Reproductive Health Survey Georgia 2005

Final Report

REPRODUCTIVE HEALTH SURVEY GEORGIA, 2005

FINAL REPORT

Editors:

Florina Serbanescu, MD, MPH
Paata Imnadze, MD, PhD
Zaza Bokhua, MD
Nick Nutsubidze, MD
Danielle B. Jackson, MPH
Leo Morris, PhD, MPH

National Center for Disease Control and Medical Statistics (NCDC)
Ministry of Labor, Health, and Social Affairs (MoLHSA)
Department of Statistics, Ministry of Economic Development
TBILISI, GEORGIA

Division of Reproductive Health,
Centers for Disease Control and Prevention (DRH/CDC)
ATLANTA, GEORGIA USA

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Additional information about this report may be obtained from the Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC), Mailstop K-23, 4770 Buford Highway, NE, Atlanta, 30341–3724 USA. Fax (770) 488-6242; Tel (770) 488-6200.

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Preface

Public health efforts toward improving the health of women, infants and children, control of infectious diseases, and increasing life expectancy are important factors in raising productivity, reducing poverty, and promoting sustained economic growth, in addition to their intrinsic value as important humanitarian aims. For these efforts to be successful, public health professionals have to identify the needs of women and children, to design and implement appropriate interventions, and to monitor and evaluate those interventions.

The first national reproductive health survey ever conducted in Georgia took place in 1999/2000 and provided essential baseline population-based data on reproductive health status and health care utilization. Results showing low usage of modern contraception and high rates of unintended pregnancies proved to be instrumental in designing and implementing new health strategies and programs and promoting health care reforms. Since then, family planning supply efforts have been intensified, the number of sites and physicians providing free family planning services has been expanded and reproductive health information, education and communication activities were strengthened. The 2005 follow-up survey, with a similar content and design, provides another accurate snapshot of the situation of health for women and children in Georgia and allows for the study of trends in reproductive health knowledge, behaviors and practices.

The 2005 survey has also been instrumental in helping Georgia meet the demand for data to monitor the national development programs and to report on progress toward the Millennium Development Goals (MDGs). To address these goals, the government of Georgia set up strategies that target poverty reduction through sustainable and rapid economic growth, as is outlined in the Economic Development and Poverty Reduction Programme (EDPRP). The government's readiness to address reproductive health is clearly delineated in this national policy strategic document. The Ministry of Health, Labor and Social Affairs (MoHLSA) is directly responsible for implementing several reproductive health reforms, including: "compliancy with international standards in the health sector;" a revision of the basic package of medical care for mothers and children; "improvement of the material-technical base" of health care services for mothers and children; and maternal and child death reviews "to elaborate relevant preventive measures." The survey provides the MoHSLA with a much needed ability to track progress of key indicators for program outcomes and helps formulate targeted interventions to avert the reproductive health consequences of poverty in Georgia.

By making available appropriate national and region specific data on reproductive health status and service delivery and enhancing the ability of local organizations to collect, analyze and disseminate such information, these two surveys brought a tremendous contribution to fostering collaboration among governmental agencies (MoHSLA, National Center for Disease Control and Medical Statistics, Ministry of Economy), international donors (USAID and UNFPA) and technical experts (Centers for Disease Control and Prevention), whose common goal is to inform policies and advance appropriately designed reproductive health sector reforms. It is my pleasure and privilege to express my gratitude to these organizations for their dedication and allocation of time and resources. To my staff and all of the individuals involved in bringing this work to successful completion, my deepest thanks for your invaluable contributions.

Lado Chipashvili, MD, PhD
Georgian Minister of Labor, Health and Social Affairs

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Most of all, we would like to thank the 6,376 women who made such a major contribution to our knowledge of women's reproductive health in Georgia by their participation in the GERHS05. We are grateful to our highly skilled interviewers, supervisors, and data entry personnel for their commitment, discipline, and dedication to the project.

GEORGIA

REFERENCE MAP

* Abkhazia: Autonomous region not under government control

Executive Summary

Georgia is a country with strong cultural identity. Ethnic Georgians represent 84% of the total population with Armenians and Azeri being the largest ethnic minorities. With the dissolution of the Soviet Union, Georgia has faced over a decade of socioeconomic and political transition, and progress toward development has been somewhat uneven. Although major reforms of various sectors have been attempted, including health sector reform initiated in 1995, several factors have challenged these efforts. While some health indicators have improved, many are still lagging behind. Healthcare expenditures comprise a decreasing portion of public expenditures, resulting in the under-resourcing of medical facilities that places the Georgian healthcare system far behind other European countries, including family planning and reproductive health services.

Since the 1990s, there has been some improvement in the area of reproductive health. Contraceptive prevalence has increased and reliance on abortion to prevent unplanned births has decreased. Maternal mortality and infant death are also declining, but all are still serious problems in Georgia. Regional and socioeconomic disparities are sometimes quite significant, and in some cases are worse than the pre-transition period.

Over the past several years, the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), and other multilateral and bilateral donors have invested resources to improve access to family planning and other reproductive health services in Georgia. Through funds provided by USAID and UNFPA, a nationwide Reproductive Health Surveys (RHS) was conducted in Georgia in 1999, and has now been followed up with a second survey in 2005; both with the purpose of assessing and responding to reproductive health needs of the population.

The 2005 Georgia RHS (GERHS05) is a collection of important demographic and reproductive health indicators. These indicators are used to examine health trends and set targets for improvement, allocate resources, and monitor performance of reproductive health programs. Several findings of the GERHS05 are highlighted below:

GERHS05 Overview

- As the Georgian government sets forth to develop a new comprehensive national Reproductive Health Policy, the timing of the GERHS05 has been ideal.
- Designing the sample to produce estimates for 11 regions of the country enables key stakeholders to better assess reproductive health at the subnational level.
- This survey yielded a 99% response rate with virtually all selected respondents agreeing to be interviewed.

Characteristics of Households and Respondents

- While the majority of households had tap water in their residence or yard (76%) there still exists a significant disparity with this being the case for 95% of urban households, yet only 54% of rural households.
- The majority of respondents were of Georgian ethnicity (87%), followed by Azeri (5%) Armenian (5%) and other ethnicities (2%).
- Eighty percent of women were Georgian Orthodox and 13% were Muslim.
- Educational attainment is wide-spread in

Georgia with 84% of women reporting at least completion of secondary education. Over a third of women had gone on to complete university or postgraduate work (35%).
- Most women (79%) reported not working outside of the house, a situation that was even more pronounced in rural areas where job availability is very low.

Marriage and Fertility

- Sixty percent of women in the sample were married or in consensual unions, 6% had been married previously and 35% had never been married.
- Women in Georgia tended to marry early with the median age of first marriage being 21.6 years old.
- Consistent with the regional trends, Georgia's fertility rates have been declining since the 1970s. The total fertility rate of 1.6 children per woman in Georgia for 2002–2005 was higher than in Eastern Europe, but lower than in Central Asian republics.
- Compared to 1999, the 3-year period fertility rate had declined slightly (from 1.7 to 1.6 births per woman).
- Georgian women initiate and complete childbearing at early ages, with the highest fertility levels reported among 20- to 24-year-old and 25- to 29-year-old women.
- Generally, peak fertility occurred at ages 25–29 among women with the highest educational attainment, whereas peak fertility among women with lower educational levels occurred at ages 20–24.
- Median age at first birth was 23.2 years, practically unchanged compared to 1999
- Fertility also peaks before age 24 among rural, women, and Azeri and Armenian women.

Pregnancy Intention Status

- Fifty-one percent of Georgian women reported their last pregnancy as unintended, with the majority of those being unwanted.
- Younger women were more likely to want an additional one or more children, whereas the majority of older women wanted to stop childbearing.
- Among fecund married women who had had two or more children, the majority (78%) were ready to terminate childbearing.
- Almost all unintended pregnancies had ended in induced abortion.

Induced Abortion

- The total induced abortion rate in Georgia has decreased since 1999 from 3.7 to 3.1 abortions per woman, but at 3.1 abortions per woman it is among the highest documented in the region.
- More than one-half of Georgian women obtaining abortions between 2002–2004 were of ages 25–29 years (164 abortions per 1,000 women) and 30–34 years (165 abortions per 1,000 women) and the vast majority were married.
- Reports of higher abortion rates among rural women, less educated women, and women of Azeri descent suggest that access to services is unequal and that Georgia's family planning program needs to expand its reach to disadvantaged subgroups.
- Main reasons given for choosing abortion included: desire to stop childbearing (63%), desire to space the next birth (19%), and socioeconomic circumstances that prevent the family to support another child (15%).
- In 2000–2004, virtually all abortions (97%) were performed in governmental health facilities; the average amount paid for a nonhospital abortion (performed in women's consultation clinics) was $15 and the average cost for a hospital abortion was $17.

- General abortion rate reported in GERHS05 is 6 times higher than the official estimates for 2002–2004 (104 vs. 14.8 abortions per 1,000 women), indicating that abortion surveillance needs to be strengthen.

Maternal and Child Health Services

- Use of prenatal care was high with 95% of pregnant women having received at least one prenatal examination. Initiation of prenatal care in the first trimester was more common in urban areas than in rural areas (79% vs. 63%) and was most widespread in Tbilisi (84%).
- Seventy-five percent of women received at least 4 prenatal care visits and this was more common among women in urban areas (86%) than in rural areas (64%).
- Most women received their prenatal care from either women's consultation clinics or maternity hospitals.
- In both 1999 and 2005, about one in twelve births (8%) were delivered at home, the majority without skilled attendance; home births were the highest among Azeri women, increasing from 26% in 1999 to 40% in 2005.
- Although twice as many women reported receiving postpartum care in 2005 than in 1999 (22% vs. 11%), this service is still vastly underutilized in Georgia. Despite this increase, fewer women received comprehensive counseling. Eighty percent of newborns received a well-baby checkup, but this varied significantly by region, ranging from a low of 58% in the region of Guria to a high of 88% in the region of Tbilisi.
- At 93%, mothers reported the vast majority of births as having been registered; however, registered births ranged from a low of 84% in the region of Kvemo Kartli to a high of 99% in the region of Samtskhe-Javakheti. Home births were least likely to be registered (72%).

Breastfeeding

- The majority (88%) of babies born within the five years leading up to the 2005 survey had been breastfed, virtually unchanged compared to 1999. Infants born to Armenian women in particular, had even higher rates of breastfeeding (94%) in comparison to those of other ethnicities.
- Compared to 1999, the percentage of infants who were breastfed during the first 24 hours of life has increased significantly (from 33% to 58%), owing in part to twice as many babies who were placed to breast during the first hour following birth.
- On average, the duration of any breastfeeding was 10.1 months, the duration of full breastfeeding was 3.7 months, and the duration of exclusive breastfeeding was 1.8 months. These durations were similar across virtually all respondent characteristics.

Perinatal & Childhood Mortality

- Of all births that occurred during the five years prior to the survey, 16 per 1,000 were stillbirths. The stillbirth rate was highest among women who delivered after age 35 (43.5 stillbirths per 1,000 women aged 35–44), women who did not receive any prenatal care (37.3 stillbirths per 1,000), and women who suffered complications during their pregnancies (44.6 stillbirths per 1,000).
- The infant mortality rate, the rate at which babies less than one year of age die, has continued to steadily decline over the past 15 years, from 40.7 per 1,000 live births in 1990–1999 to 21.1 per 1,000 live births in 2000–2004. More specifically, the neonatal mortality rate went down from 25.0 to 16.8 per 1,000 live births and the post-neonatal mortality declined from 15.7 to 4.3 per 1,000 live births.

- As a result, the under-5 mortality rate had declined by 27%, from 44.8 to 32.7 per 1,000 live births.
- Most of the decline in infant and under-5 mortality rates is explained by a significantly lower probability of dying among babies aged 28 days up to one year of age, which was 3.7 times lower in 2000–2004 compared to 1990–1999.
- The children at highest risk of dying were those whose mothers were young adults, had less education, were living in households with low socioeconomic status, and were of Azeri or Armenian ethnic background; infant and under-5 mortality rates were higher for male infants, those born after two or more previous births, and those born with a birth interval of less than 24 months.

Contraception Awareness

- Virtually all respondents (97%) had heard of at least one modern method—particularly the condom (95%), IUD (94%), and oral contraceptives (81%). However, only 39% of women had heard of female contraceptive sterilization (tubal ligation) and few (5%) had heard of vasectomy.
- There is a considerable gap between awareness of a contraceptive method and knowledge of how that procedure or product is used.
- Almost two-thirds of married women have a potential demand for contraception, including 16% whose demand has yet to be met.

Contraceptive Use

- Georgia is a relatively low contraceptive-use country, as demonstrated by the high percentage of women who have never used contraceptives: 58% of women declared that they had never used a contraceptive method in 2005, down from 62% in 1999.
- The peak years of ever-use are long after women have had their desired number of children: ever-use of contraceptives had been reported by fewer than one-half of women less than 30 years of age and, in general, declined among women who have reached 40 years of age.
- Nearly half of married women are currently using contraception (47%), including 27% who use modern methods. Progress has been made since 1999, with use of modern methods surpassing use of traditional methods in 2005. Specifically, there was a three-fold increase in the current use of oral contraceptives (from 1% to 3%), although this prevalence is still very low, while use of IUDs and condoms increased from 10% to 12% and from 6% to 9%, respectively, and the use of traditional methods remained basically unchanged.
- Among married women currently using contraception, 26% were using the IUD (12% out of 47%), followed by 24% using withdrawal (11% out of 47%), 21% using periodic abstinence (10% out of 47%), 18% using condoms (9% out of 47%), and 6% using oral contraceptives (3% out of 47%).
- Most couples obtained modern contraceptive methods from the public medical sector (52%)—primarily women's consultation clinics and government hospitals with gynecology wards—and from private pharmacies (39%), while only 1% obtained supplies from private clinics.
- Although non-use remains the principal direct cause of abortion in Georgia, some women may also terminate pregnancies resulted from accidental conceptions while using contraceptive methods, particularly traditional, less effective methods, whose failure rate (i.e. the probability of becoming pregnant while using contraception) are the highest (25% for users of periodic abstinence and 18% for users of withdrawal).
- Between 1999 and 2005, the overall

contraceptive failure rate at one-year of use remained constant (13%), but failure associated with the use of traditional methods had increased slightly (from 18% to 21%) and failure associated with the use of modern methods had decreased (from 6% to 4%).

Potential Demand for Contraception

- Almost two-thirds of married women have a potential demand for contraception, including 16% whose demand has yet to be satisfied (i.e. have a unmet need for any contraceptive methods). Between 1999 and 2005, the unmet need for contraception among married women decreased from 24% to 16%, mostly as a result of increased use of modern methods.
- Despite increased use of modern contraceptives, 37% of married women continued to be at risk of unplanned pregnancy because they do not use effective contraceptive methods.
- The unmet contraceptive need for limiting births among married couples is three times higher than for spacing births (12% vs. 4%) and this ratio did not changed since 1999.
- The most commonly cited reasons for not using contraception are exposure-related reasons; about one-half (55%) of married women believed that they were not at risk of getting pregnant because they were currently pregnant (14%) or breastfeeding (8%), they had suspected or confirmed subfecundity (21%), or they had infrequent sexual activity (12%). Less than 5% of women have mentioned access-related reasons (e.g. cost, knowledge of a source, availability) and health concerns.
- Among married women who were not using contraceptive methods, 42% reported that they intend to use a method in the future, including 23% who would like to start using contraception within the next 12 months. One half of these women intend to used the IUD, 17% and 12%, respectively, prefer to use condoms or oral contraceptives, and 14% want to adopt a traditional method.

Contraceptive Counseling

- Family planning counseling in Georgia is currently available only through specialized facilities (gynecology and reproductive health service clinics) that are primarily located in urban areas, is mostly offered as part of postpartum or post-abortion care, and it seldom includes distribution of supplies or prescription for supplies. Thus, Georgia has a great need for new policies that will expand the scope of contraceptive counseling and allow integration its integration with other reproductive health services at the primary care level.
- Most family planning services in Georgia are provided by Ob/Gyns and “reproductologists” (physicians who have received extra training related to reproductive issues), both of whom traditionally have little expertise in providing client-oriented family planning counseling. Under a recent MoLHSA initiative, primary health care physicians in two regions (Imereti and Kakheti) were given special training in client-centered family planning counseling and were authorized to provide such counseling in rural ambulatory clinics.
- Most respondents were advised by a gynecologist or reproductologist to use their current or most recent modern method (61%), while only 1% were advised by a pharmacist and 38% be non-health professionals; the source of advice varied widely by the type of modern contraceptive method used.
- Among recent users, general counseling about contraceptive methods and contraceptive effectiveness have doubled since 1999.
- Women who decide to end their pregnancies in abortion and do not adopt an effective

contraceptive method afterwards are likely to be at high risk for repeat abortion. Both abortion providers and family planning service providers should be able to offer contraceptive counseling and services as soon as possible after an abortion. More women reported receipt of contraceptive information in 2000–2005 compared to 1994–1999 (22% vs. 15%), but the proportion who had received a contraceptive method or prescription remained disappointedly low (6% vs. 5%).

- Contraceptive counseling was not much more prevalent during perinatal health care visits, although rates of contraceptive counseling during prenatal care have increased (from 20% in 1999 to 26% in 2005), as have rates of such counseling during postnatal care visits (from 20% to 31%).

Women's Health

- A quarter of women reported visiting a health care facility in the last year, and a large majority of them (88%) attended governmental health clinics.
- The prevalence of routine gynecological visits has been particularly low in the Caucusus region. GERHS05 shows further decline in the proportion of Georgian women who had accessed this preventative service within a year prior to the survey (30% in 1999 to 20% in 2005).
- The prevalence of cervical cancer screening has not changed since 1999, and remains very low with only 4% of women reporting that they had ever been screened.
- The two most important reasons women gave for not having a cancer screening were lack of a recommendation from their health provider and lack of awareness.
- Awareness of breast self-examination was higher among women who had routine gynecological exams.
- Almost one in ten Georgian women (9%) reported having ever smoked (at least 100 cigarettes), and almost one in four (24%) have used alcohol. Six percent of women smoked daily or almost daily in the 30 days preceding the survey and 4% consumed alcohol daily or almost daily in that same time period.
- PID was the most commonly reported health condition among women of reproductive age at 19% of all respondents and 29% of currently married respondents. PID was almost nonexistent among adolescent women, and rates of ever having had PID increased with age among sexually experienced women.

Family Life Education and Young Adult Behaviors

- The large majority of respondents (80%) support FLE in school, including education on "how pregnancy occurs," sexually transmitted infections, and contraception.
- Fewer than half (49%) of young women reported having had at least one school-based course that addressed family life education by age 18. This varied significantly by urban versus a rural residence (61% vs. 35%, respectively) and by specific regions with as few as 30% having had such a course in Racha-Svaneti and as much as 74% in Guria.
- Fewer than one in three young women (aged 15–24 years) in Georgia reported sexual experience (30%); of those, the overwhelming majority reported sexual initiation after marriage.
- One of the most noticeable differences in age at first intercourse is across education levels, with the majority of women with technicum or university education delaying sex until past age 24. On average, women with only secondary or less education did not delay sex past age 24.
- Among young women who had their first sexual intercourse between ages 13 and 15 years, the majority had partners who were 6 or more years older.

- Among sexually active young women, 99% percent did not use contraceptives at first sexual intercourse, but only 78% of those women reported a desire to get pregnant as the reason.

Sexually Transmitted Infection and HIV/AIDS

- Eighty-nine percent of respondents have heard of at least one STI other than HIV/AIDS.
- Georgia has the highest syphilis incidence rate among the Caucasus countries and registered an almost threefold increase between 1995 and 1998. However, the GERHS05 has shown a decreased awareness of syphilis (75%, down from 82% in 1999).
- In 1999 and in 2005 the main source of information about STIs had been messages received through mass-media (73% and 63%).
- Awareness of HIV/AIDS was almost universal (95%), reflecting an improvement from 1999.
- A slight majority (52%) of women knew that a person can be infected with HIV and be asymptomatic or not show any clinical symptoms of the disease.
- Only 57% women surveyed believed that a person can do something to reduce the risk of contracting HIV.
- Only 15% of the women were aware that drugs exist to reduce mother-to-child-transmission of HIV.
- Overall, 48% of respondents had knowledge of all three of the basic ways HIV can be transmitted from mother to child.
- Seventy-eight percent of women said that they would care for a family member who became sick with the AIDS virus. However, only 21% said a family member's HIV infection should not be kept a secret; 23% said that they would buy fresh vegetables from a vendor who was HIV-infected; and 24% would want a female teacher infected with HIV to continue teaching in school.

Domestic Violence

- Women in Georgia tend to report much less current (5%) or lifetime (2%) physical abuse by an intimate partner than other women in Eastern Europe.
- Physical abuse by an intimate partner affected all women, regardless of ethnicity or socioeconomic and educational background, and was the highest (30%) among previously married women (whose marriages may have dissolved as a result).
- Domestic violence has consequences for children too. An average of 14% of women reported that they had experienced parental physical abuse as a child. Seven percent of women reported having ever heard or seen abuse between their parents.
- Living in households with low gender equity was associated with a higher risk of any type of domestic violence.
- Among women who had ever experienced physical abuse, about one in five had not disclosed their experience to anyone. Those who had primarily discussed it with a family member or friend and only 5% reported it to the police, 4% sought medical help, and 3% sought legal counsel.

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Key Indicators

	Georgia	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Fertility														
Total fertility rate (births per woman)	1.6	1.5	1.7	1.7	1.4	1.6	1.9	2.0	1.6	1.5	1.3	1.5	2.0	1.7
Ideal number of children (children per family)	2.8	2.8	2.8	2.8	2.8	2.8	3.1	2.6	2.7	2.6	2.8	2.7	2.7	2.8
Median age at first sexual intercourse (women ages 15–44)	21.3	22.1	20.5	20.2	23.0	20.2	20.3	20.0	20.7	21.7	22.4	21.4	21.2	23.6
Median age at first marriage (women ages 15–44)	21.6	22.5	20.7	20.5	23.6	20.4	20.6	20.2	20.9	22.0	22.7	21.7	21.5	23.9
Median age at first live birth (women ages 15–44)	23.2	24.1	22.3	22.4	25.4	21.9	22.2	21.8	22.3	23.5	24.1	23.3	22.8	26.0
Age–specific fertility rate (women ages 15–19)	48.1	36.7	62.8	82.7	29.9	50.8	77.6	47.6	28.1	74.5	43.0	45.2	64.4	24.4
Induced Abortion														
Total induced abortion rate (abortions per woman)	3.1	2.8	3.5	3.8	3.0	3.9	3.7	4.4	2.5	2.6	2.4	3.0	3.8	1.6
General Abortion Rate (abortions per 1,000 women 15–44)	104	93	118	127	97	128	124	132	79	81	86	103	127	62
Age-specific induced abortion rate (women 15–19) (abortions per 1,000)	13	8.7	17.4	26.0	7.2	0	20.5	10.0	7.7	5.5	12.9	18.8	16.1	0
Abortions in the 5 years preceding the survey for which the woman had:														
Received postabortion counseling	21.8	26.7	16.8	19.9	30.7	15.2	11.6	7.4	17.9	16.8	27.9	27.2	19	25.5
Received a contraceptive method or prescription postabortion	6.3	7.8	4.9	4.6	8.0	3.4	2.1	1.0	5.0	4.5	9.8	10.7	9.5	13.4
Experienced postabortion complications	5.4	6.0	4.8	1.7	7.6	5.4	4.1	7.8	1.4	2.5	2.3	9.0	4.0	8.1
Perinatal and Childhood Mortality														
Stillbirth rate (per 1,000 births)	16.0	16.7	15.3	9.7	19.9	12.9	16.8	40.4	5.8	7.9	7.0	20.3	13.8	12.8
Infant mortality rate (per 1,000 live births)	29.0	25.6	32.3	46.8	27.0	28.1	34.7	42.1	25.8	8.8	10.6	22.1	47.5	31.6
neonatal	19.1	20.6	17.7	27.1	23.4	21.9	17.1	33.7	11.4	0.0	3.5	16.2	34.8	22.2
postnatal	9.9	5.0	14.6	19.7	3.5	6.3	17.6	8.4	14.5	8.8	7.1	6.0	12.7	9.4
Child mortality rate (per 1,000 live births)	3.8	1.4	6.0	4.8	0.0	9.1	0.0	2.7	14.3	4.1	0.0	1.9	10.2	3.3
Under-5 mortality rate (per 1,000 live births)	32.7	27.0	38.1	51.3	27.0	37.0	34.7	44.7	39.8	12.8	10.6	24.0	57.2	34.7
Family Planning														
Heard of any method (all women ages 15–44)	96.9	99.5	93.8	91.4	99.8	99.3	86.2	93.3	99.3	99.8	98.8	99.2	97.9	98.4
Know how to use at least one method (all women ages 15–44)	79.4	83.2	74.7	76.5	86.2	85.1	65.8	78.3	70.8	83.2	69.9	87.8	83.2	78.9
Never used a method (all women ages 15–44)	58.0	55.8	60.8	61.5	55.7	57.2	67.6	55.0	52.3	63.8	61.9	55.7	53.2	66.9
Currently using a method (married women ages 15–44)	47.3	51.7	42.6	39.6	50.1	43.6	32.4	45.1	63.3	44.9	47.1	48.1	53.0	46.6
Unmet need for any contraceptive method (married women ages 15–44)	16.4	13.0	19.8	22.1	13.7	16.8	26.6	12.2	6.3	18.4	18.4	16.3	15.1	18.8
Unmet need for modern contraception (married women ages 15–44)	37.0	33.2	40.9	36.0	32.4	39.6	42.9	43.5	39.9	41.9	35.9	32.9	37.6	38.7
Maternal and Child Health														
Births in the 5 years preceding the survey for which the mother had:														
Received prenatal care from a health professional	95.4	97.7	93.0	88.9	98.9	91.6	92.9	97.0	95.9	93.7	93.7	99.2	91.0	93.6
4+ prenatal care visits	75.0	86.2	63.9	58.9	89.9	79.4	55.5	62.2	71.4	61.0	78.1	83.6	78.6	66.3
Initiated prenatal care during the 1st trimester	70.6	78.8	62.5	55.6	83.7	64.5	66.0	60.6	64.3	71.4	68.3	77.2	70.3	69.2
Delivered in a health facility	92.4	98.9	86.5	70.0	100.0	96.8	84.9	96.0	90.6	88.1	100.0	98.4	97.2	91.0
Delivered with the assistance of a health professional	96.3	98.0	94.7	83.1	98.2	97.4	97.9	97.5	98.2	98.4	98.6	97.2	95.2	98.1
Delivered by C-section	13.0	13.7	11.9	14.5	13.9	14.7	11.4	9.5	7.7	9.9	17.6	13.2	13.5	15.5
Pregnancy complications	12.6	15.6	9.5	8.2	17.2	17.6	9.0	15.1	8.5	13.6	8.3	13.5	9.7	9.5
Received postpartum care	21.8	25.4	18.3	23.2	24.3	23.9	7.6	14.1	22.8	8.7	19.0	38.2	14.5	10.3
Infants in the 5 years preceding the survey who:														
Received well-baby visits	79.9	87.4	72.4	71.5	88.2	85.6	64.8	72.2	83.0	57.9	83.1	87.2	81.3	64.7
Were ever breastfed	88.4	87.0	89.8	89.9	85.8	83.7	91.5	92.8	90.6	85.7	82.4	90.1	95.8	87.2
Women's Health														
Use of healthcare in the last 12 months	25.2	26.9	23.2	20.8	30.3	27.7	21.7	22.8	24.1	28.8	22.1	22.9	23.9	28.2
Women who perceived cost as a barrier to healthcare	58.9	49.5	70.3	68.8	45.3	67.6	68.2	70.7	51.6	81.0	57.7	62.5	69.3	69.9
Women who had ever had a pap smear	4.2	5.4	3.0	1.3	6.1	3.1	3.4	3.3	3.9	2.4	6.7	4.0	3.6	1.7
Current Smokers	5.9	10.2	0.8	1.2	15.2	1.8	1.5	0.5	6.7	0.8	2.0	2.4	2.1	2.0
Current Drinkers	23.9	26.1	21.2	21.6	27.4	21.7	16.8	5.5	22.5	11.5	28.0	31.6	26.3	24.1
Ever had Pelvic Inflammatory Disease	18.5	19.0	17.9	12.5	19.3	23.7	17.6	19.1	18.4	21.7	19.6	17.4	21.0	11.5
Ever diagnosed with high blood pressure	11.6	11.7	11.4	7.7	13.4	12.7	7.9	9.5	11.2	13.1	12.7	11.6	19.1	13.3
Family Life Education														
Support for any Family Life Education (women ages 15–44)	80.0	84.0	75.2	81.1	82.0	80.1	69.7	80.0	74.5	77.1	82.9	86.8	78.8	85.7
Discussion with parents on any Family Life Education topic	81.4	83.3	79.2	83.2	79.9	77.9	72.7	84.6	78.7	88.6	87.6	89.2	73.4	88.3
Exposure to Family Life Education in school	48.9	60.7	34.5	33.3	69.6	49.1	38.7	41.7	36.8	73.6	46.9	38.3	51.3	30.0
HIV/AIDS														
Knowledge that HIV can be asymptomatic	52.3	63.6	38.6	40.6	69.4	51.8	34.7	55.0	49.0	38.4	39.0	54.8	57.8	30.5
Correct knowledge of maternal-to-child-transmission	47.6	51.9	42.3	40.6	54.2	53.6	42.2	55.0	40.8	45.2	41.4	47.7	50.2	46.0
Knowledge of all 3 principle ways of preventing HIV	74.3	81.3	65.7	73.3	83.4	80.1	57.3	69.0	65.7	86.5	65.4	80.1	70.0	78.5
Knowledge of where HIV-testing is provided	41.9	53.6	27.7	31.7	65.5	40.2	34.3	31.9	29.4	26.2	25.2	38.7	41.8	26.8

* numbers are percentages unless otherwise indicated

Chapter 1

INTRODUCTION

1.1 Background

Situated on the eastern shore of the Black Sea and nestled in the Caucasus Mountains (the highest mountain chain in Europe), Georgia is part of the Caucasus region and a veritable gateway between Asia and Europe. Georgia has a surface area of 69,670 square kilometers—of which more than half is above 900 meters in altitude—and a population of approximately 4.4 million (Georgia Census, 2002). Towering mountain ranges subdivide Georgia into a western portion, which the ancient Greeks called Colchis, and the eastern plateau, called Iberia in the ancient world. Mountain chains also isolate the northern region of Svaneti from the rest of Georgia. The country shares borders with Turkey, Armenia, and Azerbaijan in the south. In the north, Georgia borders on several regions of Russia, including North Ossetia, Ingushetia, Chechnya, and Dagestan separated from Georgia by the Greater Caucasus Mountain range.

Slightly more than half (51%) of the population resides in urban areas, including almost 1.1 million people in Tbilisi, the capital of Georgia. The second largest city is Kutaisi, capital of the Imereti region, with a population of 186,000 (State Department for Statistics, 2003). Outside Tbilisi (which consists of 9 administrative units or kvartals), the country is divided into 11 administrative regions, which are subdivided into 53 districts or raions, and the separatist regions of Abkhazia and South Ossetia.

The population growth rate of Georgia was negative at -0.92% in 2005 (UNFPA, 2005), partly because of increasing emigration and because fertility fell below replacement level over the past decade. As

a result, the proportion of the population aged 65 years or older reached 18% in 2005. About 19% of the total population is under 15 years old. Women of reproductive age (15–44 years) make up 23% of the population (State Department for Statistics, 2003). The life expectancy at birth in 2004 was one of the highest in the Soviet-bloc countries: 77.6 years for women and 69.4 years for men (UNFPA, 2005).

The official language of the country is Georgian, which belongs to the South-Caucasian group of languages and has its own alphabet (Mkhedruli)—one of the fourteen unique alphabets that exist in the world today. The distinctive language and alphabet have helped preserve Georgian national identity, despite numerous periods of foreign occupation and attempted assimilation.

According to the 2002 Georgia Census, Georgians, the predominant ethnic group, represented 84% of the total population. Armenians (6%) and Azeri (6%) are the largest ethnic minorities, with most Armenians clustered in the Samtskhe Javaheti region and most Azeris in Kvemo-Kartli. Less than 2% of the population is ethnic Russian, down from 6% at the 1989 Census.

1.2 Health Care

The status of women's health in Georgia is strongly influenced by cultural, historical, and socioeconomic factors. The previous communist regime, notorious for its lack of support for family planning and other preventive services, had a particularly profound impact on women and their reproductive health. With the dissolution of the Soviet Union in 1991 and Georgia's subsequent independence, the country entered a long period of socioeconomic and political transition in which major reforms of different sectors have been planned and carried out. Several factors, however, slowed the country's progress toward a successful economy and health sector reforms. Separatist movements in the regions of Abkhazia and South Ossetia in the early 1990s resulted in civil war and the internal displacement of hundreds of thousands of people. The economy collapsed soon after the country lost Moscow's financial support and the preferential trade agreements with other former Soviet republics. The dramatic fall of Georgia's economy resulted in widespread unemployment, corruption, energy shortages, and a rapid deterioration of living conditions. As a result of rapidly shrinking resources, the health expenditures as a percent of total public expenditures declined abruptly from 13.2% in 1991 to 0.54% in 1994 (World Bank, 2002), and the inherited Soviet-style health system, primarily funded through public monies, became unsustainable. The Soviet-style health system, which placed emphasis on curative rather than preventive services and allocated funding according to the number of hospital beds, relied on too many hospitals and hospital-based specialized physicians and did not maintain an adequate supply of primary health care services. With the disappearance of the centralized Soviet administration and the post-communist economic decline, the costly hospital-based curative system became impossible to maintain; most hospitals lacked minimal equipment, drugs, and supplies and could not afford the maintenance costs.

In response to the collapse of the publicly-supported hospital-based health system, Georgia initiated an extensive health sector reform program in 1995. The process was designed to address all aspects of the health-care sector and to place emphasis on quality of care, improved access, efficiency, and rehabilitation of the Primary Health Care (PHC) system. One of the first steps taken toward implementing the reforms was to create a legal basis for them through decrees, resolutions and laws issued by the office of the president, cabinet of ministers, ministry of health, and parliament (Gzirishvili and Mataradze, 1998). Health sector reform fundamentally changed the ways health care is financed in Georgia. There has been a transition to program-based financing, and payroll-tax–based social insurance schemes have been introduced. The government supported the development of a medical insurance market by enacting the Law on Medical

Insurance (Government of Georgia, 1997). This law provided the legal basis for the transformation from state coverage of health care to medical insurance coverage. Since then, the role of the Ministry of Labor, Health and Social Affairs has changed from being a direct provider of health services to policy maker, planner, and regulator of health services. Ongoing reform of the PHC system was supported by various international donors through technical assistance in financing forecasting and management, training of family doctors, and rehabilitation of PHC clinics.

The Rose Revolution of November 23, 2003 and the election of Mr. Saakashvili as President on January 4, 2004 were followed by the establishment of a Cabinet of Ministers and by considerable reform of key ministries, including the Ministry of Health.

Georgia's progress toward social and economic development has been uneven. By some measures, health has improved—for example, life expectancy is on the rise after a serious decline in mid-1990s, and couples are more likely to use modern contraception and less likely to have an abortion to prevent unplanned births. Other indicators, such as the maternal mortality ratio of 32 per 100,000 live births, and infant death rate of 17.6 per 1,000 live births, although declining, are still unacceptably high (UNFPA, 2005). Also, new public health threats have emerged (e.g. HIV/AIDS, TB resistance), and the transition from curative, specialized, hospital-based health care to primary health care prevention and treatment is still ongoing. Healthcare expenditures as a percentage of the general health budget continue to be low (3.6% of total budget expenditures, or in Georgian laris 33.2 million out of 904.8 million) (Health Policy, 2004). In addition, regional and socioeconomic disparities within the country are sometimes quite significant, and by some measures, health disparities have even worsened compared to the pre-transition period because of unaffordable out-of-pocket health costs. Georgia has recently experienced economic growth—between 2001 and 2004 the GDP increased by 6%, on average—but this growth apparently has not yet led to any reductions in poverty rates (IMF, 2004).

In conclusion, although Georgia has made substantial progress in implementing health care reforms (by developing the legal basis for reforms, changing the health financing system, developing a health insurance system, and introducing structural changes in the health care system), little attention has been given to the delivery of health care services and existing or emerging public health problems. Despite the progress made during the last decade, the legacy of the past, compounded by the present lack of resources, continues to place Georgia far behind other European countries in family planning and reproductive health services.

1.3 Reproductive Health

The United Nations International Conference on Population and Development (ICPD), held in Cairo in 1994, revolutionized the approach to population and development by placing a special emphasis on the status, empowerment, and social participation of women, and by introducing the concept of sexual rights as basic human rights. The Cairo Programme of Action defines reproductive health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (PoA, 1994). This definition stipulates that couples need to "be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services." Although nonbinding, the Programme of Action constitutes an ethical commitment by the international community and a cornerstone in developing national reproductive health programs and strategies.

Abortion rates in Georgia are extremely high. Survey estimates for the period 1997–1999 documented a total induced abortion rate of 3.7 abortions per woman, the

world's highest documented abortion rate for that time period. Contraceptive prevalence among Georgian women who were married or in a civil union was the lowest among any of the former Soviet republics with survey data. Only 40% of such women reported using any method of contraception, and only half of them used a modern method, principally the IUD (10%) and condoms (6%). Women reported frequent use of traditional methods (withdrawal, calendar), general lack of awareness of modern contraceptives, and poor quality of information about many reproductive health issues. Among married women, unmet need for modern contraception was 44%, on average, and as high as 54% among those with three or more children (Serbanescu et al., 2001b). Despite an overwhelming desire to limit fertility, less than 1% of women had undergone tubal ligation. To date, laws, administrative regulations, and restricted availability have severely limited access to voluntary surgical sterilization in most countries of Eastern and Central Europe, including Georgia.

The official maternal mortality ratio increased by almost 20% between 1990 and 2000 (from 41 to 49 maternal deaths per 100,000 live births), with the peak rate occurring in 1997 (70.6 maternal deaths per 100,000 live births). From 2000, the rate fell slightly, but was still higher in 2004 than in 1990 (45.3 versus 41 per 100,000) (UNFPA, 2006). Survey estimates for the infant mortality rate during 1995–1999 of 41.6 infant deaths per 1,000 live births (CI =30.4, 52.8) were higher than in most of the other former Soviet-bloc countries of Central and Eastern Europe and much higher than the official estimates for the same period (CDC and ORC/Macro, 2003). From 2000, the infant mortality rate fell to 23.8 per 1,000 in 2004 (State Department for Statistics, 2005).

The transition of the health care system from being government-financed to being payroll-tax–based led to the adoption of the new four-visit prenatal-care model in 1996, which was recently modified according to World Health Organization recommendations (WHO, 2002). The State United Social Insurance Fund of Georgia (SUSIF), through its basic-benefit package for obstetric care, covers four free-of-charge prenatal visits per pregnancy (at 13, 20–22, 30–32 and 36 weeks of pregnancy) and delivery costs, but postpartum care is not included under this program. As a result of this program, about 3 in 4 women who gave birth during 1996-2000 attended at least 4 prenatal care visits, and 92% gave birth in hospitals with obstetric care, but only 11% received postpartum care.

1.4 Reproductive Health Surveys in Georgia

Since the early 1990s, the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), and other bilateral and multilateral donors have worked with the Georgian government and local non-governmental organizations to increase access to family planning services. Most of the efforts have focused on designing client centered family planning and reproductive health policies and programs, training physicians and other medical professionals, organizing public information campaigns, and developing a nationwide system for delivery of contraceptive supplies.

Due to the state's financial limitations, reproductive health, and family planning in particular, have been the major focus of UNFPA assistance in Georgia. Over the past 12 years, UNFPA has been the only donor agency that provided Georgians with a wide choice of family planning methods through several contraceptive-supply projects. During the past six years, both UNFPA and USAID invested heavily in capacity building and development of training materials for medical personnel and information materials and messages for the general public.

Through UNFPA and USAID contributions, Georgia has increased women's access to modern contraceptives and other reproductive health services. However, many challenges remain, particularly in reaching the most vulnerable women and improving the quality of

services. To help policymakers and program managers assess and respond to current needs, nationwide surveys on reproductive health were conducted in Georgia in 1999 and 2005.

Periodic household-based probability surveys are the best and most timely way to collect data on a wide assortment of health topics that is essential to determining the health needs of Georgian families and the types of services they should receive. The 1999 Georgia Reproductive Health Survey was the first population-based national survey of this type ever conducted in Georgia. The 1999 survey had a sample of 7,798 women aged 15–44 years, including an oversample of 1,655 internally displaced women living in government facilities.

A second-round nationwide reproductive health survey, the GERHS05, was carried out during the first part of 2005; the aim of the 2005 survey was to assess the impact of new programs and provide planning data for upcoming women's reproductive health projects and information, education, and communication campaigns. Both the 1999 and the 2005 surveys were similar in design and content; the main difference was that the most recent cycle did not include a separate sample of internally displaced women living in nonresidential housing. Instead, the 2005 survey employed a sampling design that allowed for independent regional estimates for the most important reproductive health indicators.

The 2005 survey also addresses the increased need for data in light of the United Nation's Millennium Development Goals (MDGs), which were adopted in 2000 and target a reduction of maternal mortality by three-quarters between 1990 and 2015, as well as improvements in child survival. The MDGs have drawn new attention to the need for better data for policy making and for measuring progress. Even when they are complete (as is usually the case in industrialized countries), vital records, census data, and program data often do not provide sufficient information to adequately assess public health problems and to evaluate public policy and program initiatives. Furthermore, the available data usually satisfy the needs of centralized decision-making but are less useful for describing the health status and burden of disease of populations at sub-national levels. The 2005 survey is responsive to increased demand for health data from managers, decision-makers, and others from the international development community, who need the data to design effective health service programs.

Funding for both surveys was primarily provided by two major international donors: USAID, which supported technical assistance from the US Centers for Disease Control and Prevention for survey design, implementation, and dissemination, and UNFPA, which covered all costs related to field work, translation, and dissemination seminars. CDC's Division of Reproductive Health was responsible for coordinating survey activities for both surveys and provided technical assistance to Georgia's National Centers for Disease Control and Health Statistics and the Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA), a key stakeholder.

1.5 Survey Objectives

Set within the context of overall social and economic development in Georgia, the aim of the GERHS05 was to obtain national and regional estimates of basic demographic and reproductive health indicators, in order to set targets for improvement, allocate resources, and monitor performance of family planning and maternal and child health programs.

Specific objectives of the GERHS05 were to:

- Assess current levels and trends in fertility, abortion, contraception, and various other reproductive health issues;
- Enable policy makers, program managers, and researchers to evaluate existing reproductive health programs and develop new strategies;

- Study factors that affect fertility, contraceptive use, and maternal and infant health, such as geographic and socio-demographic factors, breastfeeding patterns, use of induced abortion, and availability of family planning services;
- Identify characteristics of women at risk of unintended pregnancy;
- Identify subgroups at high risk for adverse reproductive health outcomes and obtain data needed to develop targeted interventions;
- Obtain data on the knowledge, attitudes, and behavior of young adults aged 15–24 years;
- Obtain data on levels of reported sexually transmitted disease (STD) symptoms and knowledge about transmission and prevention of HIV/AIDS.

1.6 Data Dissemination and Use

By making available appropriate country- and region-specific data on reproductive health and related health services and enhancing the ability of national organizations to collect, analyze, and disseminate such information, the survey has fostered collaboration between the Georgian government, international donors, and other partners. For example, both USAID and UNFPA will use the 2005 survey data to monitor their programs in Georgia within the context of Georgian health sector reforms and poverty reduction strategies. The survey will help to identify the linkages among health needs, health services, and health sector reforms and how they influence each other. Thus, international bilateral and multilateral donors (e.g., USAID, UN agencies, World Bank, UK Department for International Development, the European Union) and various government partners (e.g., MoLHSA and the Ministry of Economic Development) can use these data for developing new health strategies and health sector reforms under the national Economic Development and Poverty Reduction Programme—and for monitoring and evaluating progress toward achieving the UN Millennium Development Goals.

As such, the GERHS05 project could not have been carried out at a better time. In 2004, with donor support, the Georgian government initiated the development of a comprehensive national Reproductive Health Policy and set up a reproductive health and family planning (RH/FP) policy working group within the MoLHSA. These efforts are mainstreamed under the "Cooperation in Health System Transformation (CoReform)" project, a USAID-supported initiative designed to provide advice to the Government of Georgia on the entire range of issues associated with reproductive health in the country. The primary tasks of the CoReform project are to identify strengths, weaknesses, and gaps related to RH/FP policies and laws and their application; to develop recommendations for policy revisions in support of enhanced access to quality RH/FP services; to draft the national reproductive health strategy and develop guidelines for its implementation as a component of the updated National Health Strategy; to identify both supporting factors and barriers to implementation of the new policy; and to strengthen public/private partnerships and collaborations to support the objective of increased acceptability and utilization of RH/FP services.

Key areas at the program level that are targeted for rehabilitation or improvement by the new policy are the health management information system; the logistics and supply system for essential RH/FP supplies; training for service providers to enable them to offer quality RH/FP counseling and services; public education and health campaigns to increase demand for quality services; adoption of best practices and lessons learned from previous activities in Georgia and elsewhere into the system of RH/FP service provision; and collaboration between these services and other government programs. In response to these reproductive health priorities, USAID funded Healthy Women in Georgia, a three-year "demonstration project" implemented by John Snow Research and

Training Institute, Inc. that undertakes a variety of reproductive health and safe motherhood activities in three geographical areas: Imereti, Kakheti, and Tbilisi.

The UNFPA-supported interventions, which are designed to advance the RH/FP agenda within the context of UNFPA's five-year strategy, the 2006-2010 Country Programme, are geared toward two main targets: first, to improve the national laws, policies, and standards of care in accordance to international standards and best health care practices; and second, to increase access to quality reproductive health services and information. Main activities supporting the first component include provision of cost-free contraceptive and reproductive health commodities and medical equipment, training of medical personnel, and feedback on the development of the national reproductive health strategies. Efforts toward increasing access to reproductive health services will focus on raising awareness and knowledge, especially among young people, and expanding service provision to remote areas and to minority and internally displaced populations via mobile teams. Baseline data on health status and health care utilization will be instrumental in monitoring the impact of UNFPA's new five-year strategy.

Additionally, the two-cycle survey project in Georgia has served to facilitate a mutually enriching exchange of experience and knowledge between US governmental and UN entities, as well as between Georgian governmental and non-governmental organizations.

By making data on reproductive health and service utilization available and enhancing the ability of local organizations to collect, analyze and disseminate such information, the surveys have fostered collaboration between international and local partners to assess program performance and make evidence-based decisions on policies related to public health. As a continuation of these activities, USAID is currently supporting several follow-up training activities that are designed to 1) familiarize policy makers and program managers with survey findings and highlight the ways in which they complement official statistics, 2) increase survey data utilization at national and sub-national levels and across sectors (public, private voluntary, and private commercial sectors); and 3) continue to build local ownership and skills. UNFPA, who has been instrumental in advocacy and awareness-raising activities among policymakers for integration of ICPD and MDG indicators into the national development agenda and the national resource allocation system, will continue to work closely with the various government agencies that seek to build national capacity in management information systems. Ultimately, enhanced survey data dissemination, translation, and utilization will increase in-country recognition of international contributions to development of the health and family planning sectors and will build support for national strategic objectives.

Chapter 2

METHODOLOGY

The GERHS05 was designed and administered by the Centers for Disease Control and Prevention (CDC), a part of the US Department of Health and Human Services, in collaboration with the Georgian Centers for Disease Control (NCDC) and the Georgian Ministry of Health (MoLHSA). Similar reproductive health survey (RHS) projects were conducted in seven other countries in Eastern Europe beginning in the mid-1990s. A major purpose of the RHS is to produce national estimates of factors related to pregnancy and fertility, such as sexual activity and contraceptive use; use of abortion and other medical services; and maternal and infant health. The first RHS was conducted in Georgia in 1999; a new cycle was implemented in March 2005, with field work ending in July of that year. A major function of successive cycles of the survey is to produce comparable time trend data. Generally, the 2005 survey was modeled after the 1999 RHS and other similar surveys conducted in the region with technical assistance from CDC. The proposed content of the second RHS was reviewed and commented upon by Georgian national experts, government representatives, and researchers from inside and outside governmental organizations, as well as donor agencies. A final panel of experts was set up (see Annex D) to discuss the expanded draft questionnaire. Additional revisions were made in the months following that meeting, and the final questionnaire was pretested in December 2004.

The majority of the expert panel recommendations were addressed, with the exception of two: 1) a request for increase in the sample size, which was not possible due to budgetary constraints; and 2) the inclusion of a sample of men in the survey, which was deferred also for budgetary reasons and because it was judged to be less urgent (since a small scale survey of male respondents of reproductive age was scheduled to be fielded by a different Georgian agency in mid-2005).

Because the survey collected information from a representative sample of Georgian women aged 15–44 years, the data can be used to estimate percentages, averages, and other measures for the entire population of women of reproductive age residing in Georgian households in 2005.

2.1 Sampling Design

Similar to the 1999 RHS survey, the GERHS05 was a population-based probability survey consisting of face to face interviews with women of reproductive age (15–44 years) at their homes. The survey was designed to collect information from a representative sample of approximately 6,000 women of reproductive age throughout Georgia (excluding the separatist regions of Abkhazia and South Ossetia). The population from which the respondents were selected included all females between the ages of 15 and 44 years, regardless of marital status, who were living in households in Georgia during the survey period.

The questionnaire was designed to collect information on the following:

- Demographic characteristics
- Household assets (durable goods and dwelling characteristics)
- Fertility and child mortality
- Family planning and reproduction preferences
- Use of reproductive and child health care services
- Range and quality of maternity care services
- Use of preventive and curative health care services
- Reproductive health care expenditures
- Perceptions of health service quality
- Risky health behaviors (smoking and alcohol use)
- Young adult health education and behaviors
- Intimate partner violence
- HIV/AIDS and other STDs

Because a wealth of similar reproductive health survey data from other countries in Eastern Europe are available, cross-country comparisons can be made, and successful regional approaches could be adapted to the country-specific context.

The current survey used a stratified multistage sampling design that used the 2002 Georgia census as the sampling frame (State Department for Statistics, 2003). To better assist key stakeholders in assessing the baseline situation at a sub-national level, the sample was designed to produce estimates for 11 regions of the country. Census sectors were grouped into 11 strata, corresponding to Georgia's administrative regions; three small regions, Racha-Lechkhumi, Kvemo Svaneti, and Zemo Svaneti were included in one stratum, identified as the Racha-Svaneti stratum. Data are also representative for the urban-rural distribution of the population at the national level.

The first stage of the three stage sample design was selection of census sectors, with probability of selection proportional to the number of households in each of the 11 regional sectors. The first stage was accomplished by using a systematic sampling process with a random starting point in each stratum. During the first stage, 310 census sectors were selected as primary sampling units (PSUs), as shown in Table 2.1.

The overall sample consisted of 310 PSUs, and the target number of completed interviews was 6,200 for the entire sample, with an average of 20 completed interviews per PSU. The minimum acceptable number of interviews per stratum was set at 400, so that the minimum number of PSUs per stratum was set at 20. With these criteria, 20 PSUs were allocated to each stratum, which accounted for 220 of the available PSUs. The remaining 80 PSUs were distributed in the largest regions in order to obtain a distribution of PSUs approximately proportional to the distribution of households in the 2002 census. An

additional 10 PSUs were added to the smallest stratum, Racha-Svaneti, to compensate for the considerable sparseness of women of reproductive age in this stratum. Unlike the 1999 survey, a separate sample of internally displaced persons was not selected for the 2005 survey.

