIEW

901. In general, what has been your most important source of information about AIDS or HIV? (Where or from whom have you learned the most about AIDS?)

- | | |
|---------------------------|-----------------|
| 1. Teacher in school | 7. School |
| 2. Family | 8. TV |
| 3. Friends | 9. Radio |
| 4. Co-Workers | 10. Mass media |
| 5. Doctor/Nurse | 20. Other _____ |
| 6. Family Planning Clinic | 88. DK |

902. Do you think a person can be infected with the AIDS virus and not have any clinical signs of the disease?

- 1 Yes
- 2 No
- 8 Don't know

903. Do you believe a person can become infected with AIDS in the following ways? **(READ A-L)**

	<u>YES</u>	<u>NO</u>	<u>DK</u>
A Receiving a blood transfusion	1	2	8
B Using public bathrooms	1	2	8
C Kissing on the mouth	1	2	8
D Having heterosexual relations	1	2	8
E Men having homosexual relations	1	2	8
F Shaking hands	1	2	8
G Donating blood	1	2	8
H Using a non-sterile syringe/needle	1	2	8
I Mosquito bites	1	2	8
J Using objects of a person with AIDS	1	2	8
K Getting a manicure, pedicure or haircut	1	2	8
L Having medical or dental treatment	1	2	8

904. Do you think the following persons generally have no risk, a low risk, or a high risk of getting AIDS?

	<u>NO RISK</u>	<u>LOW RISK</u>	<u>HIGH RISK</u>	<u>DEPENDS</u>	<u>DK</u>
A. Married woman	1	2	3	4	8
B. Married man	1	2	3	4	8
C. Homosexual man	1	2	3	4	8
D. Homosexual woman	1	2	3	4	8
E. Prostitute	1	2	3	4	8
F. Intravenous drug user	1	2	3	4	8
G. Sexually active woman, unmarried	1	2	3	4	8
H. Sexually active man, unmarried	1	2	3	4	8

905. What can a person do to reduce the risk of getting AIDS?

	<u>SPONTANEOUS</u>		<u>PROBED</u>		<u>DK</u>
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	
A Use condoms	1	2	3	4	8
B Avoid relations with prostitutes	1	2	3	4	8
C Do not donate blood	1	2	3	4	8
D Have only 1 sexual partner	1	2	3	4	8
E Ask partner to get tested for AIDS	1	2	3	4	8
F Do not have sexual relations	1	2	3	4	8
G Sterilize needles	1	2	3	4	8
H Avoid relations with homosexuals	1	2	3	4	8
I Other _____	1	2	3	4	8

906. Do you think that you have any risk of getting AIDS?

- 1 Yes
- 2 No-----> **END OF INTERVIEW**
- 8 Don't know -----> **END OF INTERVIEW**

907. Would you say that you have a low risk or a high risk?

- 1 Low risk
- 2 High risk
- 8 Don't know

END OF INTERVIEW

TIME INTERVIEW ENDED ___ ___ : ___ ___