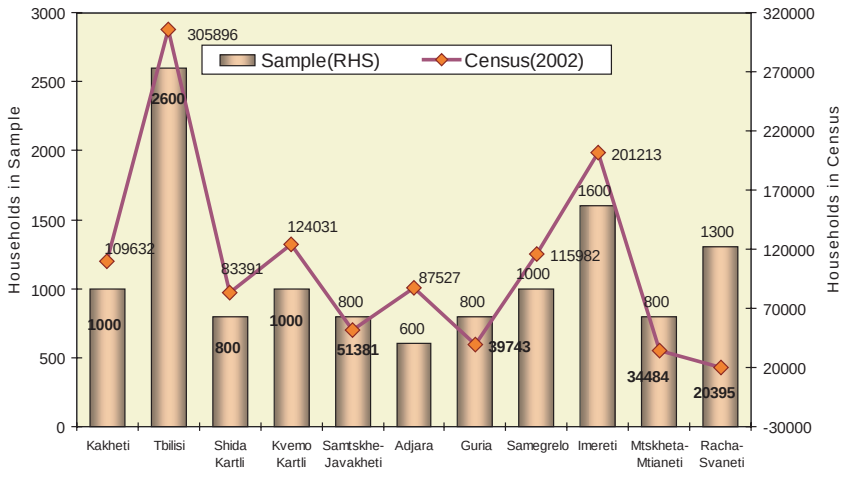
Figure 2.1 compares the distribution of households in the sample (shown with bars) and the distribution of households in the 2002 Census (line graph) by the 11 strata. The sampling fraction ranges from 1 in 16 households in the Racha-Svaneti stratum (the least populated stratum) to 1 in 146 in Adjara. As shown in Table 2.1, if the ratio of households in the census to households in the sample is above 100.0, the region has been under-sampled, whereas if the ratio is less than 100.0, the region has been over-sampled.

In the second stage of sampling, clusters of households were randomly selected from each census sector chosen in the first stage. Determination of cluster size was based on the number of households required to obtain an average of 20 completed interviews per cluster. The total number of households in each cluster took into account estimates of unoccupied households, average number of women aged 15–44 years per household, the interview of only one respondent per household, and an estimated response rate of 98%. In the case of households with more than one woman between the ages of 15 and 44, one woman was selected at random to be interviewed.

2.2 Data Collection

The interviews were performed by 35 female interviewers trained in interview techniques, survey procedures, and questionnaire content. Interviewer training took place at the NCDC headquarters just before data collection began. At the end of the training period, seven teams were selected, each consisting of four female interviewers, one supervisor, and two drivers. Fieldwork was managed by staff of NCDC, with technical assistance from CDC, and lasted from March through July 2005. Each team was assigned several primary sampling units and traveled by car throughout the country on planned itineraries. Although most interviews were conducted in Georgian, a Russian language questionnaire was also available. All interviewers were bilingual. Azeri-speaking health professionals facilitated interviews with monolingual Azeri respondents. Completed questionnaires were first reviewed in the field by team supervisors and then

Figure 2.1 **Number of Households in the 11 Strata of the GERHS05 Sample and the 2002 Census**



taken by the fieldwork coordinators to the National Center for Medical Statistics and Information, an NCDC-affiliated center, for data processing.

The field unit for GERHS05 consisted of two coordinators who divided the fieldwork assignments among the seven mobile teams of interviewers and supervisors. The field work coordinators and supervisors prepared interviewer assignments and were responsible for monitoring the progress of each interviewer, performing field observations, conducting in-person verifications of the interviewers' work, and conducting refusal conversion efforts. Field supervisors were also responsible for analyzing each interviewer's weekly production and quality of work, reviewing errors, and serving as the point of contact for the data entry supervisors. In addition, the supervisors were available to their interviewers as needed. The seven field supervisors made weekly progress reports to their assigned field work coordinator.

2.3 Response Rates

Of the 12,338 households selected in the household sample, 6,402 included at least one eligible woman (aged 15–44 years). Of these identified respondents, 6,376 women were successfully interviewed, yielding a response rate of 99%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed and were very cooperative. Response rates did not vary significantly by geographical location (Table 2.3).

2.4 Quality Control Measures

A number of measures were taken to ensure that the data were of the highest possible quality. First, the questionnaire, already refined during the first RHS in Georgia in 1999, was revised carefully and reviewed by a panel of Georgian experts; in subsequent meetings and informal consultations, CDC sought advice on how to design a more effective and useful survey instrument. As a result, the content of the questionnaire was expanded substantially and made more relevant for programmatic needs. Second, the questionnaire was tested extensively, both before and during the pretest and prior to beginning the field work. Testing included practice field interviews and simulated interviews conducted by both CDC and NCDC staff. The questionnaire was translated into Georgian and Russian and back-translated into English. Third, the 35 interviewers and supervisors were trained for seven full days in the classroom and another week in the field; the training was very interactive with several practical exercises that allowed for selection of the most highly qualified staff from an original pool of 55 trainees. Fourth, interviewers were instructed to make several visits during the initial day of household contacts when selected respondents were absent; if they still could not complete the interviews, up to three additional visits on different days were scheduled. This reduced the overall nonresponse rate to very low levels—less than 1%. Fifth, supervisors were trained to review and edit the questionnaires immediately after each interview; thus, if they noticed errors or omissions the interviewers or the respondents had made, the interviewers could make immediate corrections during short follow-up revisits. These edits reduced the item nonresponse rate for most questions to less than 2%. Sixth, supervisors and field work coordinators spot-checked the quality of each interviewer's work often and carefully. This process of verifying fieldwork was a critical component of the overall quality control system. Seventh, the inclusion of life histories (marital history and pregnancy history) and the five-year month-by-month calendar of pregnancy, contraceptive use, and union status helped respondents accurately recall the dates of one event in relation to the dates of others they had already recorded. Finally, legal ranges, pre-coded variables, consistency checks, and skips were programmed into the data entry software, so that data entry supervisors would notice errors or inconsistencies and could send problematic interviews back to the field for follow-up visits.

2.5 Sampling Weights

The purpose of the RHS is to produce statistical estimates that are nationally representative. National estimates are produced by devising a "sampling weight" for each re-

spondent that adjusts for her probability of selection in the sample. The weights for the RHS were calculated as follows: First, the weight was adjusted to reflect the selection of only one eligible woman from each household with women of reproductive age. In cases where households included more than one eligible female respondent, the woman who was selected for interview received an additional weight. Second, the weight was adjusted to reflect that women residing in the regions with sparser populations were selected at higher rates (i.e., were oversampled) relative to those residing in regions with high density of the population, who were under-sampled. Because the overall response rate (99%) was so high, no weighting was needed to adjust for the survey staff's inability to locate some eligible women or for nonresponse among those who were located. After the weighted survey population distribution was broken down by five-year age-groups and by residence and was compared with the Census estimates, poststratification weights were not deemed to be necessary (see Section 2.6).

Except for Table 2.3, all tables in this report present weighted results, but the unweighted number of cases, used for variance estimation, is shown in each table. Generally, tables where percent distributions are shown should add up to 100%, but due to rounding they may add up to either 99.9% or 100.1%.

2.6 Comparison with Official Statistics

The weighted percentage distribution of women selected in the 2005 survey sample by 5-year age groups differs only slightly from the 2002 official estimates: The survey sample slightly over-represents young adult women (15- to 24-year-olds) and under-represents women aged 35–39 by less than two percentage points. However, after confidence intervals are taken into account, there are no significant differences except for a slight difference for 35- to 39–year-olds (16.5% vs. 17.0%) (Table 2.6 and Figure 2.6). The urban/rural distribution of the sample retains the same overrepresentation and under-representation for women aged 15–24 and 35–39 years, respectively, particularly in urban areas. Because the overall response rate was 99%, there is only one factor that may have contributed to these differences; official estimates reflect the age composition recorded in 2002, 3 years before the survey took place. Unfortunately, official census projections were not available at the time of writing this report, but age projections made by CDC (which did not take out-migration into account) suggest that these small differences would disappear if the sample were to be compared with census projections.

Figure 2.6 **Age Distribution of Women Aged 15–44 Years 2005 RHS and 2002 Census**

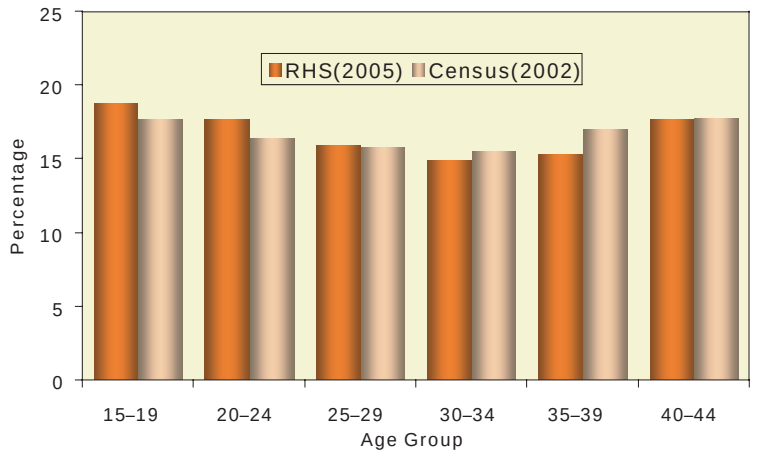


Table 2.1 Number of Households (HH) in the GERHS05 Sample and the 2002 Census and the Ratio of the Number of Households in the Census to the Number of Households in the Sample, by Region
Reproductive Health Survey: Georgia, 2005

Strata (Regions)	No. of HH in Census	No. of PSUs in Sample	No. of HH to be Sampled	Ratio of HH-Census to the HH in Sample	Expected No. of Completed Interviews
Kakheti	109,632	25	1,000	109.6	500
Tbilisi	305,896	65	2,600	117.7	1,300
Shida Kartli	83,391	20	800	104.2	400
Kvemo Kartli	124,031	25	1,000	124.0	500
Samtskhe-Javakheti	51,381	20	800	64.2	400
Adjara	87,527	20	600	145.9	400
Guria	39,743	20	800	49.7	400
Samegrelo	115,982	25	1,000	116.0	500
Imereti	201,213	40	1,600	125.8	800
Mtskheta-Mtianeti	34,484	20	800	43.1	400
Racha-Svaneti†	20,395	30	1,300	15.7	600
Total	1,173,675	310	12,300	95.4	6,200

*Source: SDS, 2002 Census Population

† Includes the regions of Racha-Lekhumi, Kvemo Svaneti, and Zemo Svaneti as one stratum.

HH = households; PSU = primary sampling unit

Table 2.3 Results of Household Visits and Interview Status of Eligible Women, by Residence (Percentage Distribution) — Reproductive Health Survey: Georgia, 2005

		Residence		
Household Visits	Total	Tbilisi	Other Urban	Rural
Identified eligible women	51.9	55.2	52.7	50.1
No eligible women	47.1	44.2	46.7	48.5
Resident(s) not at home	0.1	0.2	0.1	0.0
Household Refusal	0.0	0.2	0.0	0.0
Unoccuppied household	0.9	0.3	0.6	1.3
Total	100.0	100.0	100.0	100.0
No. of Households Visited	12,338	2,618	3,358	6,362
Eligible Women				
Completed interviews	99.4	99.1	99.8	99.6
Selected respondent absent	0.2	0.2	0.0	0.1
Selected respondent refused	0.1	0.2	0.1	0.0
Other	0.3	0.5	0.1	0.3
Total	100.0	100.0	100.0	100.0
No. of Eligible Women Identified	6,402	1,444	1,768	3,190
No. of Completed Interviews	6,376	1,431	1,765	3,180

Table 2.6 Percentage of Women Aged 15–44 Years With Complete Interviews by Age Group by Residence, Compared With Official Census Estimates
Reproductive Health Survey: Georgia, 2005

	GERHS05 (±95% Confidence Interval)			2002 Official Estimates*		
Age Group	Total	Urban	Rural	Total	Urban	Rural
15–19	18.7 (1.3)	18.4 (1.3)	19.1 (1.3)	17.6	16.7	18.8
20–24	17.6 (1.3)	17.9 (1.3)	17.2 (1.3)	16.4	16.2	16.7
25–29	15.9 (1.3)	15.4 (1.2)	16.6 (1.3)	15.8	15.9	15.8
30–34	14.9 (1.2)	15.6 (1.2)	14.1 (1.2)	15.5	15.6	15.3
35–39	15.3 (1.2)	15.3 (1.2)	15.3 (1.2)	17.0	17.4	16.6
40–44	17.6 (1.3)	17.4 (1.3)	17.7 (1.3)	17.7	18.3	16.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

*Source: SDS, 2003. Population of Georgia in 2002.

Chapter 3

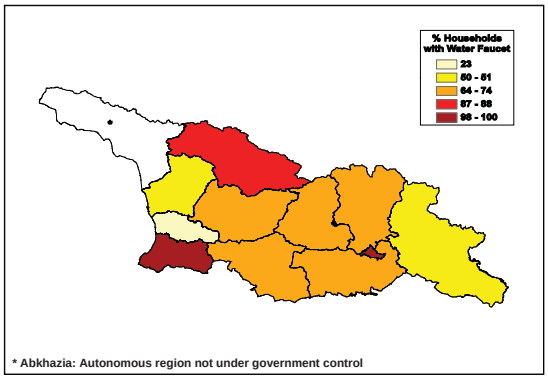
CHARACTERISTICS OF THE SAMPLE

3.1 Household characteristics

In order to assess the socioeconomic conditions of the respondents, the GERHS05 included questions on the availability of various amenities and goods in households with respondents aged 15–44 years. The presence or absence of many of these amenities and goods are often associated with the health and well-being of members of a household.

As shown in Table 3.1.1, the source of drinking water for 76% of the households is a tap found either in the residence or in the yard. An additional 12% of the households obtain their drinking water from a private well, while 6% obtain their water from a public tap. As expected, piped water in the household or in the yard is more common in urban areas (95%) than in rural areas (54%), and is almost universally available in the Tbilisi and Adjara regions (Figure 3.1.1). Private well water is the primary source of drinking water in the Guria region and the second most important source in the Samegrelo region, while public taps are an important source of drinking water in the Kakheti and Samtskhe-Javakheti regions.

Figure 3.1.1 **Percentage of Households with Piped Water, by Region**



For the households that obtain their drinking water from a public tap, public well, or a spring, river, pond, or lake (surface water), the average amount of time it takes to obtain water is 17.6 minutes in urban areas and 16.4 minutes in rural areas (data not shown).

In general, 46% of the households have a flush toilet, while 54% have a pit latrine. The probability of having a flush toilet is highest in the Tbilisi region (93%) and lowest in the Kakheti region (11%) (Figure 3.1.2). With the exception of Tbilisi, Adjara, and Imereti, three-quarters or more of households in each of the remaining regions rely on pit latrines for waste disposal.

The principal source of energy used in Georgia households for cooking is wood (48%), followed by natural gas (38%), and electricity (8%). The vast majority of rural households use wood for cooking (88%), while nearly two-thirds of urban households use natural gas. The use of natural gas is highest in the Tbilisi region (79%) and lowest in the Samtskhe-Javakheti region (4%).

More than half of the households are heated centrally with wood stoves (56%), followed by individual room-based heating with electric, gas, kerosene, or other space heaters (42%). The vast majority of Georgian households lack central heating. As shown in Figure 3.1.3, place of residence (urban versus rural) is associated with availability of amenities. Households of rural respondents are the least likely to have piped water in the residence or in the yard, a flush toilet, gas- or electricity-based cooking, central heating, or 24-hour electrical service.

As shown in Table 3.1.2, the principal materials used for roofing are tile or concrete (72%), followed by corrugated iron (23%). Tile or concrete roofing is predominately used in the Tbilisi and Samtskhe-Javakheti regions (over 80%), while corrugated roofing is the most often used material in the Racha-Svaneti region (55%).

Only 37% of the respondents reported that electricity is available in their households 24 hours per day; this is most common in three regions: 64% in Tbilisi, 69% in Samtskhe-Javakheti, and 71% in Adjara (Table 3.1.3). On average, households have access to only 15 hours of electricity per day, but availability varies greatly by region (Figure 3.1.4).

Figure 3.1.2 **Percentage of Households with Flush Toilet, by Region**

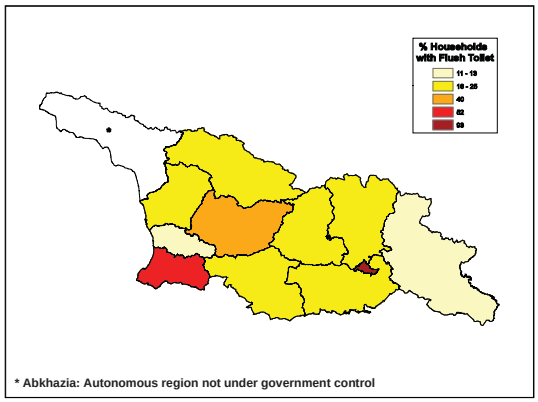


Figure 3.1.3 **Availability of Basic Services in Households with Women Aged 15–44 Years, by Residence**

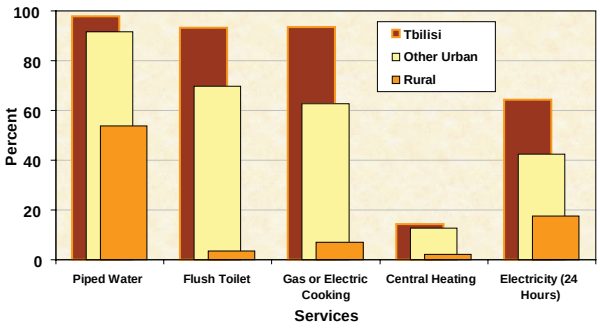
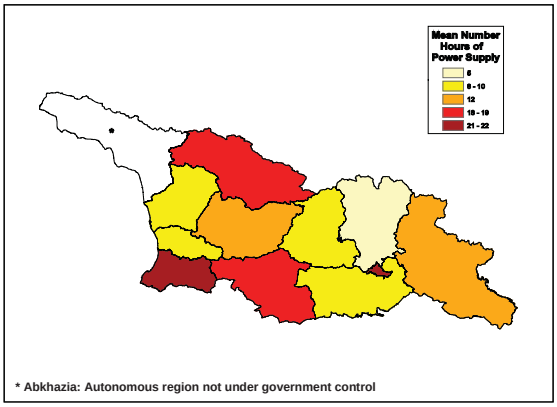


Figure 3.1.4 **Mean Number of Hours (per Day) of Power Supply, by Region**



The regions least likely to have 24-hour electrical service include Mtskheta-Mtianeti, Shida Kartli, and Samegrelo (Figure 3.1.5). Over 13% of households in Kakheti and Mtskheta-Mtianeti do not have any electrical power.

As shown in Figure 3.1.6, there was a dramatic increase in the availability of 24-hour electrical service between the 1999 and 2005 RHS surveys, from less than 10% in 1999 to almost 40% in 2005. During the same period, there was only a slight increase in the percentage of households with a flush toilet or a land-line telephone, while the percentage of households with central heating remains very low.

As shown in Table 3.1.4 and Figure 3.1.7, almost every household has a television (97%), with little difference between urban and rural households. The likelihood of possessing other household goods is higher in urban than in rural areas. Nearly 80% of households have a refrigerator; the urban/rural differential is almost 20 percentage points in favor of the urban households. While 37% of the respondents reported that their household has a land-line telephone, 56% reported that their household has a cell phone. Interestingly, only 4% of rural households have a land-line telephone, but 42% have a cell phone, which could be explained by the increased accessibility and affordability of cell phone services. In contrast, access to land-lines has not been expanded during recent years. The percentages for land-line telephones and cell phones in urban households are 64% and 67%, respectively. Overall, of the households that have a land-line telephone, 49% also have a cell phone; of the households that do not have a land-line telephone, 51% have a cell phone. The proportion of households with at least one cell phone ranges

Figure 3.1.5 **Percentage of Households with 24-hour Power Supply, by Region**

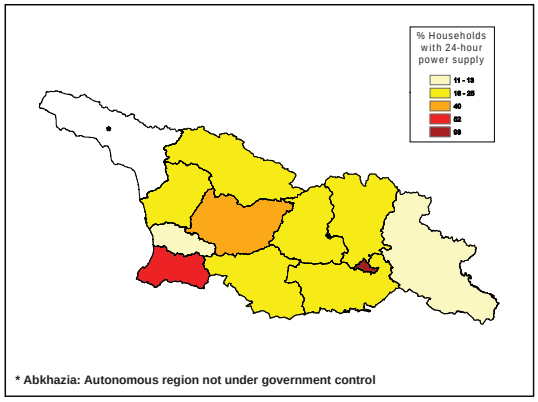


Figure 3.1.6 **Availability of Basic Services in Households with Women Aged 15–44 Years: 1999 and 2005**

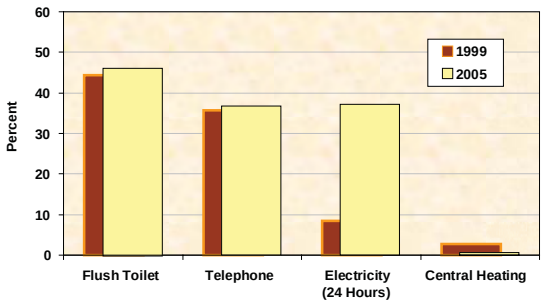
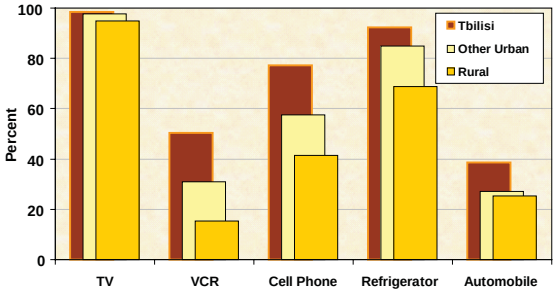


Figure 3.1.7 **Availability of Amenities and Goods in Households with Women Aged 15–44 Years**



from a low 33% in Guria to a high 77% in Tbilisi (Figure 3.1.8).

Overall, 29% of households have a functioning automobile; ownership rates are highest in Tbilisi (39%). Almost 35% of households own a vacation home (villa); ownership rates are highest in the Mtskheta-Mtianeti region (50%), the Shida Kartli region (53%), and the Tbilisi region (64%).

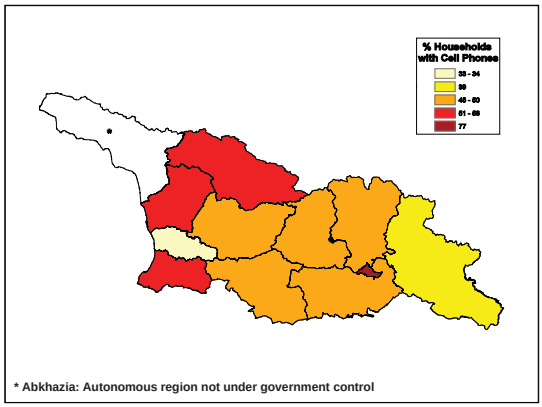
Availability of most household goods remained stable between the 1999 and 2005 RHS (Figure 3.1.9). The only substantial increase was in ownership of cell phones, from less than 10% in 1999 to almost 56% in 2005. In contrast, during the interval between the surveys, the percentage of households with a refrigerator or a functioning automobile decreased.

Slightly more than 85% of the respondents live in a privately owned flat or house (Table 3.1.5); rates are highest among respondents who live in the Kakheti, Shida Kartli, Kvemo Kartli, and Samtskhe-Javakheti regions—over 90%. Only 78% of Tbilisi respondents live in a privately owned flat or house, while almost 12% live in rented space. Nearly 9% of respondents (presumably single women) live with their immediate family.

As shown in Table 3.1.6, a typical household has, on average, 4.1 rooms, excluding bathrooms and the kitchen. Respondents living in the Guria and Samegrelo regions report the highest average number of rooms (over 5), while Tbilisi respondents report the lowest (2.7 rooms). As shown in Figure 3.1.10, the number of rooms that a household has increases as place of residence becomes less urban.

On average, a respondent's household had 4.7 people (Table 3.1.7). Households in urban areas had fewer people (4.4) than did rural households (5.1). The average household size was lowest in Tbilisi (4.2 persons) and highest in Samtskhe-Javakheti and Adjara (5.1 persons). One- or two-person households are very uncommon in Georgia. Overall, one-person households represent only 1% of all households, and two-person households only 6%.

Figure 3.1.8 **Percentage of Households with Cell phones, by Region**



* Abkhazia: Autonomous region not under government control

Figure 3.1.9 **Availability of Amenities and Goods in Households with Women Aged 15–44 Years: 1999 and 2005**

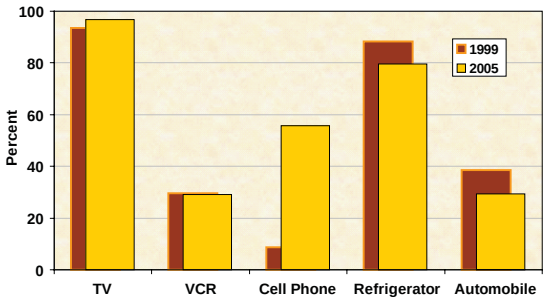
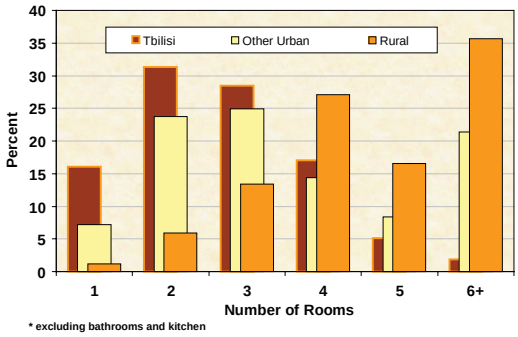


Figure 3.1.10 **Number of Rooms* in Households with Women Aged 15–44, by Residence**



* excluding bathrooms and kitchen

Overcrowding in households can be assessed by dividing the averages in Table 3.1.7 by the averages from Table 3.1.6. Overall, there is an average of 1.1 persons per room, with 1.3 in urban areas, and 1.0 in rural areas. In Tbilisi there are, on average, 1.5 persons per room.

All respondents were asked "How do you rate the material status of your family?"; response options are shown in Table 3.1.8 and Figure 3.1.11. Seventy percent of respondents said that "we can somehow satisfy our needs." An additional 24% of the respondents stated that "we can hardly make ends meet." Overall, only 6% declared that "we can easily satisfy our needs,"; 10% in the Tbilisi region agreed with this statement. The percentage of households which "can hardly make ends meet" is highest in rural areas (31%) and in the Guria region (46%).

All household amenities and goods, including uncrowded living conditions, were summed to create a score to classify the socioeconomic status (SES) of the household. (The same methodology was used to assess the SES distribution of the population in the 1999 Georgia RHS and other reproductive health surveys in Eastern Europe and former Soviet Union countries.) Equal values were assigned for possession of each amenity or good. For each household, this inventory yielded a score; reliability was assessed using the Cronbach coefficient alpha. Based on this initial evaluation, ten items were selected for use in the SES score (alpha coefficient=.67). Figure 3.1.12 shows the percentage distribution of households SES scores in 1999 and 2005; scores ranged from 0 to 10, where 0 represented the lower end (no score-related amenities and goods present in the household) and 10 represented the higher end (all 10 items present in the household). The score was further divided into terciles to create three levels for the SES variable. Respondents with a score of 0–3 amenities were classified as living in households with low SES; those with scores between 4 and 6 were classified as having middle SES; and those with scores of 7 or higher were considered as having high SES. As shown in Figure 3.1.13, more women were living in households with

Figure 3.1.11 **Respondents' Evaluation of the Material Status of the Household, by Residence**

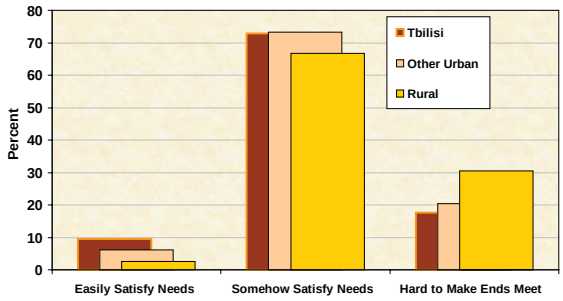


Figure 3.1.12 **Percentage Distribution of Households by the Number of Basic Amenities and Goods Available: 1999 and 2005**

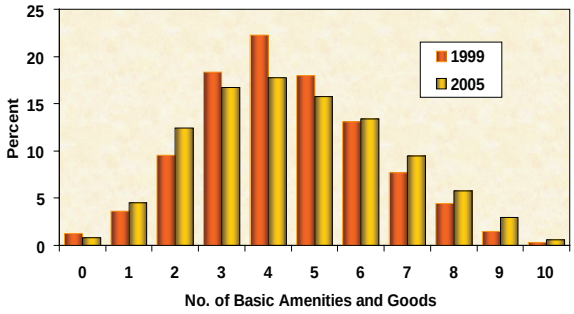
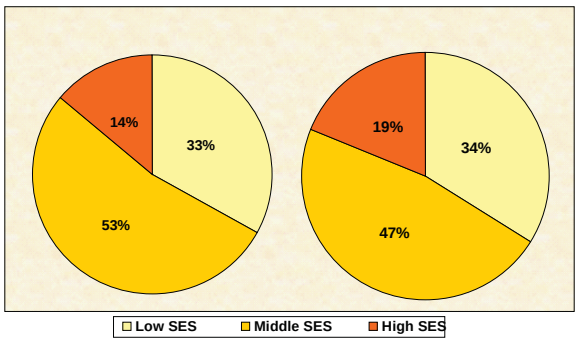


Figure 3.1.13 **Household Socioeconomic Status (SES) in 1999 and 2005**



high SES in 2005 than in 1999 (19% vs. 14%), fewer women were living in middle-SES households (47% vs. 55%), whereas the proportion living in low-SES households remained practically unchanged.

3.2 Characteristics of the respondents

As shown in Table 3.2.1, the respondent age distribution is fairly uniform, both overall and across place of residence. Tbilisi respondents tended to be slightly younger, with an average age of 29 years, compared to respondents who live in other urban areas (29.2 years) and in rural areas (29.1 years). Overall, 36% of the respondents were young adults (15–24 years of age) at the time of interview, a percentage that does not vary significantly by residence.

Nearly 60% of the respondents were legally married or living in a consensual union; the vast majority were legally married. The percentage of respondents who were married or living in a consensual union increases as place of residence becomes more rural. Slightly more than one-third of the respondents had never been married or had never lived with a partner. Less than 6% of the respondents stated that they had been previously married and were now either divorced or separated.

Figure 3.2.1 summarizes the marital status of the respondents by age groups. The vast majority of women aged 15–19 years have never been married or lived with a partner. By the time women are 20–24 years of age, about 46 % are married or living in a consensual union, and by the time they are 25–29 years of age, 68 % are married. The proportion of married respondents continues to increase with age, and by the time women reach 40–44 years of age, 93% have been married. Only 7% of the women in this age group have never been married. The proportion of women who have previously been married increases from 0.4 % among women aged 15–19 years to 11% among women aged 40–44 years.

Overall, 41% of the respondents had no living children at time of interview. Rates were highest among Tbilisi respondents (42%), and lowest among rural respondents (38%) (Figure 3.2.2). Slightly more than 16% of the respondents reported having one living child, while 30% reported having two living children, and 12% having three or more. Tbilisi respondents tended to have, on average, fewer living children (0.9) than respondents who live in other urban areas (1.1) and in rural areas (1.4).

Georgian women are well-educated, as evidenced by the fact that only 16% have less than a complete secondary education. In general, respondents living in Tbilisi and other urban areas were better educated than those living

Figure 3.2.1 **Current Marital Status by Age Group among Women Aged 15–44 Years**

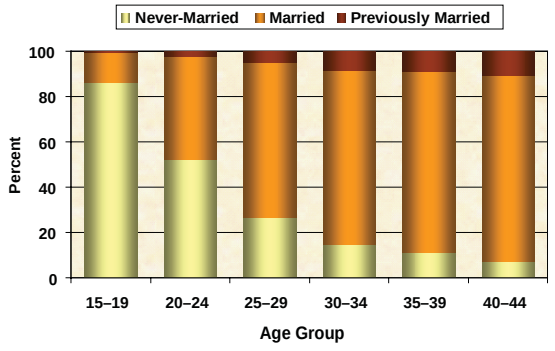
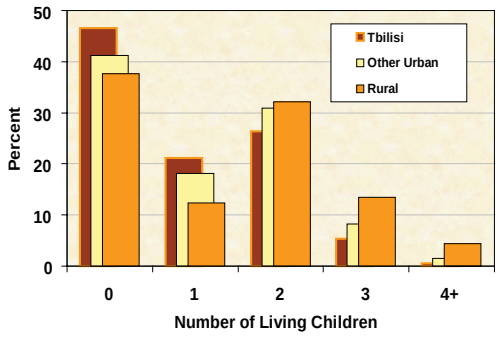


Figure 3.2.2 **Number of Living Children among Women Aged 15–44 Years, by Residence**



in rural areas (Figure 3.2.3). For example, as shown in Table 3.2.1, respondents living in Tbilisi were almost three times more likely than rural respondents to have received university training. The regions with the least educated populations are Kvemo Kartli, Samtskhe-Javakheti, Kakheti, and Guria: only 37%–42% of respondents have 12 or more years of education (Figure 3.2.4). The educational attainment of the respondents will be further discussed later on in this chapter.

Slightly more than one-third of the respondents lived in low-SES households, while 47% lived in middle-SES households, and 19% in high-SES households (Figure 3.2.5). The percentage living in a low-SES household was highest for rural respondents (55%) and lowest for Tbilisi respondents (5%). In contrast, only 4% of rural respondents were classified as living in high-SES households, compared to 45% of respondents living in Tbilisi.

Only one in five of the respondents reported working outside of the home at least 20 hours per week. Rural women were less likely to work outside of the home (14%) than women residing in Tbilisi and urban areas (29% and 26%). Figure 3.2.6 shows the percentage of women working outside the home, by region. The percentage is highest among women living in the Racha-Svaneti region and lowest in the Samtskhe-Javakheti region.

Figure 3.2.3 **Educational Attainment among Women Aged 20–24 Years, by Residence**

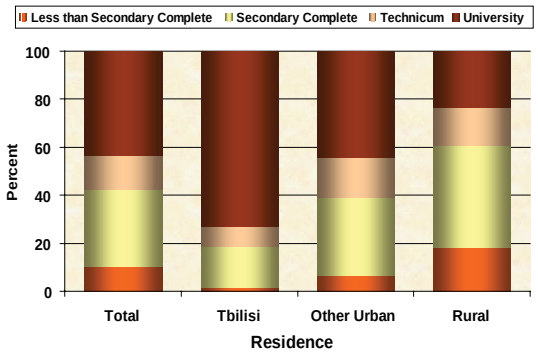


Figure 3.2.4 **Percentage of Women with Post-secondary Education, by Region**

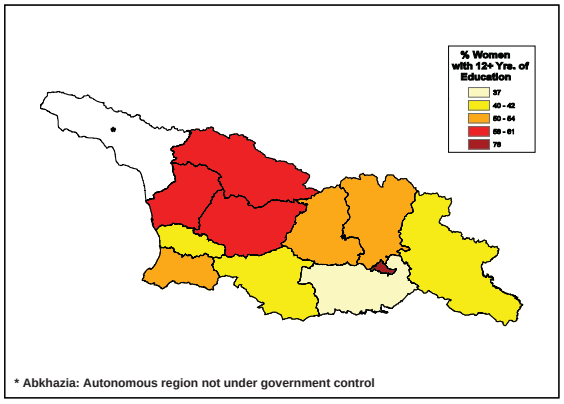


Figure 3.2.5 **Socioeconomic Status of the Household, by Residence Households with Women Aged 15–44 Years**

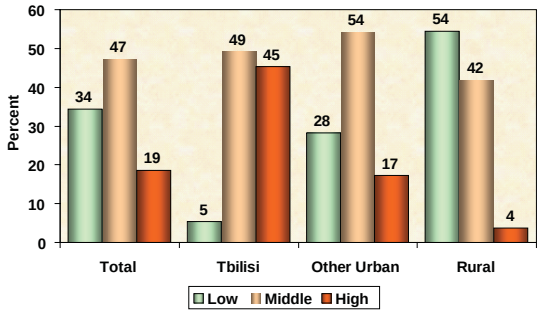
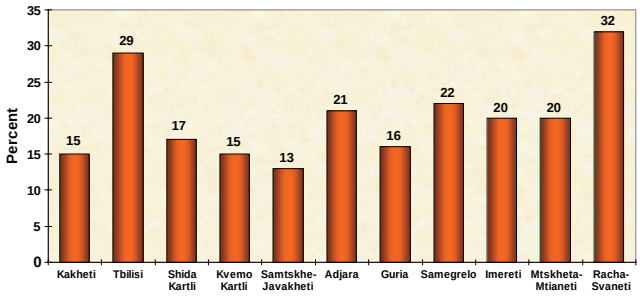


Figure 3.2.6 **Percentage of Women Aged 15–44 Years Who Are Currently Working, by Region**



The vast majority of the respondents reported themselves to be Georgian (87%). Respondents of other ethnic backgrounds, such as Azeri and Armenian, were more likely to live in rural areas.

The dominant religion among the survey respondents is Georgian Orthodox (80%). Most remaining respondents declared that they were Muslim. As noted in the table, the majority of Muslims live in rural areas, where they constitute 23% of the population.

Tables 3.2.2 and 3.2.3 provide additional details on the educational attainment of the respondents. Focusing first on Table 3.2.2, the likelihood of having less than a secondary complete education is greatest in the Kvemo Kartli region (32%), followed by Kakheti (28%), Guria (24%), Samtskhe-Javakheti (23%), and Adjara (21%). Not surprisingly, respondents living in these regions are the least likely to receive university training and, to a certain degree, technical training. However, a sizeable proportion of women living in these regions have a secondary complete education; in each of these regions, the percentage is above the national average. With regards to higher education, the Tbilisi region stands out: 59% of respondents have undergone university training. No other region in the country is within 20 percentage points of achieving the same educational attainment rates as Tbilisi. This disparity is likely due to lack of access to higher education among women living outside of Tbilisi.

Table 3.2.3 presents the percentage distribution of respondents by the highest level of education attained, age group, and residence. Focusing on the top panel of the table, younger women are more likely than older women to have a university education, while older women are more likely to have received technical training. Overall, younger women are getting a better education than their mothers and aunts did. As expected, urban women are much better educated than rural women in each age group. For example, the percentage of women aged 25–29 years with university training declines from 68% among women living in Tbilisi to 46% among women living in other urban areas and only 33% among women living in the rural areas of the country. However, rural women appear to be making progress: 43% of rural women aged 20–24 have a secondary complete education, compared to 35% of rural women aged 40–44 years, and 33% of rural women aged 25–29 have university training, compared to only 17% of rural women aged 40–44 years. However, despite these improvements, rural women in Georgia still lag behind their urban counterparts in educational attainment, as is the case in most countries.

Table 3.1.1 Availability of Basic Services in the Household by Residence and Region: Percentage of Households With Women Aged 15-44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Basic Services	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Source of Drinking Water														
Tap in residence/yard	76.2	94.7	53.7	49.9	97.9	69.0	63.8	73.4	99.7	23.3	50.9	73.2	69.7	86.7
Public tap	6.4	1.4	12.5	26.7	0.1	9.8	11.0	21.9	0.3	4.5	3.0	2.8	10.3	6.3
Well water in residence/yard	12.3	2.9	23.8	15.4	2.1	17.0	6.9	0.3	0.0	46.0	43.5	20.7	10.7	3.3
Public well	2.6	0.6	5.1	4.8	0.0	1.8	6.0	0.2	0.0	21.7	2.6	2.2	5.9	2.5
Surface water	1.5	0.3	3.0	3.2	0.0	2.4	4.6	4.1	0.0	4.5	0.0	1.1	3.4	1.2
Bottled water	0.9	0.1	1.8	0.0	0.0	0.0	7.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Toilet Facilities														
Flush toilet	46.2	81.2	3.5	11.0	93.3	24.1	25.4	24.0	52.2	13.3	17.6	39.5	17.9	20.7
Pit latrine	53.7	18.7	96.3	88.7	6.6	75.9	74.5	76.0	47.5	86.7	82.2	60.5	82.1	79.1
Other	0.1	0.1	0.2	0.3	0.1	0.0	0.1	0.0	0.3	0.0	0.2	0.0	0.0	0.2
Energy Used for Cooking														
Electricity	8.4	13.5	2.1	0.3	14.4	2.7	2.7	10.5	9.1	3.1	4.8	10.5	7.4	19.4
Natural gas	37.5	64.2	5.0	17.5	79.0	18.7	33.1	4.3	24.7	10.0	14.3	31.1	17.0	10.4
Wood	48.2	15.5	88.1	80.5	0.7	73.6	61.7	63.1	57.4	82.0	75.6	53.9	67.0	70.3
Other	5.9	6.8	4.7	1.7	5.9	5.1	2.4	22.1	8.7	4.9	5.3	4.5	8.6	0.0
Type of Heating System														
Central heating	0.7	1.3	0.1	0.2	2.1	0.2	0.1	0.3	0.3	0.4	0.5	0.1	0.8	0.0
Own boiler	1.0	1.8	0.2	0.8	3.1	0.0	0.3	0.0	0.1	0.0	0.3	0.3	0.6	0.2
Individual room heating	41.8	61.4	17.9	22.8	82.5	33.0	34.7	36.2	7.5	12.3	17.0	41.5	26.5	30.9
Stove heating	55.8	35.0	81.2	73.6	11.7	66.7	64.7	62.9	91.6	87.3	82.0	57.8	72.1	65.8
No heating	0.5	0.5	0.5	2.7	0.4	0.2	0.1	0.0	0.1	0.0	0.0	0.3	0.0	3.1
Other	0.1	0.1	0.2	0.0	0.2	0.0	0.0	0.5	0.3	0.0	0.2	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.2 Principal Materials Used in the Roof by Residence and Region: Percentage of Households with Women Aged 15-44 Years Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Principal Materials	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Tile or concrete	72.1	79.0	63.8	73.6	82.4	67.9	69.6	86.0	51.4	73.4	79.6	68.5	59.0	41.9
Corrugated iron	23.2	17.7	29.9	24.3	15.0	23.7	22.8	13.1	47.1	26.6	12.2	24.4	28.2	54.8
Rudimentary roof (plastic/carton)	1.3	1.4	1.3	0.6	1.0	5.3	0.4	0.5	0.3	0.0	0.3	2.1	8.4	0.2
Natural materials	0.5	0.3	0.7	1.5	0.5	0.7	0.3	0.2	0.4	0.0	0.0	0.0	0.6	3.1
Other	2.8	1.7	4.3	0.0	1.2	2.4	6.9	0.0	0.7	0.0	7.9	4.9	3.8	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.3 Number of Hours per Day That Electricity Is Available in the Household, by Residence and Region Among Households With Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Number of Hours	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
None	3.1	0.4	6.5	13.7	0.0	0.4	0.7	0.0	0.0	6.3	3.8	6.0	13.2	7.0
1-6 hours	33.9	17.0	54.5	37.4	0.8	72.3	57.4	18.8	7.2	51.7	62.6	58.3	67.6	11.0
7-12 hours	12.6	10.9	14.8	18.3	3.7	20.1	29.6	11.6	10.6	18.4	14.7	7.5	17.6	18.6
13-18 hours	3.9	5.5	1.9	2.0	9.1	0.4	2.8	0.0	4.5	1.8	2.1	0.9	0.0	3.1
19-23 hours	7.8	12.0	2.6	2.7	22.1	0.2	1.4	0.2	6.7	0.0	0.0	4.1	0.0	0.4
24 hours	37.1	53.1	17.7	22.0	64.2	4.3	5.6	69.3	70.8	21.3	16.1	19.3	1.3	58.9
Does not know	1.5	1.1	2.0	3.9	0.1	2.4	2.6	0.2	0.1	0.4	0.7	3.9	0.2	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average No. of Hours	15.0	18.9	10.2	12.4	22.0	7.9	9.6	18.7	20.8	9.3	8.2	11.7	5.2	17.9
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.4 Availability of Various Household Amenities and Goods in the Household by Residence and Region Among Households With Women Aged 15–44 Years (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Amenities and Goods	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kvemo	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Refrigerator	79.6	88.5	68.8	72.5	92.4	78.6	77.6	74.8	76.3	65.0	62.9	80.6	74.2	73.8
Television	96.7	98.0	95.0	91.4	98.5	97.3	95.8	98.8	96.9	93.5	95.9	97.2	97.3	96.5
VCR	29.1	40.4	15.4	13.1	50.3	18.8	27.5	31.4	28.3	12.3	14.2	20.4	20.2	17.0
Functioning automobile	29.4	32.8	25.3	24.1	38.6	22.6	26.5	30.5	31.9	21.3	22.6	24.7	29.6	25.2
Telephone	36.8	63.7	3.9	8.6	80.2	20.1	25.0	19.1	26.4	8.6	14.3	28.7	16.2	11.9
Cell phone	55.6	67.2	41.5	38.8	77.2	45.7	47.8	48.8	55.5	33.3	54.2	46.6	45.4	51.1
Vacation home/villa	34.9	47.7	19.2	23.2	64.1	52.7	34.6	5.5	13.9	9.2	7.4	25.9	50.0	14.9
Air conditioner	5.5	9.7	0.4	0.6	15.7	1.1	2.2	1.4	2.5	0.6	1.3	2.2	3.4	1.2
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.5 Type of Living Arrangements by Residence and Region: Households With Women Aged 15–44 Years (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Type of Living Arrangements	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Lives in privately owned flat or house	85.3	81.7	89.6	90.2	77.9	90.8	91.9	91.6	85.0	86.5	82.0	88.3	84.5	84.1
Lives in rental space (room, flat, or house)	4.1	7.4	0.1	0.3	11.8	0.9	1.5	1.4	2.7	0.2	1.3	0.4	2.5	0.8
Lives with immediate family	8.6	7.6	9.8	9.0	6.3	7.8	5.7	6.2	11.8	13.1	14.2	8.1	12.0	12.7
Lives with other relatives	1.3	2.0	0.5	0.3	2.5	0.2	0.8	0.9	0.3	0.2	2.5	1.3	1.1	1.0
Other	0.8	1.3	0.1	0.2	1.5	0.4	0.1	0.0	0.1	0.0	0.0	1.9	0.0	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.6 Number of Rooms in the Household by Residence and Region: Households With Women Aged 15–44 Years (Percent Distribution) Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Number of Rooms*	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
1	6.9	11.6	1.2	1.8	16.1	5.8	8.1	1.9	2.8	0.6	1.2	3.3	2.3	1.8
2	17.7	27.4	5.9	8.0	31.3	10.0	14.4	8.6	17.7	7.6	5.4	17.9	14.9	10.4
3	20.7	26.7	13.4	16.1	28.5	13.2	21.0	22.6	20.7	13.9	9.4	20.4	18.9	17.2
4	20.8	15.7	27.1	28.8	17.0	25.9	24.3	31.6	16.5	23.3	16.8	19.6	23.7	20.2
5	11.2	6.8	16.6	15.1	5.1	13.2	10.2	14.7	12.4	11.0	17.1	14.0	13.0	14.1
6	10.6	5.5	16.9	18.3	0.7	16.3	10.0	10.5	13.9	14.5	23.4	10.2	12.4	17.6
7	3.3	1.7	5.2	3.5	0.6	3.4	3.1	3.3	3.0	9.2	7.1	4.8	2.1	5.1
8 or more	8.7	4.7	13.6	8.4	0.6	12.1	8.8	6.9	12.9	19.8	19.6	9.8	12.6	13.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average No. of Rooms	4.1	3.3	5.0	4.6	2.7	4.6	4.4	4.3	4.5	5.4	5.6	4.3	4.5	4.9
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

*Not Including kitchen and bathroom

Table 3.1.7 Number of Persons Living in the Household by Residence and Region: Households With Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Number of Persons	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
1	1.1	1.9	0.2	0.0	2.7	0.2	0.4	0.0	1.2	0.0	1.2	0.5	0.2	0.8
2	5.5	7.6	3.0	3.8	9.2	4.2	4.1	2.9	3.1	3.9	5.1	5.5	2.9	6.3
3	14.2	17.8	9.9	10.9	19.5	13.0	11.4	7.6	10.3	11.2	14.2	15.6	12.2	10.8
4	29.0	31.9	25.3	30.3	31.1	22.3	31.5	25.0	24.3	29.0	28.8	29.9	32.8	28.4
5	23.4	21.4	25.9	22.3	19.8	30.1	23.5	29.0	24.9	28.8	22.4	24.0	24.6	23.9
6	15.4	11.0	20.7	20.5	9.9	16.3	16.3	19.0	18.6	17.4	16.6	16.1	16.2	16.8
7	7.4	5.4	9.8	8.0	5.2	8.0	8.4	9.7	10.5	4.3	8.6	6.2	8.2	8.8
8 or more	4.0	3.0	5.3	4.2	2.6	6.0	4.5	6.9	7.0	5.3	3.1	2.2	2.9	4.3
Not sure	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average No. of Persons	4.7	4.4	5.1	4.9	4.2	4.9	4.8	5.1	5.1	4.9	4.7	4.6	4.8	4.8
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.1.8 Self-Reported Evaluation of the Material Status of the Family by Residence and Region: Households With Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

		Residence		Region										
Material Status of the Family	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Can easily satisfy our needs	5.5	7.8	2.6	3.0	9.5	4.7	5.0	3.8	4.8	1.4	3.6	3.6	4.0	5.1
Can somehow satisfy our needs	70.2	73.0	66.7	71.2	72.8	60.1	60.7	70.0	75.3	52.6	69.7	77.4	66.2	68.7
Can hardly make ends meet	24.2	19.0	30.5	25.5	17.7	34.6	34.3	25.3	19.9	46.0	26.7	18.8	29.6	26.2
Does not know	0.1	0.1	0.2	0.3	0.0	0.5	0.0	0.9	0.0	0.0	0.0	0.2	0.2	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,376	3,196	3,180	538	1,431	430	576	434	490	388	506	782	374	427

Table 3.2.1 Percentage Distribution of Women Aged 15–44 Years by Selected Characteristics by Residence: Reproductive Health Survey: Georgia, 2005

		Residence		
Characteristic	Total	Tbilisi	Other Urban	Rural
Age Group				
15–19	18.7	17.1	19.9	19.0
20–24	17.7	19.7	16.3	17.3
25–29	16.0	15.2	15.6	16.6
30–34	14.9	17.3	14.1	13.8
35–39	15.2	14.7	15.7	15.2
40–44	17.6	15.9	18.4	18.1
Marital Status				
Married	59.5	53.2	57.9	64.2
Previously married	5.8	6.7	6.8	4.5
Never married	34.7	40.1	35.3	31.2
No. of Living Children				
0	41.0	46.6	41.2	37.6
1	16.3	21.1	18.2	12.3
2	30.3	26.4	30.9	32.2
3	9.8	5.4	8.2	13.4
4 or more	2.5	0.5	1.5	4.4
Education Level				
Secondary complete	16.3	6.6	13.8	23.6
Secondary complete	27.4	17.5	27.7	33.1
Technicum	21.4	16.6	23.5	23.0
University/postgraduate	34.9	59.3	35.0	20.3
Socioeconomic Status				
Low	34.4	5.4	28.5	55.3
Middle	46.9	49.2	54.1	41.0
High	18.8	45.4	17.4	3.7
Employment Status				
Working	21.1	28.5	26.0	13.6
Not working	78.9	71.5	74.0	86.4
Ethnic Group				
Georgian	87.0	90.8	92.4	81.5
Azeri	5.2	0.5	1.9	10.1
Armenian	5.4	4.7	4.1	6.6
Other	2.4	4.1	1.6	1.8
Religion				
Georgian Orthodox	80.1	92.2	85.8	69.3
Other Orthodox	5.3	5.7	3.5	6.2
Muslim	13.0	0.4	9.2	22.9
Other/none	1.5	1.6	1.5	1.5
Total	100.0	100.0	100.0	100.0
No. of Cases	6,376	1,431	1,765	3,180

Table 3.2.2 Highest Education Level of the Respondents by Region: Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Education Level					
Region	Secondary Incomplete or Less	Secondary Complete	Technicum	University/ Postgraduate	Total	No. of Cases
Total	16.3	27.4	21.4	34.9	100.0	6,376
Kakheti	28.4	31.4	17.2	23.1	100.0	538
Tbilisi	6.6	17.5	16.6	59.3	100.0	1,431
Shida Kartli	10.7	35.9	27.7	25.7	100.0	430
Kvemo Kartli	31.9	30.7	17.4	20.1	100.0	576
Samtskhe-Javakheti	22.6	36.9	21.9	18.6	100.0	434
Adjara	20.5	29.7	23.7	26.1	100.0	490
Guria	24.1	34.4	21.5	20.0	100.0	388
Samegrelo	14.0	27.5	24.7	33.8	100.0	506
Imereti	12.2	30.1	27.4	30.3	100.0	782
Mtskheta-Mtianeti	16.6	29.4	27.7	26.3	100.0	374
Racha-Svaneti	11.0	28.2	27.6	33.3	100.0	427

Table 3.2.3 Highest Education Level of the Respondents by Residence and Age Group: Women Aged 15–44 Years (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

	Education Level					
Residence and Age Group	Secondary Incomplete or Less	Secondary Complete	Technicum	University/ Postgraduate	Total	No. of Cases
Total	16.3	27.4	21.4	34.9	100.0	6,376
15–19	50.9	25.9	5.6	17.5	100.0	930
20–24	10.2	32.3	14.0	43.5	100.0	1,079
25–29	8.1	28.2	18.3	45.4	100.0	1,139
30–34	6.8	25.5	26.2	41.5	100.0	1,110
35–39	7.9	25.2	34.2	32.8	100.0	1,048
40–44	8.4	27.0	33.3	31.3	100.0	1,070
Tbilisi	6.6	17.5	16.6	59.3	100.0	1,431
15–19	33.5	26.4	6.5	33.5	100.0	193
20–24	1.6	17.0	8.6	72.8	100.0	254
25–29	1.0	19.9	10.8	68.3	100.0	241
30–34	0.0	14.1	18.4	67.5	100.0	285
35–39	0.7	13.4	28.9	57.0	100.0	233
40–44	2.0	14.0	29.3	54.7	100.0	225
Other Urban	13.8	27.7	23.5	35.0	100.0	1,765
15–19	48.8	27.9	8.0	15.3	100.0	270
20–24	6.6	32.6	16.7	44.0	100.0	273
25–29	4.5	27.7	21.9	45.9	100.0	298
30–34	2.1	26.5	30.5	40.9	100.0	302
35–39	3.3	26.2	35.4	35.2	100.0	304
40–44	8.1	25.4	32.0	34.5	100.0	318
Rural	23.6	33.1	23.0	20.3	100.0	3,180
15–19	61.6	24.4	3.6	10.4	100.0	467
20–24	18.1	42.5	16.1	23.3	100.0	552
25–29	14.1	33.0	20.2	32.7	100.0	600
30–34	14.9	33.4	29.3	22.4	100.0	523
35–39	15.0	31.3	36.5	17.2	100.0	511
40–44	11.9	34.8	36.3	17.1	100.0	527

Chapter 4

FERTILITY AND PREGNANCY EXPERIENCE

One objective of the GERHS05 was to assess current levels and trends of fertility and pregnancy experiences and to identify factors that might influence reproductive behaviors. To obtain information about reproductive patterns, the survey included a series of questions on childbearing, the use of induced abortion, desired family size and fertility preferences, and planning status of all pregnancies in the last five years. All survey based statistics regarding pregnancy experiences were derived from a complete lifetime pregnancy history, which consisted of information about all births, abortions, and fetal losses, including date of pregnancy outcome, pregnancy duration, and survival status of child. Each woman was asked to give a detailed history of all pregnancy outcomes, from the time of her first pregnancy up to the time of the interview. This information represents an important addition to vital statistics routinely compiled at the local and state level, because it allows for analysis of fertility and abortion differentials by background characteristics and health behaviors. It also allows for more accurate national and regional estimates of pregnancy events: the 1999 reproductive health survey revealed that official statistics understated births and abortions (Serbanescu et al., 2001b).

4.1 Fertility Levels and Trends

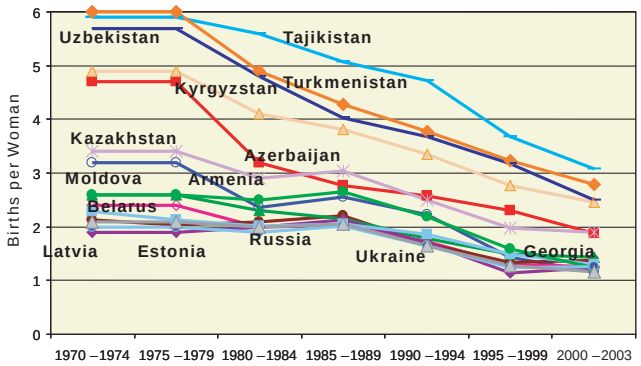
Demographically, Georgia has much in common with the other former Soviet-bloc countries, with whom it shares recent social, political, and economic changes since the fall of communism, as well as the inheritance

of the centralized state subsidized health care system. However, total fertility rates vary widely among the former Soviet republics. Fertility rates range from well above the replacement level of 2.1 births per woman in the Central Asian republics to close to one birth per woman in some of the European Soviet republics (Ukraine, Russia, Belarus, and the Baltic countries) (WHO, 2005a). Overall, childbearing rates have fallen substantially in all countries, particularly during the late 1990s (Figure 4.1.1).

Many recent fertility analyses have been performed in terms of age specific and total fertility rates. The total fertility rate (TFR) is computed by accumulating the age specific fertility rates (ASFRs) in each age group and multiplying the sum by five (the number of year-exposures in each group). The TFR is thus defined as the average number of live births a woman would have during her reproductive lifetime (age 15–44 years) if she experienced the currently observed ASFRs. Numerators for the ASFRs were calculated by selecting live births that occurred during 3-year periods preceding the survey and grouping them (in 5 year age groups) by the age of the mother at the time of pregnancy outcome (calculated from the mother's reported date of birth). ASFR denominators represent the number of woman years lived by mothers in each specified 5 year age group during the same 3 year period.

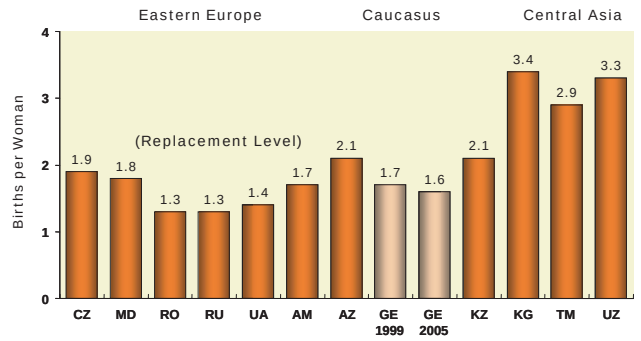
The TFR of 1.6 children per woman in Georgia for 2002–2005 was higher than in Eastern Europe, but lower than in the Central Asian republics (Figure 4.1.2). Survey estimates in most countries were either identical to or within survey sampling errors when compared with official estimates for the same period. The only clear exceptions were Georgia and Armenia, countries where survey estimates exceeded official estimates by at least 30% in 1999 (CDC and ORC/Macro, 2003). The underestimation of births in these two countries has been attributed to delays in registration of a child's birth by the parents (Serbanescu et al., 2001; Aleshina and Redmond, 2005). As in other former Soviet republics, the registration of births depends on the willingness of parents to request the official birth certificate from the civil registries, but in Armenia and Georgia, the birth registration fees

Figure 4.1.1 **Total Fertility Rates in the Newly Independent States, 1970-2003**



Source: WHO/Europe, European HFA Database, June 2005

Figure 4.1.2 **Total Fertility Rates among Women Aged 15–44 Years: Recent Survey Estimates in Eastern Europe and Eurasia**



Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.*
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan

were quite high and may have caused many families to delay certification of birth. (The birth certificate fee has since been abolished in Georgia.) Another contributing factor, which affected the estimation of birth rates and any other official population-based statistics, was the use of inflated denominators. Because denominators in the official rates were derived from projections of the 1989 census population without adjustment for out-migration, the resulting overestimation of the resident female population resulted in underestimation of the rates. In Georgia, this problem was minimized once the 2002 census figures became available, and efforts are underway to retroactively recalculate birth and death rates using these figures.

Recently, Georgia took additional steps to improve birth and death registration. In 2002, for example, Georgia enhanced the civil registration of births and deaths by adding a parallel system under which health facilities are required to forward individual birth or death records to sub-national public health centers. Individual records are then sent by these centers to the Georgia State Department for Statistics, where they are compared to records received from the civil registries that are based on certification requests initiated by families ([WHO and CMSI, 2003). As a possible consequence of this enhancement, the gap between survey- and official record-based estimates of fertility has narrowed (Figure 4.1.3). The remaining difference could be explained by several other factors, including 1) sampling variability (the lower bound of the 95% confidence interval of the total fertility rate calculated from the survey data is only marginally higher than the official rate for the corresponding years); 2) denominator bias (the slight overestimation of the female population enumerated by the 2002 census is still an issue because no out migration adjustments have been applied); and 3) misclassification of live births into fetal deaths at the health facility level (this very common practice from the days of the Soviet Union may still affect official statistics, but it has little influence on mothers' recalls of pregnancy outcomes) (Aleshina and Redmond, 2005).

ASFRs for the period 2002–2005 are shown in Table 4.1.1 and Figure 4.1.4. Similar to women in other

Figure 4.1.3 **Three-Year-Period Total Fertility Rate in Georgia Survey Estimates and Official Sources: 1999 and 2005**

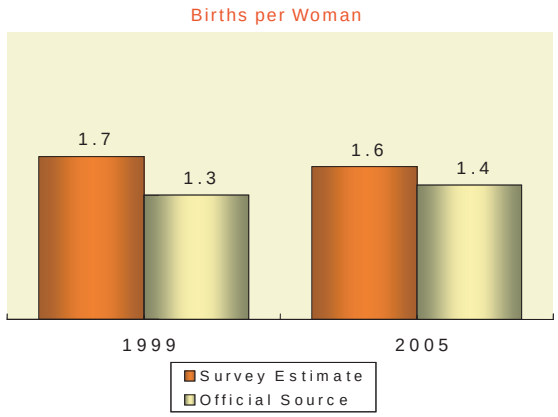
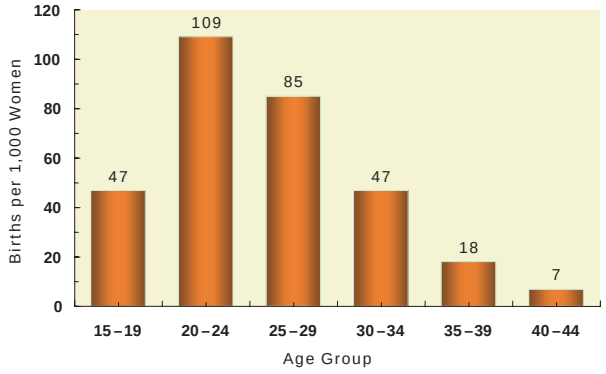


Figure 4.1.4 **Three-Year-Period (2002–2005) Age-Specific Fertility Rates per 1,000 Women Aged 15–44 Years:**

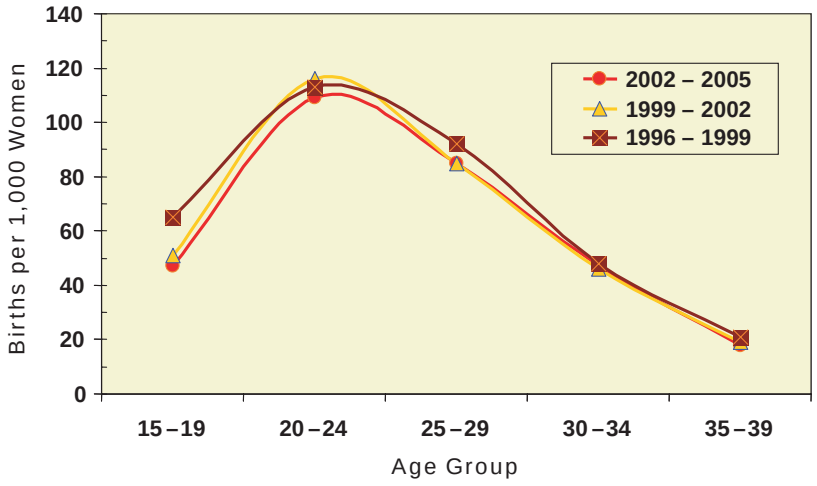


countries of the region, Georgian women initiate and complete childbearing at an early age. The highest fertility levels are among 20- to 24 year old and 25- to 29 year old women, accounting for 35% and 27%, respectively, of the TFR. Fertility among adolescent women (47 births per 1,000 women aged 15–19 years) is the third highest (and equal to the ASFR for 30- to 34 year old women), contributing 15% to the TFR. Women aged 35–39 and 40–44 make minimal contributions to total fertility; their ASFRs account for only 7% and 2%, respectively, of overall fertility.

Using data from the 1999 and 2005 Georgia reproductive health surveys, fertility trends can compared across three 3 year periods (Table 4.1.1 and Figure 4.1.5). Compared to rates during the two previous periods (1996–1999 and 1999–2002), fertility declines in 2002–2005 were hardly significant. The only notable decline was in the youngest age group. For example, between 1996–1999 and the most recent 3 year period (2002–2005), the ASFRs for 15- to 24 year old women (contributing to over 50% of the TFR in both time periods) declined by 28% and 6%, respectively, whereas the TFR declined by 8%. There was almost no change in fertility among older women. Thus, because the contribution to the overall fertility is low among older age groups, the slight decline in the TFR was almost exclusively due to declines in fertility rates of young adults.

Table 4.1.2 also shows the cumulative past fertility of women interviewed in the GERHS05 (calculated as the percentage distribution of women by the number of live births and stratified by the current age of each woman at the time of the interview). Overall, 41% of all women aged 15–44 years were childless at the time of the interview, but only 9% of married women had not had their first child. Although only 7% of all women reported giving birth before age 20, by age 29, 66% of them had given birth. About one in ten women remained childless at the age of 44. Conversely, one in two of the 13% of 15- to 19-year-olds who were married had already had her first child; four of five married 20- to 24-year olds had given birth; and 90% of women younger than 30 years had had their first child. Only 3% of married women remained childless after age 34 years. A minority of women had three or more children (15% of all women and 24% of currently married women).

Figure 4.1.5 **Three-Year-Period Age-Specific Fertility Rates for Three Time Periods All Women Aged 15–39 Years**



4.2 Fertility Differentials

Fertility among women living in urban areas, including Tbilisi, was on average almost 20% lower than among rural-dwelling women in the 3 year period preceding the interview (Table 4.2). Most of the difference between rural and urban fertility rates was due to higher ASFRs among rural residents aged 15–24 years. Fertility rates at age 25 and older were similar in rural and urban areas. By region, fertility rates were the lowest in Samegrelo (1.3 children per woman) and Tbilisi (1.4 children per woman); fertility was the highest in Samtskhe-Javakheti and Mtskheta-Mtianeti (2.0 children per woman), followed by Kvemo-Kartli (1.9 children per woman) (Figure 4.2.1). The highest adolescent ASFR was reported by residents of Kakheti, Kvemo-Kartli, and Guria (Figure 4.2.2), probably because the average age of first marriage and first birth is lower in these regions than in the rest of the country. Fertility differences according to education were more pronounced among younger women. Generally, peak fertility occurred at ages 25–29 among women with the highest educational attainment, whereas peak fertility among women with lower educational levels occurred at ages 20–24. Fertility rates of ethnic minorities, particularly among the Azeri minority (2.6 children per woman) were substantially higher than those of the Georgians, the major ethnic group (1.5 children per woman), due to much higher ASFRs among Azeri women aged 15–29 (Figure 4.2.3). Fertility rates were similar for internally displaced persons (IDP) (1.64) and non IDP women (1.56).

Figure 4.2.1 **Three-Year-Period (2002–2005) Total Fertility Rate by Region**

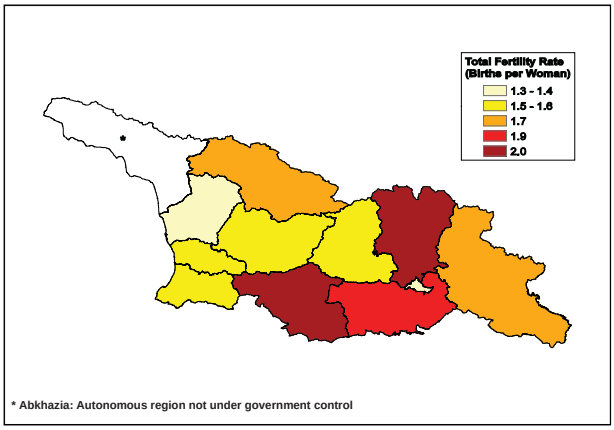


Figure 4.2.2 **Three-Year Period (2002–2005) Age-specific Adolescent Fertility Rates (ASFR) by Region**

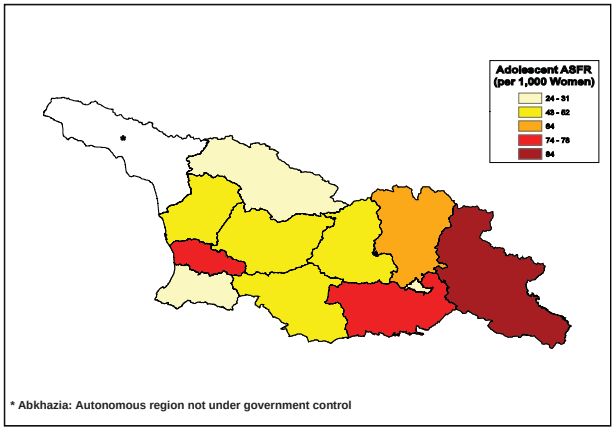
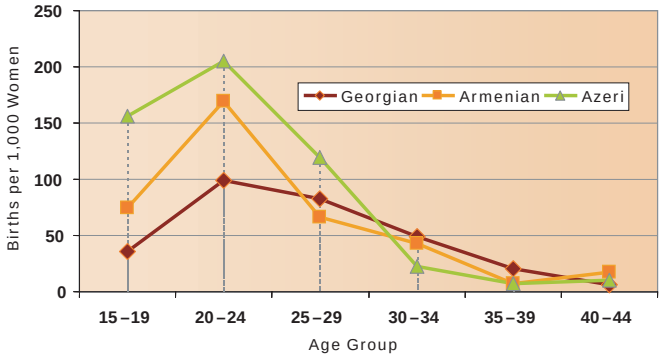


Figure 4.2.3 **Three-Year-Period (2002–2005) Age-Specific Fertility Rates by Ethnicity**



4.3 Nuptiality

Because the main exposure to the risk of pregnancy occurs among women who are married or in a consensual union, reproductive health behaviors are greatly influenced by marital status. Survey results showed that the median age at first marriage among women of reproductive age in Eastern Europe and Central Asia is between 20 and 22 years of age (CDC and ORC/Macro, 2003). Most countries of the region

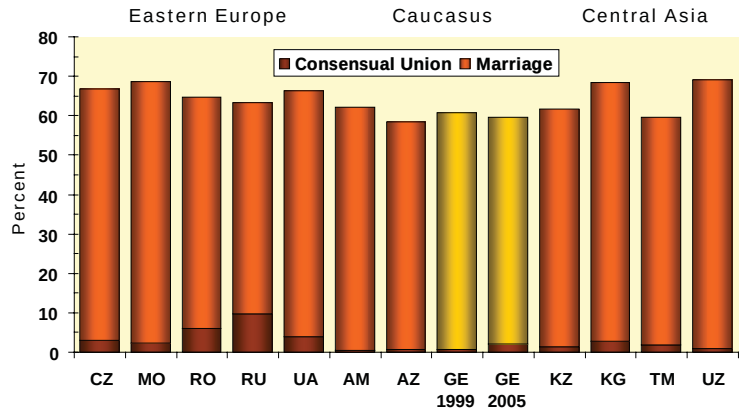
exhibit the highest fertility rates among currently married young adults, for two reasons: the probability of having a child is much higher among married women and couples typically have a strong desire to initiate childbearing soon after marriage (first birth typically occurs within 2 years after first marriage),. Thus, it is important to know the marital distribution by age group and the changes over time in age at first union and at first birth.

The proportion of currently married women in Georgia (58%) was comparable to that of other countries of the region (ranging from 54% in Russia to 68% in Uzbekistan). In addition, a small proportion of women (2%) were living in consensual unions, a rate that is similar to Central Asian countries, but much lower than in other countries of the region (10% of women in Russia, 6% in Romania, and 4% in Ukraine) (Figure 4.3.1). At the time of GERHS05, 6% of women were previously married (e.g., widowed, divorced, or separated from a spouse or from a partner in a consensual union). More than 1 in 3 women (35%) had never been married or lived with a partner. The slight decrease in the proportion of currently married women aged 15-44 between the 1999 and 2005 surveys (from 60% to 58%) is likely due to a decline in the number of very young people marrying (as discussed below) and to a recent increase in de facto (consensual) marriages (from 0.8% in 1999 to 2% in 2005).

The proportion of currently married women (either legal or consensual marriage) was higher in rural areas than in urban areas (64% vs. 56%) and in the regions of Shida Kartli (68%), Samtskhe-Javakheti (64%), and Kvemo Kartli and Kakheti (63%)(Table 4.3). The proportion of previously married women was slightly higher in urban areas than in rural areas (7% vs. 5%), as was the proportion of never-married women (38% vs. 31%).

Rates of marriage increased rapidly with age, from 13% among 15- to 19-year-olds to 46% among women aged 20–24, and to 68% among 25- to 29-year-olds; the rate reached a maximum of 82% for women aged 40–44. Rates of separation, divorce, and widowhood also increased with age, reaching a maximum of 11% among women aged 40–44. The proportion of never-married women decreased sharply with age, from 86% among 15- to 19-year-olds to 52% among women aged

Figure 4.3.1 **Percentage of Women Aged 15–44 Years Who Are Currently Married or in Consensual Unions: Recent Survey Estimates in Eastern Europe and Eurasia**



Source: CDC and ORC/Macro, 2003. Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan

20–24, 27% among women aged 25–29, and 15% among women aged 30–34. Among women aged 35 or older, about 9% of women had never been married.

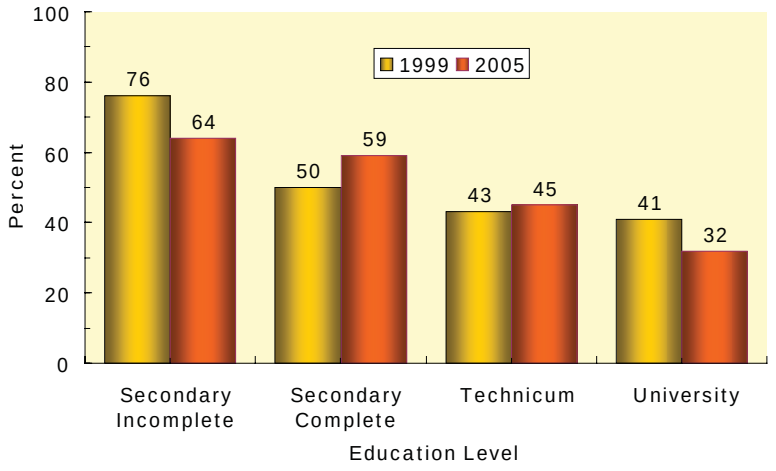
The proportion of women married or in union was significantly lower among women who did not complete high school (39%) than among women with a completed secondary or technicum education (68% and 72%, respectively) and those with university or postgraduate education (55%). In studying the impact of education on marital levels, it should be kept in mind that the youngest women are less likely to marry because they are still in school and the youngest age for official marital eligibility is 16 years of age. Among women aged 20–24, however, the likelihood of being in a marital relationship, either consensual or formal, was inversely correlated with education. For example, 59%–64% of 20- to 24-year-old women with high school education or less were in union, compared with only 32–45% of 20- to 24-year-olds with some postsecondary education (Figure 4.3.2). This finding lends credence to the view that women tend to postpone marriage until after achieving their desired education goals.

4.4 Age at First Intercourse, Union, and Birth

Age at first union and age at first sexual intercourse play an important role in determining fertility. Delays in these events decrease the number of reproductive years that a woman spends at risk of getting pregnant and increase the likelihood of having fewer children. Age at first birth also has a direct impact on fertility because postponing the first birth may contribute to the decline of the TFR.

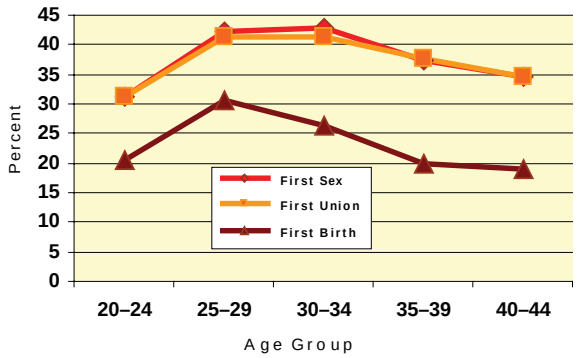
Information on age at first sexual intercourse, first union, and first live birth for all women are presented by age of the respondent at the time of interview in Table 4.4.1. The left side of the table shows the proportion of respondents within each 5-year age cohort who have ever had sexual intercourse (top panel), ever been in formal or consensual marriage (middle panel), and ever had a live birth (bottom panel) before reaching specific ages. The overall median age (age by which 50% of women aged 15–44 have experienced the event) and the median age within each age group are also displayed for each event. By comparing the proportion of women within different cohorts who experienced various events

Figure 4.3.2 **Percentage of Currently Married Women Aged 20–24 Years by Education Level: 1999 and 2005**



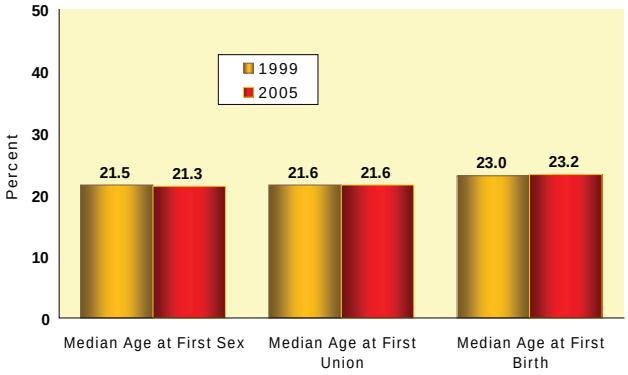
before age 20, it is possible to detect whether the average age of occurrence of each event has changed over time. For example, the proportion of women who had sexual intercourse before age 20 has increased from 36% among 40- to 44-year-olds to 42%–43% among 25- to 34-year-olds, while declining to 31% among 20–24 year-olds. However, there is little or no gap between sexual exposure and entry into a union. Across age cohorts, the proportion of respondents who reported sexual experiences before marriage remained essentially very low because the proportion of married women by age 20 is almost identical with the proportion of sexually experienced women (Figure 4.4.1). Similarly, median age at first intercourse for each cohort was only slightly lower than corresponding median age at first marriage. Thus, the 2005 survey confirms an earlier finding that in Georgia, sexual abstinence before marriage is a common practice. Apparently, traditional norms are strong and have not been altered by recent changes that have influenced young adult reproductive behaviors in the industrialized world and in some of the Eastern European former Soviet-bloc countries.

Figure 4.4.1 **Percentage of Women Aged 20–44 Years Who Had Sexual Debut, First Union, and First Birth before Age 20 by Current Age**



Among the youngest cohort, the decline in the proportion of women who married before age 20 may be a reflection of the recent trend away from early marriage. Since the number of women pursuing higher education attainment had also risen and the job opportunities for young qualified people had expanded, it is very likely that young Georgian women tend to delay the first union and first birth to a later age, after gaining qualifications and a steady income. This trend is particularly interesting and has potential implications for future fertility patterns and fertility control measures. Given that the youngest Georgian women tend to marry at slightly older ages than older cohorts, but continue to have a relatively early start (1–2 years after the first marriage) and end to childbearing, their fertility is likely to remain below the replacement level. However, compared with their counterparts in older cohorts, they will spend a slightly greater time at risk of premarital pregnancy and have a greater need for reversible, effective contraception.

Figure 4.4.2 **Median Age at First Sex, First Union and First Birth Among Women Aged 15–44 Years: 1999 and 2005**



In 2005, the median ages at first union and first birth were 21.6 and 23.2, respectively (Figure 4.4.2), similar to the corresponding figures documented by the 1999 survey.

Georgian women thus continue to marry considerably earlier than in Western Europe, where the average age at first marriage is about 27 years (UNECE, 2002). On the other hand, the median age at first intercourse was slightly younger in 2005 than in 1999 (21.3 vs. 21.6), which corroborates the finding that the proportion of young adults who reported premarital sexual intercourse, although very low, had doubled between the 1999 and 2005 surveys (from 1.3% in 1999 to 2.7% in 2005) while the proportion with any sexual experience remained fairly unchanged (70%).

Urban women reported the initiation of sexual activity, union, and childbearing almost 2 years later than rural women (Table 4.4.2). The highest median age for all these events was reported by women residing in the Tbilisi area, suggesting that the high cost of living, the presence of education opportunities, and a competitive career market in the capital may delay sexual debut, union, and childbearing. Interestingly, women residing in Racha-Svaneti, which is primarily a mountainous area, reported similarly high median ages for onset of sexual activity, union, and childbearing, but probably for entirely different reasons: Judging from the scarcity of women and men of reproductive age in the region (documented in the census and in the 2005 RHS), a possible explanation for delayed median onset of these events might be that the adult population, particularly the male population, is seeking higher education training and employment elsewhere. Differentials in median age of experiencing sexual activity, union, and childbearing were most significantly affected by education. The median age at first intercourse, first marriage, and first birth was 5–6 years older in women with university education compared to those who had not completed secondary education

4.5 Recent Sexual Activity

Current sexual activity is an essential indicator for estimating the proportion of women who are at risk of having an unintended pregnancy and are therefore in need of contraceptive services. It also has major implications for the selection of a contraceptive method that best suits the reproductive behavior and fertility preferences of each individual. As shown in Table 4.5, 35% of all women aged 15–44 who were interviewed in the GERHS05 reported that they had never had sexual intercourse. Additionally, 4% of all women were pregnant, and 3% reported postpartum abstinence at the time of the interview. For all women with sexual experience who were not currently pregnant or postpartum (58%), only 47% were currently sexually active (i.e., had had intercourse within the month preceding the interview). Thus, if we exclude respondents who have never had intercourse, 81% of sexually experienced women were currently sexually active (47% of 58%).

Among women who were married or living with a partner, 79% reported having had intercourse at least once within the past month, and 5% had had intercourse within the previous 3 months (Table 4.5). Conversely, only 10% of previously married women had had intercourse within the past 3 months. Most previously married women (70%) reported that their last sexual intercourse occurred 1 or more years ago, presumably while they were still married. Less than one percent of never-married women reported having had any sexual experience.

Almost 1 in 3 young adult women (i.e., those aged 15–24) reported sexual intercourse; of those, 18% reported their last sexual encounter within the past 30 days, and 10% were pregnant or in early postpartum. More than 80% of women aged 25 or older reported sexual experience. Of those, more than two-thirds had had intercourse within the past month.

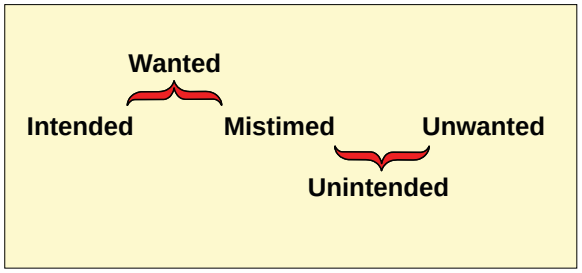
4.6 Planning Status of the Last Pregnancy

Accurate documentation of reproductive intentions is important for understanding a population's fertility rates, fertility-related behaviors, and contraception needs. Unintended pregnancies are more likely to be

associated with elective termination of pregnancy, inadequate prenatal care, unfavorable maternal behaviors, and pregnancy or perinatal complications (Brown and Eisenberg, 1995). Unintended pregnancy that results in a live birth is associated with physical abuse and violence during pregnancy and the 12 months preceding conception (Goodwin, 2000).

Conventional measures of unintended pregnancy are designed to reflect a woman's intentions before she became pregnant (Henshaw, 1998). Thus, for each pregnancy ended since January 2000, all respondents in GERHS05 were asked about the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either planned (i.e., wanted at the time it occurred), mistimed (i.e., occurred earlier than desired), unwanted (i.e., occurred when no children, or no more children, were desired), or unsure. Mistimed and unwanted pregnancies together constitute unintended or "unplanned" pregnancies (Westoff, 1976) (Figure 4.6.1).

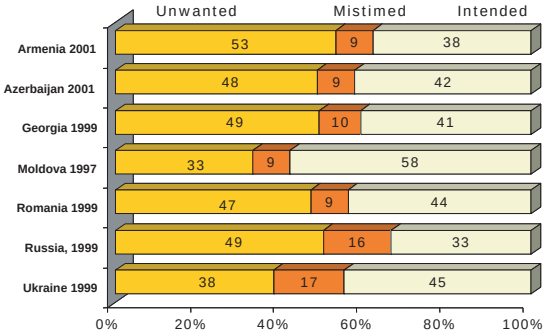
Figure 4.6.1 **Demographic Terminology for Pregnancy Intentions**



*Source: Westoff, 1976

Reliable information on pregnancy intentions, however, is difficult to collect. One common problem is the underreporting of pregnancies that ended in induced abortions. Because the majority of these pregnancies are mistimed or unwanted, unplanned pregnancies will be underreported to the extent that abortions are underreported. However, abortion underreporting does not appear to be a major concern in GERHS05 because abortion rates calculated from the survey exceeded recent officially reported levels. Another problem might be due to retrospective rationalization and ambivalence about pregnancy intention when the outcome is a live birth. Compared to self-assessments of pregnancy intention at the time of conception, retrospectively reported intentions after the child is born tend to be more positive (Miller, 1994). Thus, the data presented here represent conservative estimates of the true levels of unplanned conceptions.

Figure 4.6.2 **Planning Status of the Most Recent Pregnancy Among Women Aged 15–44 Years: Selected Countries in Eastern Europe and Central Asia***

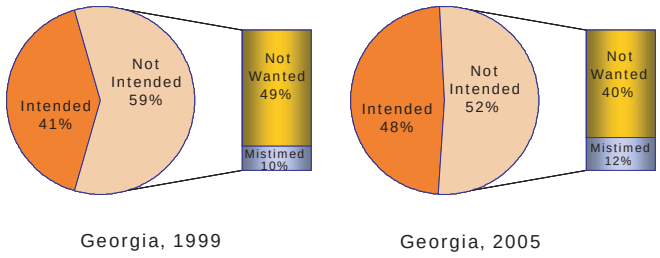


* Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*

Similar to other former Soviet-bloc countries, where reliance on abortion as a means of fertility control is common, the proportion of pregnancies in Georgia that are unplanned was quite high (Table 4.6 and Figure 4.6.2). In the GERHS05, 51% of women reported their

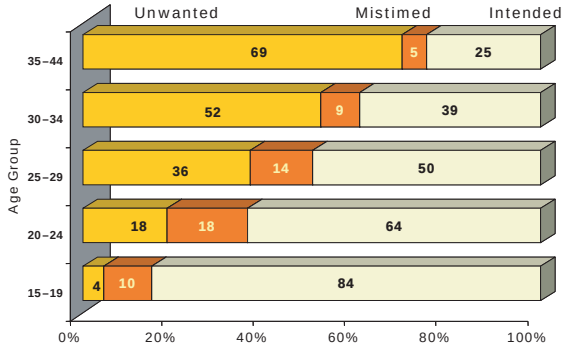
last pregnancy as unplanned. Moreover, the majority of unplanned pregnancies were unwanted; mistimed pregnancies were relatively infrequent. In the GERHS05, 12% of women reported their pregnancies as mistimed and 40% reported them as unwanted, meaning that 77% of unplanned pregnancies were reported as being unwanted rather than mistimed. Fewer women reported they experienced unplanned pregnancies in 2005, compared to 1999 (52% vs. 59%), and fewer unintended pregnancies were unwanted conceptions (Figure 4.6.3). The majority of women whose last pregnancies resulted in live births said those births were intended (95%). Conversely, all but a small percentage of women whose last pregnancy ended in induced abortion reported that their conceptions were unplanned (98%). A relatively high proportion (22%) of women whose last pregnancy ended in miscarriage or stillbirth reported that it was an unwanted conception. This is 11 times the proportion of women with live births who reported an unwanted pregnancy, suggesting that either unintendedness had a negative influence on pregnancy development and outcome or some of these outcomes may have been in fact induced abortions, misreported as other fetal losses because of the respondent's bias toward giving a socially desirable response. The relatively high unintendedness rate of these pregnancies was similar to that observed in the 1999 survey and in other countries in Eastern Europe (Serbanescu, 1995, 1998, 2001).

Figure 4.6.3 **Planning Status of the Most Recent Pregnancy (in the Last 5 Years) Among All Women Aged 15–44 Years: 1999 and 2005**



Both the proportion of pregnancies that were unplanned and the ratio between unwanted and mistimed conceptions varied with age and the number of living children. Among 15- to 19 year olds, most pregnancies were intended, and of those that were not, the majority were mistimed rather than unwanted (the unwanted to mistimed ratio for these women was about 1:2). Among women aged 20 years or older, more pregnancies were unintended, and the unwanted to mistimed ratio ranged from almost 1:1 among 20- to 24 year olds to almost 3:1 among 25- to 29 year olds, 6:1 among 30- to 34 year olds, and 13:1 among those aged 35 years or older (Figure 4.6.4). Thus, mistimed pregnancies were rapidly replaced by unwanted pregnancies with an increase in maternal age, primarily because the desire for birth-spacing is

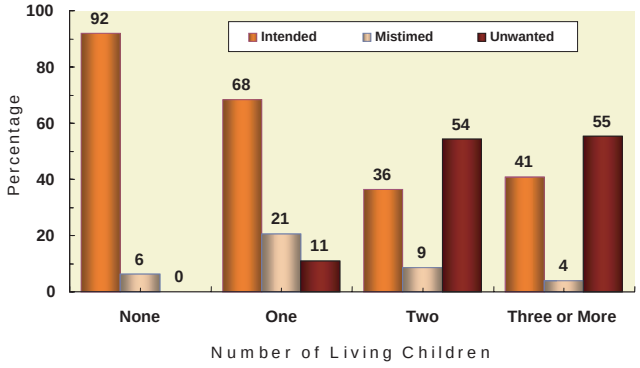
Figure 4.6.4 **Planning Status of the Most Recent Pregnancy, by Maternal Age among Women Aged 15–44 Years**



Due to rounding, categories don't always add up to 100%.

replaced by the desire to terminate childbearing. As a result, virtually all unintended pregnancies were unwanted at older ages. Similarly, women who had never had a live birth and women with only one child (presumably younger women) were less likely to report that their last pregnancies were unwanted than were women with two or more live births (Figure 4.6.5). Unintended pregnancy rates did not vary significantly with socioeconomic status, ethnic background, or IDP status, but were slightly higher among women with a technicum education than among women with university education.

Figure 4.6.5 **Planning Status of the Most Recent Pregnancy (in the Last 5 Years) by Number of Living Children: Married Women Aged 15–44 Years**



4.7 Future Fertility Preferences

The preference among women for small families is reflected not only in below-replacement fertility levels and high abortion rates, but also in the commonly stated desire to not have more children. Knowledge about fertility expectations in a population is essential for helping couples to avoid unplanned pregnancies and attain their desired family size. Public health officials and health care providers should always consider fertility preferences in their efforts to lower rates of unplanned pregnancy and induced abortion. The data presented in Table 4.7.1 and Figure 4.7.1 demonstrate that only about one in four women currently married or in consensual union wanted more children; an additional 6% were unsure if they wanted to have more. A substantial proportion (13%) reported that either they or their partners were infecund. Those women were not asked about their future fertility preferences. The intention to have no more children increased rapidly with increasing number of living children (Figure 4.7.2). Among women who had had three or more children, the majority (80%) were ready to terminate childbearing. Conversely, among those with no living children, only 1% said they did not want children. Similar rates were documented in the 1999 survey. Among women who wanted more children, the timing of the next birth was also influenced by parity. The majority of childless women wanted to have a child right away or within a year, whereas women

Figure 4.7.1 **Future Fertility Preferences of Married Women Aged 15-44 Years**

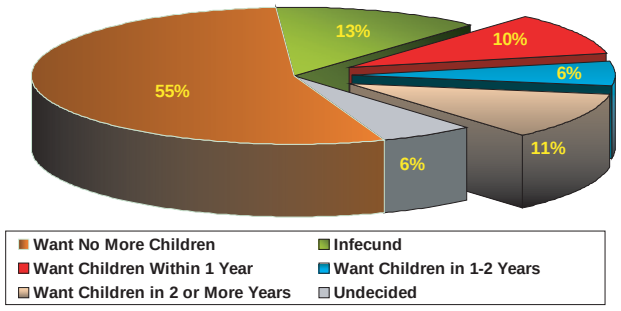
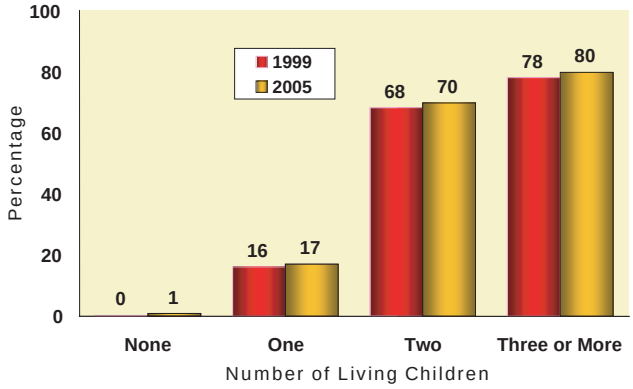


Figure 4.7.2 **Intention to Have No More Children by Number of Living Children Among Married Women Aged 15–44 Years: 1999 and 2005**



with one or more children wanted to have another child after 1 or more years.

In Eastern Europe, women tend to have had all the children they desire at a relatively young age, leaving them exposed to the risk of unplanned pregnancy for many of their reproductive years. Not surprisingly, young Georgian women were much more likely than women aged 30 or older to want more children (bottom panel of Table 4.7.1). The intention to have more children decreased from 81% among the youngest age group to 40% among 25- to 29 year olds and to less than 10% for women aged 35 and older. Even among those who desired additional children, most wanted to wait at least 1 year, with the exception of the very few women aged 35 or older who still wanted to have a (another) child right away.

When we restrict the study of fertility desire to married women who can get pregnant (i.e., fecund women), the inverse relationship with parity is even more striking. Overall, 63% of Georgian women who could conceive reported that they did not want to have more children, but this proportion increased from 19% among those with one living child to 92% among women with three or more children (Table 4.7.2 and Figure 4.7.3). Among women with one child, the desire to terminate childbearing was twice as high for urban women as for rural women (24% vs. 12%). It was also twice as high for women with postsecondary education when compared to the least educated women (21% vs. 11%). At any parity, the intention to terminate childbearing was directly correlated with age. This pattern is similar to the one documented in the 1999 survey and in other countries of the region (Figure 4.7.4) (CDC and ORC/ Macro, 2003).

The developing family planning program in Georgia needs to account for the fertility preferences of Georgian couples, in order to provide the most appropriate contraceptive methods for each couple's needs. Younger women, most of whom want to have one or more children, are more likely to need birth-spacing methods, whereas older women, the majority whom want to stop childbearing, need long term or permanent contraceptive methods.

Figure 4.7.3 **Percentage of Fecund Married Women Aged 15–44 Years Who Wanted No More Children, by Parity**

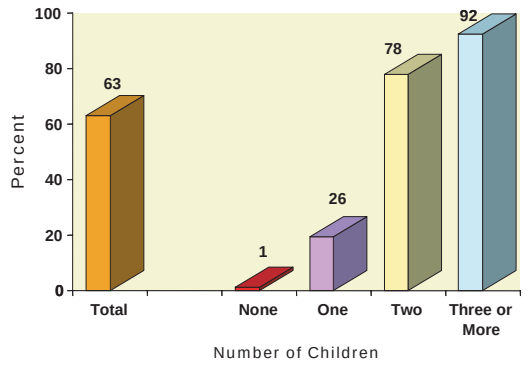
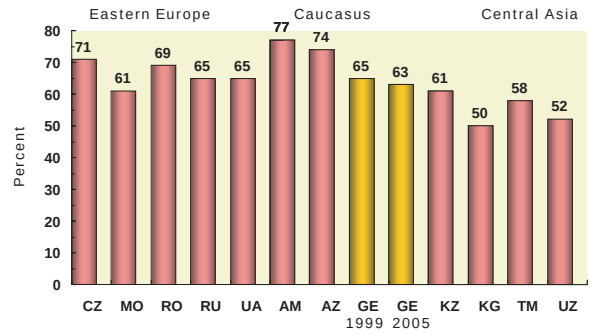


Figure 4.7.4 **Percentage of Fecund Married Women Aged 15–44 Years Who Want No More Children: Recent Survey Estimates in Eastern Europe and Eurasia**



Source: CDC and ORC/Macro, 2003. Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan

Table 4.1.1 Three-Year, Age-Specific Fertility Rates and Total Fertility Rates for Three Time Periods Among All Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Age-Specific Fertility Rate (per 1,000)*		
Age Group (Years)	2002–2005 GERHS05†	1999–2002 GERHS05‡	1996–1999 99GERHS¶
15–19	48	51	65
20–24	110	116	113
25–29	84	85	92
30–34	45	46	48
35–39	19	19	21
40–44	(7)	(1)	(7)
Total Fertility Rate (per Woman)	1.6	1.6	1.7

* Age at birth.

† Births occurring between March 2002 and February 2005.

‡ Births occurring between March 1999 and February 2002.

¶ Births occurring between December 1996 and November 1999.

( ) Time exposed partially truncated because not all cases had exposure throughout the period of analysis.

Table 4.1.2 Number of Children Born Alive by Current Age of Respondents Among All Women and Among Married Women Aged 15–44 Years
Reproductive Health Survey: Georgia 2005

		All Women					
		Age Group (Current Age)					
Number of Children Born Alive	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	40.8	93.3	62.2	34.3	19.9	14.3	10.0
1	15.6	5.6	24.2	22.8	18.2	13.5	11.0
2	28.7	1.2	12.2	33.5	44.0	44.5	43.4
3	10.9	0.0	1.5	7.7	14.2	20.3	24.0
4 or more	4.0	0.0	0.0	1.6	3.7	7.3	11.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,376	930	1,079	1,139	1,110	1,048	1,070
		Married Women					
		Age Group (Current Age)					
Number of Children Born Alive	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	9.2	50.2	21.1	9.8	5.2	3.3	2.9
1	22.2	41.1	49.9	29.4	18.3	12.9	8.9
2	45.1	8.7	25.8	47.5	54.2	51.9	47.3
3	17.1	0.0	3.2	10.9	17.6	22.9	27.3
4 or more	6.5	0.0	0.0	2.4	4.7	9.0	13.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,119	156	557	829	872	841	864

Table 4.2 Three-Year* Age-Specific Fertility Rates and Total Fertility Rates Among All Women Aged 15–44 Years by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Age-Specific Fertility Rate (per 1,000)†						Total Fertility Rate (Births per Woman)
Characteristic	15–19	20–24	25–29	30–34	35–39	40–44	15–44
Total	48	110	84	45	19	7	1.6
Residence							
Urban	37	94	81	51	20	7	1.5
Rural	63	131	87	39	18	7	1.7
Region							
Kakheti	83	104	85	35	17	11	1.7
Tbilisi	30	78	79	63	20	13	1.4
Shida Kartli	51	102	93	47	13	9	1.6
Kvemo Kartli	78	161	91	31	12	12	1.9
Samtskhe-Javakheti	48	166	113	46	13	6	2.0
Adjara	28	160	74	33	15	0	1.6
Guria	74	68	79	57	8	7	1.5
Samegrelo	43	96	78	15	36	0	1.3
Imereti	45	97	83	49	22	3	1.5
Mtskheta-Mtianeti	64	140	106	56	20	5	2.0
Racha-Svaneti	24	105	132	62	8	7	1.7
Education							
Secondary incomplete or less	70	162	60	21	11	10	1.7
Secondary complete	58	145	71	40	12	6	1.7
Technicum	26	98	71	32	20	8	1.3
University/postgraduate	24	81	101	63	26	7	1.5
Socioeconomic Status							
Low	61	116	86	48	26	6	1.7
Middle	45	113	74	40	17	8	1.5
High	28	96	106	54	13	7	1.5
Ethnicity							
Georgian	37	101	82	47	20	7	1.5
Azeri	158	201	118	21	6	10	2.6
Armenian	71	169	66	43	6	17	1.9
Other	68	122	133	30	35	0	1.9
IDP-Status							
IDP	59	104	58	62	39	0	1.6
Non-IDP	48	110	85	45	18	7	1.6

* March 2002–February 2005

Table 4.3 Current Marital Status of Women Aged 15-44 Years by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Marital Status					
Characteristic	Married	Consensual Union	Previously Married	Never Married	Total	No. of Cases
Total	57.5	2.0	5.8	34.7	100.0	6,376
Residence						
Urban	53.7	1.9	6.8	37.6	100.0	3,196
Rural	62.1	2.1	4.5	31.2	100.0	3,180
Region						
Kakheti	60.9	2.0	4.8	32.3	100.0	538
Tbilisi	50.0	3.1	6.7	40.1	100.0	1,431
Shida Kartli	65.9	1.8	6.9	25.4	100.0	430
Kvemo Kartli	59.4	3.8	7.9	28.9	100.0	576
Samtskhe-Javakheti	63.6	0.2	3.6	32.6	100.0	434
Adjara	61.3	0.7	3.1	34.8	100.0	490
Guria	54.6	1.0	4.9	39.5	100.0	388
Samegrelo	56.7	0.7	6.4	36.2	100.0	506
Imereti	59.7	1.2	4.7	34.4	100.0	782
Mtskheta-Mtianeti	59.0	3.6	6.7	30.7	100.0	374
Racha-Svaneti	52.1	0.0	6.5	41.5	100.0	427
Age Group						
15-19	12.0	1.3	0.4	86.3	100.0	930
20-24	43.0	2.8	2.1	52.1	100.0	1,079
25-29	66.0	2.1	5.2	26.7	100.0	1,139
30-34	73.8	3.1	8.4	14.7	100.0	1,110
35-39	78.4	1.9	8.7	11.1	100.0	1,048
40-44	80.9	1.0	11.0	7.1	100.0	1,070
Education						
Secondary incomplete or less	35.9	2.7	3.2	58.2	100.0	907
Secondary complete	65.7	2.1	5.9	26.3	100.0	1,786
Technicum	70.3	1.7	7.2	20.8	100.0	1,466
University/Postgraduate	53.2	1.8	6.0	39.0	100.0	2,217
Socioeconomic Status						
Low	57.5	2.1	6.9	33.6	100.0	2,277
Middle	57.8	1.7	4.9	35.6	100.0	3,028
High	56.8	2.6	5.8	34.9	100.0	1,071
Ethnicity						
Georgian	56.6	1.7	5.6	36.1	100.0	5,545
Azeri	67.5	6.5	3.4	22.6	100.0	292
Armenian	60.6	1.9	7.1	30.5	100.0	382
Other	62.5	4.3	12.2	21.0	100.0	157
Employment						
Working	54.9	1.1	12.2	31.8	100.0	1,422
Not working	58.2	2.3	4.0	35.5	100.0	4,954

Table 4.4.1 Percentage of Women Aged 15–44 Years Who Had Their First Sexual Relation, First Union, and First Birth Before Selected Ages by Current Age
Reproductive Health Survey: Georgia, 2005

	Age at First Sexual Intercourse					Has Had Sexual Intercourse	Never Had Intercourse	Median Age	No. of Cases*
Current Age	<15	<18	<20	<22	<25				
15–19	1.1	(9.8)	(13.7)	NA	NA	13.7	86.3	†	929
20–24	2.0	15.8	31.1	(42.5)	(48.2)	48.2	51.8	†	1,079
25–29	2.2	25.5	42.3	53.6	65.5	73.5	26.5	21.0	1,133
30–34	0.7	20.8	42.8	57.1	69.9	85.3	14.7	20.6	1,103
35–39	0.6	16.1	37.9	56.0	72.4	89.1	10.9	21.0	1,037
40–44	0.3	14.6	35.6	54.6	72.4	93.0	7.0	21.2	1,062
Total	1.2	16.8	33.2	45.2	55.6	65.3	34.7	21.3	6,343

	Age at First Union					Ever in Union	Never in Union	Median Age	No. of Cases
Current Age	<15	<18	<20	<22	<25				
15–19	1.1	(9.8)	(13.7)	NA	NA	13.7	86.3	†	930
20–24	2.0	15.8	31.1	(42.0)	(47.9)	47.9	52.1	†	1,079
25–29	2.4	24.7	41.3	53.1	65.0	73.3	26.7	21.4	1,139
30–34	0.6	20.0	41.4	55.6	68.8	85.3	14.7	21.1	1,110
35–39	0.7	15.8	37.6	55.4	71.7	88.9	11.1	21.4	1,048
40–44	0.3	13.2	34.6	53.7	71.2	92.9	7.1	21.5	1,070
Total	1.2	16.3	32.6	44.6	55	65.3	34.7	21.6	6,376

	Age at First Live Birth					Has Had Live Birth	Never Had Live Birth	Median Age	No. of Cases
Current Age	<15	<18	<20	<22	<25				
15–19	0.2	(4.2)	(6.6)	NA	NA	6.6	93.4	†	930
20–24	0.4	8	20.1	(32.3)	(37.5)	37.5	62.5	†	1,079
25–29	0.8	11.6	30.2	44.2	57.1	65.3	34.7	23.0	1,139
30–34	0	7.4	26.1	44.1	61.9	80	20	22.8	1,110
35–39	0.3	4.6	20	41	62.8	85.5	14.5	23.1	1,048
40–44	0.1	3.1	19.1	38.4	60.2	90	10	23.3	1,070
Total	0.3	6.4	19.9	33.5	46.3	59	41	23.2	6,376

( ) Time exposed partially truncated because not all cases had exposure throughout the period of analysis.

NA = Not Applicable

* The date of first sexual intercourse and date of first union exclude 33 cases not reporting correctly.

† Omitted because less than 50% in that age group had married by the age at the beginning of the interval.

Table 4.4.2 Median Age at First Sexual Intercourse, First Union, and First Birth by Selected Characteristics Among All Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

Characteristic	Median Age at First Intercourse	Median Age at First Union	Median Age at First Birth
Total	21.3	21.6	23.2
Residence			
Urban	22.1	22.5	24.1
Rural	20.5	20.7	22.3
Region			
Kakheti	20.2	20.5	22.4
Tbilisi	23.0	23.6	25.4
Shida Kartli	20.2	20.4	21.9
Kvemo Kartli	20.3	20.6	22.2
Samtskhe-Javakheti	20.0	20.2	21.8
Adjara	20.7	20.9	22.3
Guria	21.7	22.0	23.5
Samegrelo	22.4	22.7	24.1
Imereti	21.4	21.7	23.3
Mtskheta-Mtianeti	21.2	21.5	22.8
Racha-Svaneti	23.6	23.9	26.0
Education			
Secondary incomplete or less	19.1	19.3	20.3
Secondary complete	19.6	19.8	21.3
Technicum	21.1	21.5	23.0
University/postgraduate	24.4	24.7	26.4
No. of Cases	6,343	6,376	6,376

Table 4.5 Sexual Activity Status by Current Age for Women Aged 15-44 Years
Reproductive Health Survey: Georgia 2005

		Marital Status		
Sexual Activity Status	Total	Married/In Union	Previously Married	Never Married
Never had intercourse	34.6	0.0	0.0	99.4
Currently pregnant	4.4	7.4	0.3	0.0
Postpartum	2.6	4.4	0.1	0.0
Within the last month	47.3	78.9	4.4	0.2
1-3 months ago	3.2	4.7	5.7	0.1
Over 3 month ago but within last year	2.1	2.2	12.9	0.1
One year or longer	5.3	2.1	69.7	0.2
Unknown interval	0.5	0.2	6.9	0.0
Total	100.0	100.0	100.0	100.0
No. of Cases	6,376	4,119	386	1,871

		Age Group		
Sexual Activity Status	Total	15-24	25-34	35-44
Never had intercourse	34.6	69.5	20.7	8.7
Currently pregnant	4.4	6.3	5.6	1.2
Postpartum	2.6	3.5	3.7	0.7
Within the last month	47.3	18.2	59.0	68.6
1-3 months ago	3.2	0.7	2.7	6.4
Over 3 months ago but within last year	2.1	0.8	2.2	3.4
One year or longer	5.3	0.9	5.8	9.9
Unknown interval	0.5	0.0	0.4	1.1
Total	100.0	100.0	100.0	100.0
No. of Cases	6,376	2,009	2,249	2,118

Table 4.6 Planning Status of the Last Pregnancy by Selected Characteristics Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

Characteristic	Planning Status of Last Pregnancy				Total	No. of Cases
	Intended	Mistimed	Unwanted	Not Sure		
Total	48.4	11.5	39.6	0.5	100.0	2,744
Pregnancy Outcome						
Current pregnancy	87.7	8.9	3.4	0.0	100.0	302
Live birth	95.0	2.8	2.1	0.1	100.0	989
Induced abortion	1.4	19.3	78.7	0.7	100.0	1,306
Other pregnancy outcome*	69.4	6.2	21.7	2.7	100.0	147
Residence						
Urban	48.8	14.0	36.8	0.4	100.0	1,308
Rural	48.0	8.8	42.6	0.6	100.0	1,436
Age Group						
15–19	84.4	10.4	4.4	0.8	100.0	211
20–24	63.8	17.6	18.3	0.3	100.0	649
25–29	49.6	13.7	36.4	0.4	100.0	736
30–34	39.4	8.5	51.8	0.3	100.0	630
35–44	24.6	5.3	69.2	0.9	100.0	518
Number of Living Children						
0	91.9	6.3	0.0	1.8	100.0	52
1	68.4	20.5	10.9	0.2	100.0	834
2	36.3	8.7	54.2	0.7	100.0	1,346
3 or more	40.8	3.8	55.2	0.2	100.0	512
Education						
Secondary incomplete or less	46.4	9.5	43.8	0.3	100.0	294
Secondary complete	47.6	10.3	41.6	0.5	100.0	879
Technicum	39.8	9.2	50.7	0.3	100.0	641
University/postgraduate	55.3	14.6	29.5	0.6	100.0	930
Socioeconomic Status						
Low	46.5	8.5	44.8	0.2	100.0	998
Middle	49.2	11.8	38.5	0.6	100.0	1,262
High	50.0	16.0	33.3	0.7	100.0	484
Ethnicity						
Georgian	48.6	12.3	38.6	0.5	100.0	2,315
Azeri	47.0	6.1	46.4	0.5	100.0	175
Armenian	46.7	6.8	45.4	1.0	100.0	174
Other‡	49.0	9.7	41.3	0.0	100.0	80
IDP Status						
IDP	50.1	11.3	38.6	0.0	100.0	83
Non-IDP	48.4	11.5	39.7	0.5	100.0	2,661

* Includes pregnancies resulting in stillbirth, miscarriage or ectopic pregnancy.

† Age of the woman at the time of pregnancy outcome, except for 302 pregnant women for whom the age is that at the time of the interview.

‡ Includes Russian, Ossetian, Kisti, and other ethnic groups.

Table 4.7.1 Fertility Preferences by Number of Living Children and Age Group Among Married Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

		Number of Living Children*			
Preference for Children	Total	0	1	2	3+
Want more children	26.5	64.8	64.3	12.6	4.0
Want pregnancy right away	6.6	52.4	11.6	1.3	0.7
Want a child within a year	3.2	9.1	5.1	2.2	1.5
Want a child within 1–2 years	5.8	2.8	15.8	3.2	0.9
Want a child after 2 or more years	10.9	0.5	31.8	5.9	0.9
Undecided	5.8	0.5	6.9	7.2	2.7
Want no (or no more) children	55.0	0.8	17.1	69.7	79.7
Subfecund, infecund couple	12.7	33.9	11.7	10.4	13.6
Total	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,119	239	1,013	2,088	779

		Age Group					
Preference for Children	Total	15–19	20–24	25–29	30–34	35–39	40–44
Want more children	26.5	80.9	68.2	39.7	20.5	8.7	3.8
Want pregnancy right away	6.6	29.3	13.5	8.3	5.1	2.7	1.9
Want a child within a year	3.2	4.6	4.8	4.1	4.0	2.1	1.6
Want a child within 1–2 years	5.8	12.9	14.6	8.9	6.0	2.2	0.3
Want a child after 2 or more years	10.9	34.1	35.3	18.4	5.4	1.7	0.0
Undecided	5.8	9.3	9.3	10.7	6.8	3.1	1.0
Want no (no more) children	55.0	7.2	18.2	42.9	63.8	74.4	69.3
Subfecund, infecund couple	12.7	2.5	4.2	6.7	8.8	13.7	25.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,119	156	557	829	872	841	864

* Women who were pregnant at the time of the interview are classified as having one more child than the actual number.

Table 4.7.2 Percentage of Fecund Married Women Aged 15–44 Years Reporting They Want No More Children, by Number of Living Children and Selected Characteristics Reproductive Health Survey: Georgia, 2005

		Number of Living Children*			
Characteristic	Total	0	1	2	3+
Total	63.0	1.3	19.4	77.8	92.3
No. of Cases	3,622	150	889	1,890	693
Residence					
Urban	59.6	2.3	23.5	78.7	88.9
Rural	66.5	0.0	12.4	76.9	94.2
Age Group					
15–24	16.3	0.0	5.6	41.5	52.3
25–34	58.2	0.0	16.2	70.4	87.5
35–44	89.9	†	60.9	93.6	96.3
Education					
Secondary incomplete or less	66.3	†	11.3	70.2	95.3
Secondary complete	62.4	0.0	16.8	75.0	92.4
Technicum/university	62.7	2.1	21.4	80.5	91.1

* Women who were pregnant at the time of the interview are classified as having one more child than the actual number.

† Fewer than 25 cases in this category.

Chapter 5

INDUCED ABORTION

5.1 Induced Abortion in Georgia and Other Former Soviet-bloc Countries

Before the break-up of the Soviet Union in 1991, a characteristic feature of countries under Soviet influence was their heavy reliance on abortion as a means of fertility control. In these countries, abortion has long been readily available, whereas effective means of contraception have not. Viewed as a basic reproductive right of women in the former Soviet-bloc countries, abortion was legalized in the region well ahead of the Western European countries. Except for Romania—where abortion was illegal before 1990—women in the other ex-Soviet bloc countries had broad access to free-of-charge or affordably priced legal abortions. For the entire Soviet Union in 1989, the abortion-to-live-birth-ratio was 1.3:1, the abortion rate was 96 per 1,000 women aged 15–49, and the lifetime induced abortion rate was 3.3 abortions per woman. Russia, Belarus, and Ukraine had consistently reported the highest rates of abortion, whereas the rates in Central Asia were substantially lower (Goskomstat USSR, 1990).

The widespread use of abortion in the former Soviet Union resulted from many factors. Chief among these were the liberal government policies toward abortion, centralised medical systems that focused more on curative than on preventive care, and limited access to high quality methods of contraception. Before 1990, the medical establishments of these countries were relatively isolated from advances in western contraceptive technology such as the low-dose pill,

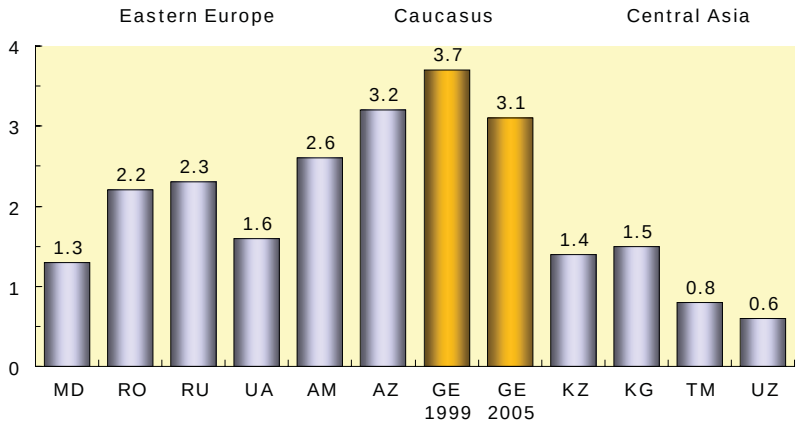
which has reduced the serious side effects of oral contraceptives. These factors continued to play a role in some of these countries, whose rates and ratios of abortion were among the highest in the world (CDC and Macro, 2003; Henshaw et al., 1999). Since the mid-1990s, however, the use of modern effective methods of contraception has increased, with a corresponding decrease in the abortion rates (Popov and David, 1999). Nevertheless, reliance on abortion as a means of fertility control is still high and, with the exception of Central Asia, all the independent countries that emerged from the collapse of the Soviet Union have abortion rates equal to or greater than their fertility rates.

In all the former Soviet Union countries, including Georgia, abortion is available without restrictions during the first 12–14 weeks of gestation. Beyond this gestational age, abortion is available only on medical or selected socioeconomic grounds (e.g. woman is widowed, homeless, or has low family income). Abortion is typically performed by trained physicians either in public or private clinics or hospitals. In most countries, the official cost of a legal abortion in a state-run facility is not covered by health insurance, but is relatively low. However, in many places, unofficial payments or payments for 'extra' services, such as anaesthesia, can increase the cost beyond what a low-income family may be able to afford.

Despite the similarities in availability and cost of abortions throughout the region, population-based surveys have documented considerable regional variations in total abortion rates. In previous surveys, the highest rates were in the Caucasus where, at current age-specific rates, a woman would typically have had more than three abortions during her lifetime in Azerbaijan and Georgia and more than two abortions in Armenia. The total induced abortion rate (TIAR) documented by the 1999 survey (3.7 abortions per woman) was probably as high as anywhere in the world. In Eastern Europe, the rates were variable, being higher in Romania and Russia (2.2 and 2.3 abortions per woman) than in Moldova and Ukraine (1.3 and 1.6) (Figure 5.1.1).

In countries with advanced health information systems, abortion data that are collected via retrospective surveys are viewed as less complete than the official estimates. In reality, however, the reproductive and

Figure 5.1.1 **Total Abortion Rates per Woman – Women Aged 15–44 Years: Recent Survey Estimates in Eastern Europe and Eurasia**

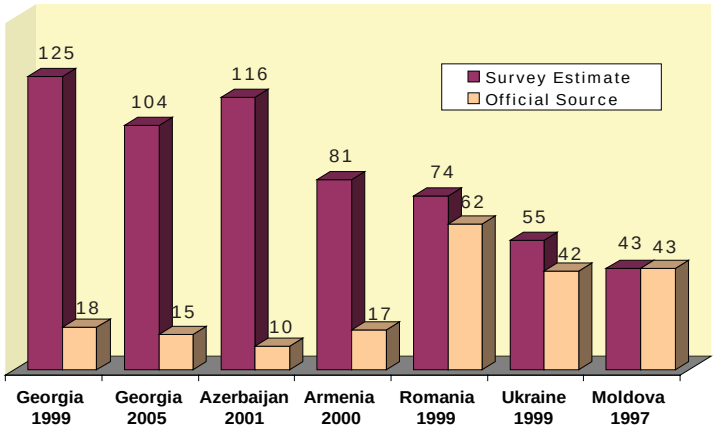


Source: CDC and ORC/Macro, 2003. Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan

demographic health surveys conducted in the region have documented substantial underreporting in the official statistics. Figure 5.1.2 compares abortion statistics from the surveys and from government sources in terms of the general abortion rate (GAR), a summary measure that indicates the annual number of abortions per 1,000 women of reproductive age. With the exception of Moldova, where there is good agreement between the abortion levels from both data sources, in all other countries the survey estimates exceed government rates by at least 20%. In the Caucasus, the survey estimates are several times higher than official rates—which suggests the presence of a breakdown in the government system for collecting abortion statistics. Overall, it appears that government statistics underestimate abortion levels in most of the surveyed countries.

Accurate estimates of abortion incidence are difficult to obtain in any country. The accuracy of abortion statistics depends on the presence and quality of health information infrastructure, the methodologies employed to measure abortion rates at health facility or population levels, the procedure's legal status, and societal and cultural norms (Alan Guttmacher Institute, 1999; Rossier, 2003). In countries where abortion is legal, abortion data are generally collected by government agencies that compile statistics from health facilities and abortion providers. Official statistics on abortion are available for all the former Soviet-bloc countries, but the post-Soviet era has seen a deterioration of state-run health facilities, an expansion of the private health sector, and a decline in monitoring and evaluation of health activities. The absolute number of abortions is most likely undercounted because of lack of reporting of procedures in the private sector, inherent problems related to registration data in state run health facilities (such as inaccurate classification of abortion procedures and failure to record or report them) and in some countries, the persistence of abortions performed outside clinical settings. Denominator inflation, as explained in the previous chapter, is another key factor, particularly in the countries that rely on long-term census projections to estimate their total population count. Additionally, the massive internal or external territorial disputes, population displacements, or out migration that all three countries in the Caucasus region have experienced may have caused significant disruptions in the collection of health statistics and population counts in recent years.

Figure 5.1.2 **General Abortion Rates (per 1,000 Women) in Eastern Europe: Survey Estimates and Governmental Sources**



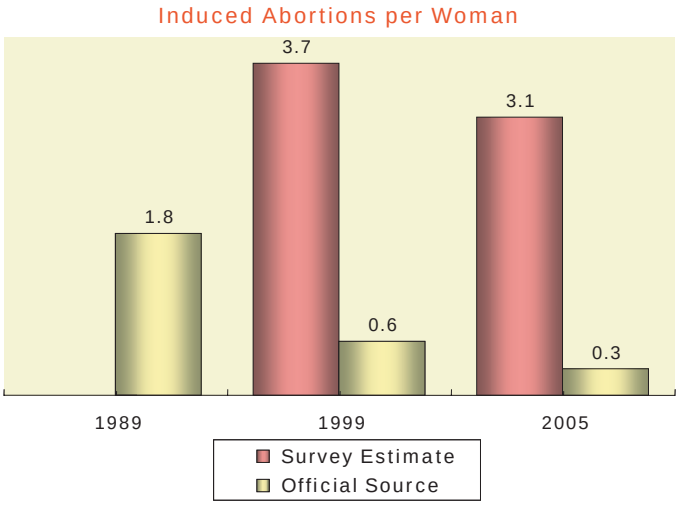
Source: CDC and ORC Macro, 2003. Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

In the former Soviet-bloc countries, several unique factors associated with the reporting of abortion made survey estimates more reliable than the official statistics. Population-based surveys have been widely used to obtain information on sexual and reproductive health, including abortion, particularly in the absence of quality health statistics collected from medical facilities The accuracy of abortion reporting in sample surveys is influenced by the nature of the survey, the wording of the questions asked, the legal status and public opinion of the procedure, and the respondents' background characteristics (Jones and Darroch Forrest, 1992; Smith et al., 1999). Because abortion has long been legal, readily available, and widely practiced in the region, social stigma, commonly an important factor in industrialized countries, does not seem to seriously affect reporting. To improve reporting, reproductive and demographic health surveys collect information on abortion in an indirect way, by asking respondents full pregnancy histories followed by questions about each pregnancy outcome. The main limitations of abortion reporting in surveys include the potential for omissions or misclassifications associated with abortions obtained outside the legal system, normative response biases (i.e. response modification so answers become more socially desirable); and recall biases. Despite these limitations, survey-based estimates of abortion rates and ratios are consistently higher throughout the region. An additional benefit is that they can be studied in a broader context of reproductive health behaviors (e.g., fertility and union dynamics, demand and unmet need for contraception).

5.2 Abortion Levels and Trends

Before the Soviet Union's breakup, the official abortion rate of 1.8 abortions per woman in Georgia was significantly lower than the USSR average of 3.3 abortions per woman, but it was still the highest in the Caucasus region (Goskomstat USSR, 1990). Reported vital statistics data indicate a steep decline in abortion rates since the break up of the former Soviet Union (from 1.8 abortions per woman in 1989 to 0.6 abortion per woman in 1997–1999 and 0.5 abortion per woman in 2002–2004), but this decline is not supported by RHS data (Figure 5.2.1).

Figure 5.2.1 **Trends in the Total Induced Abortion Rate: Survey Estimates and Governmental Sources**

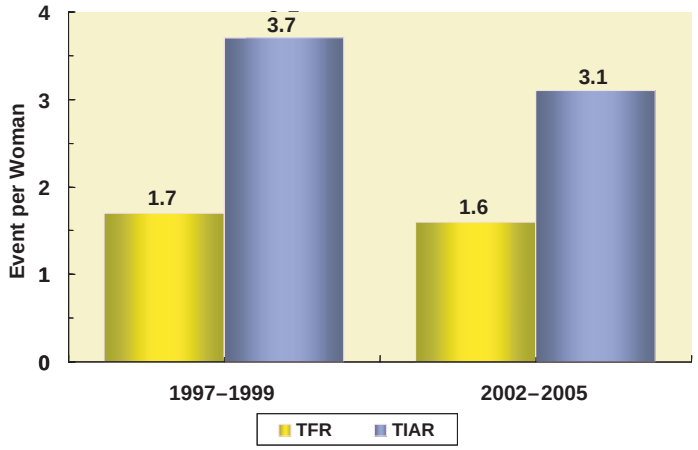


GERHS05 data show that abortion rates in Georgia are still higher than those found in most other recent surveys in Eastern Europe (Figure 5.1.1). The GERHS05 documented a TIAR of 3.1 abortions per woman, which is still high, even by Eastern Europe standards, but significantly lower than the rate documented 5 years ago (a 16% decline). The age-specific abortion rates (ASIARs) per 1,000 women aged 15–44 (Table 5.2.1) represent the proportion of women in each specific age group who terminated pregnancy by induced abortion within the 3-year period preceding the survey. The rates were calculated by using the age of the woman at the time of the pregnancy's termination. The TIAR was calculated by summing the ASIARs for the same 3-year period used in the analysis of fertility levels. Similar to the total fertility rate (TFR), the TIAR describes the number of abortions a woman would have had in her lifetime under the current ASIARs. The official statistics do not routinely calculate lifetime total abortion rates. Based on the most recent ASIARs for abortions performed in governmental facilities, as reported by the Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA), the estimated TIAR for the period 2002–2005 was only 0.5 abortions per woman, almost 75% lower than the pre-independence level. Compared with the survey estimates, the official ASIARs are generally low, but they are substantially lower for the three age groups that contribute to 75% of abortions: the ASIAR among women aged 25–29 (28 induced abortions per 1,000 women vs. 164 per 1,000), the ASIAR among women aged 30–34 (20 induced abortions per 1,000 women vs. 167 per 1,000), and the ASIAR among women aged 35–39 (12 induced abortions per 1,000 women vs. 110 per 1,000).

The GERHS05 data were also used to calculate the general abortion rate (the number of abortions per 1,000 women aged 15-44) in the 3 years preceding the survey. The general abortion rate was 104 abortions per 1,000 women aged 15–44 years, compared to only 15 per 1,000 reported in the official statistics (UNFPA, 2006). The survey-based estimate of the abortion-to-live–birth ratio was 1.5 induced abortions for each live birth (1.5:1), compared to the ratio reported by official statistics of 0.3 abortions for each live birth (UNFPA, 2006).

Based on survey estimates, in 2002–2005 the TIAR was nearly twice the TFR (3.1 vs. 1.6), whereas in 1997–1999 it had been more than twice higher (3.7 vs. 1.7) (Figure 5.2.2). Unlike fertility, which is most

Figure 5.2.2 **Changes in Total Fertility Rate and Total Abortion Rate Between 1999 and 2005**



concentrated at ages 20-24 years, abortions are most concentrated at ages 25–29 years (164 induced abortions per 1,000 women) and 30–34 years (165 per 1,000), the two age groups that account for 53% of the TIAR. The third highest age specific abortion rate occurred among women aged 20–24 years. With the exception of women aged 15-24, ASIARs are significantly higher than ASFRs, particularly among women aged 35 and older (Figure 5.2.3). These findings suggest that Georgian women achieve their desired family size at young ages, after which most pregnancies are unplanned and are intentionally terminated.

Abortion trends can also be estimated using the pregnancy history reports (Table 5.2.2 and Figure 5.2.4). In 1996–1999, the TIAR was 3.7 abortions per woman, but in 2002–2005 it had dropped to 3.1. Most of the decline occurred between 1996–1999 and 1999–2002 Age-specific abortion rates went down in all but one age group. The greatest declines occurred among women aged 15–19 (a 59% decline), followed by those aged 20–24 (a 24% decline), and those aged 25–29 (a 14% decline). The ASIAR of women aged 40–44 years, who made a minimal contribution to the overall abortion rate, increased slightly (8%). Decreases in abortion rates among women aged 15–24 years, although sizeable, had a lesser impact on the overall decline, since their contribution to the total abortion rate was relatively low (22% in 2002–2005 and 26% in 1996–1999).

Figure 5.2.3 **Three-Year-Period (2002–2005) Age-Specific Fertility and Abortion Rates per 1,000 Women Aged 15–44 Years**

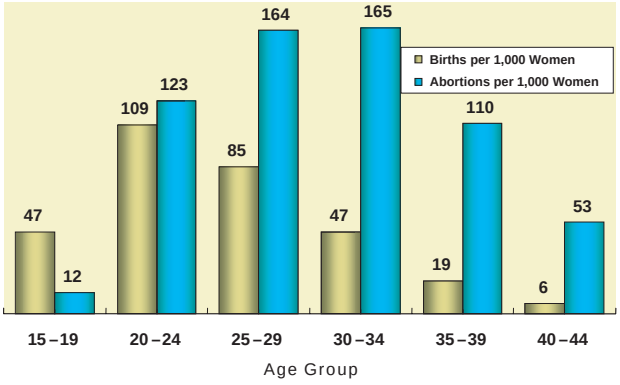
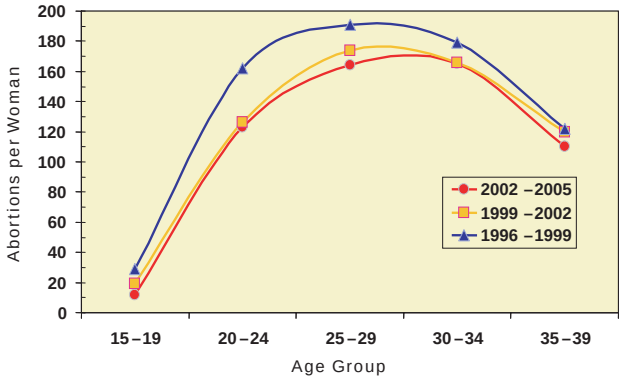


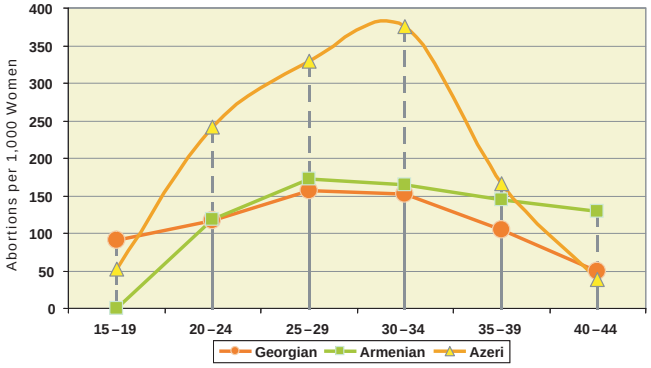
Figure 5.2.4 **Three-Year-Period Age-Specific Abortion Rates for Three Time Periods Among All Women Aged 15–39 Years**



5.3 Induced Abortion Differentials

As shown in Table 5.3.1, total and age-specific abortion rates among all women were equally high and varied little by the women's background characteristics, with the exception of the Azeri ethnic group, who reported substantially higher rates (Figure 5.3.1). Total abortion rates were higher in rural areas than in urban areas (3.5 vs. 2.8 abortions per woman), and

Figure 5.3.1 **Three-Year-Period (2002–2005) Age-Specific Abortion Rates, by Ethnic Group**



were highest among residents of Samtskhe-Javakheti (4.4 abortions per woman), Shida and Kvemo Kartli (3.9 and 3.7 abortions per woman, respectively), and Kakheti and Mtskheta-Mtianeti (3.8 abortions per woman) (Figure 5.3.2). The TIAR was highest for women with less than complete secondary education; on average, these women underwent 2.3 abortions more than women with a university education (4.7 vs. 2.4 abortions per woman).

As shown in Table 5.3.2, 43% of Georgian woman of reproductive age reported having had at least one induced abortion. The likelihood of having an abortion is positively associated with age because exposure to risk of pregnancy, particularly unintended pregnancy, increases with age. Although few adolescents reported any abortions (1.9%), by ages 20–24 the percentage rises to 18%; it increases to 50% among 25- to 34-year-olds and over 70% among women aged 35 and older. The likelihood of having an abortion is also positively associated with the number of living children. This is to be expected because Georgian women typically achieve their desired family size of one or two children fairly rapidly, after which they spend many years trying (often unsuccessfully) to avoid unintended pregnancy and subsequent abortions. The likelihood of having at least one abortion was somewhat greater among rural women and women who have at least completed secondary education.

As shown in Figure 5.3.3, the use of abortion was also heavily influenced by pregnancy order, which refers to the number of prior pregnancies, including live births, induced abortions, miscarriages, and other outcomes. Women with no prior pregnancies were the least likely to have pregnancies ending in abortion (1%) and the most likely to have a live birth (88%). The likelihood of abortion increases rapidly with the number of prior pregnancies. Although women with one prior pregnancy have a lower likelihood of having an abortion than a live birth (36% vs. 56%), the likelihood of resorting to abortion is significantly higher than that of carrying the

Figure 5.3.2 **Three-Year-Period (2002–2005) Total Induced Abortion Rate, by Region**

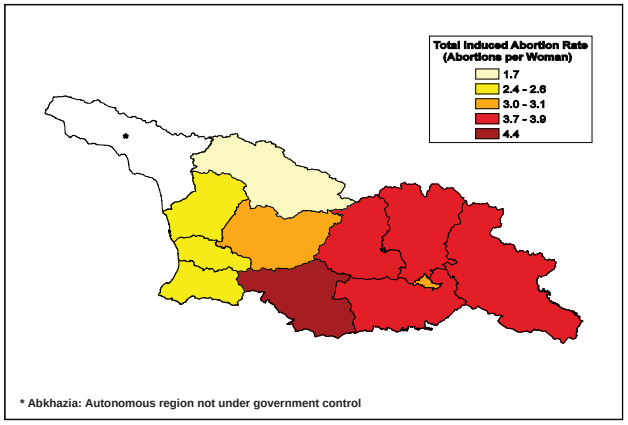
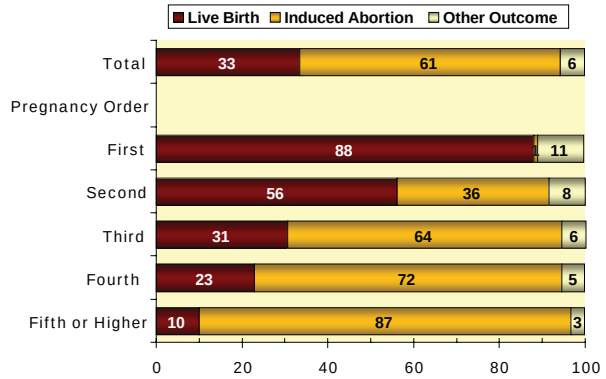


Figure 5.3.3 **Percentage Distribution of Pregnancies by Pregnancy Outcome by Pregnancy Order Among Pregnancies Occurring in the Last 5 Years**

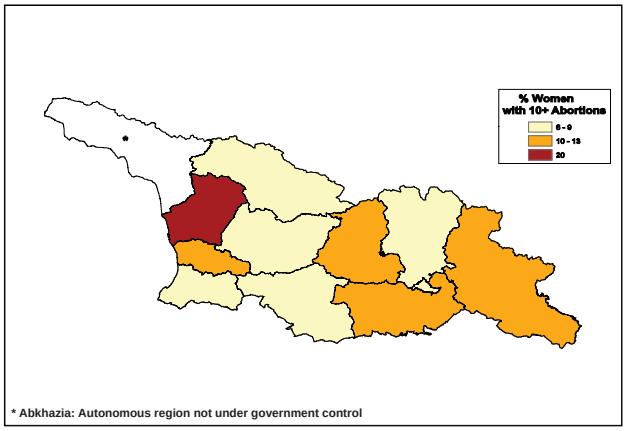


pregnancy to term among women with two or more prior pregnancies. Thus, the induced-abortion-to-live-birth ratio is directly correlated with pregnancy order, increasing from 0.01:1 among women with no prior pregnancy to 2.1:1 among women with two prior pregnancies, 3.1:1 among women with four prior pregnancies, and 8.7:1 among those with five or more prior pregnancies.

Among women who have ever had an abortion, 24% reported they had only one abortion, 20% had two abortions, 15% had three abortions, and 41% had four or more abortions, including 10% who had 10 or more lifetime abortions (Table 5.3.2 and Figure 5.3.4). Women with abortion experience reported, on average, 4.3 lifetime abortions. Women who reported multiple abortions were more likely to live in Samegrelo region (Figure 5.3.4), to be older, and to have high parity.

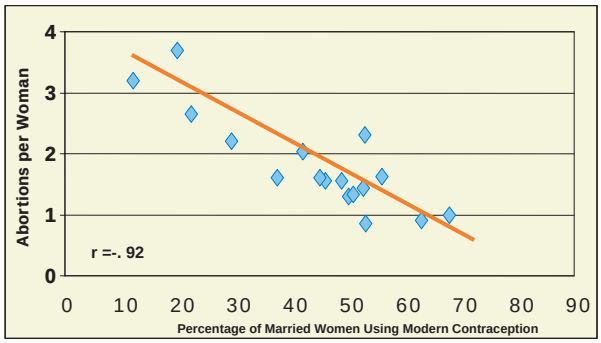
One means to reduce unintended pregnancies that result in abortion is through the provision of family planning services. In countries around the world, increases in the use of modern contraceptives have, over time, been associated with decreases in the numbers of abortions (Figure 5.3.5). As discussed in Chapter 9, potential demand for family planning services is highest among subgroups of women who have also reported higher rates of induced abortion (rural women, those who are less educated, and women of Azeri descent), a finding that indicates access to services is not equal and that the family planning program in Georgia needs to expand its reach.

Figure 5.3.4 **Percentage of Women with 10 or More Lifetime Abortions, by Region**



* Abkhazia: Autonomous region not under government control

Figure 5.3.5 **Total Induced Abortion Rate and Modern Contraceptive Use Among Married Women of Reproductive Age During the Late 1990s/2001 in Selected Countries in Eastern Europe and Eurasia***



* Source: Westoff, CF, 2005. *Recent Trends in Abortion and Contraception in 12 countries*

5.4 Abortion Services

As is the case with all the former Soviet republics, Georgia was subject to the liberal abortion legislation and regulations issued by the former USSR. Abortion on request has been available within the first 12 weeks of gestation since a Soviet Supreme Council decree on abortion was issued in November 1955.

The decree, entitled "On the Elimination of Induced Abortion Prohibition," reinstated the first Soviet abortion law, which was issued in November 1920 and revoked in June 1936. The 1955 law remained in force for many years, essentially unchanged except for several minor additions and modifications. In 1987, early abortions by electric vacuum aspiration after mandatory pregnancy testing were authorized by the Order of the Ministry of Health of the USSR No. 757 (June 5, 1987). These procedures were called "mini-abortions" because they are performed in the earliest stages of gestation (in women whose menstrual period is no more than 20 days overdue, roughly corresponding to a maximum of 6 weeks of pregnancy), involve minimal cervical trauma (i.e., do not require cervical dilatation and anesthesia), and use electrical vacuum aspiration rather than sharp curettage. The same order permitted mini-abortions to be performed outside hospitals, in ambulatory clinics. Starting in 1989, early pregnancy termination by vacuum aspiration was officially recognized as a legal abortion procedure, but it was reclassified as "menstrual regulation" and reported separately from the induced abortion statistics. Such reclassification, however, can be misleading because menstrual regulation does not require a pregnancy confirmation and is not regarded legally as an abortion (WHO, 1997). In all the former Soviet Union countries, menstrual regulation by vacuum aspiration is performed after pregnancy has been confirmed; the primary intent is to terminate an unwanted pregnancy, so it should be reported as a component of the total abortion statistics.

Additional regulations were issued to permit induced abortion during the first 28 weeks of gestation on medical and social grounds (USSR MOH, Order No. 234 of March 1982 and Order No.1342 of December 1987) and, briefly, to legalize "commercial" abortions in private clinics and for-fee sections of state hospitals (legalized in March 1988 by the USSR MOH and outlawed in December 1988 by a decree issued by the Council of Ministers) (USSR MOH, 1988; USSR Council of Ministers, 1988). Under the current law, induced abortion can be performed only by gynecologists, using either vacuum aspiration or sharp curettage; abortion procedures are permitted only in medical facilities that have been state-certified for performing abortion. Outpatient medical facilities (e.g., women's consultation clinics and private clinics) can perform induced abortion only by vacuum aspiration.

After asking respondents to report their complete pregnancy histories, the 2005 survey collected additional information on respondents' last four abortions performed since January 2000 via a detailed abortion history. For each abortion, questions were asked about the reason for abortion; the place where the procedure was performed; abortion registration and payments; use of local or general anesthesia and antibiotic prescriptions; number of nights, if any, spent in the hospital after the procedure (abortion patients are typically released the same day of the procedure if they do not have postabortion complications); and the presence or absence of early and late postabortion complications. Data were collected starting with the most recent procedure, in an attempt to minimize recall biases.

Virtually all abortions (99%) were reported to have been performed in the first trimester of gestation (Table 5.4.1). Most abortions (61%) were reported to be performed between 7 and 9 weeks, 23% were performed before 7 weeks, 16% were performed between 10 and 12 weeks, and less than one percent were reported as late abortions (13 weeks or more). Abortions after 9 weeks of gestation were reported more often by rural women, women with three or more children, women with less than complete secondary education, and women with low socioeconomic status (SES). Between 1999 and 2005, the proportion of late abortions (after 12 weeks of gestation) to total abortions had dropped from 10% to less than 1%, while more abortions were performed within 7–12

weeks of gestation (Figure 5.4.1). Since probability of complications increases with gestational age, these changes are likely to have played an important role in declining rates of morbidity associated with legal abortions (see below).

Of all abortions reported by survey respondents in the past 5 years, more than half (56%) were mini-abortions (Table 5.4.2 and Figure 5.4.2). Mini-abortions were more prevalent among respondents residing in Tbilisi (71%) and other urban areas (62%) than among rural residents (41%). The proportion of abortions classified as mini-abortions decreased somewhat with woman's age and increased directly with education and SES.

By law, all abortions must be performed in hospitals, ambulatory clinics, or cabinets (offices), by gynecologists. As shown in Table 5.4.3, most induced abortions occurring in 2000 or later were performed in gynecological wards (57%); forty percent were performed in state-run ambulatory units, such as women's consultation clinics (WCCs); and only 3% were performed in private clinics. Abortions performed in WCCs were more prevalent in Tbilisi and other urban areas (58% and 44%) than in rural areas (29%). In Tbilisi, abortions performed in WCCs outnumbered those performed in hospitals (58% vs. 39%), whereas abortions among women from other areas were more likely to take place in hospitals. The proportion of abortions performed in private clinics and in WCCs increased with education and SES. Early abortions (i.e., mini-abortions) performed by vacuum aspiration were slightly more likely to occur in WCCs than in hospitals (52% vs. 45%). About a fourth of abortions by dilatation and curettage (D&C) were performed in WCCs, although such ambulatory clinics are not licensed to perform these procedures. Thus, D&C abortions performed in ambulatory clinics, along with abortions performed outside medical facilities, are likely to substantially contribute to the underreporting of abortions by the Ministry of Health.

Less than one percent of pregnancy terminations were reported to have taken place outside the health system; however, the majority of those abortions

Figure 5.4.1 **Gestational Age at the Time of Pregnancy Termination Among Abortions Performed in the 5 Years Prior to the Survey: 1999 and 2005**

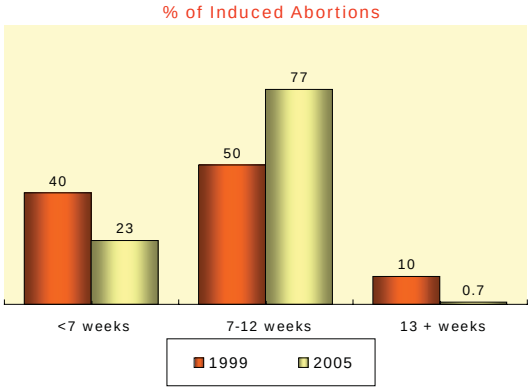
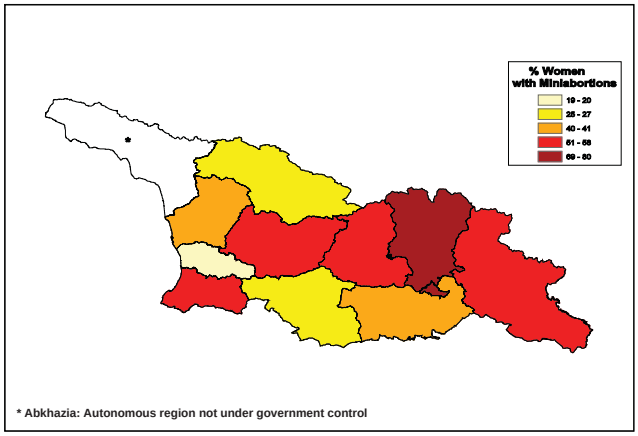


Figure 5.4.2 **Percentage of Women with Mini-abortions in the Past 5 Years, by Region**

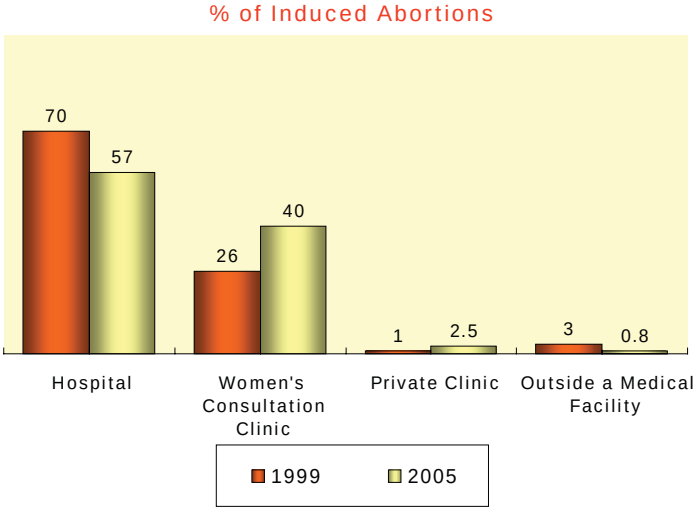


were performed by either D&C or vacuum aspiration, suggesting that they were performed by qualified physicians at either their homes or the respondents' homes (data not shown). Because abortions performed outside medical facilities (either self-induced, performed by lay persons, or performed by doctors outside the health system) are illegal, it is likely that women were reluctant to admit these outcomes, in spite of the interviewer's assurance of anonymity. Therefore, this figure is probably an underestimate of the proportion of abortions performed outside the health facilities.

Compared to 1999, fewer abortions in 2005 were performed in hospitals (gynecological wards) and more in WCC, perhaps as a result of the overall decline in the gestational age at the time of pregnancy termination (Figure 5.4.3). Notably, fewer abortions were performed outside medical facilities in 2005 compared to 1999 (0.8% vs. 3.2%) and more abortions were performed in private clinics, but the overall contribution of the private sector remains very low (2.5% vs. 1%).

Almost half (42%) of abortions were preceded by ultrasound exam (Table 5.4.4). Ultrasound screening was more likely among women in Tbilisi (75%) than in other urban areas (38%) or rural areas (26%) and among those with a high SES (65%). Twice as many mini-abortions as D&C abortions were preceded by ultrasound exam, which suggests that the exam may have been performed for pregnancy confirmation and assessment of gestational age. Similarly, the exam was more commonly used for abortion procedures that took place in ambulatory settings (either WCCs or private clinics) than in hospital gynecologic wards. Overall, 4% of women had the gender of the fetus determined during the ultrasound exam, though this type of assessment is very difficult during the first trimester of pregnancy. Women with three or more living children, those with low education level and of Azeri or Armenian ethnic descent, and women with gestational age of 10 or more weeks were more likely to have known the gender of the fetus after the ultrasound exam.

Figure 5.4.3 **Location of Abortions Performed in the Last 5 Years Prior to the Survey: 1999 and 2005**



Almost 1 out of 4 abortions (23%) were reportedly due to method failure (Table 5.4.5). Over 80% of women who were using contraceptive methods at the time of getting pregnant reported the use of traditional methods. Rural women, women with low education and SES levels, and women of Azeri or Armenian ethnic background were the least likely to report contraceptive use (mostly traditional methods) before the aborted pregnancy.

In Georgia, almost all abortions are performed for a fee (which varies from one facility to another). Reported abortion payments were lower among rural women than urban women, and among abortions performed outside of Tbilisi, and increased directly with education and SES. At the time of the survey, mean charges for an abortion procedure were almost 29 lari (about US$16.00). The amount paid for an abortion ranged from no payment to over 100 lari (Table 5.4.6). Only 1.6% of abortions were performed at no charge; 28% of abortion payments were 24 lari or less, 50% were between 25–34 lari, 19% were between 35 and 100 lari, and just under one percent was more than 100 lari.

On average, women in urban areas, including those living in Tbilisi (Figure 5.4.4), those with university training, and those with high SES, paid more for an abortion than other women. The cost of abortions performed at 10 or more weeks of pregnancy was 28% higher than abortions performed in the first 9 weeks of pregnancy. The average abortion payment did not vary by type of medical facility, but a D&C abortion was, on average, almost 20% more costly than a mini-abortion.

Between 2000–2005, 50% of abortions were performed with local (cervical) anesthesia, 8% with intravenous anesthesia, and 40% without any anesthesia (Figure 5.4.5). Compared to 1999, a greater proportion of abortions were performed with some form of anesthesia, which may have contributed to a reduction in morbidity associated with legal abortion (see below) The likelihood of receiving anesthesia was higher in urban areas than in rural areas and inversely correlated with the patient's age, increased with the

Figure 5.4.4 **Mean Payment for an Abortion Obtained in the Past 5 Years, by Region**

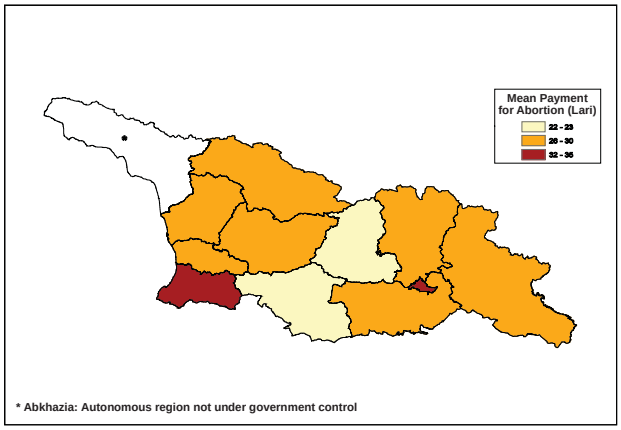
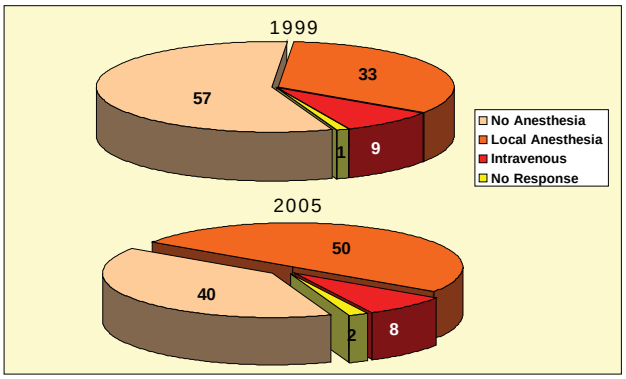


Figure 5.4.5 **Type of Anesthesia Provided During Abortion Procedures Among Abortions Performed in the 5 Years Prior to the Survey: 1999 and 2005**



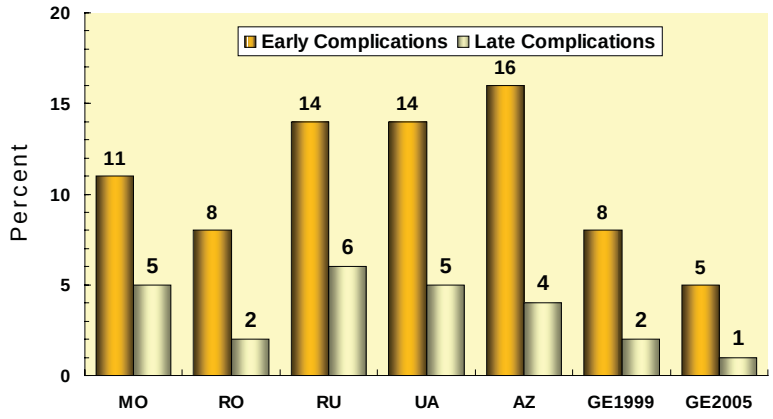
respondent's education and SES, and was directly related to gestational age (Table 5.5.1). Anesthesia rates for abortions performed by D&C were not significantly different from those for mini-abortions performed by vacuum aspiration (59% vs. 58%).

5.5 Abortion Complications

Although standard surgical abortion is remarkably safe when compared to childbirth or other surgical procedures, it has an inherent risk of complications (Cates, 1982). Legally induced abortions are associated with some risk of postoperative complications, the incidence and severity of which are strongly correlated with age of gestation, parity, woman's age, surgical procedure, operator's skill, type of anesthesia, and preexisting pathology (Henshaw et al., 1999). Abortions performed at 7 to 9 weeks of gestation have significantly fewer complications than those performed at 10 and 14 weeks. Similarly, abortions performed by vacuum aspiration have fewer complications than the D&C procedure. Legality alone does not make the procedure safe. Shortage of equipment, crowded facilities, poor hygienic conditions, and inadequate standards of care may increase the risk of post-abortion complications. These factors may turn women seeking pregnancy termination away from hospitals or may increase the waiting time between an initial consultation and admission to a designated facility. When delays in hospital admission place the gestation age beyond the 12-week legal limit, women may seek an illegal, risky abortion outside a licensed facility. Unsafe abortion carries a high risk of mortality and morbidity. Each year, 26% of maternal deaths in Eastern Europe and the former Soviet Union are abortion-related, compared to 13% worldwide (WHO, 2004). Official statistics on abortion-related mortality in Georgia are scarce, but 37% of maternal deaths in 2004 were due to sepsis, including some abortion–related cases (UNFPA, 2006).

Reproductive health surveys conducted in the region asked all respondents who had abortions in the 5 years preceding a survey about the occurrence of medical complications after pregnancy termination, but did not obtain data on abortion-related mortality. Survey estimates of postabortion complications are usually based on symptoms or conditions reported by respondents and therefore may be less accurate than hospital-based statistics. As shown in Figure 5.5.1, the rates of early abortion-related complications (within

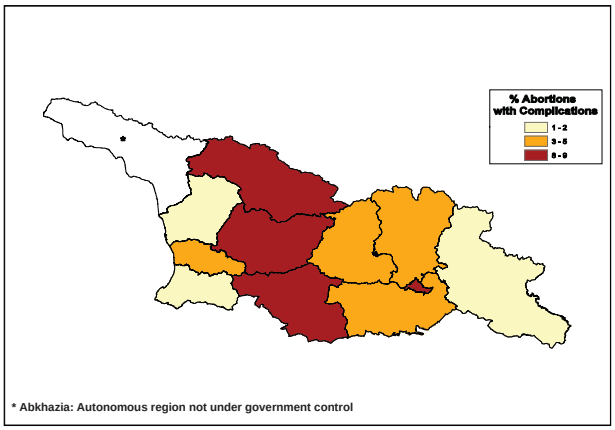
Figure 5.5.1 **Prevalence of Early and Late Post-Abortion Complications: Eastern Europe RHS Survey Data**



6 months) and late complications (6 months or later) ranged from 5%–16% and 1%–6%, respectively. These rates are high relative to those reported for first-trimester abortions in the United States (0.9%) and France (3%) (Hakim-Elahi, et al., 1990; Thonneau et al., 1998).

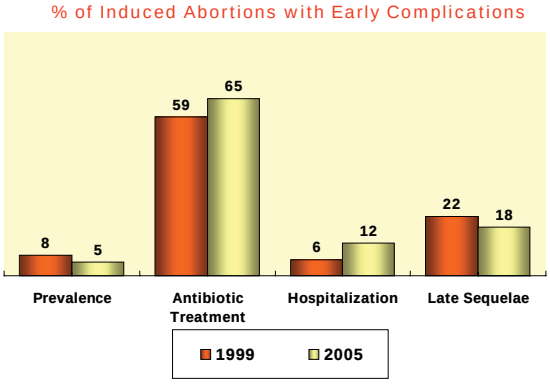
The 2005 survey in Georgia showed that 6% of all abortions performed since 2000 were followed by immediate complications (5%) or late sequelae (1.3%) (Table 5.5.1). Reports of early and late complications did not vary significantly by respondents' background characteristics, but there was some regional variation. Between 8% and 9% of women in Tbilisi, Imereti, Samtskhe-Javakheti, and Racha-Svaneti reported early or late postabortion complications, compared to only 1%-2% in Adjara, Samegrelo and Kakheti (Figure 5.5.2). The prevalence of early complications increased by 70% after 10 weeks of gestation and was 50% higher after D&C procedures than after mini-abortions.

Figure 5.5.2 **Percentage of Women with Early or Late Post-Abortion Complications, by Region**



The prevalence of postabortion complications was lower in 2005 than in 1999; only 6.3% of pregnancy terminations were followed by early or late complications in 2000–2005, compared to 10% in 1994–1999, a 37% decline (Figure 5.5.1). The decrease in abortion morbidity can be largely attributed to an increase in the level of mini-abortions (from 40% in 1999 to 56% in 2005), which are usually performed through vacuum aspiration and are followed by fewer complications. Another risk factor that is strongly associated with morbidity from legal abortion is gestational age at the time of the abortion. Between 1999 and 2005, the proportion of total abortions that were late abortions (after 12 weeks of gestation) dropped from 10% to less than 1%. Also, changes in clinical protocols may have also reduced the risk of complications. For example, 32% of all abortions were followed with antibiotic treatment in 2005, compared to just 24% in 1999; during the same period, treatment for early abortion complications increased from 59% to 65% (Table 5.5.1 and Figure 5.5.3) and the use of anesthesia increased from 42% to 58%. The percentage of abortion recipients that were hospitalized for postabortion complications doubled, from 6% in 1999 to 12% in 2005. Perhaps as a result of better management of early complications, fewer abortions with early complications

Figure 5.5.3 **Prevalence and Characteristics of Early Abortion Complications Among Abortions Performed in the 5 Years Prior to the Survey: 1999 and 2005**



were followed by late complications (from 22% in 1999 to 18% in 2005).

Most of the early complications involved prolonged pelvic pain (52%), severe or prolonged bleeding (49%), high fever (32%), and pelvic infection (29%); 5% of complicated abortions had perforations of the uterus (Table 5.5.2). With the exception of uterine perforation, little information is available on the severity of early complications. As discussed previously, only 12% of immediate complications required one or more nights of hospitalization.

5.6 Reasons for Abortion

The life circumstances which influence a woman's decision to have an abortion provide evidence of how barriers to family planning services may affect women's lives. Women's reported reasons for ending pregnancies have been consistent in the region (Figure 5.6.1). Most of the abortions in the five years preceding the surveys were obtained because a woman wanted no more children or because the family socioeconomic circumstances could not support another child. Overall, between 66% and 95% of abortions were for these two reasons (CDC and Macro, 2003).

Similarly, the GERHS05 documented that most induced abortions (63%) are sought because of the woman's desire to limit childbearing (Table 5.6 and Figure 5.6.2). Nearly 1 in 5 abortions (19%) were obtained because the woman wanted to space childbearing, while 15% were due to of economic or social reasons (e.g., low income, unemployment, fear of losing a job, or crowded living conditions). Only 1.4% of abortions took place for maternal health reasons (i.e., pregnancy was threatening the woman's physical or mental health), and 1% took place because of fetal defects or potential risks for the baby. Less than one percent of women reported partner-related reasons (e.g., the partner objected to the pregnancy). Compared to 1999, women in 2005 were less likely to have abortions for socioeconomic reasons

Figure 5.6.1 **Most Important Reason for Having an Induced Abortion Among Women Aged 15–44 With at Least one Abortion in the Past 5 Years: Eastern Europe RHS Survey Data**

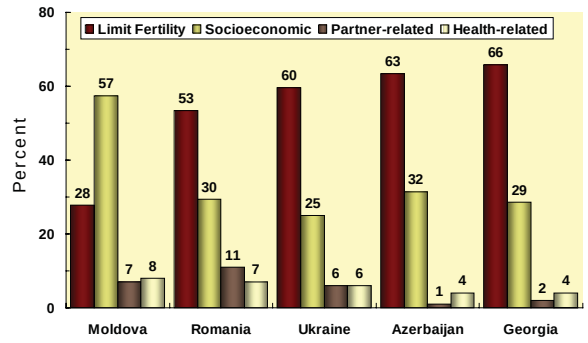
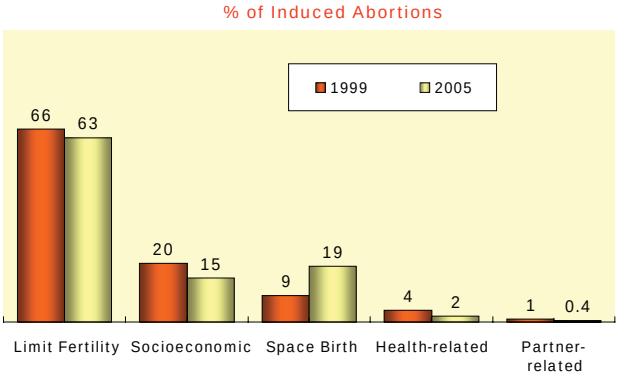


Figure 5.6.2 **Most Important Reason for Pregnancy Termination Among Abortions Performed in the 5 Years Prior to the Survey: 1999 and 2005**



and more likely to have them for spacing the next birth, perhaps as a result of the recent economic progress in the country.

The use of abortion for limiting childbearing was mentioned slightly more often by rural women (who already have a higher mean number of living children than urban women) and women over age 34 (76%), who also have more children, on average. A woman's desire for no (more) children as a reason for abortion was strongly correlated with pregnancy order, from 14% among women pregnant for the second time to 41% among women with two previous pregnancies and 76% among those with four or more previous pregnancies. Use of abortion for spacing the next birth was more common among urban residents, women aged 15-24 years, and those with one previous pregnancy. Socioeconomic reasons were reported more often in urban areas, especially in Tbilisi, where the cost of living is more expensive and housing shortages are a growing problem.

Thus, women seeking abortions seem to be mostly motivated mainly by family size and socioeconomic impact the family members, especially their children. The primary reason given for having abortions was "wanting no more children," which implies that these pregnancies were unintended, an indication of insufficient family planning services in the country. Furthermore, the proportion of women reporting use of abortion for limiting childbearing changed relatively little between 1999 and 2005. Survey findings also suggest that women independently make the decision to have an abortion or are in agreement with their partner. Partner objection to pregnancy was an uncommon reason for abortion, regardless of the respondent's background characteristics.

In conclusion, survey-based abortion estimates in Georgia are significantly higher than the official statistics, presumably because government reporting systems significantly underreport abortions. Because it is likely that some abortion underreporting has also taken place in the survey, survey-based levels of abortion should be viewed as conservative estimates of the true magnitude of abortion practices at the population level.

In addition to providing more accurate documentation of abortion levels and trends, survey estimates can be used to more broadly assess the burden of unwanted pregnancy and the need for increased access to and use of contraceptive services.

In Georgia, improved access to contraception will lead to a reduction in unintended pregnancy and a decrease in the national abortion rates. The fact that an increasing proportion of Georgian women having abortions live in rural areas and are poor and less-educated underscores the importance of subsidized family planning services and expanded coverage of these services. The International Conference on Population and Development Programme of Action urges countries to reduce abortion rates by increasing availability of post-abortion counseling, education, and family-planning. Since 1999, Georgia has made substantial progress in this regard. Abortion rates have been falling, increasing numbers of women use modern contraception methods, and fewer women have an unmet need for modern contraception. Still, more efforts are needed to achieve further reduction in abortion rates, particularly given that two-thirds of women have abortions because they do not want any more children. However, because no contraceptive method is perfectly fail-safe, family planning cannot prevent all unintended pregnancies. Reliance on traditional methods of contraception—which is typical among rural, poor, and less educated women, the same groups that have high abortion rates—is highly associated with method-failure and subsequent abortion. While national family planning efforts need to be intensified and users of traditional methods need to be educated about the availability of more effective methods, access to safe abortion should continue to be made available. Worldwide, abortions performed in safe conditions are associated with very low rates of morbidity and mortality. The recent decline in complications after legal abortions in Georgia is proof that clinical practice has been improving and that fewer abortions are taking place outside medical facilities. Efforts to further replace abortion with contraception should focus on increasing access to a variety of high quality, affordable birth control methods, rather than limiting availability of safe abortion services.

Table 5.2.1 Three-Year* Age-Specific Induced Abortion* Rates among Women Aged 15–44 Years: GERHS05 and Ministry of Health (MoLHSA) Estimates Reproductive Health Survey: Georgia, 2005

	Age-Specific Induced Abortion Rate (per 1,000)*	
Age Group	2002–2005 GERHS05†	2002–2004 MoLHSA‡
15–19	13	6.0
20–24	126	22.1
25–29	164	28.7
30–34	167	20.0
35–39	110	11.7
40–44	(54)	2.9
Total Abortion Rate (per woman)	3.1	0.5
General Abortion Rate (per 1,000 women aged 15-44)	**104**	**14.8**

* Age at induced abortion.

† Abortions occurring between March 2002 and February 2005.

‡ Abortions occurring between January 2002 and December 2004; includes spontaneous abortions.

( ) Time exposed partially truncated because not all cases had exposure throughout the period of analysis.

Table 5.2.2 Three-Year Period, Age-Specific Abortion Rates and Total Abortion Rates for Three Time Periods Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	Age-Specific Induced Abortion Rate (per 1,000)*		
Age Group	2002–2005 GERHS05†	1999–2002 GERHS05‡	1996–1999 99GERHS¶
15–19	13	19	29
20–24	126	126	162
25–29	164	174	191
30–34	167	166	179
35–39	110	120	122
40–44	(54)	(56)	(49)
Total Abortion Rate (per woman)	3.1	3.3	3.7

* Age at induced abortion.

† Abortions occurring between March 2002 and February 2005.

‡ Abortions occurring between March 1999 and February 2002.

¶ Abortions occurring between December 1996 and November 1999.

( ) Time exposed partially truncated because not all cases had exposure throughout the period of analysis.

Table 5.3.1 Three-Year Period, Age-Specific Abortion Rates and Total Abortion Rates for Three Time Periods Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	Age-Specific Induced Abortion Rate(per 1,000)†						Total Abortion Rate (Abortions per Woman)
Characteristic	15–19	20–24	25–29	30–34	35–39	40–44	15–44
Total	13	126	164	167	110	54	3.1
Residence							
Urban	9	116	158	139	92	52	2.8
Rural	17	138	171	203	130	57	3.5
Region							
Kakheti	26	152	144	245	130	53	3.8
Tbilisi	7	102	160	152	112	60	3.0
Shida Kartli	0	187	233	176	71	108	3.9
Kvemo Kartli	21	158	182	166	176	41	3.7
Samtskhe-Javakheti	10	135	218	223	122	173	4.4
Adjara	8	71	125	118	124	55	2.5
Guria	6	94	146	125	103	51	2.6
Samegrelo	13	109	139	131	81	16	2.4
Imereti	19	149	171	186	73	31	3.1
Mtskheta-Mtianeti	16	212	199	205	109	21	3.8
Racha-Svaneti	0	47	115	102	82	0	1.7
Education							
Secondary incomplete or less	22	261	267	243	97	42	4.7
Secondary complete	14	188	196	191	112	33	3.7
Technicum	11	105	207	156	115	83	3.4
University/postgraduate	3	65	110	147	105	45	2.4
Socioeconomic Status							
Low	14	144	176	196	86	42	3.3
Middle	15	126	165	150	119	71	3.2
High	2	97	142	155	128	42	2.8
Ethnicity							
Georgian	9	120	156	155	104	51	3.0
Azeri	53	237	326	376	166	39	6.0
Armenian	0	119	173	165	145	130	3.7
Other	36	86	150	207	116	56	3.3

* March 2002–February 2005

† Age at induced abortion

Table 5.3.2 Women Aged 15-44 Who Had at Least One Abortion and Number of Lifetime Abortions by Selected Characteristics
Reproductive Health Survey: Georgia 2005

	Ever Had an Abortion		Number of Lifetime Induced Abortions Among Women Who Have Ever Had An Abortion								
Characteristic	%	No. of Cases	1	2	3	4	5–6	7–9	10+	Total	No. of Cases
Total	43.0	6,376	23.7	19.9	15.0	11.2	12.3	7.7	10.2	100.0	2,942
Residence											
Tbilisi	40.1	1,431	24.2	19.9	14.3	13.5	11.7	7.8	8.6	100.0	634
Other urban	42.0	1,765	24.9	19.9	16.0	10.0	14.6	7.3	7.3	100.0	792
Rural	45.4	3,180	22.8	19.9	14.9	10.6	11.3	7.8	12.7	100.0	1,516
Age Group											
15–19	1.9	930	88.1	7.6	4.4	0.0	0.0	0.0	0.0	100.0	32
20–24	18.1	1,079	54.3	20.1	10.6	9.1	5.8	0.0	0.0	100.0	220
25–29	44.4	1,139	29.4	27.0	15.4	11.1	10.2	4.4	2.6	100.0	537
30–34	59.1	1,110	23.1	20.3	17.3	10.5	12.6	8.0	8.1	100.0	667
35–39	70.3	1,048	21.2	17.1	15.6	10.3	13.9	10.3	11.5	100.0	722
40–44	73.5	1,070	13.8	18.3	14.3	13.2	13.9	9.2	17.4	100.0	764
Number of Living Children											
None	2.1	2,299	68.5	25.8	1.4	2.7	1.7	0.0	0.0	100.0	68
One	48.8	1,131	40.8	21.3	15.2	9.2	7.5	3.3	2.7	100.0	555
Two	77.8	2,168	19.9	20.7	14.6	11.5	14.1	9.1	10.2	100.0	1,674
Three	86.0	654	17.3	16.6	17.0	11.9	11.5	9.1	16.7	100.0	546
Four or more	85.1	124	10.3	17.3	17.0	15.5	18.3	6.3	15.4	100.0	99
Education Level											
Secondary incomplete or less	25.6	907	23.4	16.0	18.7	10.9	13.9	6.1	11.1	100.0	283
Secondary complete	48.9	1,786	23.0	18.9	13.9	12.2	12.9	8.1	11.0	100.0	919
Technicum/university	45.2	3,683	24.2	21.1	15.1	10.6	11.7	7.7	9.6	100.0	1,740
Socioeconomic Status											
Low	43.5	2,277	22.3	19.5	15.1	11.3	12.3	7.5	12.0	100.0	1,040
Middle	43.2	3,028	24.3	20.3	14.2	11.2	12.5	7.9	9.5	100.0	1,407
High	41.8	1,071	25.0	19.5	17.2	10.6	11.8	7.5	8.4	100.0	495
Ethnic Group											
Georgian	42.5	5,545	23.6	20.1	14.9	11.1	12.6	7.9	9.8	100.0	2,527
Azeri	47.1	292	18.6	13.2	21.9	10.8	13.1	7.0	15.5	100.0	149
Armenian	44.4	382	25.6	24.2	13.0	13.6	8.3	5.6	9.6	100.0	180
Other	49.8	157	35.7	19.2	9.2	9.0	9.7	5.9	11.4	100.0	86

Table 5.4.1 Gestational Age at the Time of Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 (Percentage Distribution) – Reproductive Health Survey: Georgia 2005

	Gestational Age (in Weeks)						
Characteristic	< 7	7–9	10–12	13+	Do not Remember	Total	No. of Cases
Total	22.6	60.5	16.1	0.7	0.1	100.0	3,103
Residence							
Tbilisi	31.3	56.9	10.3	1.4	0.1	100.0	683
Other urban	30.6	53.9	14.8	0.7	0.0	100.0	762
Rural	14.1	65.7	19.8	0.4	0.1	100.0	1,658
Age Group							
15–19	42.4	47.1	5.2	5.2	0.0	100.0	20
20–24	22.7	58.2	18.9	0.3	0.0	100.0	337
25–29	26.0	57.4	16.0	0.6	0.0	100.0	870
30–34	22.5	61.7	14.4	1.3	0.1	100.0	857
35–39	20.9	65.2	12.9	0.9	0.1	100.0	643
40–44	18.4	59.2	22.3	0.0	0.0	100.0	376
Number of Living Children (4+)							
0	0.0	60.5	0.0	39.5	0.0	100.0	5
1	28.0	57.5	13.0	1.5	0.0	100.0	563
2	23.1	60.6	15.7	0.5	0.1	100.0	1,924
3	18.3	63.2	18.3	0.2	0.0	100.0	527
4 or more	9.2	60.6	28.9	1.3	0.0	100.0	84
Education							
Secondary incomplete or less	15.2	59.1	25.5	0.3	0.0	100.0	353
Secondary complete	18.2	63.5	16.6	1.6	0.1	100.0	1,039
Technicum/university	26.7	59.0	13.9	0.3	0.1	100.0	1,711
Socioeconomic Status							
Low	13.7	65.1	20.5	0.5	0.2	100.0	1,126
Middle	25.3	58.3	15.5	0.9	0.0	100.0	1,466
High	33.1	57.1	8.9	0.9	0.0	100.0	511
Ethnic Group							
Georgian	24.6	57.7	16.8	0.9	0.1	100.0	2,593
Azeri	8.4	74.9	16.4	0.3	0.0	100.0	244
Armenian	15.6	76.9	7.5	0.0	0.0	100.0	182
Other	26.7	62.3	11.0	0.0	0.0	100.0	84
Type of Abortion							
Induced abortion	0.1	61.4	36.7	1.7	0.0	100.0	1,441
Mini-abortion	40.2	59.7	0.0	0.0	0.1	100.0	1,662

Table 5.4.2 Type of Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 (Percentage Distribution)
Reproductive Health Survey: Georgia 2005

	Type of Pregnancy Termination			
Characteristic	Induced abortion	Mini-abortion	Total	No. of Cases
Total	43.8	56.2	100.0	3,103
Residence				
Tbilisi	20.2	79.8	100.0	683
Other urban	37.7	62.3	100.0	762
Rural	59.4	40.6	100.0	1,658
Age Group (at Abortion)				
15–24	44.3	55.7	100.0	769
25–34	43.3	56.7	100.0	1,684
35–44	44.4	55.6	100.0	650
Order of Abortion				
1	44.8	55.2	100.0	643
2	43.6	56.4	100.0	542
3	42.5	57.5	100.0	446
4	44.9	55.1	100.0	331
5	43.2	56.8	100.0	255
6 or more	43.8	56.2	100.0	886
Education Level				
Secondary incomplete or less	61.2	38.8	100.0	353
Secondary complete	53.9	46.1	100.0	1,039
Technicum/university	34.4	65.6	100.0	1,711
Socioeconomic Status				
Low	59.3	40.7	100.0	1,126
Middle	40.8	59.2	100.0	1,466
High	21.4	78.6	100.0	511
Ethnic Group				
Georgian	39.7	60.3	100.0	2,593
Azeri	68.2	31.8	100.0	244
Armenian	69.0	31.0	100.0	182
Other	36.9	63.1	100.0	84

Table 5.4.3 Place of Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 (Percentage Distribution) Reproductive Health Survey: Georgia 2005

	Place of Pregnancy Termination					
Characteristic	Hospital/ Maternity Ward	Women's Consultation Clinic	Private Clinic	Outside a Medical Facility	Total	No. of Cases
Total	56.7	40.0	2.5	0.8	100.0	3,103
Residence						
Tbilisi	38.9	57.5	2.2	1.4	100.0	683
Other urban	54.0	44.0	1.9	0.1	100.0	762
Rural	67.4	28.8	2.9	1.0	100.0	1,658
Age Group (at Abortion)						
15–24	54.6	41.6	3.3	0.4	100.0	769
25–34	57.7	39.2	2.3	0.8	100.0	1,684
35–44	56.6	40.0	1.9	1.4	100.0	650
Order of Abortion						
1	58.7	39.2	1.7	0.4	100.0	643
2	55.8	42.6	1.0	0.6	100.0	542
3	55.9	41.8	1.8	0.5	100.0	446
4	57.5	39.8	1.8	0.9	100.0	331
5	53.5	41.3	3.6	1.6	100.0	255
6 or more	56.6	38.1	4.0	1.3	100.0	886
Education Level						
Secondary incomplete or less	69.9	26.4	3.2	0.0	100.0	353
Secondary complete	59.2	38.4	1.9	0.5	100.0	1,039
Technicum/university	52.4	43.8	2.6	1.1	100.0	1,711
Socioeconomic Status						
Low	68.8	27.7	2.5	0.0	100.0	1,126
Middle	50.6	46.0	2.7	0.7	100.0	1,466
High	48.7	48.5	1.9	0.9	100.0	511
Ethnic Group						
Georgian	53.1	43.5	2.3	1.1	100.0	2,593
Azeri	75.5	20.6	3.9	0.0	100.0	244
Armenian	81.2	16.2	2.6	0.0	100.0	182
Other	50.5	48.1	1.4	0.0	100.0	84
Type of Abortion						
Induced abortion	71.5	25.3	1.6	1.6	100.0	1,441
Mini-abortion	45.0	51.5	3.1	0.3	100.0	1,662

* Fewer than 25 cases in this category.

Table 5.4.4 Use of Ultrasound Prior to the Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 Reproductive Health Survey: Georgia 2005

	Ultrasound Use		
Characteristic	Have Ultrasound-Abortion %	Ultrasound Assessment of Gender %	No. of Cases
Total	41.5	4.1	3,103
Residence			
Urban	57.0	2.5	1,445
Rural	25.6	7.6	1,658
Residence			
Tbilisi	75.1	2.5	683
Other urban	37.9	2.5	762
Rural	25.6	7.6	1,658
AGEabor			
15–24	42.1	3.3	769
25–34	41.4	5.4	1,684
35–44	41.0	2.0	650
Number of Living Children (4+)			
0	*	*	5
1	57.6	1.0	563
2	39.0	3.3	1,924
3	34.1	10.9	527
4 or more	33.1	12.5	84
Education			
Secondary incomplete or less	29.9	11.8	353
Secondary complete	33.1	3.8	1,039
Technicum/university	48.8	3.2	1,711
Socioeconomic Status			
Low	24.5	5.1	1,126
Middle	45.1	4.6	1,466
High	65.5	2.2	511
Ethnicity			
Georgian	45.8	3.3	2,593
Azeri	14.3	21.0	244
Armenian	22.2	11.5	182
Other	40.4	0.0	84
Type of Abortion			
Induced Abortion	26.5	12.5	1,441
Mini-abortion	53.2	0.8	1,662
Abortion Facility			
Hospital/maternity ward	32.9	5.6	1,810
Women s consultation clinic	53.6	3.0	1,205
Private clinic	47.9	0.0	66
Outside a medical facility	*	*	22
Gestational Age			
<10 weeks	42.3	1.8	2,575
10+	37.4	16.7	528

*Fewer than 25 cases in this category.

Table 5.4.5 Use of Contraception at the Time of Conception by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 Reproductive Health Survey: Georgia 2005

	Contraceptive Use			
Characteristic	Any Method %	Any Traditional Method %	Any Modern Method %	No. of Cases
Total	22.7	18.8	3.7	3,103
Residence				
Tbilisi	28.1	19.2	8.8	683
Other urban	26.3	23.8	2.4	762
Rural	18.0	16.2	1.6	1,658
Age Group (at Abortion)				
15–24	16.7	12.9	3.6	769
25–34	23.6	19.9	3.7	1,684
35–44	26.9	22.9	3.6	650
Number of Living Children				
None	*	*	*	5
One	19.1	12.9	6.2	563
Two	24.7	21.5	3.1	1,924
Three	21.1	17.7	2.8	527
Four or more	16.2	12.1	4.1	84
Education Level				
Secondary incomplete or less	16.7	15.8	0.9	353
Secondary complete	16.2	14.3	1.8	1,039
Technicum/university	27.6	22.1	5.3	1,711
Socioeconomic Status				
Low	16.7	14.8	1.7	1,126
Middle	22.4	19.5	2.9	1,466
High	35.1	25.1	9.6	511
Ethnic Group				
Georgian	25.4	21.2	4.0	2,593
Azeri	5.6	5.6	0.0	244
Armenian	12.4	8.5	3.8	182
Other	15.4	11.1	4.3	84
Type of Abortion				
Induced abortion	17.9	14.6	3.1	1,441
Mini-abortion	26.4	22.2	4.1	1,662

* Fewer than 25 cases in this category.

Table 5.4.6 Cost of a Procedure for Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005
Reproductive Health Survey: Georgia 2005

	Cost of Abortion (in Lari)*										
Characteristic	Mean Payment†	None	< 20	20–24	25–29	30–34	35–100	> 100	Do not Remember	Total	No. of Cases
Total	28.8	1.6	8.8	19.2	24.5	25.4	19.2	0.7	0.6	100.0	3,103
Residence											
Tbilisi	34.7	1.1	1.9	6.0	22.4	32.4	34.1	1.0	1.0	100.0	683
Other urban	28.2	1.7	15.5	17.5	23.9	22.6	17.0	1.2	0.6	100.0	762
Rural	26.0	1.8	9.0	27.0	26.0	23.0	12.4	0.4	0.3	100.0	1,658
Age Group (at Abortion)											
15–24	29.9	1.2	9.6	16.5	25.4	24.4	21.4	0.9	0.6	100.0	769
25–34	28.4	1.7	8.1	19.8	25.2	25.9	18.2	0.5	0.7	100.0	1,684
35–44	28.5	1.9	9.4	20.8	22.2	25.2	19.0	1.1	0.3	100.0	650
Order of Abortion											
1	30.0	2.3	7.5	17.4	22.4	27.3	21.2	0.9	1.0	100.0	643
2	29.2	2.2	8.6	16.2	22.7	27.4	21.7	0.6	0.5	100.0	542
3	28.4	1.9	7.6	20.2	25.8	24.3	18.7	0.7	0.7	100.0	446
4	27.8	1.8	11.6	19.6	23.9	26.1	16.1	0.8	0.0	100.0	331
5	28.7	1.1	9.2	15.6	30.2	22.8	19.7	1.4	0.0	100.0	255
6 or more	28.4	0.8	9.2	22.3	25.1	23.8	17.6	0.5	0.5	100.0	886
Education Level											
Secondary incomplete or less	27.6	0.6	7.6	23.5	25.4	30.1	12.5	0.3	0.0	100.0	353
Secondary complete	27.7	1.1	10.7	23.2	24.8	23.8	14.9	1.2	0.2	100.0	1,039
Technicum/university	29.7	2.2	7.9	16.0	24.2	25.3	23.1	0.6	0.9	100.0	1,711
Socioeconomic Status											
Low	26.3	1.8	7.3	28.8	25.4	24.4	11.6	0.5	0.2	100.0	1,126
Middle	28.6	1.3	10.9	16.5	24.0	26.2	20.3	0.4	0.5	100.0	1,466
High	34.4	2.3	5.8	7.3	24.3	25.2	31.5	2.1	1.5	100.0	511
Ethnic Group											
Georgian	29.1	1.6	8.8	16.4	26.3	25.5	19.9	0.8	0.7	100.0	2,593
Azeri	25.4	2.3	10.7	43.4	14.0	17.7	11.2	0.7	0.0	100.0	244
Armenian	28.4	2.3	2.6	22.3	16.0	37.3	19.4	0.0	0.0	100.0	182
Other	31.1	.	13.8	15.3	22.3	22.6	24.6	1.4	0.0	100.0	84
Type of Abortion											
Induced abortion	31.4	2.3	3.7	23.2	19.0	25.2	24.7	1.4	0.5	100.0	1,441
Mini-abortion	26.7	1.1	12.7	16.1	28.8	25.5	14.9	0.2	0.6	100.0	1,662
Abortion Facility											
Hospital/ maternity ward	29.9	1.8	6.6	21.6	23.1	25.2	19.8	1.0	0.8	100.0	1,810
Women's consultation clinic	27.4	1.0	10.8	16.0	27.4	26.1	18.3	0.2	0.3	100.0	1,205
Private clinic/office	29.5	1.7	26.2	12.5	15.9	22.2	17.1	4.3	0.0	100.0	66
Outside a medical facility	‡	‡	‡	‡	‡	‡	‡	‡	‡	100.0	22
Gestational Age											
<10 weeks	27.5	1.6	9.9	18.7	26.7	26.4	15.7	0.4	0.5	100.0	2,575
10+	35.2	2.0	3.2	21.7	13.7	20.2	36.2	2.2	0.8	100.0	528
Antibiotics-Abortion											
Yes	31.7	1.5	5.5	14.4	27.1	27.4	21.4	1.8	0.9	100.0	1,005
No	27.5	1.7	10.3	21.4	23.3	24.4	18.2	0.2	0.4	100.0	2,098

*At the time of survey approximately 1.8 lari = 1.00 US dollar.

† Mean payment per abortion does not include payments of unknown amount.

‡ Fewer than 25 cases in this category.

Table 5.5.1 Abortion Clinical Practice and Prevalence of Early and Late Complications by Selected Characteristics Among Pregnancies Ended in Abortion in 2000–2005 Reproductive Health Survey: Georgia 2005

	Clinical Practice				Postabortion Complications			
Characteristic	Anesthesia	Antiobiotic Treatment	One or More Nights Hospitalized	No. of Cases	Early	No. of Cases	Late	No. of Cases*
Total	58.4	31.9	0.8	3,103	5.0	3,103	1.3	3,007
Residence								
Tbilisi	62.2	46.2	0.5	683	7.1	683	1.4	672
Other urban	64.2	33.8	0.7	762	3.9	762	0.8	740
Rural	53.5	23.3	1.1	1,658	4.5	1,658	1.4	1,595
Age Group (at Abortion)								
15–24	59.4	32.0	0.5	769	4.3	769	1.1	746
25–34	58.3	34.5	1.3	1,684	6.0	1,684	1.7	1,629
35–44	57.5	26.0	0.3	650	3.8	650	0.6	632
Order of Abortion								
1	64.3	33.8	0.6	643	4.9	643	1.3	621
2	61.0	34.4	1.4	542	5.4	542	1.4	527
3	59.4	33.4	0.5	446	5.0	446	1.4	435
4	53.1	31.8	0.4	331	5.3	331	1.6	322
5	55.7	35.9	0.6	255	5.0	255	1.9	246
6 or more	55.1	27.6	1.1	886	4.8	886	0.9	856
Education Level								
Secondary incomplete or less	49.5	25.2	2.1	353	6.8	353	1.2	336
Secondary complete	58.0	26.4	0.6	1,039	5.1	1,039	1.5	1,002
Technicum/university	60.4	36.4	0.7	1,711	4.6	1,711	1.2	1,669
Socioeconomic Status								
Low	52.1	22.7	1.1	1,126	4.0	1,126	1.0	1,089
Middle	61.6	33.5	0.6	1,466	5.2	1,466	1.3	1,418
High	62.1	45.7	0.8	511	6.5	511	2.0	500
Ethnic Group								
Georgian	60.1	34.7	0.6	2,593	4.8	2,593	1.2	2,517
Azeri	53.2	16.1	0.7	244	2.1	244	1.1	239
Armenian	42.6	15.7	4.5	182	12.6	182	2.0	171
Other	55.6	28.9	1.9	84	6.5	84	2.2	80
Type of Abortion								
Induced abortion	59.2	28.9	1.4	1,441	6.1	1,441	1.6	1,395
Mini-abortion	57.7	34.2	0.4	1,662	4.2	1,662	1.1	1,612
Abortion Facility								
Hospital/ maternity ward	57.8	29.2	1.2	1,810	5.7	1,810	1.6	1,746
Women's consultation clinic	61.3	35.9	0.5	1,205	3.6	1,205	0.9	1,174
Private clinic/office	37.3	30.2	0.0	66	8.5	66	0.0	66
Outside a medical facility	†	†	0.0	22	†	22	†	21
Gestational Age								
<10 weeks	58.6	31.6	0.8	2,575	4.5	2,575	1.3	2,489
10+	57.4	33.1	1.0	528	7.7	528	1.3	518
Early Complications								
Absent	58.6	30.1	0.3	2,947	0.0	2,947	0.4	2,859
Present	57.4	65.4	11.5	156	100.0	156	18.3	148

* Includes sequelae at six months after the abortion (96 cases with less than six months since abortion were excluded). Respondents experiencing more than one type of complication were asked to report only the most severe.
† Fewer than 25 cases in this category.

Table 5.5.2 Induced Abortions Performed in 2000–2005 by Type of Complications by Gestational Age – Reproductive Health Survey: Georgia 2005

Type of Early Complications	Total	Gestational Age (in weeks)	
		<7	7–12
Prolonged pelvic pain	51.7	43.7	54.2
Severe bleeding	48.9	41.1	51.2
High fever (over 38°)	32.4	30.9	32.9
Infectious vaginal discharge	29.1	31.7	28.3
Perforation	5.0	1.6	6.0
Other problem	2.0	0.0	2.6
No. of Abortions with Early Complications	156	36	120

Table 5.6 Most Important Reason for Abortions Performed During the 5 Years Prior to the Survey by Selected Characteristics (Percentage Distribution)
Reproductive Health Survey: Georgia 2005

	Reason for Abortion								
Characteristic	Want No (More) Children	Want to Postpone Childbearing	Socio-Economic Reasons	Risk to Maternal Health	Risk to Fetal Health	Partner Objected to Pregnancy	Other	Total	No. of Cases
Total	62.6	19.4	14.8	1.4	0.9	0.4	0.5	100.0	3,103
Residence									
Tbilisi	54.5	23.4	16.9	2.4	2.0	0.1	0.6	100.0	683
Other urban	60.9	21.7	14.4	1.1	1.3	0.1	0.5	100.0	762
Rural	67.8	16.2	13.9	1.0	0.1	0.6	0.4	100.0	1,658
Age Group*									
15–24	39.7	45.9	11.1	1.8	1.4	0.0	0.2	100.0	357
25–34	55.6	23.5	17.6	1.5	1.2	0.2	0.5	100.0	1,727
35–44	80.3	4.9	12.1	1.1	0.3	0.7	0.6	100.0	1,019
Socioeconomic Status									
Low	69.0	14.9	14.4	0.3	0.2	0.8	0.3	100.0	1,126
Middle	58.8	21.3	16.4	2.1	0.9	0.1	0.4	100.0	1,466
High	60.2	23.4	11.5	1.6	2.2	0.2	0.9	100.0	511
Pregnancy Order									
First	†	†	†	†	†	†	†	100.0	7
Second	13.7	65.9	16.5	1.6	1.8	0.0	0.4	100.0	268
Third	41.4	34.8	20.2	2.5	0.5	0.2	0.3	100.0	417
Fourth	55.8	22.6	18.5	0.9	1.3	0.1	0.9	100.0	434
Fifth or higher	75.5	9.2	12.7	1.1	0.7	0.5	0.4	100.0	1,977

*Age at pregnancy termination.

† Fewer than 25 cases in this category.

Chapter 6

MATERNAL AND INFANT HEALTH

Pregnancy and childbirth complications are the leading cause of disability and death for women of reproductive age in developing countries. The World Health Organization (WHO) estimates an enormous toll of maternal and child mortality and morbidity worldwide: Annually, 529,000 maternal deaths occur during pregnancy (some 68,000 as a consequence of unsafe abortion), childbirth, or the postnatal period, more than 4 million infants die during the first 28 days after birth, and a further 6.6 million young children die before turning 5 years of age annually (WHO, 2006). For every maternal death, 30 times as many mothers suffer from pregnancy-related complications. For every newborn baby who dies, at least another 20 suffer birth injury, infection, complications of preterm birth, or other neonatal conditions (Save the Children Fund, 2004).

The health and survival of newborn children is closely linked to that of their mothers because lack of or inadequate care during pregnancy, childbirth, and the postpartum period is associated with inadequate postnatal infant care. In addition, children whose mothers die of pregnancy-related causes are more likely to die because they are motherless (UNICEF, 2005).

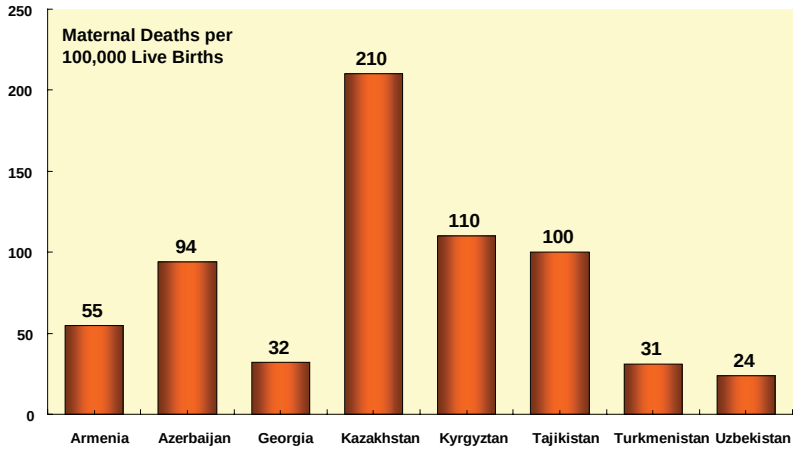
The Millennium Development Goals, which were adopted at the United Nations Millennium Summit in 2000, constitute a global commitment to reduce poverty and improve well-being, including that of mothers and their children. The goals include a reduction of maternal mortality and child-under-five mortality by three-quarters between 1990–2015 (United Nations, 2000). The Millennium Development Goals have called attention to the need for better data for policy

making and for measuring development progress. The correct identification and classification of maternal and infant deaths and their contributing factors is an essential prerequisite for determining the extent of the problem and for developing effective safe-motherhood strategies.

6.1 Maternal and Child Health in Georgia and the Former Soviet Union

Maternal and infant health in Central Asia and the Caucasus warrants special attention. The health of mothers and their children are important measures of well-being in the region, but verifiable estimates of maternal and infant mortality are hard to obtain. The national vital registration systems that are in place in the region are comprehensive, but they share a common history of inaccurate death statistics, rooted in the common Soviet–era practice of rewarding "positive" results while omitting or misclassifying undesirable statistics, for fear of disciplinary actions. As such, official estimates of maternal mortality are low, while model-based synthetic estimates from WHO, UNICEF, and the United Nations Population Fund (UNFPA) are as high as 210 maternal deaths per 100,000 live births in Kazakhstan and 94 per 100,000 live births in Azerbaijan (WHO, 2004) (Figure 6.1.1). In Georgia, the synthetic maternal mortality estimate in 2000 was 32 maternal deaths per 100,000 live births (CI=12 per 100,000–53 per 100,000), well within the range published by the official statistics for that year. However, direct survey measurements for infant mortality in the region have documented rates that are several times higher than the official estimates (CDC and Macro, 2003). In Georgia, as a result of discrepancies documented by the 1999 Reproductive Health Survey and the first national census, the State Department for Statistics revised infant and maternal mortality estimates in 2002 for all the figures published after 1989 (SDS, 2005).

Figure 6.1.1 **Estimated Maternal Mortality in 2000: Caucasus and Central Asia**



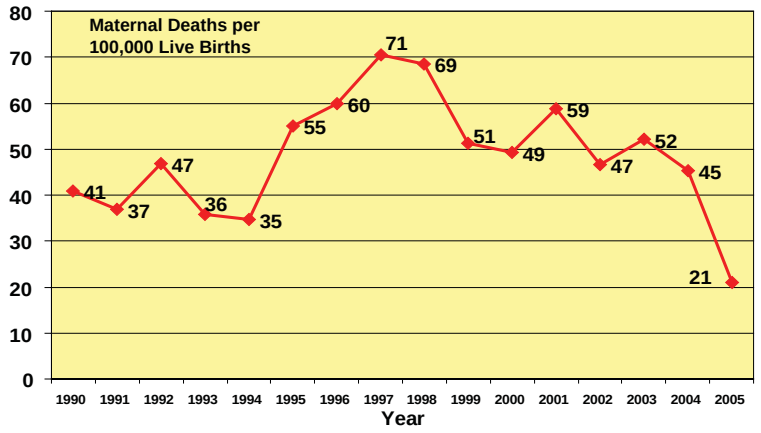
Source: WHO, 2004

Maternal mortality in Central and Eastern Europe and Central Asia is, on average, several times higher than in Western Europe; abortion, obstetric hemorrhage, sepsis, and pregnancy-induced high blood pressure account for the majority of maternal deaths. Factors contributing to high maternal mortality include a deficient health infrastructure that cannot afford to replace outdated obstetric equipment and facilities; a lack of essential supplies needed to provide basic emergency obstetric care; insufficient or inadequate transportation of high risk cases to referral centers; delays in adopting evidence-based best medical practices and in training medical personnel; and a high reliance on abortion rather than modern methods of contraception to control fertility. Although the medical care infrastructure in these countries comprises the full range of facilities and medical personnel, in reality, health care services are often ill-equipped to provide quality prenatal and postnatal care, timely diagnosis and referral of high-risk pregnancies, and emergency obstetric care, especially in rural areas. This situation may explain the unexpected coexistence of relatively high maternal mortality levels with almost universal skilled attendance at birth and high utilization of prenatal care services.

In recent years, an increasing number of countries in the region have reported improvements in the health of mothers, babies and children, but in some countries the situation has actually worsened. In Georgia, for example, the official maternal mortality ratio has increased by almost 20% between 1990 and 2000 (from 41 to 49 maternal deaths per 100,000 live births). The peak rate occurred in 1997 (70.6 maternal deaths per 100,000 live births). From 2000, the rate fell slightly, but was still higher in 2004 than in 1990 (45.3 per 100,000 versus 41 per 100,000) (Figure 6.1.2). The most recent estimate of 21 maternal deaths per 100,000 live births in 2005, however, is more than 50% lower than the 2004 level (UNFPA, 2006).

A number of factors can have a considerable impact on the health of a woman, the health of her baby, and the outcome of her pregnancy, including utilization of health care services related to pregnancy, location

Figure 6.1.2 **Maternal Mortality in Georgia: "Revised" Official Estimates for 1990–2005**



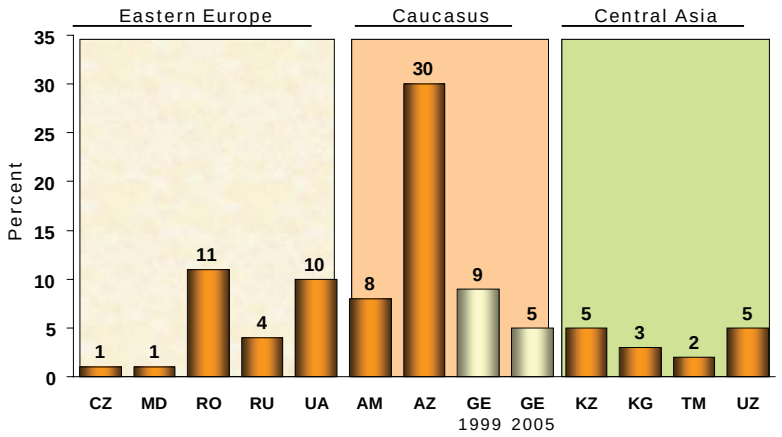
Source: Georgian MoLHSA in UNFPA, 2006

and type of assistance at delivery, and postpartum behaviors, including breastfeeding. Under Soviet health guidelines, women's access to perinatal care was free of charge and consisted of three components: preconception care, prenatal care, and postnatal care (CDC, 1999). Changes in health care systems and financing of health care since the fall of communism have had a significant impact on some perinatal care services. The GERHS05 collected detailed information regarding the actual experiences of respondents during pregnancy, delivery, and the postpartum period. These topics, as well as infant and child mortality, are examined in this chapter. All estimates reported here are based on respondents' reports as recorded in a lifetime pregnancy history and a detailed birth history for all births carried to term since January 2000. In the absence of reliable official statistics, these data can be used to identify problem areas and to help set program priorities, goals, and strategies for improving pregnancy outcomes and the health of mothers and infants.

6.2 Prenatal Care

Prenatal care is important for preventing, identifying, and treating conditions that can affect the health of an expectant mother or her baby. To ensure the optimal health of mother and child, experts recommend that prenatal care is initiated during the first trimester of pregnancy, continues throughout gestation at specified intervals, and is comprehensive (i.e., includes risk assessment, risk reduction or treatment of medical conditions, and counseling). Comprehensive prenatal care can decrease perinatal maternal and infant morbidity and mortality by identifying and addressing potential risk factors that contribute to poor outcomes. Population-based surveys conducted in former Soviet-bloc countries since the breakup of the Soviet Union documented very high prenatal care coverage in the region, with only one country (Azerbaijan) reporting 30% of pregnant women with no prenatal care (Figure 6.2.1) (CDC and Macro, 2003).

Figure 6.2.1 **Percentage of Women Receiving No Prenatal Care Among Live Births in the Last 5 Years: Eastern Europe and Eurasia**



Note: CZ=Czech Republic; MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan.

Until 1995, recommendations for prenatal care in Georgia followed the standards set by the Soviet Union, which were similar to those used in industrialized countries. Standard prenatal care (for uncomplicated pregnancies) included routine visits according to gestational age, as follows: monthly visits before 12 weeks of pregnancy; bi-monthly visits from 12 to 30 weeks of gestation; and weekly or bi-monthly visits until delivery (CDC, 1999). This schedule comprised 12–14 visits throughout the pregnancy. However, declines in socioeconomic conditions in Georgia have reduced funding for health care considerably and made it impossible to support the standard prenatal care model.

The transition of the health care system from being supported by government financing to a payroll-tax–based system led to the adoption of a new four-visit prenatal care protocol in 1996, which was later modified according to WHO recommendations introduced in 2002 (WHO, 2002). The new WHO prenatal care model recommends that the first prenatal care visit include a comprehensive assessment of health conditions and potential risk factors to classify pregnant women into two groups: those who will follow the basic prenatal care program (about 75% of all pregnant women) and those who need referral to a higher level of care. Components of the basic model of prenatal care include screening for and treating locally endemic illnesses in accordance with national protocols (e.g., screening for syphilis); education of the woman and her family members on signs of pregnancy complications requiring medical attention; and counseling on nutrition, birth preparedness, breastfeeding, and post-partum family planning.

Under the 1997 Georgian Law on Health Care, Article 132, maternity care is currently covered through mandatory medical insurance (Government of Georgia, 1997). In accordance with the new WHO protocol, the State United Social Insurance Fund of Georgia (SUSIF), through its basic-benefit package for obstetric care, covers four free-of-charge prenatal visits per pregnancy (at 13, 20–22, 30–32 and 36 weeks of pregnancy). The protocol for each visit includes oral history, clinical examination, laboratory tests, ultrasound examination (at 20-22 weeks), screening (for syphilis, Rh isoimmunization, and HIV), and counseling. Women who are identified as having risk factors during the first visit are referred for more specialized care and/or further testing. This additional care is not covered under SUSIF, except for the following complications: threatened premature labor, pre-eclampsia/eclampsia, and kidney pathologies.

A free-of-charge delivery voucher in the amount of 400 Georgian lari (about USD 228.00) is provided to socially vulnerable populations; vouchers for other pregnant women cover only 200 Georgian lari (about USD 114.00) toward delivery costs (CoReform Project, 2005). Women seeking delivery vouchers are required to be enrolled at a Women's Consultation Center and must complete a special request form, and submit the request to the SUSIF that issues nominal vouchers. Delivery vouchers entitle the recipients to seek delivery services at any maternity clinic participating in the state program. Beginning in 2007, the government will pay incentives of 50 lari per pregnant woman to enroll at Women's Consultation Centers and will restrict issuance of delivery vouchers to only those women who complete the four minimum prenatal visits.

Under current primary health care reform efforts, the Georgian government, in collaboration with donor organizations, is rehabilitating the primary health care network (including equipment, training, and development of quality-of-care protocols). Although recommended by the WHO model, postpartum care is not covered under the state program. Once the reform process is complete, it is anticipated that family practitioners will provide most postpartum care and will refer mothers with any signs of complications to specialized care.

Table 6.2.1 presents the percentage of births (live births and stillbirths) from January 2000 to date of interview for which the respondents reported that

they received prenatal care. Although differences in prenatal care may exist between women having stillbirths and those having live births, the small number of stillbirths reported for the period under consideration does not allow the separate study of pregnancies ended in stillbirth. Thus, we present patterns of health service utilization for all births since January 2000, without distinguishing between liver births and stillbirths.

Use of prenatal care was high: 95% of pregnant women received at least one prenatal examination (Figure 6.2.2). The percentage of pregnant women that received no prenatal care ranged from a low of 1% in Tbilisi to a high of 11% in the Kakheti region. The probability of not receiving prenatal care was highest among women whose maternal age was 35-44 years at time of delivery (10%), women with less than a secondary complete education (14%), women with low socioeconomic status (10%), and those for whom the child's birth order was third or higher (11%). Almost 12% of Azeri women received no prenatal care. According to the results of the 1999 Reproductive Health Survey, 9% of mothers who gave birth in the 5 years prior to the survey received no prenatal care, compared to only 5% in 2005 (Figure 6.2.3). The greatest reductions in the number of women receiving no prenatal care were in rural areas (from 14% to 7%), among women with less than complete secondary education (from 30% to 14%), and among Azeri women (from 28% to 12%).

Nearly 71% of respondents initiated prenatal care during the first trimester of their pregnancy (Table 6.2.1). Urban women were more likely than rural women to initiate prenatal care during the first trimester (79% vs. 63%), as were women living in the regions of Tbilisi (84%) and Imereti (77%), compared to those living in the other regions of the country (Figure 6.2.4). Women with a tertiary level education and those of high socioeconomic status were more likely to report that they began receiving prenatal care in the first trimester than less educated women and those of low socioeconomic status. Overall, initiation of prenatal care in the first trimester increased from

Figure 6.2.2 **Percentage of Women Receiving No Prenatal Care by Selected Characteristics—Births in 2000–2005**

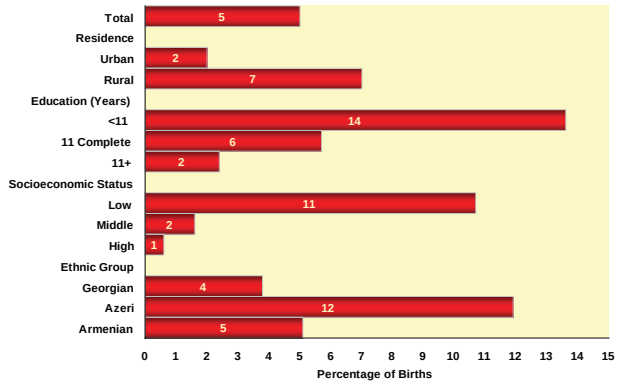


Figure 6.2.3 **Percentage of Women Receiving No Prenatal Care by Selected Characteristics—Births in the Last 5 Years: 1999 and 2005**

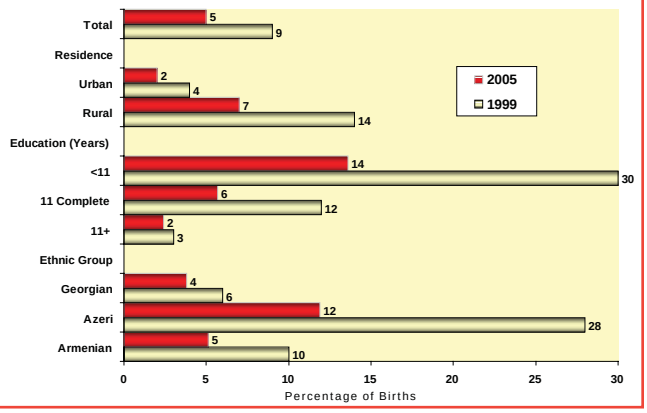
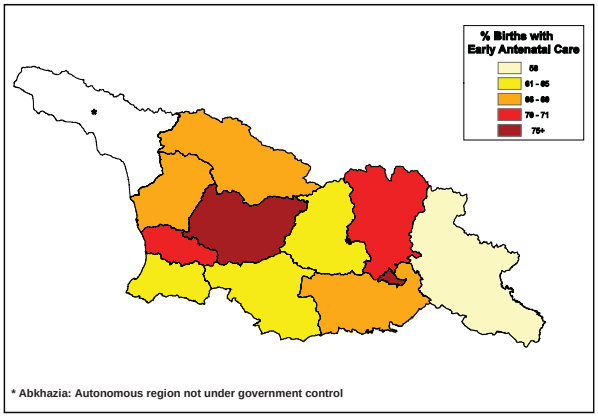


Figure 6.2.4 **Proportion of Births with First Prenatal Visit Occurring in the First Trimester, by Region**



63% in 1999 to 71% in 2005, and the improvement was consistent across all subgroups (Figure 6.2.5).

Overall, 75% of pregnant women received four or more prenatal care examinations (Table 6.2.1); rates were lower in rural areas than in urban areas (64% vs. 86%). Completion of a minimum of four prenatal visits was more common in the regions of Tbilisi (90%) and Imereti (87%) and least common in the regions of Kvemo Kartli and Kakheti (56% and 59%, respectively) (Figure 6.2.6). As expected, the percentage of pregnant women receiving four or more prenatal examinations increased as their educational attainment and socioeconomic status increases, from 51% among women with less than a full secondary education to 83% among women with a tertiary education, and from 58% among women of low socioeconomic status to 92% among women of high socioeconomic status. The percentage of pregnant women receiving four or more prenatal examinations increases with maternal age, up to and including women aged 25–34 at time of delivery, but declines among women who were 35–44 years old at time of delivery. In contrast, the probability of receiving four or more examinations decreases as birth order increases, from a high of 81% among first order births to a low of 62% among third or higher order births. As noted in the table, Azeri women were the least likely to have had four or more prenatal examinations—only 45% did so.

The finding that the percentage of pregnancies receiving 10 or more prenatal examinations increases as the educational attainment and socioeconomic status of the expectant mothers increases is expected. More affluent families can afford to cover additional visits at their own expense. Notably, 23% of pregnancies ending in first order births received 10 or more prenatal examinations, compared to less than 16% of pregnancies of second order or higher.

While both overall use of prenatal care and the initiation of care in the first trimester improved since 1999, (from 91% to 95% and from 63% to 71%, respectively), the percentage of pregnant women receiving four or more examinations remained unchanged (76%). On the

Figure 6.2.5 **Initiation of Prenatal Care in the 1st Trimester by Selected Characteristics—Births in the Last 5 Years: 1999 and 2005**

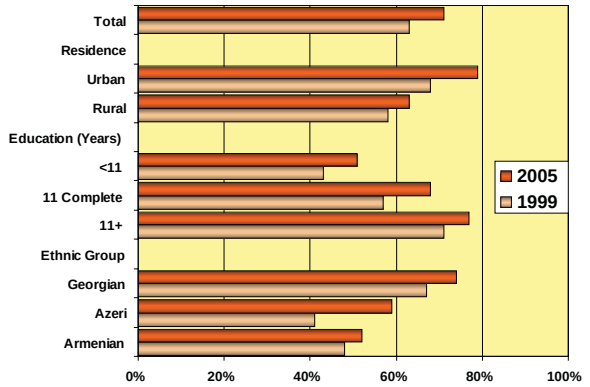
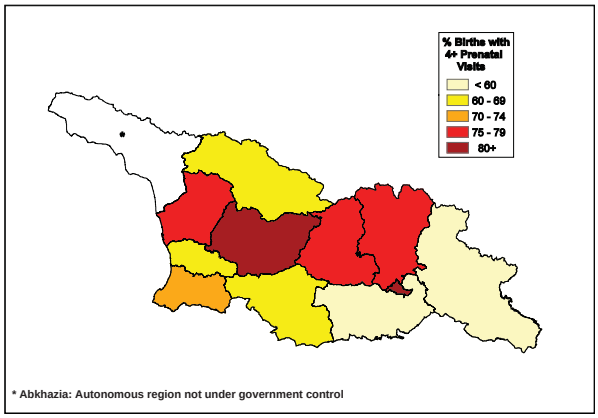


Figure 6.2.6 **Completion of at Least 4 Prenatal Care Visits by Region Among Births in 2000–2005**



contrary, some of the most disadvantaged groups of women, rural residents, those with less than a complete secondary education, and residents of the southern regions were slightly less likely to have received four or more visits in 2005 compared to 1999 (Figures 6.2.7 and 6.2.8).

As shown in Figure 6.2.9, in 2005 the vast majority of women received most of their prenatal care from either women's consultation clinics (53%) or maternity hospitals (37%). Only 6% of the women received care from rural ambulatory or village hospitals, while 4% received care in private clinics. Use of private facilities and maternity hospitals for prenatal care increased from 1999 to 2005 (from 1% to 4% and from 14% to 37%, respectively).

Because data on the initiation and frequency of prenatal care visits can only be used to evaluate the quantitative dimension of prenatal care (i.e., the degree to which services are utilized), the 2005 survey included additional questions to assess adequacy of the of prenatal care. Specifically, respondents were asked about what types of counseling they received and which assessments were performed during the prenatal visits. Dissemination of health messages is an important component of prenatal care visits. In the absence of routine preconception care, the first prenatal visit is a critical opportunity to screen women for behavioral risk factors (e.g., tobacco and alcohol use), medical and genetic risks, and occupational risks and to provide comprehensive counseling. Counseling should cover maternal behaviors and exposures that may affect the health of the fetus, nutrition, the importance of rest, and early signs and symptoms of pregnancy complications. In addition, as the time of delivery approaches, counseling should prepare women for what they will face when giving birth and provide accurate information regarding labor, delivery, and techniques to reduce pain and anxiety during labor. Also, counseling about breastfeeding and family planning after birth should be initiated during the prenatal period and reinforced during postpartum care.

As shown in Table 6.2.2, 77% of women who attended prenatal care clinics received some counseling about nutrition during pregnancy; 69% received information

Figure 6.2.7 **Completion of 4+ Prenatal Care Visits Residence and Education Among Births in the Last 5 Years: 1999 and 2005**

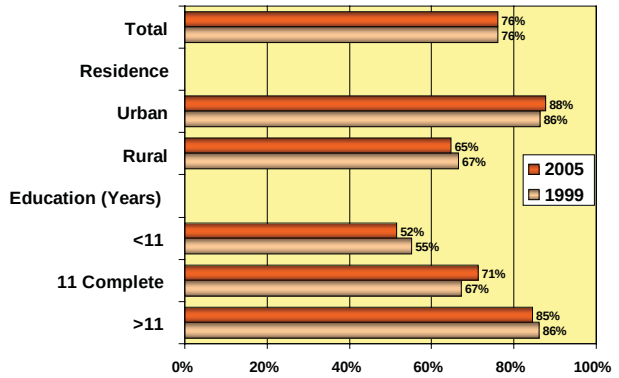


Figure 6.2.8 **Completion of at Least 4 Prenatal Care Visits by Region Among Births in the Last 5 Years: 1999 and 2005**

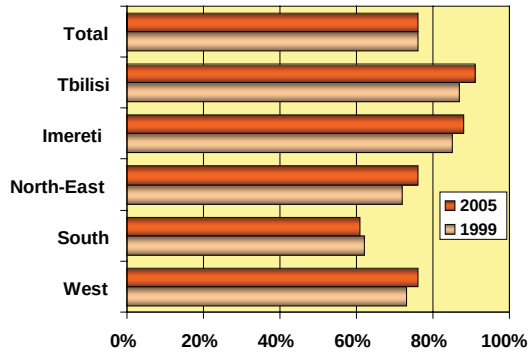
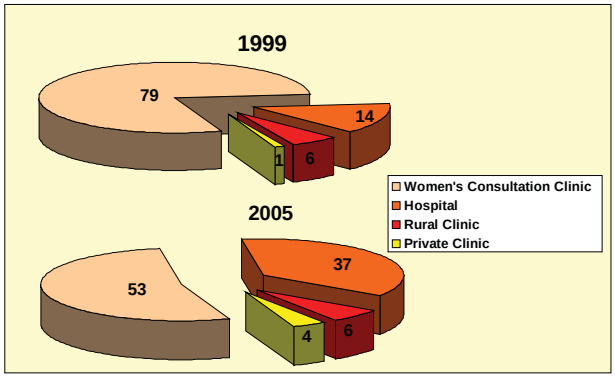


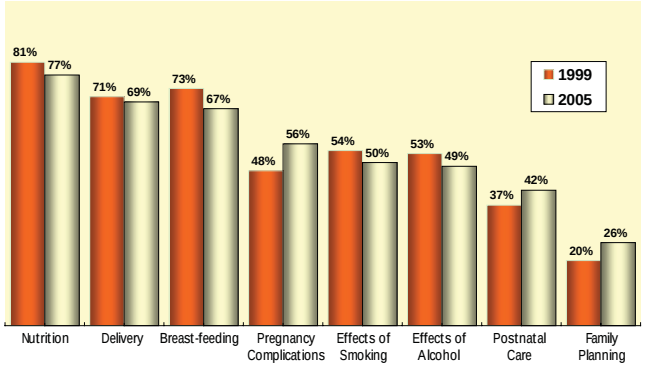
Figure 6.2.9 **Primary Location of Prenatal Care Visits Among Births in the Last 5 Years: 1999 and 2005**



about delivery; and 67% received information about breastfeeding. About 1 in 2 women received information on potential complications during pregnancy and their early signs (56%) and the negative effects of smoking and alcohol (50% and 49%, respectively); 42% of women received information about postnatal care; and only 27% of women received information about family planning after birth. Maternal characteristics that appear to be associated with lower levels of counseling for most of the topics include rural residence, residence in Samtskhe-Javakheti and the western regions (Samegrelo and Adjara), less than complete secondary education, a history of three or more previous births, and receiving most of the prenatal visits in rural ambulatory clinics or village hospitals. The proportion of women receiving information during prenatal care visits was directly correlated with the number of prenatal visits.

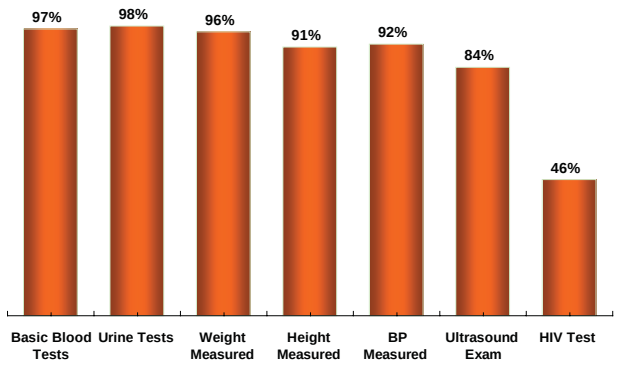
Compared to 1999, the overall level of counseling did not change significantly in 2005 and there is no consistent pattern of change; on a positive note, rates of counseling on early signs of pregnancy complications and postpartum family planning have improved slightly (Figure 6.2.10).

Figure 6.2.10 **Type of Counseling Received During Prenatal Care Among Births in the 5 Years Prior to the Survey: 1999 and 2005**



In addition to counseling, prenatal care should include a detailed medical history of the woman and her family, including information about risk factors and genetic disorders; a detailed obstetrical history; clinical and obstetrical examination; measurements of maternal weight, height, and blood pressure; urine tests; basic blood tests; an ultrasound exam (during the second visit); and tests for various types of infection (e.g., syphilis and HIV). Tables 6.2.3 and 6.2.4 and Figure 6.2.11 show the percentage of women receiving prenatal care who underwent selected examinations and measurements. Overall, almost all women (91%–98%) had at least one routine measurement of maternal weight, height, and blood pressure; urine tests; and basic blood tests; 46% had an HIV test during the prenatal period; and 84% had at least one ultrasound exam. Receipt of measurements and tests during prenatal care was closely tied to educational attainment, socioeconomic status, maternal age, and number of prenatal care visits. Measurements were least likely to be included in prenatal care visits if the care was provided in rural ambulatory clinics and

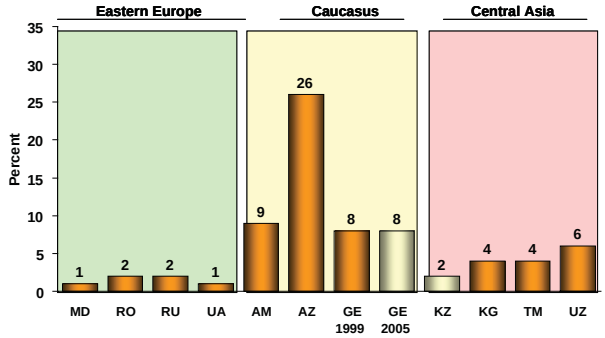
Figure 6.2.11 **Selected Measurements Performed During Prenatal Care Among Women Who Received Prenatal Care Live Births in the 5 Years Prior to the Survey**



hospitals and were almost universal when expectant mothers received care in the private sector. HIV screening and ultrasound exams were much more likely to be performed in urban areas than in rural areas (63% vs. 28% and 94% vs. 75%, respectively).

GERHS05 data do not allow classification of ultrasound exams by selected indications, but it is worth noting that 44% of women who reported receiving ultrasound exams had their first test during the first trimester of pregnancy and 19% received it during 14–19 weeks of gestation. This finding suggests that the first ultrasound exam may have been part of the initial pregnancy assessment—to confirm pregnancy, ensure it is neither molar nor ectopic, assess gestational age, and determine due date—rather than part of pregnancy monitoring and screening, typically recommended for exams at 20–22 weeks.

Figure 6.3.1 **Percentage of Home Deliveries Among Live Births in the 5 Years Prior to the Survey: Eastern Europe and Eurasia**



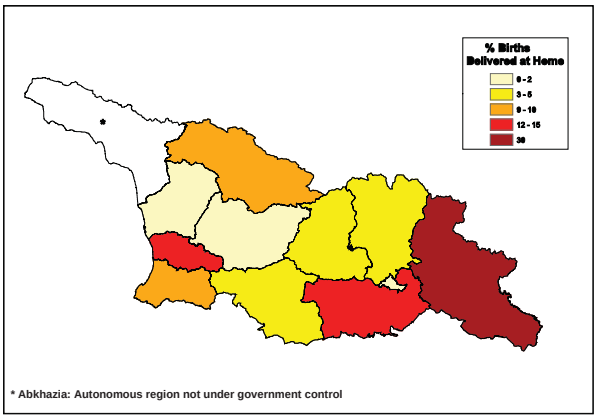
Note: CZ=Czech Republic; MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyztan; TM=Turkmenistan; UZ=Uzbekistan.

6.3 Intrapartum Care

The Soviet-style health system relied on hospital-based specialized care, including intrapartum care. Throughout the former Soviet-bloc countries, births outside of health facilities were relatively uncommon and occurred mainly in rural areas and among older and higher parity women, as well as poorly educated women (Figure 6.3.1)(CDC and Macro, 2003). Such births were least common in Eastern Europe (only 1% of deliveries in the Czech Republic and Ukraine took place outside of health facilities) and more common in the Caucasus region. In Azerbaijan, 26% of births occurred outside of health facilities, a rate more than three times higher than in Georgia and Armenia, the countries with the next highest rates.

In Georgia, the vast majority of births since January 2000 were delivered in health care facilities; only 8% of the births were delivered at home (Table 6.3.1). Virtually all births in urban areas (99%) were delivered in medical facilities; in fact, there were no home births in Tbilisi, where all births took place in either a general hospital or maternity hospitals. The percentage of home births was higher in rural areas (14%) and in the Kakheti region (30%) (Figure 6.3.2). The likelihood that a birth is attended at home increases as maternal

Figure 6.3.2 **Percentage of Home Deliveries by Region Among Births in 2000–2005**



* Abkhazia: Autonomous region not under government control

age, educational attainment, and socioeconomic status decreases, and as birth order increases (Figure 6.3.3; birth order figures not shown).

Overall, between the 1999 and 2005 surveys, the percentage of births attended at home remained virtually unchanged (about 8%). However, among Azeri women, there was an increase in home deliveries, from 26% in 1999 (CI=19%–33%) to 40% in 2005 (CI=30%–50%)(Figure 6.3.4). Given the small number of Azeri women selected in the sample, however, this difference is not statistically significant.

Table 6.3.2 shows the amount of time spent in a medical facility prior to delivery and the length of stay after delivery. The average time spent in a medical facility prior to delivery was about 7 hours. Considering that the average duration of labor is between ten hours for nulliparous women and six hours for multiparous women, most women were admitted for delivery around or right after the onset of labor. The average time spent in the hospital prior to delivery was shorter for rural women and for women with lower educational attainment or socioeconomic status. In contrast, women with any pregnancy complications and those who delivered by cesarean section were more likely to report a longer pre-delivery hospital stay than other women.

SUSIF standards of care stipulate 4 days of postpartum hospital care after uncomplicated deliveries, 5 days after pregnancy or delivery complications, and 6 days after deliveries by cesarean section. GERHS05 data show that 44% of women who gave birth in a medical facility were discharged in the first 4 days after delivery, while 35% were discharged after 5 days (right panel of Table 6.3.2). One in five women was discharged after 6 days. As expected, women who delivered by cesarean section and women who had pregnancy complications were more likely than their counterparts to have longer hospital stays.

Among the births that took place in a medical facility, 13% were delivered by cesarean section, ranging from a high of 18% in the region of Samegrelo to a low of 8% in the region of Adjara (Table 6.3.3 and Figure 6.3.5). As is the case in many countries,

Figure 6.3.3 **Percentage of Home Deliveries by Selected Characteristics Among Births in 2000–2005**

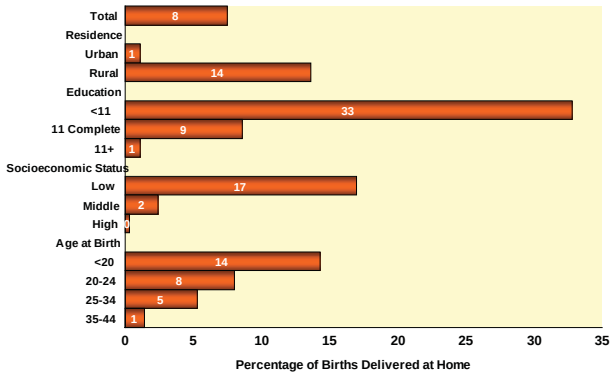


Figure 6.3.4 **Percentage of Home Deliveries, by Ethnic Group Among Births in the 5 Years Prior to the Survey: 1999 and 2005**

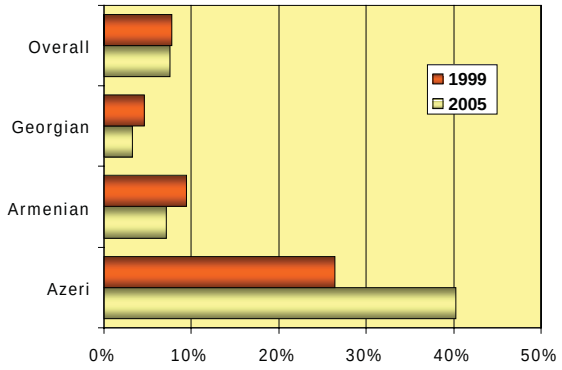
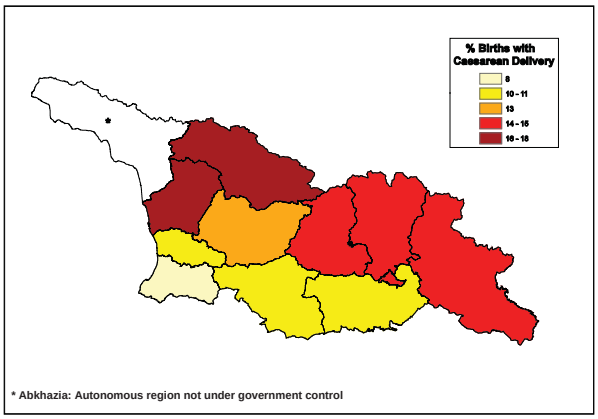


Figure 6.3.5 **Percentage of Caesarean Deliveries by Region—Births in 2000–2005**



the probability of delivering by cesarean section increases as maternal age, educational attainment, and socioeconomic status increases. Nineteen percent of women with pregnancy complications reported that they delivered by cesarean section.

Respondents were asked to identify the most important reason why they had delivered by cesarean section (Figure 6.3.6). The most frequent reasons given by the respondents included fetal malpresentation (22%), cesarean section performed on request (20%), previous cesarean section (16%), prolonged labor (14%), fetopelvic disproportion (11%), and fetal distress (10%); 7% reported that they received a cesarean section due to "other" factors. According to the Georgian Obstetrics and Gynecology Association, patient request of cesarean section delivery is not considered a medical indication. Women who lived in rural areas were twice as likely as urban women to report having a cesarean section due to prolonged labor (19% vs. 10%) and half as likely to have had a cesarean section performed on request (12% vs. 26%)(data not shown). Compared to the 1999 survey, the prevalence of cesarean deliveries doubled in most of regions; the greatest percentage increase was in the North-East region (3.5 times higher prevalence in 2005 than in 1999)(Figure 6.3.7). Most of these increases are attributable to the adoption of more inclusive indications for cesarean delivery into clinical practice.

Figure 6.3.6 **Primary Reason for Caesarean Delivery Among Births in 2000–2005**

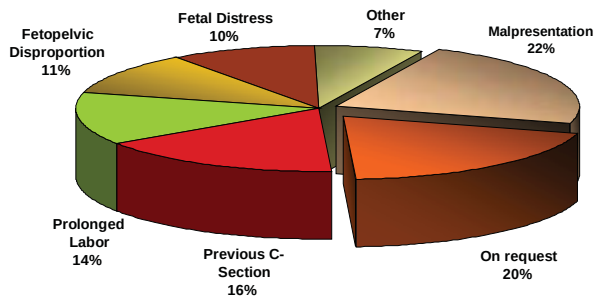
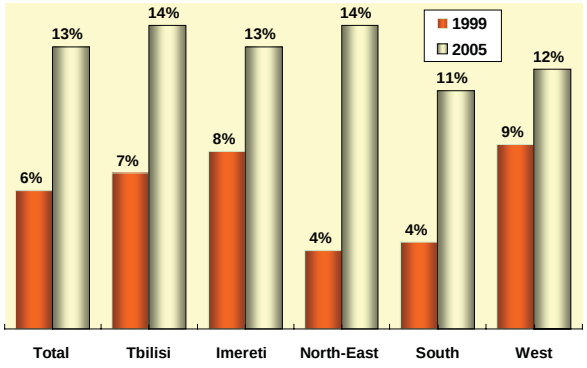


Figure 6.3.7 **Percentage of Caesarean Deliveries by Region Among Births in the 5 Years Prior to the Survey: 1999 and 2005**



6.4 Postpartum Care

Post-delivery assessments of the health of both the mother and infant are important, as is comprehensive counseling. Care of a new mother after delivery ensures that she is in good physical health and is prepared to care for her infant. The postpartum period is a critical time for health care providers to evaluate the physical and psychological health of a new mother and her infant, to detect and treat postpartum complications, and to provide counseling and support needed to address any specific problems related to child care (WHO, 2002). As discussed before, the WHO postpartum four-visit model is not currently included in the state program.

However, because the majority of deliveries take place in maternity hospitals, some immediate postpartum care to the mother and her newborn is provided by attending physicians and nurses during the post-birth hospital stay (4–6 days). Any postpartum care that is provided after the hospital discharge, tends to be focused on health and development of the newborn; maternal health usually receives little follow-up (CoReform Project, 2005)

As shown in Table 6.4.1, only 22% of mothers received postpartum care, but this was double the percentage found in the 1999 Reproductive Health Survey (Figure 6.4.1). Obviously, postpartum care is substantially less utilized in Georgia than prenatal care (95%). Despite the increase in rates of postpartum care between 1999 and 2005, Georgia ranks last in the region with regard to the percentage of women receiving such care, which highlights the need to include postpartum care coverage under the state maternal and child care program (Figure 6.4.1).

Rates of postpartum care ranged from a low of 8% in the region of Kvemo Kartli to a high of 38% in the region of Imereti (Figure 6.4.2). Rates increased with increases in the educational attainment and socioeconomic levels of respondents and were slightly higher among women who experienced complications during pregnancy (p=0.06). Of the women who received postpartum care, over 70% were counseled at least once on breastfeeding, breast care, child care, and nutrition. Notably, only 31% of the women received counseling on family planning. Although more new mothers had received postpartum care in 2005 compared to 1999, fewer women received comprehensive counseling. Rates of counseling on breastfeeding, self-care, child care, and especially immunization and nutrition declined during this period; only family planning counseling rates increased (from 20% to 31%) (Figure 6.4.3).

WHO recommends that the first postpartum visit take place within one week after birth (WHO, 2002) As shown in Table 6.4.2, 38% of respondents reported making a postpartum visit during the first six days after delivery, while an additional 45% made their initial visit one to two weeks after delivery; 16%

Figure 6.4.1 **Percentage of Mothers Receiving Postpartum Care Among Live Births in the 5 Years Prior to the Survey: Eastern Europe and Caucasus**

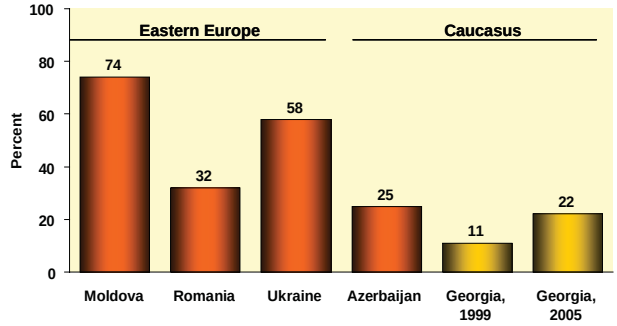


Figure 6.4.2 **Percentage of Mothers Receiving Postpartum Care by Region Among Live Births in 2000–2005**

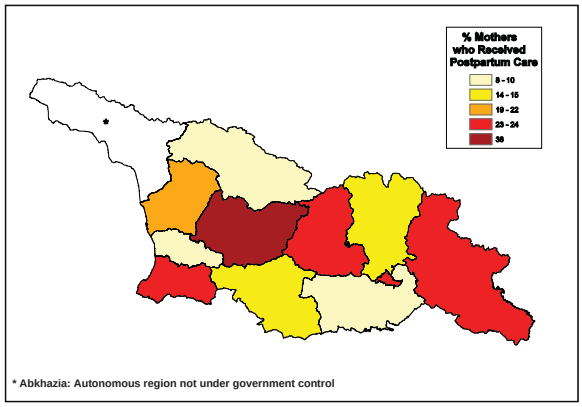
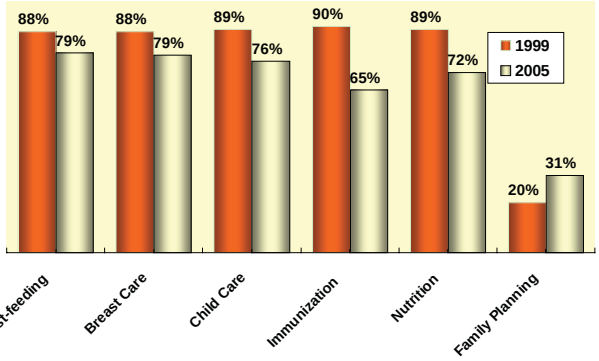


Figure 6.4.3 **Types of Postpartum Counseling Received by Women Who Received Postpartum Care Among Live Births in the 5 Years Prior to the Survey: 1999 and 2005**



of the women who received postpartum care made their initial visit more than two weeks after delivery. Unfortunately, the survey did not collect information about the type of health facility or health professional that provided postpartum care, or if the care was received in conjunction with well-baby check-ups.

Each mother was asked if a health professional checked the baby's health and, if so, how soon after delivery the examination was made. As shown in Table 6.4.3, overall, 80% of newborns received a well-baby checkup, the percentage was 87% in urban areas, compared to 72% in rural areas (p<0.01). The use of well-baby care ranged from a low of 58% in the region of Guria to a high of 88% in the region of Tbilisi (Figure 6.4.4). As has been the case with other indicators discussed in this chapter, the likelihood of receiving well-baby care increases as the educational attainment and socioeconomic status of the mother increases. Of the respondents who took their newborn to a health professional to be examined, 21% took their infant during the first six days following delivery, while 54% made their initial visit one to two weeks after delivery. An additional 24% took their newborn for an examination more than two weeks following delivery. Urban women were more likely than rural women to take their infant for a checkup soon after delivery (p<0.01).

As shown in Table 6.4.4, nearly 93% of births were registered, according to the mother. The percentage of births that were registered ranged from a low of 84% in the region of Kvemo Kartili to a high of 99% in the region of Samtskhe-Javakheti (Figure 6.4.5). Home births were least likely to be registered (72%). The majority of women registered their births during the first six days following delivery (70%), while an additional 27% did so one to four weeks after delivery. Urban women were more likely than rural women to register their births soon after delivery.

Figure 6.4.4 **Completion of Well-Baby Check-ups by Region Among Live Births in 2000–2005**

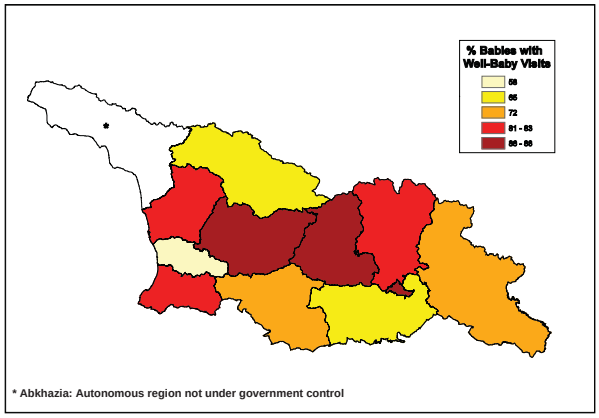
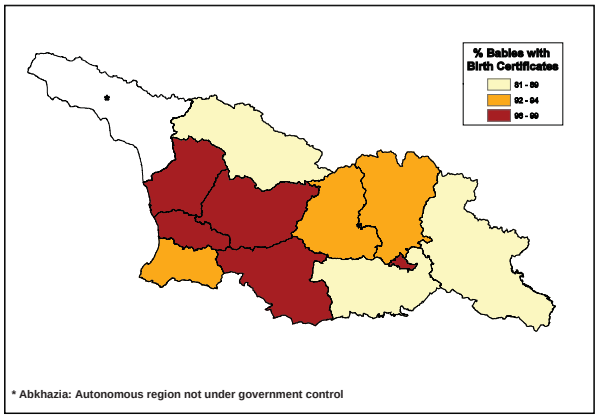


Figure 6.4.5 **Percentage of Babies with Birth Certificates Issued by Region Among Live Births in 2000–2005**



6.5 Smoking and Drinking During Pregnancy

Use of tobacco and alcohol during pregnancy are major risk factors for poor pregnancy outcomes. Maternal smoking is a major risk factor for poor pregnancy outcomes and is linked to low birth weight, preterm deliveries, sudden infant death syndrome, and respiratory problems in the newborn (DiFranza and Lew, 1996). The damaging effects of alcohol use during pregnancy include fetal growth retardation, mental retardation, physical abnormalities, especially dysmorphic facial features, and altered neonatal behaviors. No amount of alcohol is considered safe to drink during pregnancy, and there is a linear relationship between the quantity of alcohol consumed and the chances of birth defects (fetal alcohol syndrome) or physical and mental developmental problems. Research also suggests that women who drink alcohol while pregnant are more likely to have pregnancies ended in miscarriage, stillbirth, or premature delivery (Wilsnack SC et al., 1984; Kesmodel U et al., 2002).

Respondents who gave birth during the five years prior to the 2005 survey were asked "On average, how many cigarettes did you smoke per day after you found out you were pregnant?" and "How many times per week did you drink alcoholic beverages during the pregnancy?" As shown in Table 6.5, only 3.5% of the women were smokers at the time that they discovered they were pregnant, but almost two thirds of them (2.2%) continued to smoke after they found out they were pregnant. The proportion of women who continued to smoke during pregnancy was highest in Tbilisi (6.6%), among women whose maternal age at birth was 35–44 years (5%), and among women of "other" ethnicity (5.9%). Most of the mothers who smoked during pregnancy smoked five or more cigarettes per day. Only 1.3% of women reported drinking during pregnancy; most of these women (65%) consumed alcohol less than once per week (data not shown).

6.6 Pregnancy and Postpartum Complications

Routine measurement of blood pressure is an essential component of health risk assessment during prenatal visits. As shown in Table 6.6.1, 92% of women with births in the last five years reported routine measurement of their blood pressure during pregnancy. The probability of not having routine blood pressure measurements was highest among women living in the regions of Kvemo Kartli and Guria, and among women with less than a full secondary education.

Of the women whose blood pressure was measured, 11% were identified as having high blood pressure. The prevalence of reported high blood pressure during pregnancy was highest among women living in the regions of Tbilisi and Adjara, women whose maternal age at delivery was 35–44 years, and women who were giving birth to their third or higher birth order child. Overall, less than 1% of the women were hospitalized due to high blood pressure.

Nearly 13% of women with births in the last five years reported pregnancy complications requiring medical attention (Table 6.6.2). The conditions mentioned most often were risk of preterm delivery, anemia, water retention or edema, high blood pressure, and weak cervix. Pregnancy complications requiring medical attention were slightly more prevalent among women living in urban areas (16%) and women whose maternal age at delivery was 35–44 years (20%), and among third or higher order births (15%). Only 4% of women with pregnancy complications reported that they had been hospitalized for these conditions (data not shown). The probability of being hospitalized is directly associated with educational attainment and socioeconomic status.

Postpartum complications reported by women who gave birth in the five years prior to the survey are shown in Table 6.6.3. Overall, 14% of the women reported at least one postpartum complication. The complications mentioned most often were painful uterus, severe bleeding, painful urination, breast infection, and high fever. Rates of reported complications was slightly higher among women living in the region of Tbilisi, women who delivered by cesarean section and women whose children's birth weight was less than 2,500 grams.

6.7 Poor Birth Outcomes

Of all births that occurred during the five years prior to the survey, 16 per 1,000 were stillbirths (Table 6.7). This rate is comparable with the rate of 15.7 per 1,000 reported by governmental sources for the 2000–2004 period (WHO, 2005a).

Stillbirth rates ranged from a low of 7 stillbirths per 1,000 births in the region of Samegrelo to a high of 40.4 per 1,000 in the region of Samtskhe-Javakheti, but these differences are not statistical significant due to the small sample size in each region. The stillbirth rate was highest among women with a maternal age of 35–44 years at delivery, women who did not receive any prenatal care, and women who suffered complications during their pregnancies.

Overall, the low birth weight rate, which is the percentage of live births with birth weight under 2,500 grams, was nearly 5% among infants born alive. Slightly higher rates were reported by women living in the regions of Mtskheta-Mtianeti, Kvemo Kartli, Shida Kartli, and Samtskhe-Javakheti. Women with a maternal age of 35–44 years, women with first order and third order or higher births, and women who delivered by cesarean section also reported higher rates of low birth weight.

The reported prematurity rate (percentage of live births delivered before 37 weeks of gestation) for the same time period was 5%. Higher prematurity rates were associated with third or higher birth orders and pregnancy complications, and were also higher among Armenian women.

6.8 Breastfeeding

Infant feeding practices influence the health of both the child and the mother. Breastfeeding is a primary determinant of an infant's nutritional status and susceptibility to morbidity. Early initiation of breastfeeding permits the newborn to benefit immediately from colostrum, which is highly nutritious and contains antibodies necessary to protect babies from infection before their immune systems are fully mature. The health of the mother is also affected by breastfeeding, because it delays the return of ovulation and thus ensures a period of time during which she is not susceptible to the risk of another pregnancy.

WHO recommends that all infants are fed exclusively on breast milk from birth to 4–6 months of age and that some breastfeeding continue until the child is at least one year old (WHO, 1991). An infant is considered to be "exclusively" breastfed if he or she receives only breast milk and is "almost exclusively" or predominantly breastfed if he or she receives breast milk accompanied by water or other liquids (except other types of milk). Children with exclusive or almost exclusive breastfeeding are considered to be "fully" breastfed (Labbok and Krasovec, 1990).

Table 6.8.1 and Figure 6.8.1 show that 88% of infants born since January, 2000 were breastfed. This rate is essentially unchanged from the rate of 87% reported in the 1999 survey. Differences in breastfeeding by residence, region (Figure 6.8.2), maternal age, educational attainment, and birth order were slight, although Armenian women reported higher rates of breastfeeding than women of other ethnicities (94%). Among babies who weighed less than 2,500 grams at birth, only 62% were reported to have been breastfed.

According to WHO recommendations, early breastfeeding (i.e., within the first hour of life) should be encouraged after all spontaneous deliveries. However, only 10% of infants were breastfed within the first hour following birth. The percentage of infants that were breastfed within the first hour ranges from a high of 26% in the region of Samtskhe-Javakheti to a low of 0% in the region of Guria. An additional 48% of infants were breastfed within 1–23 hours after birth. Thus, overall, 58% of the infants were breastfed within the first day. Among infants delivered by cesarean section, only 31% were breastfed within the first day, while nearly 39% were breastfed for the first time 48 or more hours following birth. Since the 1999 survey, the proportion of babies who were breastfed within the first hour after birth doubled (from 5% to 10%), while the proportion of those who received breast milk 1–23 hours after birth increased from 28% to 48% (Figure 6.8.3).

Figure 6.8.4 compares breastfeeding rates in Georgia with other countries in the region. With respect to the

Figure 6.8.1 **Percentage of Children Ever Breastfed Among Children Born in the 5 Years Prior to Survey: 1999 and 2005**

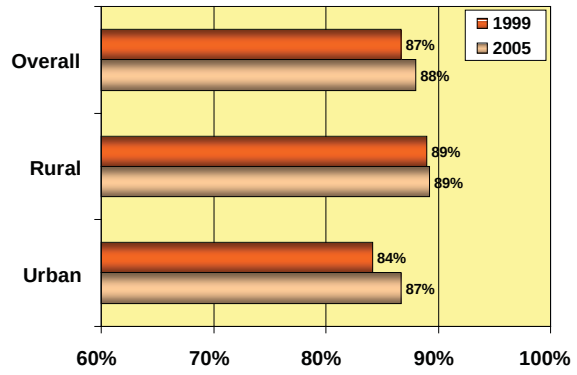


Figure 6.8.2 **Percentage of Children Ever Breastfed by Region Among Children Born in 2000–2005**

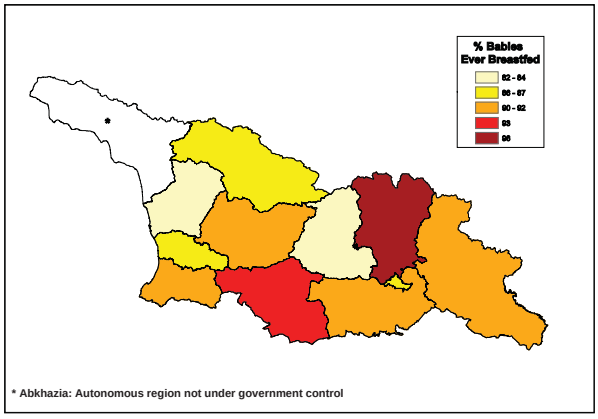


Figure 6.8.3 **Initiation of Breastfeeding Following Birth (in Hours) Among Children Born in the 5 Years Prior to the Survey: 1999 and 2005**

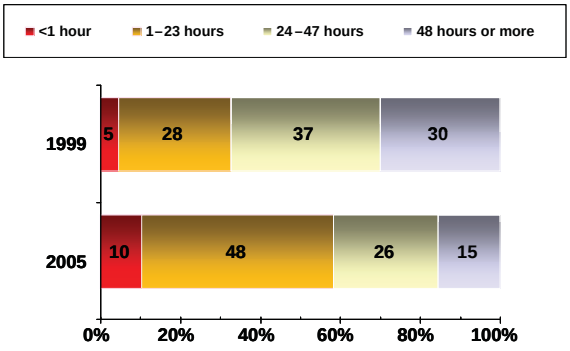
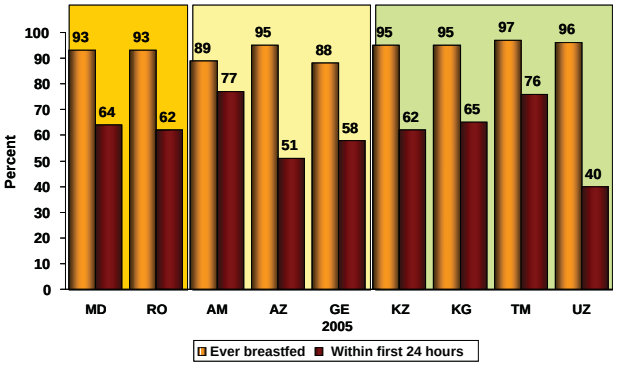


Figure 6.8.4 **Percent of Children Ever Breastfed and Initiation of Breastfeeding in the First 24 Hours Among Live Births in the 5 Years Prior to the Survey: Eastern Europe and Eurasia**



percentage of infants ever-breastfed, Georgia is in last place, followed by Armenia. With respect to the percentage of infants who were breastfed within the first day following birth, Georgia has the third lowest figure (58%), after Azerbaijan (51%) and Uzbekistan (40%).

The proportion of children under 5 years old still being breast-fed at the time of the survey was calculated by month of age (0–59 months); the denominator included all live births in the 5 years preceding the survey, regardless of survival. Those proportions were summed together to calculate the mean duration of breast-feeding. This method is known as the "current status mean" method (WHO, 1991). Durations of exclusive and full breast-feeding were calculated in the same way. Table 6.8.2 and Figure 6.8.5 show data on the mean duration of breastfeeding. The mean duration of any breastfeeding was 10.1 months, down slightly from the 10.6 months recorded in the 1999 survey. The mean duration of full breastfeeding (either exclusive breastfeeding or breastfeeding with water or liquids other than milk) was 3.7 months, unchanged from the 1999 survey. The duration of exclusive breastfeeding (only breast milk) was 1.8 months, an increase of about three weeks from the 1999 survey. With one exception, breastfeeding patterns were similar across all of the categories shown in Table 6.8.2. The exception is birth order: breastfeeding increases as birth order increases, suggesting that longer durations occur among older women and women living in the rural areas of Georgia.

Figure 6.8.6 compares mean duration of breastfeeding in Georgia with other countries in the region. In general, Georgia is intermediate with respect to duration of any breastfeeding and exclusive breastfeeding, while it is in fifth place with respect to duration of full breastfeeding.

Figure 6.8.5 **Average Duration of Breastfeeding (in Months) by Type of Breastfeeding Among Live Births in the 5 Years Prior to the Survey: 1999 and 2005**

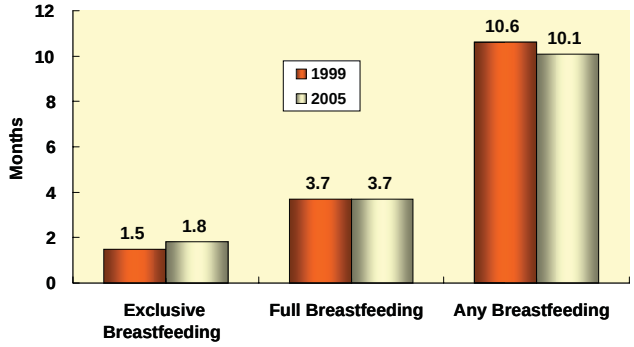
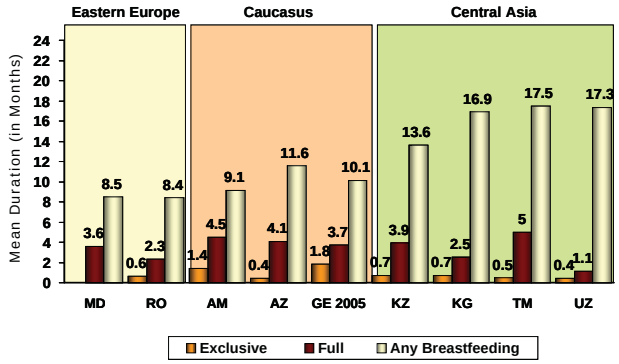


Figure 6.8.6 **Mean Duration of Breastfeeding (in Months) by Type of Breastfeeding Among Live Births in the 5 Years Prior to the Survey: Eastern Europe and Eurasia**



6.9 Infant and Child Mortality

One of the eight Millennium Development Goals is to decrease mortality worldwide among children under five by two-thirds between 1990 and 2015. In order to meet this goal, efforts must be scaled up worldwide to save the lives of children in their first year of life and particularly during their first four weeks.

Globally, average infant mortality rates have fallen steadily over recent years, from 65 per 1,000 in 1990 to 62 per 1,000 in 2000 and 58 per 1,000 in 2004. Consequently, rates of mortality among all children have fallen from 95 per 1,000 live births in 1990 to 84 per 1,000 live births in 2000 and 79 per 1,000 live births in 2004 (UNICEF, 2005). Yet, 10.6 million children still die each year, including about 6 million infants who die before they are one year old; 99% of these deaths occur in low- and middle-income countries. A substantial proportion of infant and child mortality is due to newborn mortality; in 2000, the neonatal death rate was 30 per 1,000 live births, which is about 40% of all deaths in children under 5 years of age and more than half of infant mortality. The major direct causes of neonatal deaths globally are infections (36%), premature birth (28%), and asphyxia (23%) (Lawn et al., 2005). Among children under 5, 73% of deaths are attributable to six causes: pneumonia (19%), diarrhea (18%), malaria (8%), neonatal sepsis or pneumonia (10%), preterm delivery (10%), and asphyxia at birth (8%) (Bryce et al., 2005).

The infant mortality rate (the probability of dying between birth and the first birthday, expressed per 1,000 live births), is an important measure of a nation's health status, well-being, and development status. One of the principal objectives of the GERHS05 was to estimate levels of and trends in infant and child mortality based on birth histories and child survival information obtained from a representative sample of Georgian women. The survey questionnaire included a series of questions for each live birth: date of birth, sex of child, survival status, and for children who had died, age at death. This information allows a direct calculation of infant and child mortality rates for precise periods of time, by means of life tables. A similar methodology has been employed by other population-based reproductive and demographic health surveys in the region, which allows comparative analyses across countries where these studies have been implemented.

Survey data-based mortality estimates should be viewed as minimum estimates because they may be subject to underreporting. For example, information on a deceased child whose mother has also died will simply not be gathered; some mothers may not acknowledge a child who died shortly after birth; others may not recall the exact date of birth or may be unwilling or unable to recall at what age a child has died. Despite these limitations, population-based survey estimates of infant and child mortality are quite robust and have proved instrumental in countries where official birth and death rates are incomplete or inaccurate. As shown in Figure 6.9.1, estimates from government sources in many former Soviet countries tend to underestimate the infant mortality rate, sometimes by a considerable margin. Survey-based infant mortality estimates in Georgia, Romania, and Uzbekistan in the late 1990s and early 2000s exceeded the official rates by 50%–70%; they exceeded official estimates by more than 100% in Armenia, Kazakhstan, Kyrgyzstan, and Turkmenistan; and by more than 300% in Azerbaijan (CDC and ORC Macro, 2003).

Survey data also have limitations. Because surveys count events experienced by a randomly selected sample, rather than the entire population, the resulting estimates are subject to a certain degree of sampling error (see Appendix B). To adjust for sampling error, 95% confidence intervals around survey estimates can be calculated; consequently, we can say with certainty that the true value of a statistic lies within the boundaries of the 95% confidence interval. The true value may be either higher or lower than the sample estimate. In the case of survey estimates of infant mortality rates (IMR)

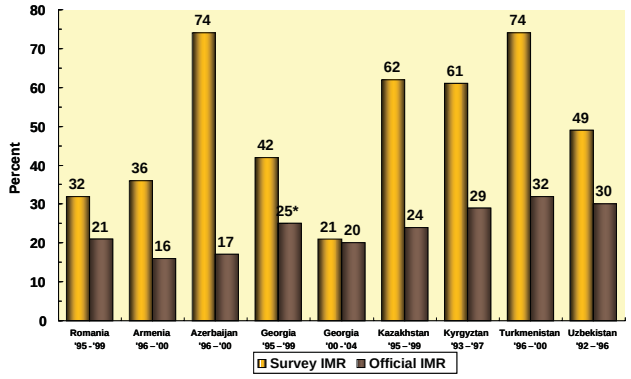
presented in Figure 6.9.1, the lower limit of the confidence interval is well above the official estimate in all but one country (Romania), suggesting that the official figures are subject to significant underreporting.

Although higher than in most of the former Soviet-bloc countries of central and eastern Europe, the IMR in Georgia is lower than the estimated IMRs in the republics of central Asia, and is gradually declining. The decline is less obvious in official vital records data because of substantial underreporting prior to 2002, particularly in the figures published by the national State Department of Statistics (SDS) (Figure 6.9.2). The official statistics are subject to limitations in that they are dependent on the accuracy of medical records of births and infant deaths, civil registry records, and calculations of aggregated official reports.

Two different sources of births and death data exist in Georgia. The SDS collects information from civil registration offices, which are responsible for the issuance of official births and deaths certificates to family members who submit birth or death certificates from medical facilities. The Center for Medical Statistics and Information (CMSI) collects aggregated reports of births and deaths from hospitals, maternity centers, and outpatient clinics. These reports are mainly used by Ministry of Labor, Health and Social Affairs (MoLHSA)and are not included in the governmental official reports, but they have consistently documented more births and deaths than the SDS reports.

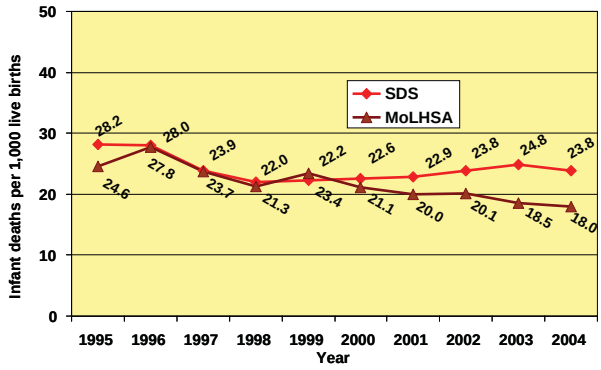
Recently, after an assessment conducted by WHO, SDS, and CMSI that showed substantial underreporting in SDS data, the government of Georgia, in collaboration with UNFPA and other international donors, launched an initiative to improve the vital registration system (WHO and CMSI, 2003). The MoLHSA put forth recommendations for implementation and calculation of child health indicators, revised the format of the medical death certificate, and provided instructions for completing and issuing the certificate (Order Nos. 141 of Oct. 2000 and 94/0 of Dec. 2000). A presidential decree—Decree 31 of December 10, 2002—put forth new rules for birth and death registration (Government of Georgia, 2002). With UNFPA support, training for health providers involved in certifying births and deaths and SDS coders, who are responsible for assigning ICD-10 codes, has been instituted throughout the country, although the sustainability of the

Figure 6.9.1 **Survey Estimates and Official Statistics Rates of Infant Mortality (IMR) in Eastern Europe and Eurasia**



* Official estimates were revised in Georgia in 2002, from 15 deaths per 1,000 to 24.9 per 1,000

Figure 6.9.2 **Infant Mortality in Georgia: Official Estimates for 1995–2004**



Source: Revised SDS estimates available at http://statistics.ge; Georgian MoLHSA in Tsuladze et al., 2005

training program is uncertain. The SDS now receives copies of the medical birth and death certificates, matches them with reports received from the civil registries, and assigns ICD-10 codes.

Thus, IMR trends that are based on official estimates are difficult to interpret for at least two reasons. First, the official mortality data prior to 2000 were seriously underreported; the 1999 survey estimates for the IMR of 41.6 infant deaths per 1,000 live births (CI =30.4–52.8) in 1995–1999 were 70% higher than the MoLHSA and the SDS revised average for the same period. Even the lower limit of 30.4 deaths per 1,000 was still about 26% higher than the average of the estimates from either official source. Second, the changes in birth and death registration after 2002 are likely to have improved the completeness and accuracy of official estimates.

Similar to the 1999 survey, GERHS05 data were used to calculate mortality levels among respondents' children, specifically, infant mortality (i.e., deaths before the first birthday), child mortality (i.e., deaths between 12 and 59 completed months of age), and child-under-5 mortality (i.e., deaths before the fifth birthday). Infant mortality was further divided into two periods: neonatal (0–28 days) and post-neonatal (29 days to 11 completed months). Table 6.9.1 presents mortality estimates for a 10 year period prior to the 2005 and 1999 surveys. The estimated infant mortality rate for the period January 1995–December 2004 was 29.0 per 1,000 live births, and the child-under-5 mortality rate was 32.7 per 1,000. The neonatal mortality rate was estimated at 19.1 per 1,000, while the post-neonatal mortality rate was estimated at 9.9 per 1,000. Thus, the neonatal rate is now almost twice as high as the post-neonatal rate and constitutes 66% of the infant mortality rate and 58% of under-5 mortality rate for the period 1995–2004. This finding is not unexpected: child mortality after the first month of life declines faster than the neonatal mortality; hence, the proportion of deaths that occur in the first 4 weeks of life (neonatal period), particularly in the first 7 days (early neonatal period) increases over time (Lawn et al., 2005).

A comparison of the 1999 and 2005 Georgia Reproductive Health Survey estimates shows that there has been a dramatic decline in the post-neonatal mortality rate, which in turn significantly lowered the infant and child under-5 mortality over the past 15 years (Table 6.9.1 and Figures 6.9.3–6.9.5).

Figure 6.9.3 **5-Year Period Post-Neonatal Mortality Rates Among Live Births in the 10 Years Prior to the Survey: 1999 and 2005**

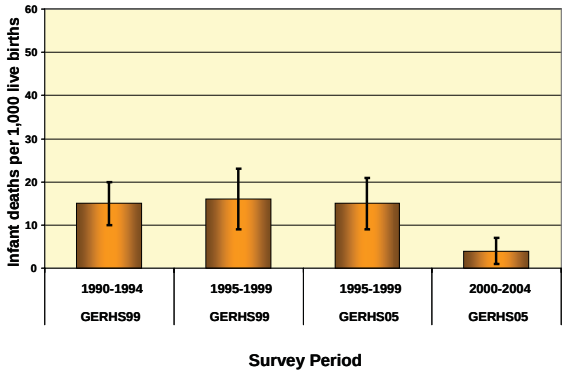


Figure 6.9.4 **5-Year Period Infant Mortality Rates Among Live Births in the 10 Years Prior to the Survey: 1999 and 2005**

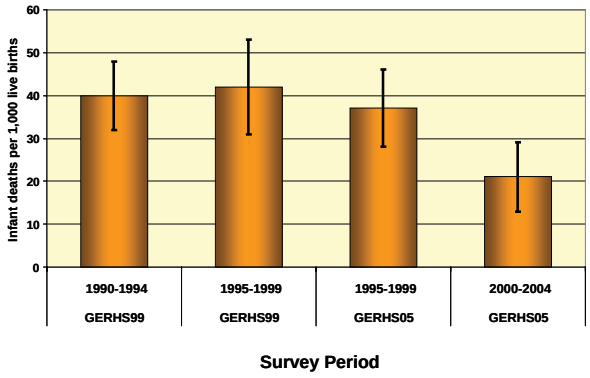
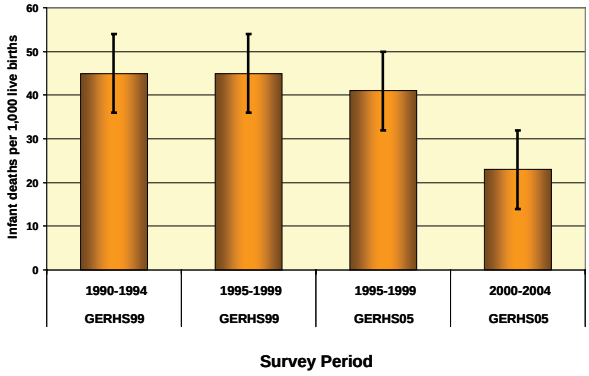


Figure 6.9.5 **5-Year Period Under-5 Mortality Rates Among Live Births in the 10 Years Prior to the Survey: 1999 and 2005**

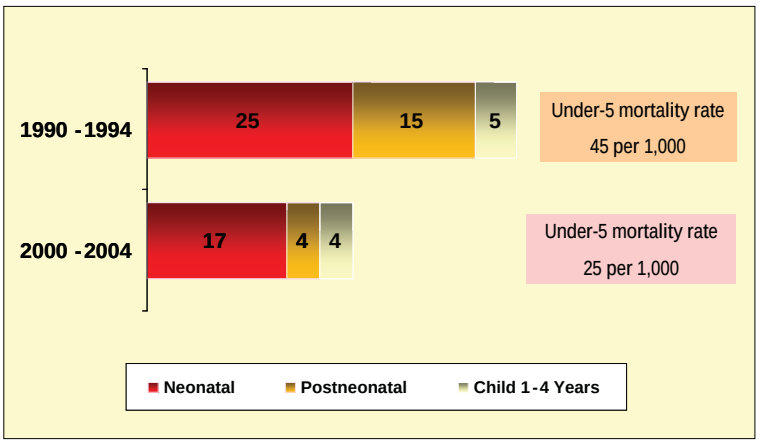


Infant mortality declined from a rate of 40 per 1,000 live births in 1990–1994 to 21 per 1,000 live births in 2000–2004; the child-under-5 mortality rate declined from 45 per 1,000 live births to 25 per 1,000 live births—a nearly 50% drop. Neonatal mortality also declined (from 25 per 1,000 to 19.1 per 1,000), while overall, child mortality remained basically unchanged (Figure 6.9.6).

As shown in Figure 6.9.3, a significant reduction occurred in the post-neonatal mortality level over a short time period. As a result, the decline in the estimated infant mortality rates during consecutive periods is also significant (Figure 6.9.4). Although there is considerable overlap between some of the confidence intervals for child-under-5 mortality estimates, the decline between the most distant periods is striking, even after accounting for sampling variability. Thus, survey estimates show a robust reduction in infant and under-5 mortality rates compared to the 1990–1994 levels, and much of the decline occurred through consistent reduction in post-neonatal mortality years. The World Summit for Children in 1990 called for a worldwide reduction in child mortality to below 70 deaths per 1000 live births—or a one-third reduction in countries with a lower mortality rate—by the year 2000 (UNICEF, 2001). Georgia has already achieved this goal: mortality is down from 45 to 25 deaths per 1,000 live births, meaning that the death of about 5,000 children under five years of age was prevented between 2000 and 2004. If the declining trend continues, it is very likely that Georgia will reach the Millennium Development Goals target of a 66% reduction in under-5 mortality rate by the year 2015 or earlier.

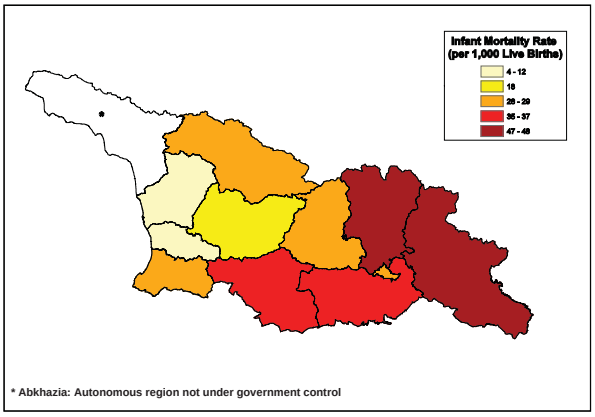
Focusing on the 2005 survey results for 1995–2004, the highest infant and under-5 mortality rates are found among children who are at greatest risk of poor health and development: those living in rural areas, those born to mothers under age 25, those whose mothers have low educational attainment, those born in households with low socioeconomic status; and those of Azeri descent (Table 6.9.2). For example, infant and under-5 mortality rates were higher among rural infants (32.3 per 1,000 and 38.1 per 1,000, respectively) than among urban infants (25.6 per 1,000 and 27.0 per 1,000). The greatest contributor to the urban/rural differential is the higher post-neonatal mortality in rural areas. The probability of dying in the post-

Figure 6.9.6 **Mortality Rates Among Infants and Children Under 5 Among Live Births in the 5 Years Prior to the Survey: 1999 and 2005**



neonatal period was three times higher among rural infants than among urban infants, which highlights the need for improvements in socioeconomic and health conditions in rural areas. Although the differences were not statistically significant, the lowest infant mortality rates were reported in Imereti, Samegrelo, and Guria and the highest rates were reported in Kakheti and Shida Kartli (Figure 6.9.7).

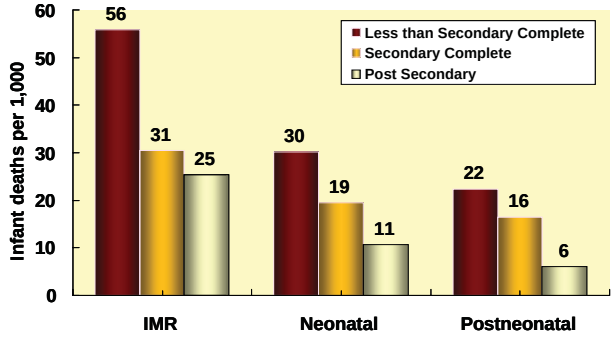
Figure 6.9.7 **Infant Mortality Rate (per 1,000) by Region—Live Births in the 10 Years Prior to the Survey**



Infant mortality rates (and subsequently, under-5 mortality rates) were particularly influenced by the educational attainment of the mother (Figure 6.9.8). Infants born to women with less than a complete secondary education had a 150% higher risk of dying than infants born to women with the highest educational attainment. Most of this risk was in the postneonatal period, when babies born to the least educated women were about 4 times more likely to die than those whose mothers were highly educated.

The risk of dying before 1 and 5 years of age, respectively, was twice as high for Azeri children than for Georgian children (54.8 per 1,000 vs. 25.2 per 1,000 and 58.1 per 1,000 vs. 29.1 per 1,000. Compared to other ethnic groups, Azeri children also exhibit a unique pattern of mortality during the first year of life. While their survival during neonatal period is very similar with that of children with other ethnic backgrounds, 63% of Azeri children die during the post-neonatal period. This is the highest post-neonatal mortality in Georgia, 3.5 times higher than the national average.

Figure 6.9.8 **Infant Mortality Rates—Live Births in the 10 Years Prior to the Survey**



Both infant mortality and under-5 mortality increased with birth order. Specifically, the children at highest risk of dying were those born to women with at least two previous births. Births occurring within a birth interval of less than 24 months had a twice as high a risk of infant and child mortality than births occurring after an interval of 24 months or greater. Approximately one-fifth of all births to respondents had occurred within a birth interval of less than 24 months. This indicates a continuing need for education programs promoting the benefits of child spacing and for greater availability of reliable, reversible methods of contraception.

Gender differentials in mortality rates were obvious only in the neonatal period, probably because girls have a well-known biological survival advantage soon after birth (Ulizzi and Zonta, 2002). Neonatal mortality among males was almost twice as high as among females (24 per 1,000 vs. 13.1 per 1,000), which contributed to higher infant and under-five mortality rates among males.

In conclusion, child survival in Georgia improved substantially over the past 15 years, mainly through reductions in post-neonatal mortality, which is more amenable to public health approaches (e.g. immunization, breastfeeding). Given that neonatal deaths account for 66% of infant mortality and 58% of child under-5 deaths in Georgia, further reductions in child mortality will depend on substantial improvements in survival during the neonatal period. Reductions in neonatal deaths, particularly early neonatal deaths, will depend on provision of effective, individualized maternal and child care. Early neonatal deaths that occur during the first seven days and account for most of the neonatal deaths could be lowered by preventing birth asphyxia, prematurity, and maternal morbidity and mortality during labor and postpartum; late neonatal deaths, which are mainly due to infections, could be prevented through correct management of neonatal infections through child-health services and better access to emergency obstetric and neonatal care. Overall, neonatal mortality rates could be reduced by educating women regarding the benefits of spacing births, ensuring access to family planning services, and improving maternal nutrition and breastfeeding.

Table 6.2.1 Initiation of Prenatal Care by Pregnancy Trimester and Number of Prenatal Visits, by Selected Characteristics Among Births in 2000–2005 (Percentage Distribution)—Reproductive Health Survey: Georgia 2005

	Trimester of First Prenatal Visit					Number of Prenatal Visits							
Characteristic	No Visits	1st	2nd	3rd	DK	No Visit	1-3	4-6	7-9	10+	DK	Total	No. of Cases
Total	4.6	70.6	23.1	1.7	0.0	4.6	19.3	37.9	18.1	19.0	1.1	100.0	2,017
Residence													
Urban	2.3	78.8	18.0	0.9	0.0	2.3	10.1	36.6	22.1	27.6	1.3	100.0	896
Rural	7.0	62.5	28.1	2.4	0.1	7.0	28.3	39.1	14.2	10.6	0.8	100.0	1,121
Region													
Kakheti	11.1	55.6	30.4	2.9	0.0	11.1	30.0	37.2	11.6	10.1	0.0	100.0	187
Tbilisi	1.1	83.7	14.3	0.9	0.0	1.1	6.4	34.9	22.5	32.5	2.6	100.0	391
Shida Kartli	8.4	64.5	25.8	1.3	0.0	8.4	12.3	38.1	32.9	8.4	0.0	100.0	138
Kvemo Kartli	7.1	66.0	24.8	2.1	0.0	7.1	35.7	30.7	13.9	10.9	1.7	100.0	213
Samtskhe-Javakheti	3.0	60.6	36.4	0.0	0.0	3.0	33.8	46.5	10.1	5.6	1.0	100.0	173
Adjara	4.1	64.3	27.5	4.1	0.0	4.1	24.6	46.8	8.8	15.8	0.0	100.0	156
Guria	6.3	71.4	22.2	0.0	0.0	6.3	31.7	45.2	9.5	6.3	0.8	100.0	114
Samegrelo	6.3	68.3	23.9	1.4	0.0	6.3	15.5	31.7	23.9	22.5	0.0	100.0	133
Imereti	0.8	77.2	21.1	0.8	0.0	0.8	11.8	40.2	19.9	26.8	0.4	100.0	229
Mtskheta-Mtianeti	7.6	70.3	19.3	1.4	1.4	7.6	11.7	42.8	25.5	10.3	2.1	100.0	134
Racha-Svaneti	5.8	69.2	19.9	4.5	0.6	5.8	26.3	37.8	17.3	12.2	0.6	100.0	149
Age Group (at Birth)													
< 20	5.9	69.4	22.3	2.2	0.2	5.9	22.5	41.2	14.7	14.5	1.2	100.0	337
20–24	4.7	69.5	24.7	1.1	0.0	4.7	19.5	38.1	17.2	19.8	0.7	100.0	717
25–34	2.9	73.6	21.4	2.1	0.0	2.9	17.3	37.0	21.4	20.5	1.0	100.0	827
35–44	10.4	63.3	25.4	0.8	0.0	10.4	21.0	33.1	14.1	18.6	2.9	100.0	136
Education													
Secondary incomplete or less	13.6	50.7	31.4	4.0	0.3	13.6	34.9	30.0	12.7	8.0	0.9	100.0	261
Secondary complete	4.9	68.1	25.5	1.5	0.0	4.9	23.7	41.8	16.0	12.9	0.7	100.0	673
Technicum/university	2.4	76.8	19.6	1.2	0.0	2.4	13.0	37.4	20.7	25.2	1.3	100.0	1,083
Socioeconomic Status													
Low	10.0	58.5	29.3	2.1	0.0	10.0	31.0	38.3	10.5	9.4	0.7	100.0	821
Middle	1.7	74.4	22.1	1.7	0.1	1.7	14.8	38.5	23.3	20.4	1.2	100.0	882
High	0.6	86.5	12.3	0.6	0.0	0.6	5.8	35.3	21.3	35.6	1.5	100.0	314
Birth Order													
First birth	2.8	78.1	17.8	1.3	0.1	2.8	14.7	38.9	18.6	23.4	1.5	100.0	912
Second birth	4.0	67.5	26.7	1.8	0.1	4.0	21.9	38.4	19.3	15.6	0.8	100.0	735
Third or higher	11.0	56.5	30.1	2.4	0.0	11.0	26.3	33.9	14.5	13.9	0.4	100.0	370
Ethnicity													
Georgian	3.5	73.8	21.2	1.4	0.1	3.5	14.9	39.0	20.3	21.4	0.9	100.0	1,673
Azeri	11.9	58.5	27.2	2.3	0.0	11.9	41.2	28.1	9.2	7.6	1.9	100.0	151
Armenian	5.2	51.5	41.5	1.9	0.0	5.2	44.7	40.6	5.4	2.2	1.9	100.0	130
Other	14.2	54.6	25.7	5.6	0.0	14.2	25.9	29.2	9.0	21.6	0.0	100.0	63
Baby's Weight at Birth													
< 2500 grams	4.3	73.7	20.7	1.3	0.0	4.3	16.9	43.8	14.2	19.2	1.6	100.0	100
2500 grams	4.3	70.8	23.2	1.6	0.0	4.3	18.8	37.9	18.6	19.3	1.1	100.0	1,880
Unknown	21.2	55.1	20.9	2.8	0.0	21.2	49.3	21.0	5.7	2.8	0.0	100.0	37

Table 6.2.2 Percentage of Births Where Women Received Specific Types of Information During Prenatal Care Visits Among Births in 2000–2005 to Women Who Had Any Prenatal Care, by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Type of Prenatal Care Information								
Characteristic	Nutrition	Delivery	Breast-feeding	Pregnancy Complications	Effects of Smoking	Effects of Alcohol	Postnatal Care	Family Planning	No. of Cases
Total	77.3	68.8	66.8	55.9	50.3	49.1	41.8	25.6	1,917
Residence									
Urban	82.3	74.7	74.1	64.0	58.1	56.7	48.2	30.2	872
Rural	72.1	62.6	59.1	47.5	42.3	41.2	35.1	20.9	1,045
Region									
Kakheti	71.2	63.6	62.0	51.6	47.8	47.3	37.0	23.4	166
Tbilisi	88.2	78.1	79.7	68.1	65.0	62.7	51.8	35.3	387
Shida Kartli	81.0	72.5	65.5	57.0	45.1	45.1	40.8	12.0	130
Kvemo Kartli	77.4	69.7	65.2	54.8	43.0	41.2	41.6	19.5	196
Samtskhe-Javakheti	66.7	68.8	57.8	57.8	42.2	41.7	47.9	9.4	167
Adjara	61.6	51.8	51.8	39.6	39.0	38.4	31.1	28.7	149
Guria	73.7	56.8	53.4	43.2	32.2	33.9	33.1	13.6	108
Samegrelo	69.9	51.9	51.1	34.6	35.3	33.8	19.5	23.3	124
Imereti	80.3	75.4	74.6	62.3	57.8	57.0	44.7	28.7	227
Mtskheta-Mtianeti	84.3	81.3	70.9	65.7	53.0	48.5	53.0	29.9	123
Racha-Svaneti	78.2	70.1	68.7	49.0	63.3	60.5	47.6	38.1	140
Education Level									
Secondary incomplete or less	70.3	63.2	56.9	42.2	37.6	37.0	29.2	13.7	227
Secondary complete	73.6	67.3	62.9	51.6	45.1	45.0	37.9	20.9	628
Technicum/university	80.8	70.9	71.0	61.3	56.0	53.9	46.7	30.8	1,062
Socioeconomic Status									
Low	70.3	63.5	58.9	44.4	42.6	41.5	31.5	19.0	739
Middle	78.7	69.6	69.2	60.1	51.3	49.8	45.5	26.4	866
High	86.9	76.8	75.7	67.6	62.6	61.6	52.2	36.4	312
Birth Order									
First birth	79.9	70.5	68.9	58.3	51.7	50.5	43.5	25.7	884
Second birth	76.6	67.2	67.0	53.9	50.6	49.0	41.1	27.1	704
Third or higher	71.1	67.3	59.8	53.2	45.7	45.1	38.2	22.2	329
Prenatal Care Visits									
1–3	63.1	52.1	50.8	41.2	37.4	35.0	27.2	17.3	405
4–6	74.2	71.1	66.4	55.9	53.3	51.3	43.8	24.0	782
7–9	85.2	76.3	73.7	60.4	56.6	57.5	46.0	26.0	363
10+	88.9	75.2	78.0	65.2	52.8	51.9	49.4	37.5	346
Don't know	*	*	*	*	*	*	*	*	21
Place of Prenatal Care									
Rural ambulatory clinic	58.1	45.6	43.2	34.7	32.2	33.8	29.2	8.5	55
Village hospital	58.5	43.2	39.1	43.2	25.4	23.0	17.2	14.6	45
Women's consultation clinic	79.2	70.9	70.5	60.4	56.8	55.6	46.3	29.1	1,004
Raional maternity/hospital	75.7	68.2	63.3	48.4	40.5	38.9	34.4	21.0	741
Private office/clinic/hospital	97.1	82.8	91.1	92.7	87.2	85.7	78.9	43.7	61
Other	*	*	*	*	*	*	*	*	11

* Excludes 11 births with other source of prenatal care.

Table 6.2.3 Selected Measurements Performed During Prenatal Care Visits by Selected Characteristics Births in 2000–2005 Among Women with Any Prenatal Care
Reproductive Health Survey: Georgia 2005

	Measurements Performed During Prenatal Care Visits						
Characteristic	Basic Blood Tests	Urine Tests	Weight Measured	Height Measured	Blood Pressure Measured	HIV Test	No. of Cases
Total	97.2	97.7	95.5	90.6	91.5	45.7	1,917
Residence							
Urban	98.8	99.2	97.5	92.4	93.7	63.1	872
Rural	95.6	96.1	93.4	88.7	89.2	27.6	1,045
Region							
Kakheti	91.8	88.0	83.2	77.7	90.2	14.7	166
Tbilisi	99.1	99.8	97.1	89.3	95.1	69.4	387
Shida Kartli	99.3	99.3	98.6	93.7	85.9	43.7	130
Kvemo Kartli	91.9	94.6	91.9	87.3	84.6	25.8	196
Samtskhe-Javakheti	99.5	99.5	99.5	90.6	87.0	31.3	167
Adjara	98.8	99.4	96.3	97.0	98.8	53.7	149
Guria	97.5	98.3	98.3	83.1	84.7	28	108
Samegrelo	97.7	97.7	97.7	97.0	91.7	39.8	124
Imereti	98.8	100.0	98.4	95.5	91.0	52.5	227
Mtskheta-Mtianeti	98.5	100.0	99.3	93.3	97.0	48.5	123
Racha-Svaneti	96.6	96.6	93.2	92.5	95.9	9.5	140
Age Group (at Birth)							
< 25	96.7	96.8	93.8	89.1	89.2	40.5	995
25–34	97.5	98.5	97.2	91.7	94.2	51	799
35–44	99.2	100.0	99.2	95.9	93.6	55.3	123
Education Level							
Secondary incomplete or less	88.6	88.4	86.5	80.2	82.1	18.3	227
Secondary complete	97.6	98.3	94.9	92.0	89.7	38.9	628
Technicum/university	98.9	99.3	97.8	92.0	94.5	55.3	1,062
Socioeconomic Status							
Low	95.0	95.9	94.1	89.3	87.6	28.5	739
Middle	97.9	98.1	96.3	92.2	93.1	47.6	866
High	99.7	100.0	96.5	89.3	95.1	73.6	312
Birth Order							
First birth	98.6	98.6	96.3	91.8	90.9	45.3	884
Second birth	95.9	97.1	94.3	88.3	91.0	46.8	704
Third or higher	96.0	96.4	95.6	92.1	94.4	44.6	329
Prenatal Care Visits*							
1–3	91.4	92.7	89.1	83.9	86.7	20.5	405
4–6	98.1	98.5	95.9	92.3	92.3	46.2	782
7–9	99.4	98.9	97.8	91.3	91.4	53.9	363
10+	99.3	99.8	99.0	93.4	94.4	62.6	346
Place of Prenatal Care†							
Rural ambulatory	81.7	80.1	75.2	75.2	81.3	16.3	55
Village hospital	74.3	84.0	76.9	74.7	69.6	14.9	45
Women's consultation clinic	98.9	99.2	97.8	94.5	93.7	59.4	1,004
Raional maternity/hospital	97.7	98.0	95.5	87.4	90.2	27.9	741
Private office/clinic/hospital	100.0	100.0	95.6	94.1	97.0	75.8	61

* Excludes 21 births with unknown number of prenatal care visits.

† Excludes 11 births with other source of prenatal care.

Table 6.2.4 Use of Ultrasound Exams During Pregnancy and Time of First Exam by Selected Characteristics – Births in 2000–2005 Among Women with Any Prenatal Care Reproductive Health Survey: Georgia 2005

	Had Ultrasound Exam		Time of First Ultrasound Exam (in weeks)						
Characteristic	%	No. of Cases	≤13	14–19	20–26	27+	Does Not Remember	Total	No. of Cases
Total	84.3	1,917	44.0	18.9	24.4	12.6	0.1	100.0	1,573
Residence									
Urban	93.5	872	51.6	18.8	19.6	10.0	0.1	100.0	794
Rural	74.8	1,045	34.1	19.2	30.6	16.0	0.2	100.0	779
Region									
Kakheti	73.9	166	35.3	14.0	35.3	14.7	0.7	100.0	121
Tbilisi	96.7	387	61.2	16.2	17.1	5.5	0.0	100.0	374
Shida Kartli	90.8	130	31.0	23.3	24.0	21.7	0.0	100.0	117
Kvemo Kartli	72.9	196	45.3	16.8	20.5	16.8	0.6	100.0	141
Samtskhe-Javakheti	77.6	167	26.8	28.9	28.2	16.1	0.0	100.0	128
Adjara	86.0	149	29.1	22.0	32.6	16.3	0.0	100.0	128
Guria	81.4	108	29.2	22.9	28.1	19.8	0.0	100.0	89
Samegrelo	79.7	124	33.0	20.8	34.0	12.3	0.0	100.0	98
Imereti	82.4	227	45.8	19.4	22.9	11.9	0.0	100.0	187
Mtskheta-Mtianeti	90.3	123	52.9	17.4	20.7	9.1	0.0	100.0	111
Racha-Svaneti	56.5	140	33.7	18.1	25.3	21.7	1.2	100.0	79
Age Group (at Birth)									
< 25	81.5	995	43.9	16.7	25.7	13.5	0.1	100.0	793
25–34	87.0	799	43.4	21.2	23.3	12.0	0.2	100.0	673
35–44	90.2	123	47.6	21.8	20.9	9.8	0.0	100.0	107
Education Level									
Secondary incomplete or less	67.5	227	39.2	16.8	26.8	16.5	0.7	100.0	147
Secondary complete	79.7	628	35.0	19.6	29.2	16.0	0.2	100.0	490
Technicum/university	90.5	1,062	49.2	19.0	21.6	10.3	0.0	100.0	936
Socioeconomic Status									
Low	73.1	739	32.9	19.0	31.3	16.6	0.2	100.0	526
Middle	88.1	866	44.4	18.4	24.0	13.0	0.2	100.0	748
High	96.4	312	58.8	20.0	15.3	5.9	0.0	100.0	299
Birth Order									
First birth	86.7	884	47.1	16.5	25.1	11.3	0.0	100.0	752
Second birth	82.5	704	40.5	19.9	24.5	14.7	0.4	100.0	569
Third or higher	81.1	329	41.9	24.7	21.6	11.8	0.0	100.0	252
Prenatal Care Visits*									
1–3	67.0	405	30.3	13.0	34.5	22.2	0.0	100.0	261
4–6	85.7	782	36.2	23.0	26.3	14.3	0.2	100.0	653
7–9	88.1	363	53.3	17.6	21.6	7.5	0.0	100.0	314
10+	94.7	346	60.0	17.1	16.3	6.2	0.3	100.0	324
Place of Prenatal Care†									
Rural ambulatory clinic	44.7	55	28.3	33.3	12.0	22.9	3.6	100.0	25
Village hospital	64.0	45	35.8	10.4	31.1	22.7	0.0	100.0	27
Women's consultation clinic	87.4	1,004	47.7	18.8	23.5	10.1	0.0	100.0	859
Raional maternity/hospital	84.1	741	36.5	19.9	27.6	15.7	0.2	100.0	602
Private office, clinic or hospital	94.1	61	71.0	11.3	7.8	9.8	0.0	100.0	57

* Excludes 21 births with unknown number of prenatal care visits.

† Excludes 3 births with other source of prenatal care.

Table 6.3.1 Place of Delivery for Births in 2000–2005 by Selected Characteristics (Percentage Distribution)—Reproductive Health Survey: Georgia 2005

Characteristic	Place of Delivery				Total	No. of Cases
	Government Hospital or Maternity Ward	Tbilisi Maternity Hospital	Other Medical Facility	At Home		
Total	71.1	20.8	0.5	7.5	100.0	2,017
Residence						
Urban	65.3	33.1	0.5	1.1	100.0	896
Rural	76.7	9.1	0.7	13.5	100.0	1,121
Region						
Kakheti	60.9	7.7	1.4	30.0	100.0	187
Tbilisi	39.3	60.7	0.0	0.0	100.0	391
Shida Kartli	86.5	10.3	0.0	3.2	100.0	138
Kvemo Kartli	63.0	20.6	1.3	15.1	100.0	213
Samtskhe-Javakheti	93.9	2.0	0.0	4.0	100.0	173
Adjara	89.5	1.2	0.0	9.4	100.0	156
Guria	85.7	2.4	0.0	11.9	100.0	114
Samegrelo	91.5	8.5	0.0	0.0	100.0	133
Imereti	95.1	1.6	1.6	1.6	100.0	229
Mtskheta-Mtianeti	62.1	34.5	0.7	2.8	100.0	134
Racha-Svaneti	82.7	8.3	0.0	9.0	100.0	149
Age Group (at Birth)						
< 20	75.6	9.6	1.0	13.9	100.0	337
20–24	72.4	19.4	0.6	7.6	100.0	717
25–34	67.9	26.4	0.4	5.3	100.0	827
35–44	69.8	28.8	0.0	1.4	100.0	136
Education Level						
Secondary incomplete or less	59.8	6.1	1.3	32.8	100.0	261
Secondary complete	78.6	13.2	0.5	7.7	100.0	673
Technicum/university	69.3	29.2	0.4	1.1	100.0	1,083
Socioeconomic Status						
Low	77.4	5.6	0.3	16.6	100.0	821
Middle	74.0	23.1	0.6	2.3	100.0	882
High	50.5	48.3	0.9	0.3	100.0	314
Ethnicity						
Georgian	72.7	23.9	0.5	3.0	100.0	1,673
Azeri	53.2	4.7	1.9	40.2	100.0	151
Armenian	85.0	7.9	0.0	7.1	100.0	130
Other	48.0	18.5	0.0	33.5	100.0	63
Birth Order						
First birth	70.5	24.4	0.4	4.7	100.0	912
Second birth	71.3	19.5	0.9	8.3	100.0	735
Third or higher	71.9	15.2	0.3	12.7	100.0	370
Baby's Weight at Birth						
< 2,500 grams	69.4	25.3	0.0	5.3	100.0	100
2,500 grams	72.1	21.2	0.6	6.1	100.0	1,880
Unknown	24.9	3.7	0.0	71.4	100.0	37

Table 6.3.2 Average Time Between Admission and Delivery and Nights Spent in a Medical Facility by Selected Characteristics Births in 2000–2005 (Percentage Distribution)—Reproductive Health Survey: Georgia 2005

	Average Time (in Hours)		Nights Spent in a Medical Facility Between Delivery and Discharge					
Characteristic	%	No. of Cases	≤4	5	6–7	8+	Total	No. of Cases
Total	7.4	2,017	44.2	35.2	13.6	7.0	100.0	1,863
Residence								
Urban	7.9	896	42.6	36.9	14.4	6.1	100.0	884
Rural	6.9	1,121	46.0	33.3	12.7	8.0	100.0	979
Region								
Kakheti	5.0	187	52.4	29.0	6.9	11.7	100.0	129
Tbilisi	8.8	391	43.0	36.4	15.5	5.1	100.0	391
Shida Kartli	7.6	138	52.0	28.7	13.3	6.0	100.0	134
Kvemo Kartli	6.0	213	61.4	24.8	7.4	6.4	100.0	178
Samtskhe-Javakheti	8.0	173	58.9	21.1	7.9	12.1	100.0	165
Adjara	8.1	156	45.2	34.2	15.5	5.2	100.0	141
Guria	7.1	114	54.1	31.5	8.1	6.3	100.0	102
Samegrelo	7.1	133	35.2	43.7	14.1	7.0	100.0	133
Imereti	7.1	229	22.7	50.4	18.6	8.3	100.0	225
Mtskheta-Mtianeti	7.1	134	37.6	39.0	18.4	5.0	100.0	130
Racha-Svaneti	8.8	149	28.9	30.3	30.3	10.6	100.0	135
Age Group (at Birth)								
< 20	6.9	337	47.4	29.5	16.2	6.9	100.0	289
20–24	5.6	717	46.7	37.4	11.5	4.5	100.0	657
25–34	8.6	827	42.2	35.1	13.5	9.2	100.0	784
35–44	10.8	136	36.7	37.9	18.3	7.1	100.0	133
Education Level								
Secondary incomplete or less	4.0	261	58.2	25.4	11.5	4.9	100.0	180
Secondary complete	7.2	673	46.7	33.3	13.3	6.7	100.0	615
Technicum/university	8.3	1,083	40.6	37.8	14.1	7.5	100.0	1,068
Socioeconomic Status								
Low	5.9	821	48.5	33.4	11.7	6.4	100.0	690
Middle	7.7	882	41.5	36.9	14.0	7.6	100.0	860
High	9.7	314	43.2	34.4	16.0	6.4	100.0	313
Birth Order								
First birth	8.8	912	41.7	36.1	14.1	8.1	100.0	867
Second birth	5.7	735	45.8	35.0	12.6	6.6	100.0	675
Third or higher	6.9	370	48.3	33.1	14.4	4.2	100.0	321
Baby Weight at Birth								
< 2,500 grams	9.4	100	39.7	26.7	14.0	19.6	100.0	94
≥2,500 grams	7.4	1,880	44.4	35.7	13.6	6.3	100.0	1,757
Don't know/didn't respond	3.2	37	*	*	*	*	*	12
Type of Delivery								
Vaginal	3.1	1,780	49.7	37.4	10.7	2.1	100.0	1,626
Cesarean section	39.7	237	6.9	20.0	33.4	39.8	100.0	237
Pregnancy Complications								
Yes	12.5	236	30.4	35.5	18.9	15.2	100.0	231
No	6.7	1,780	46.3	35.2	12.8	5.7	100.0	1,631
Don't know/didn't respond	*	1	*	*	*	*	*	1

* Fewer than 25 cases in this category.

Table 6.3.3 Percentage of Births Delivered by Cesarean Section by Selected Characteristics Among Births in 2000–2005 Delivered in Medical Facilities Reproductive Health Survey: Georgia 2005

Characteristic	Caesarean Deliveries %	No. of Cases
Total	13.0	1,863
Residence		
Urban	13.7	884
Rural	11.9	979
Region		
Kakheti	14.5	129
Tbilisi	13.9	391
Shida Kartli	14.7	134
Kvemo Kartli	11.4	178
Samtskhe-Javakheti	9.5	165
Adjara	7.7	141
Guria	9.9	102
Samegrelo	17.6	133
Imereti	13.2	225
Mtskheta-Mtianeti	13.5	130
Racha-Svaneti	15.5	135
Age Group (at Birth)		
< 20	10.4	289
20–24	8.6	657
25–34	16.2	784
35–44	20.6	133
Education Level		
Secondary incomplete or less	7.6	180
Secondary complete	10.8	615
Technicum/university	14.8	1,068
Socioeconomic Status		
Low	8.9	690
Middle	14.1	860
High	16.7	313
Birth Order		
First birth	14.1	867
Second birth	11.6	675
Third or higher	11.6	321
Pregnancy Complications		
Yes	19.3	231
No	11.9	1,632
Baby's Weight at Birth		
< 2,500 grams	14.9	94
≥ 2,500 grams	12.8	1,757
Unknown	*	12
Prolonged Labor		
No	6.2	1,651
Yes	*	16
No labor	100.0	122
Don't know/didn't respond	17.0	74

* Fewer than 25 cases in this category.

Table 6.4.1 Use of Postpartum Care and Information Received during Postpartum Visits, by Selected Characteristics Among Births in 2000–2005
Reproductive Health Survey: Georgia 2005

	Postpartum Care		Information Received During Postpartum Care						
Characteristic	%	No. of Cases	Breast Feeding %	Breast Care %	Child Care %	Inmunization %	Nutrition %	Family Planning %	No. of Cases
Total	21.8	2,017	79.4	78.7	76.2	64.9	71.7	30.6	404
Residence									
Tbilisi	24.3	391	74.5	75.5	70.0	59.1	66.4	25.5	95
Other urban	26.5	505	92.5	93.0	90.8	77.5	86.6	40.1	120
Rural	18.3	1,121	72.6	70.2	69.3	59.1	64.1	26.9	189
Age Group (at Birth)									
< 20	19.9	337	70.0	69.4	64.1	55.5	66.7	27.5	64
20–24	21.6	717	84.1	84.2	81.2	68.2	77.1	34.2	142
25–34	22.9	827	77.2	76.4	75.5	64.8	70.2	27.5	169
35–44	22.3	136	89.0	85.9	82.7	69.7	65.7	37.5	29
Education Level									
Secondary incomplete or less	13.9	261	58.6	57.3	55.1	45.9	55.0	17.8	34
Secondary complete	19.1	673	79.5	79.2	75.8	63.7	74.3	31.0	111
Technicum/university	25.4	1,083	82.0	81.3	79.2	67.8	72.8	32.1	259
Socioeconomic Status									
Low	17.0	821	72.3	70.0	70.4	52.2	61.9	28.1	126
Middle	21.3	882	83.7	82.7	80.0	70.8	77.1	32.2	175
High	33.4	314	80.2	81.9	76.6	69.0	73.7	30.9	103
Birth Order									
First birth	22.9	912	76.9	77.3	71.2	58.5	67.8	27.0	199
Second birth	22.3	735	83.0	81.5	82.6	71.6	78.7	37.1	147
Third or higher	18.1	370	78.6	76.8	77.7	69.7	68.0	27.2	58
Pregnancy Complications*									
Yes	30.3	236	76.0	77.3	76.0	68.5	75.6	29.9	70
No	20.7	1,780	80.1	79.1	76.3	64.1	71.0	30.8	333
Postpartum Complications									
Any Complications	38.9	265	70.5	73.4	69.9	51.9	64.4	19.7	104
No Complications	19.1	1,752	82.3	80.5	78.3	69.1	74.1	34.2	300

* Excludes one birth with missing information on pregnancy complications.

Table 6.4.2 Time Between Delivery and First Postpartum Visit by Selected Characteristics Among Mothers Who Had Any Postpartum Care after Delivering a Live Birth in 2000–2005
Reproductive Health Survey: Georgia 2005

	Time Between Delivery and First Postpartum Visit (in Weeks)					
Characteristic	< 1	1–2	> 2	Does Not Remember	Total	No. of Cases
Total	38.4	45.4	16.0	0.3	100.0	404
Residence						
Tbilisi	30.9	51.8	17.3	0.0	100.0	95
Other urban	47.0	40.7	12.0	0.3	100.0	120
Rural	36.7	44.7	18.1	0.5	100.0	189
Age Group (at Birth)						
< 20	42.8	31.4	25.3	0.5	100.0	64
20–24	38.1	50.2	11.2	0.5	100.0	142
25–34	34.5	48.7	16.6	0.1	100.0	169
35–44	50.2	35.1	14.6	0.0	100.0	29
Education Level						
Secondary incomplete or less	35.0	53.9	9.5	1.6	100.0	34
Secondary complete	46.6	38.4	15.0	0.1	100.0	111
Technicum/university	35.2	47.3	17.2	0.2	100.0	259
Socioeconomic Status						
Low	40.0	43.5	16.4	0.1	100.0	126
Middle	42.2	40.1	17.2	0.6	100.0	175
High	30.7	55.6	13.7	0.0	100.0	103
Place of Delivery						
Govt. hospital, maternity ward	40.5	43.5	15.9	0.1	100.0	290
Tbilisi maternity hospital	28.6	54.3	16.6	0.4	100.0	91
Other medical facility	*	*	*	*	*	3
At home	*	*	*	*	*	20
Birth Order						
First birth	36.3	46.5	16.9	0.3	100.0	199
Second birth	39.0	48.8	11.8	0.4	100.0	147
Third or higher	43.8	33.0	23.2	0.0	100.0	58

* Fewer than 25 cases in this category.

Table 6.4.3 Use of Well-baby Care and Time Between Delivery and First Visit by Selected Characteristics Among Live Births Delivered in Hospitals in 2000–2005 (Percentage Distribution)
Reproductive Health Survey: Georgia 2005

	Well-Baby Visit		Time Between Delivery and First Postnatal Well-Baby Clinic (in Weeks)					
Characteristic	%	No. of Cases	< 1	1–2	> 2	Does Not Remember	Total	No. of Cases
Total	79.9	2,005	21.1	53.9	24.3	0.7	100.0	1,713
Residence								
Urban	87.4	888	24.3	60.3	14.9	0.6	100.0	816
Rural	72.4	1,117	17.4	46.6	35.2	0.8	100.0	897
Region								
Kakheti	71.5	188	21.4	45.5	32.5	0.6	100.0	140
Tbilisi	88.2	389	29.4	61.6	8.4	0.7	100.0	360
Shida Kartli	85.6	136	18.8	49.3	31.9	0.0	100.0	125
Kvemo Kartli	64.8	211	9.4	64.4	25.6	0.6	100.0	141
Samtskhe-Javakheti	72.2	170	16.6	43.9	37.6	1.9	100.0	142
Adjara	83.0	156	22.2	47.1	30.1	0.7	100.0	138
Guria	57.9	114	7.0	51.2	41.9	0.0	100.0	81
Samegrelo	83.1	133	14.4	53.0	32.6	0.0	100.0	124
Imereti	87.2	226	24.3	51.5	23.4	0.8	100.0	222
Mtskheta-Mtianeti	81.3	133	14.5	44.3	38.9	2.3	100.0	123
Racha-Svaneti	64.7	149	9.0	70.5	20.5	0.0	100.0	117
Age Group (at Birth)								
< 25	78.7	1,049	18.9	54.2	26.2	0.7	100.0	880
25–34	80.7	824	24.5	53.1	21.5	0.8	100.0	718
35–44	84.1	132	17.9	55.8	26.3	0.0	100.0	115
Education Level								
Secondary incomplete or less	61.6	257	18.0	40.3	40.1	1.7	100.0	174
Secondary complete	77.8	666	21.7	50.6	27.0	0.7	100.0	547
Technicum/university	85.3	1,082	21.3	57.9	20.3	0.5	100.0	992
Socioeconomic Status								
Low	70.3	817	19.4	43.0	36.8	0.8	100.0	631
Middle	83.5	873	20.4	56.9	22.1	0.6	100.0	785
High	91.0	315	25.6	65.3	8.5	0.6	100.0	297
Place of Delivery								
Govt. hospital, maternity ward	80.3	1,452	19.5	52.8	27.4	0.2	100.0	1,261
Tbilisi maternity hospital	89.1	387	21.8	64.0	13.1	1.0	100.0	360
Other medical facility	*	11	*	*	*	*	*	11
At home	49.5	155	37.7	23.2	32.7	6.5	100.0	81
Birth Order								
First birth	82.7	903	21.5	55.6	22.0	0.9	100.0	807
Second birth	78.6	735	22.0	54.0	23.5	0.5	100.0	621
Third or higher	74.6	367	17.8	48.5	33.2	0.5	100.0	285

* Fewer than 25 cases in this category.

Table 6.4.4 Percentage of Babies with Birth Certificates and Time Between Delivery and Issuance of the Certificate by Selected Characterisitcs Among Live Births in 2000–2005 Reproductive Health Survey: Georgia 2005

	Baby Registered		Interval Between Delivery and Birth Certificate (in Weeks)					
Characteristic	%	No. of Cases	< 1	1–4	> 4	Does Not Remember	Total	No. of Cases
Total	92.9	2,005	69.5	26.6	2.7	1.2	100.0	1,859
Residence								
Urban	97.3	888	77.3	21.4	1.1	0.2	100.0	861
Rural	88.5	1,117	61.0	32.2	4.5	2.3	100.0	998
Region								
Kakheti	80.7	188	42.5	42.5	9.0	6.0	100.0	151
Tbilisi	97.3	389	81.8	17.5	0.5	0.2	100.0	378
Shida Kartli	93.5	136	76.2	20.3	2.8	0.7	100.0	127
Kvemo Kartli	83.9	211	70.2	25.3	4.5	0.0	100.0	173
Samtskhe-Javakheti	99.0	170	70.8	28.1	1.0	0.0	100.0	168
Adjara	91.8	156	64.3	27.4	6.4	1.9	100.0	143
Guria	96.0	114	70.2	29.8	0.0	0.0	100.0	110
Samegrelo	96.5	133	76.6	21.2	1.5	0.7	100.0	128
Imereti	98.4	226	62.8	35.6	0.0	1.7	100.0	222
Mtskheta-Mtianeti	94.4	133	65.4	28.7	4.4	1.5	100.0	125
Racha-Svaneti	89.1	149	46.8	47.5	5.0	0.7	100.0	134
Age Group (at Birth)								
< 25	91.2	1,049	67.3	28.4	3.3	1.1	100.0	956
25–34	94.9	824	71.7	25.1	2.0	1.2	100.0	779
35–44	94.8	132	73.3	21.3	3.2	2.2	100.0	124
Education Level								
Secondary incomplete or less	80.2	257	53.7	33.1	8.3	4.9	100.0	206
Secondary complete	92.2	666	66.1	30.2	2.9	0.9	100.0	615
Technicum/university	96.3	1,082	74.5	23.3	1.6	0.7	100.0	1,038
Socioeconomic Status								
Low	87.8	817	59.3	32.7	5.5	2.5	100.0	718
Middle	94.7	873	72.3	25.4	1.6	0.7	100.0	830
High	98.8	315	81.6	18.1	0.3	0.0	100.0	311
Place of Delivery								
Govt. hospital, maternity ward	93.9	1,452	70.5	27.0	1.9	0.5	100.0	1,360
Tbilisi maternity hospital	96.5	387	80.1	18.6	1.3	0.0	100.0	373
Other medical facility	*	*	*	*	*	*	*	11
At home	72.4	155	14.2	52.7	19.0	14.1	100.0	115
Birth Order								
First birth	94.3	903	73.0	23.6	2.4	1.0	100.0	848
Second birth	92.4	735	69.0	27.8	2.5	0.8	100.0	680
Third or higher	89.8	367	60.5	32.5	4.2	2.8	100.0	331

* Fewer than 25 cases in this category.

Table 6.5 Smoking and Drinking during Pregnancy and Number of Cigarettes Smoked by Selected Characteristics Among Live Births in 2000–2005
Reproductive Health Survey: Georgia 2005

Characteristic	% Who Smoked before Pregnancy	% Who Smoked during Pregnancy	Number of Cigarettes Smoked (per Day) 1–4 %	5+ %	Does Not Remember %	% Who Drank during Pregnancy	No. of Cases
Total	3.5	2.2	0.6	1.1	0.5	1.3	2,017
Residence							
Urban	6.2	3.5	1.1	2.1	0.3	2.0	896
Rural	0.9	0.9	0.1	0.0	0.8	0.6	1,121
Region							
Kakheti	1.0	1.0	0.5	0.0	0.5	0.0	187
Tbilisi	11.9	6.6	1.8	4.4	0.4	3.8	391
Shida Kartli	1.9	1.9	1.3	0.0	0.6	2.6	138
Kvemo Kartli	0.8	0.8	0.0	0.0	0.8	0.4	213
Samtskhe-Javakheti	0.0	0.0	0.0	0.0	0.0	0.0	173
Adjara	1.8	1.8	0.0	0.0	1.8	0.0	156
Guria	0.8	0.8	0.0	0.0	0.8	0.8	114
Samegrelo	0.0	0.0	0.0	0.0	0.0	0.7	133
Imereti	0.4	0.0	0.0	0.0	0.0	0.4	229
Mtskheta-Mtianeti	1.4	1.4	1.4	0.0	0.0	0.0	134
Racha-Svaneti	1.3	0.6	0.0	0.6	0.0	1.9	149
Age Group (at Birth)							
< 20	1.5	0.6	0.3	0.0	0.3	1.5	337
20–24	3.1	2.1	0.6	0.9	0.5	1.2	717
25–34	4.2	2.6	0.8	1.2	0.5	1.2	827
35–44	7.1	5.0	0.0	3.5	1.5	1.4	136
Education							
Secondary incomplete or less	0.8	0.0	0.0	0.0	0.0	2.8	261
Secondary complete	2.2	1.8	0.3	1.0	0.6	0.9	673
Technicum/university	5.0	2.9	0.9	1.4	0.6	1.2	1,083
Socioeconomic Status							
Low	1.1	0.9	0.1	0.3	0.5	0.8	821
Middle	3.5	2.6	0.3	1.6	0.8	1.0	882
High	8.8	3.8	2.3	1.5	0.0	2.9	314
Ethnicity							
Georgian	3.7	2.3	0.5	1.2	0.5	1.4	1,673
Azeri	0.0	0.0	0.0	0.0	0.0	0.6	151
Armenian	3.6	2.8	0.9	0.0	1.9	0.9	130
Other	8.1	5.9	4.1	1.8	0.0	0.0	63
Birth Order							
First birth	3.7	2.1	0.6	1.2	0.3	1.7	912
Second birth	3.2	1.7	0.5	0.8	0.4	1.3	735
Third or higher	3.8	3.5	0.9	1.2	1.4	0.3	370

Table 6.6.1 Routine Measurement of Blood Pressure (BP) During Pregnancy, Reported High Blood Pressure (HBP) During Pregnancy, and Hospitalization Rate for HBP by Selected Characteristics Births in 2000–2005 Among Women with Any Prenatal Care Reproductive Health Survey: Georgia 2005

	Routine Measurement of Blood Pressure		Told Had High Blood Pressure		Pregnancies Hospitalized for HBP (Exclusive)	Pregnancies Hospitalized for HBP (Not Exclusive)	
Characteristic	%	No. of Cases	%	No. of Cases	%	%	No. of Cases
Total	91.5	1,917	11.2	1,751	0.3	0.7	1,917
Residence							
Urban	93.7	872	12.4	818	0.4	0.4	872
Rural	89.2	1,045	9.9	933	0.3	1.0	1,045
Region							
Kakheti	90.2	166	6.0	151	0.0	1.1	166
Tbilisi	95.1	387	15.3	367	0.0	0.7	387
Shida Kartli	85.9	130	9.0	112	0.0	0.0	130
Kvemo Kartli	84.6	196	8.6	164	0.0	0.0	196
Samtskhe-Javakheti	87.0	167	4.8	145	0.0	0.5	167
Adjara	98.8	149	14.8	147	1.8	2.4	149
Guria	84.7	108	11.0	91	0.0	0.0	108
Samegrelo	91.7	124	9.0	115	0.0	0.0	124
Imereti	91.0	227	11.7	206	0.8	0.4	227
Mtskheta-Mtianeti	97.0	123	10.0	119	0.0	0.7	123
Racha-Svaneti	95.9	140	7.1	134	0.0	0.0	140
Age Group (at Birth)							
< 25	89.2	995	9.7	887	0.5	0.7	995
25–34	94.2	799	11.9	749	0.2	0.6	799
35–44	93.6	123	18.7	115	0.0	0.8	123
Education Level							
Secondary incomplete or less	82.1	227	10.1	190	0.0	0.5	227
Secondary complete	89.7	628	10.8	558	0.4	1.2	628
Technicum/university	94.5	1,062	11.6	1,003	0.3	0.4	1,062
Socioeconomic Status							
Low	87.6	739	9.7	642	0.2	0.8	739
Middle	93.1	866	12.1	813	0.6	0.7	866
High	95.1	312	11.7	296	0.0	0.3	312
Place of Prenatal Care							
Govt. hospital, maternity ward	91.4	1,423	10.2	1,298	0.5	0.7	1,423
Tbilisi maternity hospital	94.9	387	13.9	367	0.0	0.7	387
Other medical facility	*	*	*	11	*	*	11
At home	77.1	96	10.6	75	0.0	0.0	96
Birth Order							
First birth	90.9	884	10.9	804	0.1	0.6	884
Second birth	91.0	704	10.3	638	0.5	0.5	704
Third or higher	94.4	329	14.0	309	0.4	1.1	329

* Fewer than 25 cases in this category.

Table 6.6.2 Pregnancy Complications That Required Medical Attention by Selected Characteristics Among Births in 2000–2005 Among Women With Any Prenatal Care Reproductive Health Survey: Georgia 2005

	Pregnancy Complications											
Characteristic	At Least One Pregnancy Complication %	Risk of Preterm Delivery %	Anemia Related to Pregnancy %	Weak Cervix %	Water Retention or Edema %	Urinary Tract Infection %	High Blood Pressure %	Bleeding During First 6 Months %	Bleeding After 6 Months %	Rh Isoimmu-nization %	Other %	No. of Cases
Total	12.6	5.2	3.9	2.2	3.1	0.8	2.6	1.8	0.8	1.1	0.8	1,917
Residence												
Urban	15.6	6.9	5.7	3.4	3.4	1.1	2.5	2.8	0.9	1.3	1.1	872
Rural	9.5	3.5	2.1	0.9	2.7	0.5	2.8	0.8	0.8	0.9	0.4	1,045
Region												
Kakheti	8.2	4.9	1.1	2.7	1.6	0.0	2.2	0.5	0.5	0.0	0.0	166
Tbilisi	17.2	8.0	6.9	2.5	4.2	1.3	2.5	4.2	1.3	0.9	1.1	387
Shida Kartli	17.6	7.7	5.6	4.2	1.4	1.4	2.8	1.4	1.4	1.4	0.7	130
Kvemo Kartli	9.0	5.9	2.7	3.2	2.7	0.5	0.9	0.5	0.0	0.5	0.5	196
Samtskhe-Javakheti	15.1	5.2	4.2	2.6	2.1	2.1	1.0	2.1	1.6	2.1	0.5	167
Adjara	8.5	1.2	0.6	0.0	3.7	0.0	6.1	0.0	0.6	1.8	0.0	149
Guria	13.6	4.2	3.4	0.0	2.5	1.7	2.5	0.8	0.0	2.5	0.8	108
Samegrelo	8.3	4.5	0.8	0.0	3.0	0.8	1.5	1.5	2.3	0.0	0.8	124
Imereti	13.5	2.9	5.3	2.5	3.3	0.4	3.3	1.6	0.0	2.0	1.6	227
Mtskheta-Mtianeti	9.7	3.7	1.5	2.2	2.2	1.5	3.0	0.7	0.7	0.7	1.5	123
Racha-Svaneti	9.5	3.4	6.1	3.4	3.4	0.7	1.4	0.7	0.0	0.7	0.0	140
Age Group (at Birth)												
< 25	10.0	4.3	3.1	1.8	2.5	0.8	2.1	1.3	0.3	0.9	0.5	995
25–34	14.7	6.6	3.6	2.7	3.5	0.8	3.1	2.4	1.7	1.5	1.0	799
35–44	20.3	4.4	11.8	2.0	5.2	1.1	4.2	1.6	0.0	0.7	1.7	123
Education Level												
Secondary incomplete or less	4.9	2.4	1.0	1.2	1.0	0.4	1.4	0.0	0.0	0.2	0.9	227
Secondary complete	12.2	5.0	2.2	1.8	3.6	0.9	3.5	1.3	0.8	0.9	0.3	628
Technicum/university	14.5	5.9	5.5	2.6	3.2	0.9	2.4	2.4	1.0	1.4	1.0	1,062
Socioeconomic Status												
Low	9.2	3.1	2.1	0.9	2.0	0.7	2.6	0.8	0.8	0.6	0.6	739
Middle	12.9	4.6	4.2	2.2	3.5	0.8	3.0	1.6	0.5	1.7	0.7	866
High	18.4	10.7	6.8	4.4	4.1	1.2	1.9	4.2	1.6	0.6	1.5	312
Birth Order												
First birth	13.2	6.8	4.3	3.0	3.4	0.8	2.3	2.2	0.6	1.0	0.8	884
Second birth	10.9	3.4	3.2	1.7	2.4	0.9	2.6	1.5	1.2	0.9	0.5	704
Third or higher	14.5	4.2	4.4	0.6	3.5	0.7	3.8	1.2	0.6	1.6	1.2	329

Table 6.6.3 Postpartum Complications by Selected Characteristics Among Births in 2000–2005 Reproductive Health Survey: Georgia 2005

	Postpartum Complications										
Characteristic	At Least One Postpartum Complication %	Painful Uterus %	Painful Urination %	High Fever %	Bad-smelling Vaginal Discharge %	Severe Bleeding %	Breast Infection %	Infection of Surgical Wound %	Faint/ Coma %	Other %	No. of Cases
Total	13.9	5.1	3.5	3.0	2.9	3.7	3.2	2.5	0.8	1.1	2,017
Residence											
Urban	15.8	6.2	4.5	3.0	4.0	4.6	3.9	3.6	1.3	1.7	896
Rural	12.0	4.0	2.6	3.1	1.8	2.8	2.4	1.4	0.3	0.5	1,121
Region											
Kakheti	10.6	3.9	3.4	3.9	0.5	2.9	0.5	1.4	0.5	0.5	187
Tbilisi	21.2	6.8	4.0	3.1	5.3	6.0	6.2	4.4	1.8	2.6	391
Shida Kartli	16.8	5.8	5.8	3.2	4.5	4.5	1.9	5.8	0.6	1.9	138
Kvemo Kartli	9.7	5.9	2.5	3.4	1.7	2.1	2.5	1.7	1.3	0.8	213
Samtskhe-Javakheti	8.1	1.5	1.0	1.5	1.0	2.0	1.5	3.5	0.0	0.5	173
Adjara	8.8	4.7	1.8	2.9	2.9	2.3	1.2	0.0	0.0	0.0	156
Guria	11.1	3.2	4.0	3.2	0.0	4.0	0.0	2.4	0.0	4.0	114
Samegrelo	12.0	2.8	1.4	2.1	2.8	4.9	4.9	0.7	0.7	0.0	133
Imereti	14.2	5.3	6.1	2.4	2.0	2.0	3.3	1.2	0.0	0.0	229
Mtskheta-Mtianeti	17.2	4.8	3.4	4.8	3.4	5.5	3.4	4.1	0.7	0.7	134
Racha-Svaneti	10.3	3.8	3.8	3.8	1.3	4.5	1.9	1.9	1.3	1.3	149
Age Group (at Birth)											
< 25	13.6	5.7	4.2	3.2	3.1	2.8	3.4	2.3	0.8	1.1	1,054
25–34	14.7	4.9	2.7	3.1	3.0	4.5	3.5	2.6	0.9	1.1	827
35–44	12.1	1.4	3.2	1.1	0.8	5.8	0.0	2.9	0.1	1.5	136
Education Level											
Secondary incomplete or less	13.9	6.0	4.3	2.8	1.1	1.2	3.2	0.9	0.0	0.0	261
Secondary complete	10.4	4.1	4.2	1.8	2.6	3.2	2.1	1.7	1.0	0.5	673
Technicum/university	16.0	5.4	3.0	3.8	3.5	4.6	3.8	3.3	0.8	1.7	1,083
Socioeconomic Status											
Low	11.3	4.9	3.5	2.8	1.6	3.1	1.5	1.9	0.4	0.6	821
Middle	13.9	4.1	3.1	2.9	3.7	4.0	3.8	2.7	1.0	1.0	882
High	19.6	8.0	4.4	3.7	3.5	4.0	5.1	3.3	0.9	2.3	314
Birth Order											
First birth	14.9	6.1	3.9	3.5	3.4	3.8	4.1	3.3	1.0	1.0	912
Second birth	12.4	3.7	3.1	2.9	2.3	2.5	2.2	1.4	0.5	0.9	735
Third or higher	14.4	5.2	3.3	2.0	2.6	5.8	2.6	2.4	0.8	1.7	370
Type of Delivery											
Vaginal	12.8	4.6	3.2	2.5	2.9	3.6	3.2	1.8	0.8	1.0	1,780
Cesarean section	22.2	8.4	6.0	6.9	2.4	4.5	3.2	7.2	0.9	2.1	237
Baby Weight at Birth											
< 2,500 grams	25.1	4.8	3.9	1.0	6.2	16.5	2.0	3.9	0.0	1.7	100
≥ 2,500 grams	13.3	5.0	3.4	3.1	2.6	3.0	3.2	2.3	0.8	1.1	1,880
Don't know/didn't respond	13.6	11.2	7.9	5.5	5.1	5.5	5.5	5.5	2.7	0.0	37

Table 6.7 Poor Birth Outcomes by Selected Characteristics Among Births in 2000–2005
Reproductive Health Survey: Georgia 2005

Characteristic	Poor Birth Outcomes				
	Stillbirth Rate (per 1,000 Births)	No. of Births	Low Birth Weight Rate (%Live Births< 2,500 grams)	Preterm Birth Rate (%Live Births< 37 wks)	No. of Live Births
Total	16.0	2,017	4.6	4.5	1,983
Residence					
Urban	16.7	896	4.4	4.9	878
Rural	15.3	1,121	4.7	4.1	1,105
Region					
Kakheti	9.7	187	3.4	3.9	186
Tbilisi	19.9	391	4.3	6.3	382
Shida Kartli	12.9	138	5.9	5.9	136
Kvemo Kartli	16.8	213	6.0	5.5	210
Samtskhe-Javakheti	40.4	173	5.3	5.3	166
Adjara	5.8	156	3.5	1.8	155
Guria	7.9	114	2.4	0.8	113
Samegrelo	7.0	133	2.8	5.7	132
Imereti	20.3	229	5.0	2.5	224
Mtskheta-Mtianeti	13.8	134	8.4	3.5	132
Racha-Svaneti	12.8	149	4.5	4.5	147
Age Group (at Birth)					
< 20	16.2	337	5.3	5.4	332
20–24	9.2	717	3.4	3.4	709
25–34	16.9	827	4.9	4.3	812
35–44	43.5	136	6.7	8.9	130
Education Level					
Secondary incomplete or less	21.5	261	3.0	2.2	256
Secondary complete	17.5	673	5.0	5.5	661
Technicum/university	13.9	1,083	4.7	4.5	1,066
Socioeconomic Status					
Low	14.6	821	4.3	4.3	810
Middle	17.8	882	5.4	4.4	864
High	14.7	314	3.2	5.3	309
Ethnicity					
Georgian	15.1	1,673	4.6	4.2	1,646
Azeri	19.2	151	5.6	4.9	149
Armenian	19.3	130	2.5	8.2	127
Other	25.9	63	3.5	3.7	61
Birth Order					
First birth	16.1	912	5.1	4.8	896
Second birth	14.4	735	3.5	3.2	724
Third or higher	19.3	370	5.2	6.3	363
Prenatal Care Visits					
Yes	15.0	1,917	4.6	4.5	1,887
No	37.3	100	4.7	5.6	96
Type of Delivery					
Vaginal	17.6	1,780	4.4	4.5	1,747
Cesarean section	4.4	237	5.4	4.5	236
Pregnancy Complication					
Yes	44.6	234	7.3	12.3	223
No	12.1	1,783	4.2	3.5	1,760
Prolonged Labor					
No	16.0	1,785	4.4	4.4	1,756
Yes	0.0	19	16.0	20.0	19
C-Section before labor	8.6	122	4.9	5.6	121
Don't know/didn't respond	33.2	91	4.3	3.1	87

* Fewer than 25 cases in this category.

Table 6.8.1 Percentage of Children Born in 2000–2005 Ever Breastfed and Initiation of Breastfeeding by Selected Characteristics
Reproductive Health Survey: Georgia 2005

	Children Ever Breastfed		Initiation of Breastfeeding						
Characteristic	%	No. of Cases	<1 Hour	1–23 Hours	24–47 Hours	48 Hours or More	Unknown	Total	No. of Cases
Total	88.4	2,005	10.4	47.8	25.9	15.4	0.5	100.0	1,771
Residence									
Urban	87.0	888	10.7	49.4	20.5	19.2	0.2	100.0	774
Rural	89.8	1,117	10.2	46.4	31.0	11.7	0.8	100.0	997
Region									
Kakheti	89.9	188	9.7	42.5	33.9	13.4	0.5	100.0	169
Tbilisi	85.8	389	7.0	52.7	17.8	22.2	0.3	100.0	332
Shida Kartli	83.7	136	18.7	42.2	21.9	17.2	0.0	100.0	114
Kvemo Kartli	91.5	211	7.9	53.2	28.2	9.7	0.9	100.0	191
Samtskhe-Javakheti	92.8	170	26.1	40.6	23.9	8.9	0.6	100.0	156
Adjara	90.6	156	0.6	66.5	22.6	9.7	0.6	100.0	142
Guria	85.7	114	0.0	38.9	50.0	9.3	1.9	100.0	98
Samegrelo	82.4	133	2.6	56.4	29.1	12.0	0.0	100.0	108
Imereti	90.1	226	19.6	29.7	29.2	20.5	0.9	100.0	205
Mtskheta-Mtianeti	95.8	133	23.9	37.7	23.9	14.5	0.0	100.0	127
Racha-Svaneti	87.2	149	8.8	35.3	40.4	15.4	0.0	100.0	129
Age Group (at Birth)									
< 25	89.8	1,049	11.0	48.5	26.0	13.8	0.7	100.0	942
25–34	87.3	824	10.1	46.7	25.0	17.8	0.4	100.0	722
35–44	84.1	132	7.5	48.8	29.2	14.5	0.0	100.0	107
Education									
Secondary incomplete or less	89.8	257	7.8	53.1	28.8	10.3	0.0	100.0	233
Secondary complete	87.9	666	9.9	51.7	25.6	11.8	0.9	100.0	588
Technicum/university	88.4	1,082	11.3	44.4	25.3	18.6	0.4	100.0	950
Ethnicity									
Georgian	88.0	1,664	10.3	46.8	25.1	17.4	0.5	100.0	1,462
Azeri	88.5	149	6.3	56.2	28.6	8.8	0.0	100.0	132
Armenian	94.4	130	11.0	56.0	29.5	1.0	2.5	100.0	122
Other	86.3	62	24.0	34.1	31.9	10.0	0.0	100.0	55
Birth Order									
First birth	87.6	903	8.3	47.2	25.4	18.5	0.6	100.0	809
Second birth	89.2	735	12.7	47.4	26.1	13.1	0.6	100.0	651
Third or higher	89.0	367	11.2	50.5	26.5	11.6	0.2	100.0	311
Type of Delivery									
Vaginal	89.2	1,763	11.2	50.5	25.4	12.3	0.5	100.0	1,573
Cesarean section	82.6	242	4.0	27.1	29.3	38.9	0.8	100.0	198
Baby's Weight at Birth									
< 2,500 grams	62.1	91	8.1	45.8	22.8	23.3	0.0	100.0	58
≥ 2,500 grams	89.8	1,864	10.6	47.6	26.1	15.2	0.6	100.0	1,673
Unknown	82.9	50	7.0	61.2	19.9	11.9	0.0	100.0	40

Table 6.8.2 Mean Duration of Breastfeeding in Months, by Type of Breastfeeding by Selected Characteristics Among Children Aged 0–59 Months
Reproductive Health Survey: Georgia 2005

	Mean Duration of Breastfeeding (in Months)		
Characteristic	Exclusive Breast-feeding*	Full Breast-feeding†	Any Breast-feeding‡
Total	1.8	3.7	10.1
Residence			
Tbilisi	1.7	3.4	9.7
Other urban	1.5	2.9	11.0
Rural	1.8	4.0	9.8
Child Gender			
Male	1.8	3.7	10.8
Female	1.7	3.7	9.2
Age Group (at Birth)			
<30	1.8	3.7	9.7
30+	1.4	3.8	11.5
Education Level			
Secondary complete or less	1.8	3.7	10.3
Technicum/university	1.8	3.5	9.9
Ethnic Group			
Georgian	1.6	3.5	10.2
Other	2.1	4.0	10.2
Socioeconomic Status			
Low	1.5	3.3	9.5
Middle	1.9	3.9	10.9
High	1.6	3.1	9.1
Birth Order			
First birth	1.3	3.5	9.4
Second birth	2.2	3.9	10.5
Third or higher	2.6	4.0	12.2

*Exclusive breastfeeding: child is fed only breast milk

† Full breastfeeding: includes both exclusive breastfeeding and almost exlusive breastfeeding (breast milk and other liquids excluding formula and other types of milk)

‡ Any breasfeeding includes: exclusive breastfeeding; almost exclusive breastfeeding; and complementary breastfeeding (breast milk and any food or liquid).

Table 6.9.1 Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births) Among Children Born Between January 1990 and December 2004 Reproductive Health Surveys: Georgia 1999 and Georgia 2005

			GERHS05: January 1995–December 2004						GERHS99: January 1990–December 1999			
Mortality Rates	Total	CI	2000–2004	CI	1995–1999	CI	Total	CI	1995–1999	CI	1990–1994	CI
Infant Mortality	29.0	(22.9–35.1)	21.1	(13.5–28.7)	36.1	(27.1–45.1)	40.7	(34.2–47.2)	41.6	(31.0–52.2)	39.9	(32.1–47.7)
Neonatal	19.1	(14.2–24.0)	16.8	(10.7–22.9)	21.3	(13.7–28.9)	25.0	(19.7–30.3	25.4	(17.0–33.8)	24.7	(18.6–30.8)
Postneonatal	9.9	(6.4–13.4)	4.3	(1.2–7.4)	14.8	(9.1–20.5)	15.7	(11.6–19.8)	16.2	(9.1–23.3)	15.2	(10.3–20.1)
Child Mortality (1–4)	3.8	(1.3–6.4)	4.0	(0.5–8.5)	3.6	(0.9–6.3)	4.2	(2.0–6.4)	3.8	(0.9–6.7)	4.8	(1.9–7.7)
Under-5 Mortality (0–4)	32.7	(26.2–39.2)	25.0	(16.4–33.6)	39.5	(30.3–48.7)	44.8	(38.1–51.5)	45.3	(34.5–56.1)	44.5	(36.3–52.7)
Number of Cases	4,034		1,909		2,125		5,605		2,507		3,098	

Table 6.9.2 Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births) by Selected Characteristics Among Children Born Between January 1995 and December 2004
Reproductive Health Survey: Georgia 2005

Characteristic	Total	Infant Mortality Neonatal	Infant Mortality Postneonatal	Child Mortality 1–4 Year	Under-5 Mortality 0–4 Years	No. of Cases
Total	29.0	19.1	9.9	3.8	32.7	4,034
Period of Exposure						
January 1995/December 1999	36.1	21.3	14.8	3.6	39.5	2,125
January 2000/December 2004	21.1	16.8	4.3	4.0	25.0	1,909
Residence						
Urban	25.6	20.6	5.0	1.4	27.0	1,785
Rural	32.3	17.7	14.6	6.0	38.1	2,249
Region						
Kakheti	46.8	27.1	19.7	4.8	51.3	378
Tbilisi	27.0	23.4	3.5	0.0	27.0	755
Shida Kartli	28.1	21.9	6.3	9.1	37.0	293
Kvemo Kartli	34.7	17.1	17.6	0.0	34.7	416
Samtskhe-Javakheti	42.1	33.7	8.4	2.7	44.7	320
Adjara	25.8	11.4	14.5	14.3	39.8	320
Guria	8.8	0.0	8.8	4.1	12.8	215
Samegrelo	10.6	3.5	7.1	0.0	10.6	272
Imereti	22.1	16.2	6.0	1.9	24.0	469
Mtskheta-Mtianeti	47.5	34.8	12.7	10.2	57.2	288
Racha-Svaneti	31.6	22.2	9.4	3.3	34.7	308
Age Group at Birth						
< 25	32.0	20.8	11.2	2.4	34.4	2,227
25–44	25.2	17.0	8.2	5.6	30.6	1,807
Education Level						
Secondary incomplete or less	55.9	30.5	25.4	12.1	67.3	483
Secondary complete	30.2	19.4	10.7	3.3	33.4	1,310
Technicum/university	22.4	16.4	6.0	2.4	24.7	2,241
Ethnic Group						
Georgian	25.2	19.0	6.1	4.0	29.1	3,360
Azeri	54.8	20.2	34.6	3.5	58.1	276
Armenian	46.6	21.2	25.4	2.4	48.9	266
Other	33.5	14.5	19.0	0.0	33.5	132
Socioeconomic Status						
Low	38.6	21.9	16.7	5.7	44.1	1,680
Medium/High	22.7	17.3	5.4	2.5	25.1	2,354
Birth Order						
First	28.4	20.4	8.1	2.5	30.8	1,825
Second	26.0	16.7	9.3	1.7	27.6	1,497
Third or more	36.7	20.8	15.8	11.3	47.5	710
Length of Birth Interval						
First Birth	28.4	20.4	8.1	2.5	30.8	1,825
<24 months	43.5	25.4	18.0	5.9	49.1	767
24–47 months	22.9	11.7	11.2	4.8	27.6	737
48 moths or more	21.8	17.0	4.8	3.1	24.8	705
Sex of Child						
Boy	33.4	24.0	9.4	3.6	36.9	2,198
Girl	23.7	13.1	10.5	3.9	27.5	1,836

Chapter 7

CONTRACEPTIVE KNOWLEDGE

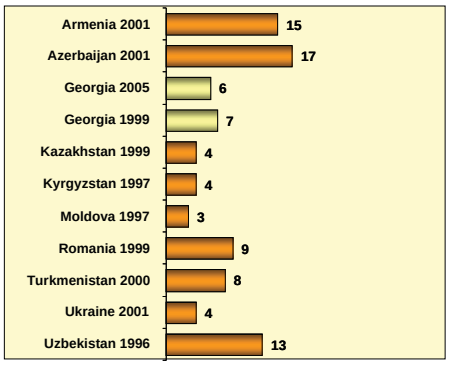
Lack of knowledge about modern methods of contraception is an important barrier to utilization of family planning services among women of reproductive age. Women who are not aware of modern contraceptive methods, do not know where they can be obtained, or do not understand how to use them correctly are more likely to have an unmet need for family planning than those who have been exposed to this information. Misperceptions about contraceptive methods and their side effects and general mistrust of modern contraception are also important barriers to utilization of the family planning services and to consistent and correct use of modern methods. During the Soviet era, the range of available modern contraceptive methods was often limited to locally produced supplies (e.g., condoms and IUDs), and potential health risks and side effects related to the use of hormonal methods were often overstated. Legal provisions to support voluntary sterilization were absent or restrictive, and few efforts were made to promote oral contraceptives after the break-up of Soviet Union, a legacy of the pro-natalist Soviet policy (Popov, 1996). In many former Soviet-bloc countries, despite sustained efforts on the part of the government and non-governmental organizations to better inform the public regarding contraception and provide a range of contraceptive methods, relatively few women are aware of modern methods other than the IUD and condoms. Thus, in order to help couples in this region achieve their reproductive health goals, family planning program managers need to better understand levels of contraceptive knowledge and the gaps in knowledge among current and potential users of contraceptives.

7.1 Contraceptive Awareness and Knowledge of Use

The GERHS05 included questions to assess awareness of specific contraceptive methods and sources for methods, perceived reliability (knowledge of method efficacy), and knowledge of how to use methods properly. This information can assist the Information, Education and Communication (IEC) and Behavior Change Communication (BCC) efforts and allow the monitoring of improvements in knowledge over time.

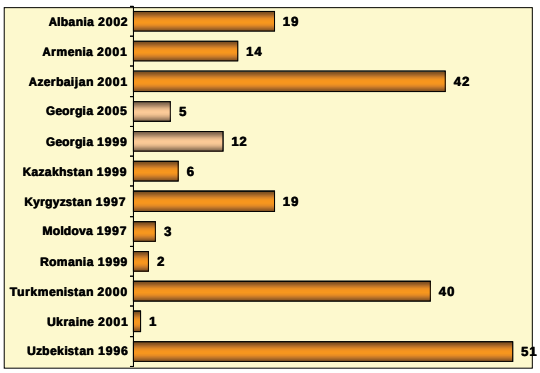
At first glance, women of reproductive age in Georgia appeared to be well aware of contraceptive methods. Virtually all respondents (97%) had heard of at least one modern method—though fewer were aware of at least one traditional method (73%) (Table 7.1.1). On average, they recognized at least three modern methods—generally the condom (95%), the IUD (94%), and oral contraceptives (81%). However, only 39% of women had heard of female contraceptive sterilization (tubal ligation) and few (5%) had heard of vasectomy. In comparison, in the other former Soviet-bloc countries, high awareness of the IUD and condoms and low awareness of methods that are less commonly used has been documented throughout the (CDC&ORC/Macro, 2003). For example, less than one in six women in Azerbaijan, Armenia, and Uzbekistan, and less than one in ten elsewhere in the region (compared to 6%-7% in Georgia) did not know about the IUD (Figure 7.1.1). Even more women in the region are aware of condoms. Lack of awareness about condoms was as low as 1%–3% in Eastern Europe, where the recent threat of an emerging HIV/AIDS epidemic may have contributed to increased awareness of the condoms' benefits in preventing sexually transmitted infections. More women were unaware of condoms in Caucasus and most of Central Asia (Figure 7.1.2). Lack of awareness about oral contraceptives was lowest in Russia, Romania, and Ukraine and higher in the Caucasus (where Georgian women

Figure 7.1.1 **Percentage of Women Aged 15–44 Years Who Had Never Heard about the IUD - Selected Countries in Eastern Europe and Central Asia***



* Source: CDC and ORC/Macro, 2003.
Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

Figure 7.1.2 **Percentage of Women Aged 15–44 Years Who Had Never Heard about Condoms - Selected Countries in Eastern Europe and Central Asia***



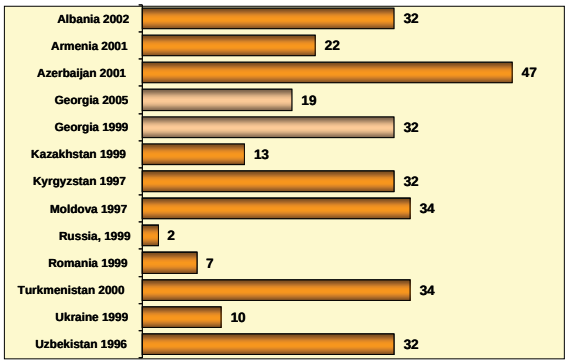
* Source: CDC and ORC/Macro, 2003.
Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

demonstrated the highest level of awareness) and in Central Asia (Figure 7.1.3). Awareness of the tubal ligation is universally low throughout the region (Figure 7.1.4).

Generally, levels of awareness about any method were lower in the Kvemo Kartli and Kakheti regions, among younger, never married women, and among those with less than complete secondary education (Tables 7.1.1–7.1.3).

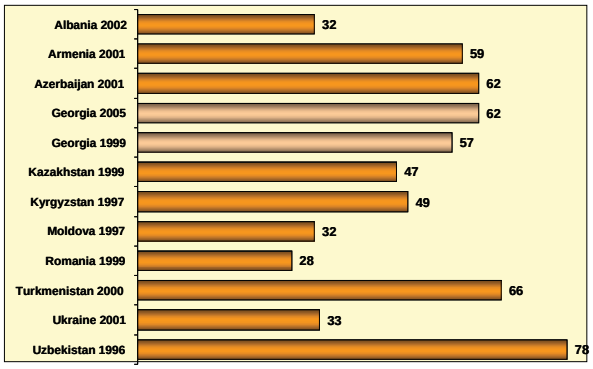
Awareness that modern methods exist may not be sufficient to motivate all women in need to start using such methods. Reproductive health surveys in Albania, Moldova, Romania, and Azerbaijan have shown that many women may be aware of at least one, and often several, contraceptive methods, but they do not know how to use the methods correctly (CDC&ORC/Macro, 2003). Although the overall level of contraceptive awareness was very high in Georgia, knowledge about how to use any modern or traditional method was much lower. Awareness of modern methods was reported by 97% of respondents, but only 75% reported knowledge of how to use these methods correctly. There was a similar disparity for traditional methods (72% vs. 56%) For the most widely known modern contraceptive methods, there was a large gap between awareness of the method and knowledge about how to use it correctly (Tables 7.1.2 and 7.1.4 and Figure 7.1.5). Although awareness of condoms and the IUD was almost universal, only two thirds of respondents knew how to use these methods. Knowledge about using oral contraceptives was much lower than awareness of it: 81% of women had heard of oral contraceptives, but less than 50% had knowledge about how to use this method correctly. On average, women reported having knowledge about correct use for only two modern methods.

Figure 7.1.3 **Percentage of Women Aged 15–44 Years Who Had Never Heard about Oral Contraceptives - Selected Countries in Eastern Europe and Central Asia***



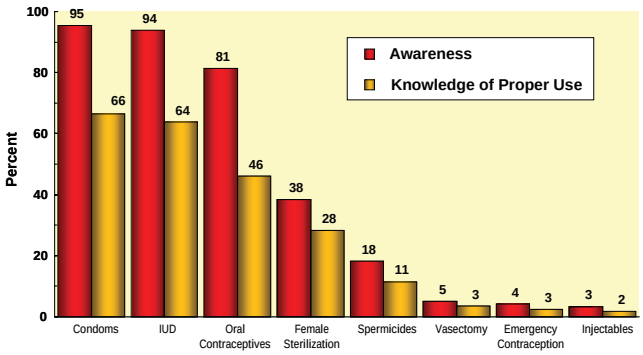
* Source: CDC and ORC/Macro, 2003.
Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

Figure 7.1.4 **Percentage of Women Aged 15–44 Years Who Had Never Heard about Female Sterilization - Selected Countries in Eastern Europe and Central Asia***



* Source: CDC and ORC/Macro, 2003.
Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

Figure 7.1.5 **Awareness and Knowledge of How to Use Modern Contraceptive Methods Among Women Aged 15–44 Years**



The gap between awareness of and knowledge about correct use of methods was greatest among never-married women (95% vs. 62%) and young adults (94% vs. 66%); this difference diminished among married women (98% vs. 89%) and with increased age of respondents (ages 25–44) (98%–99% vs. 86%–87%).Never married and young adult women, could describe, on average, how 1.6 contraceptive methods work, compared with an average of 2.5 modern methods described by women with marital experience or older women. These findings highlight the need to include information on contraceptive methods in nationwide age-appropriate sexual health education programs, given that never-married young women, who are often still in school, seem to be the least knowledgeable subgroup.

Most women of reproductive age could name at least one source for at least one supplied method of contraception (Table 7.1.5 and Figure 7.1.6). Respondents were more likely to know a source for the most commonly used modern methods (see below). For instance, 74% of women knew a source for condoms, 71% knew where to obtain IUDs, and 62% knew a source for oral contraceptives, but only 30% knew where female contraceptive sterilization procedures (tubal ligations) were performed, and very few knew where vasectomies were performed or where to get injectables, spermicides, or emergency contraception. Knowledge about sources for contraceptives increased with age and education and rates of knowledge about source was higher among women living in Tbilisi (89%) than among those living in other urban areas (80%) and rural residents (76%) (Table 7.1.5 and Figure 7.1.7). Both knowledge about correct use of methods and knowledge about sources were significantly lower among Azeri women than among other ethnic groups (Figure 7.1.8).

For commonly used methods and particularly for oral contraceptives, all three aspects of contraceptive knowledge (awareness, knowledge about correct use, and knowledge of sources) had improved in 2005

Figure 7.1.6 **Knowledge about a Source for Specific Modern Contraceptive Methods Among Women Aged 15–44 Years**

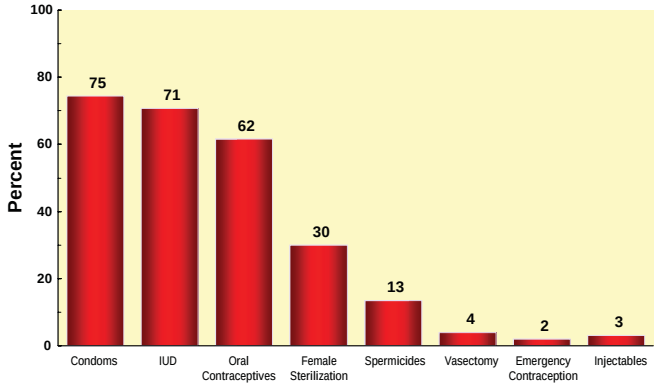


Figure 7.1.7 **Knowledge of a Source for Specific Contraceptive Methods, by Education Among Women Aged 15–44 Years**

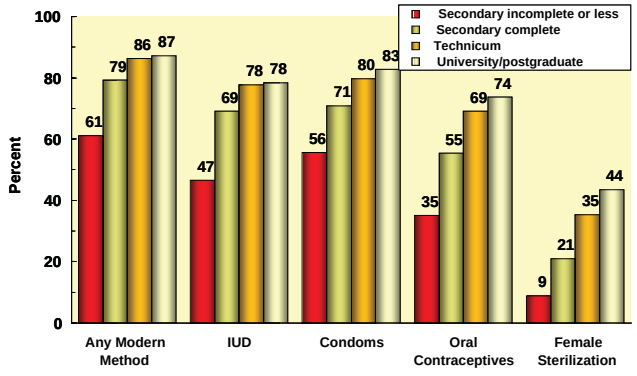
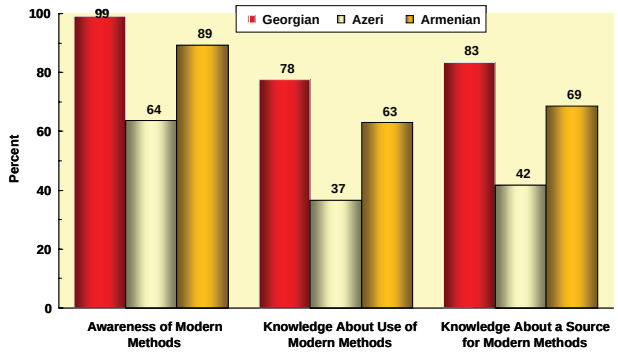
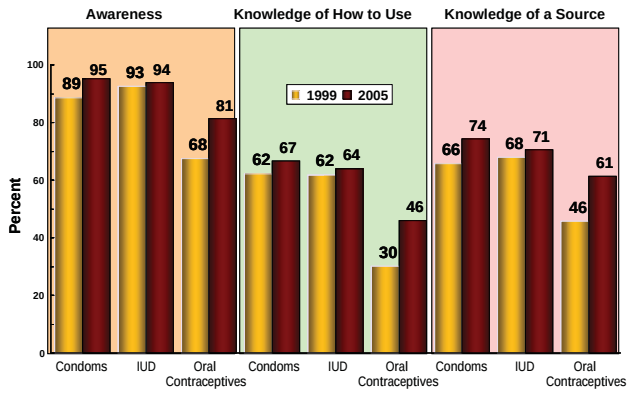


Figure 7.1.8 **Awareness of and Knowledge About Proper Use of and Source for Modern Contraceptive Methods, by Ethnicity Among Women Aged 15–44 Years**



compared to 1999. (Table 7.1.6 and Figure 7.1.9). Rates of awareness and knowledge about the least used methods (i.e., female and male contraceptive sterilization) remained unchanged or declined. The rate of increase in knowledge was higher among rural than urban residents, which narrowed the previously substantial urban-rural gap in knowledge of the most commonly used contraceptive methods. For example, awareness of oral contraceptives was 43% higher among urban residents than among rural residents in 1999, but only 22% higher in 2005. Similarly, condom awareness among urban women was 20% higher than among rural women in 1999, but only 10% higher in 2005. These improvements may be a result of recent efforts to increase access to family planning information in remote areas of Georgia, either through primary health care or through mobile health units.

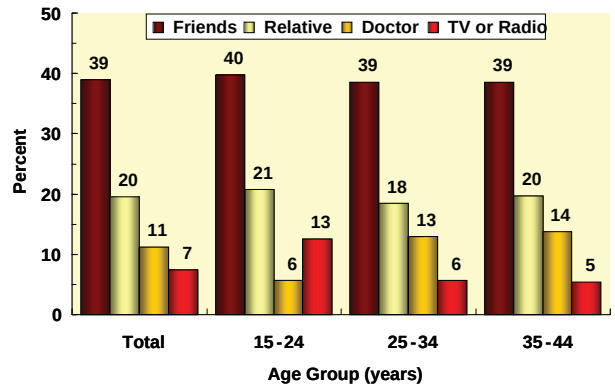
Figure 7.1.9 **Awareness and Knowledge About Most Commonly Used Modern Contraceptive Methods Among Women Aged 15–44 Years: 1999 and 2005**



7.2 Most Important Source of Information about Contraception

The GERHS05 found that for many women aged 15–44 years, the main source of information about contraceptive methods was an acquaintance or a friend (39%), followed by a relative other than a parent (20%), a physician (11%), the mass media (7% audiovisual media, 4% books, and 3% print media), or a partner or boyfriend (7%) (Table 7.2.1 and Figure 7.2.1). Parents and schools were seldom mentioned as important sources of contraceptive information (2% and 1%, respectively). Young women (i.e., those aged 15–24 years) reported similar sources of information as older women. Forty percent of young women found out about a contraceptive method in discussions with a friend or acquaintance and 24% in discussions with a parent or other relative or. They were, however, less likely than women aged 25–34 or 35–44 to have learned about contraception from a health care provider (6% vs. 13% and 14%, respectively) and twice as likely to report television or radio as their most important source of information about contraception (13% vs.

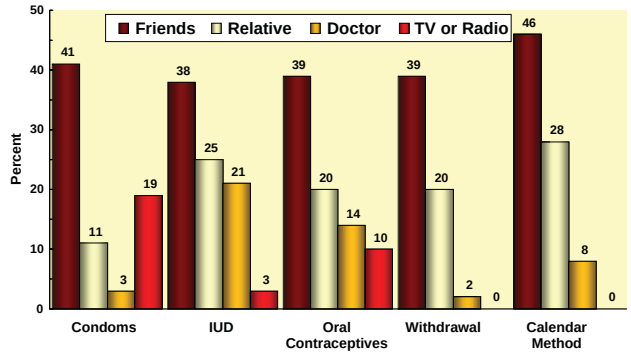
Figure 7.2.1 **Main Source of Information about Contraception by Age Group Among Women Aged 15–44 Years Who Have Heard of Specific Methods**



6% and 5%, respectively). Similar differences were found when never-married women were compared with ever-married women.

The source of contraceptive information varied only slightly by method (Table 7.2.2). For all but one method (vasectomy), the main source of information was a friend and often the second most important source was a relative. A medical health provider was mentioned as the first or second source only for the least known methods (vasectomy, injectables, and emergency contraception). As for the withdrawal method, after friends (39%), the second most important information source was a partner or husband (31%). Among respondents who had heard of the most commonly used methods in Georgia, approximately 50% to 75% rated information acquired through conversations with friends and relatives as the most important source of contraceptive knowledge (Figure 7.2.2). These findings explain, in part, the poor quality of contraceptive information (see below) and illustrate the need for increasing public health efforts in educating women about the benefits of contraception through official channels (e.g., school, mass media, and health providers).

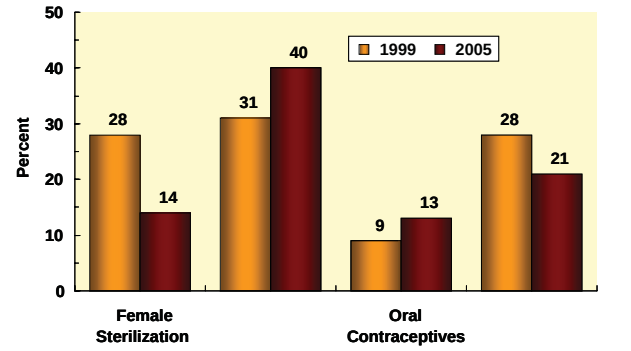
Figure 7.2.2 **Main Source of Information about the Most Commonly Used Methods Among Women Aged 15–44 Who Have Heard of Specific Contraceptive Methods**



7.3 Knowledge about Contraceptive Effectiveness

Having correct information about contraceptive effectiveness could greatly influence a couple's efforts to prevent unplanned pregnancies. In a population, rates of knowledge about the effectiveness of specific contraceptive methods is an indicator of the adequacy of contraceptive counseling and of information and education programs. In the GERHS05, no modern method was recognized as very effective by a majority of women (Table 7.3 and Figure 7.3). While 40% of women correctly stated that the IUD is very reliable (very effective in preventing pregnancy), only 14% believed that contraceptive sterilization is very reliable, as did only 37% of those who were aware of tubal

Figure 7.3 **Percentage of Women Agreeing that Specific Contraceptive Methods* Are "Very Effective in Preventing Pregnancy" Among Women Aged 15–44 Years**



* Presented from left to right in the descending order of contraceptive effectiveness when the method is used correctly and consistently.

ligation. The majority of women incorrectly thought that oral contraceptives were not very effective. In fact, the proportion of women who correctly said that oral contraceptives were very effective was lower than the proportion who incorrectly perceived the condom as very effective (13% vs. 21%). Between 1999 and 2005, the perceived effectiveness of the IUD and oral contraceptives had increased (from 31% to 40% and from 9% to 13%, respectively), but those who correctly believed that contraceptive sterilization is very effective had declined by 50% (from 28% to 14%), which is difficult to interpret, as 62% of women had never heard of tubal ligation.

Misperceptions among users of traditional methods of contraception constitute a striking example of how lack of knowledge about contraceptive effectiveness could affect informed choice. Throughout Eastern Europe, substantial proportions of users of traditional methods—who are the majority of users in some countries—believe that traditional methods are equally effective or more effective than the IUD or oral contraceptives (see also Chapter 8).

Twenty-three percent of sexually experienced young women reported talking to a partner about condom use, a method that protects against both unplanned pregnancy and sexually transmitted infection. Discussion of condom use was most prevalent among residents of Tbilisi (49%), young women with post-secondary education (33%), and those who relied on condom use at last sexual intercourse (93%) (Table 7.4.3). Communication with a partner about condom use was very high among those who used this method at last intercourse, a finding that might suggest talking about condoms can result in increased use. In contrast, only 17% of women never using condoms had ever talked to a partner about their use.

Table 7.1.1 Percentage of Women Aged 15–44 Years Who Had Ever Heard of Specific Contraceptive Methods by Region
Reproductive Health Survey: Georgia, 2005

		Region										
Contraceptive Method	Total	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Ever heard of any method	96.9	91.4	99.8	99.3	86.2	93.3	99.3	99.8	98.8	99.2	97.9	98.4
Ever heard of a modern method	96.7	91.1	99.7	99.3	85.1	92.9	99.0	99.8	98.8	99.2	97.9	98.4
Condoms	95.2	87.8	99.5	99.1	78.0	89.7	98.2	99.2	98.4	99.2	96.4	97.5
IUD	93.9	88.2	97.1	97.8	80.7	87.6	97.9	97.5	95.7	96.0	94.5	94.7
Oral contraceptives	81.3	75.4	91.9	87.3	65.4	58.3	81.3	80.4	79.9	82.8	80.3	84.0
Female sterilization	38.5	23.7	49.8	39.1	23.2	26.9	34.0	26.4	43.0	45.4	43.9	26.6
Spermicides	18.4	12.5	27.5	20.5	9.0	14.0	19.5	16.4	15.0	16.2	13.9	6.1
Vasectomy	5.1	3.0	10.7	1.1	1.1	1.7	4.3	2.0	3.5	5.3	1.9	2.5
Emergency contraception	4.2	1.2	9.1	1.1	1.1	1.2	4.6	2.5	3.3	2.9	2.9	1.0
Injectables	3.3	0.9	8.0	1.3	2.8	0.7	1.9	0.8	2.1	1.1	1.3	1.8
Average number of modern methods	3.4	2.9	3.9	3.5	2.6	2.8	3.4	3.3	3.4	3.5	3.4	3.1
Ever heard of a traditional method	72.5	68.8	79.0	81.2	58.1	63.4	69.3	60.9	70.7	75.4	81.9	68.9
Calendar (rhythm) method	68.2	65.3	75.9	78.6	54.7	47.2	58.0	53.0	69.0	74.3	79.0	64.3
Withdrawal	54.9	48.6	60.9	54.0	40.0	53.8	61.0	41.7	47.8	60.1	58.4	46.8
No. of Cases	6,376	538	1,431	430	576	434	490	388	506	936	374	273

Table 7.1.2 Percentage of Women Aged 15–44 Years Who Had Ever Heard of Specific Contraceptive Methods by Marital Status and Age Group
Reproductive Health Survey: Georgia, 2005

		Marital Status			Age Group		
Contraceptive Method	Total	Currently Married	Previously Married	Never Married	15–24	25–34	35–44
Ever heard of any method	96.9	98.3	96.6	94.8	94.2	98.4	98.6
Ever heard of a modern method	96.7	98.0	96.1	94.8	94.0	98.3	98.2
Condoms	95.2	96.2	95.4	93.8	92.9	96.9	96.4
IUD	93.9	97.2	95.8	87.9	87.1	97.8	97.8
Oral contraceptives	81.3	87.9	88.6	69.2	66.9	90.6	88.9
Female sterilization	38.5	44.9	51.9	25.1	20.4	47.9	49.4
Spermicides	18.4	23.1	21.3	9.1	8.5	24.3	23.0
Vasectomy	5.1	5.0	8.2	4.6	2.7	6.8	6.0
Emergency contraception	4.2	4.3	7.8	3.3	2.6	5.6	4.6
Injectables	3.3	3.4	6.2	2.6	2.3	3.8	4.0
Average number of modern methods	3.4	3.6	3.8	3.0	2.8	3.7	3.7
Ever heard of a traditional method	72.5	88.3	88.5	42.4	44.1	87.0	89.7
Calendar (rhythm) method	68.2	83.0	86.3	39.5	40.0	81.8	86.0
Withdrawal	54.9	73.5	77.5	19.3	25.0	68.7	74.8
No. of Cases	6,376	4,119	386	1,871	2,009	2,249	2,118

Table 7.1.3 Percentage of Women Aged 15–44 Years Who Had Ever Heard of Specific Contraceptive Methods by Educational Attainment
Reproductive Health Survey: Georgia, 2005

		Education			
	Total	Secondary Incomplete or Less	Secondary Complete	Technicum	University/ Postgraduate
Ever heard of any method	96.9	85.9	97.6	99.6	99.9
Ever heard of a modern method	96.7	85.9	97.6	99.6	99.9
Condoms	95.2	80.4	95.4	98.9	99.8
IUD	93.9	75.8	95.1	97.9	98.8
Oral contraceptives	81.3	48.9	78.8	88.9	93.7
Tubal ligation	38.5	11.6	27.7	44.5	55.2
Spermicides	18.4	2.3	13.8	20.3	27.3
Vasectomy	5.1	0.7	1.3	4.5	10.3
Emergency contraception	4.2	0.8	1.7	3.8	7.9
Injectables	3.3	0.5	1.2	2.8	6.5
Average number of modern methods	3.4	2.2	3.1	2.9	4.0
Ever heard of a traditional method	72.5	37.3	70.6	84.7	82.0
Calendar (rhythm) method	68.2	29.1	65.4	81.5	79.6
Withdrawal	54.9	28.1	53.5	68.2	59.9
No. of Cases	6,376	907	1,786	1,466	2,217

Table 7.1.4 Percentage of Women Aged 15–44 Years Who Said They Know How Specific Contraceptive Methods Are Used by Marital Status and Age Group
Reproductive Health Survey: Georgia, 2005

		Marital Status			Age Group		
Contraceptive Method	Total	Currently Married	Previously Married	Never Married	15–24	25–34	35–44
Any method	79.4	88.5	83.3	62.1	65.9	85.9	87.1
Any modern method	75.1	82.5	78.7	61.1	64.2	81.4	80.5
Condoms	66.6	71.8	71.6	56.3	57.4	72.7	70.4
IUD	64.0	72.8	67.2	48.0	49.9	71.7	71.8
Oral contraceptives	45.9	53.1	48.7	33.4	33.9	54.7	51.0
Female sterilization	28.3	33.3	34.8	18.3	14.2	36.4	36.0
Spermicides	11.5	14.9	14.6	4.7	4.4	15.8	14.8
Vasectomy	3.5	3.7	3.7	3.0	1.7	4.6	4.3
Emergency contraception	2.5	2.8	3.9	1.9	1.1	3.7	3.0
Injectables	1.7	1.8	2.6	1.3	0.9	2.0	2.3
Average number of modern methods	2.2	2.5	2.5	1.7	1.6	2.6	2.5
Any traditional method	55.5	72.3	65.4	24.5	28.6	68.4	72.5
Calendar (rhythm) method	46.7	60.9	58.6	20.4	23.1	57.9	62.1
Withdrawal	41.3	56.7	54.0	12.6	17.4	52.1	57.2
No. of Cases	6,376	4,119	386	1,871	2,009	2,249	2,118

Table 7.1.5 Percentage of Women Aged 15–44 Years Who Said They Know Where to Get Specific Contraceptive Methods by Age Group and Residence
Reproductive Health Survey: Georgia, 2005

		Age Group			Residence		
Know where to get at least one method	Total	15–24	25–34	35–44	Tbilisi	Other Urban	Rural
	80.4	71.2	86.2	85.8	89.3	79.7	76.2
Condoms	74.2	67.8	79.6	77.3	86.9	73.0	68.4
IUD	70.6	56.2	78.6	79.2	77.8	70.7	66.6
Oral contraceptives	61.4	47.8	71.3	67.6	74.7	60.9	54.4
Female sterilization	30.1	15.6	38.1	38.4	39.3	35.1	21.6
Spermicides	13.6	5.4	19.0	17.1	22.4	12.9	8.7
Vasectomy	4.1	1.9	5.6	4.9	7.8	3.9	1.9
Injectables	2.0	1.1	2.4	2.5	5.2	0.8	0.8
Emergency contraception	3.0	1.6	4.2	3.4	7.0	2.3	1.1
Average number of methods known how to obtain	2.6	2.0	3.0	2.9	3.2	2.6	2.2
No. of Cases	6,376	2,009	2,249	2,118	1,431	1,765	3,180

Table 7.1.6 Trends in Awareness of Contraceptive Methods and Knowledge of How Contraceptive Methods Are Used and Where to Get Modern Methods by Residence: Reproductive Health Surveys, Georgia 1999 and 2005
All Women Aged 15–44 Years

	GERHS 1999			GERHS 2005		
Contraceptive Method	Total	Urban	Rural	Total	Urban	Rural
	Awareness of Contraceptive Methods					
Any method	95.1	98.2	91.3	96.9	99.5	93.8
Any modern method	94.9	98.0	90.8	96.7	99.4	93.4
Condoms	88.5	95.5	79.3	95.2	99.2	90.3
IUD	92.6	95.9	88.3	93.9	96.8	90.3
Oral contraceptives	67.5	77.7	54.4	81.3	88.4	72.7
Female sterilization	43.5	48.5	37.0	38.5	47.7	27.4
Spermicides	11.3	14.6	6.9	18.4	23.6	12.1
Vasectomy	12.4	16.9	6.6	5.1	7.6	2.1
Emergency contraception	4.1	6.0	1.6	4.2	6.2	1.8
Injectables	4.3	5.8	2.5	3.3	5.2	1.1
Any traditional method	69.4	74.0	63.5	72.5	77.1	67.0
Rhythm	64.9	71.0	57.0	68.2	74.2	60.8
Withdrawal	50.3	53.6	46.1	54.9	58.0	51.0
	Knowledge of How Contraceptive Methods Are Used					
Any method	77.9	83.3	70.9	79.4	83.2	74.7
Any modern method	73.5	80.4	64.7	75.1	79.9	69.4
Condoms	62.2	71.3	50.4	66.6	72.8	59.2
IUD	61.8	67.0	55.2	64.0	67.6	59.6
Oral contraceptives	30.1	36.9	21.4	45.9	50.2	40.6
Female sterilization	30.1	35.2	23.6	28.3	35.4	19.5
Spermicides	7.0	9.6	3.6	11.5	14.8	7.6
Vasectomy	8.9	12.0	4.9	3.5	5.3	1.3
Emergency contraception	2.7	4.1	1.0	2.5	3.9	0.8
Injectables	2.6	3.8	1.0	1.7	2.5	0.7
Any traditional method	52.1	56.4	46.5	55.5	58.9	51.3
Rhythm	43.0	49.0	35.3	46.7	52.3	39.9
Withdrawal	37.9	40.0	35.1	41.3	43.0	39.2
	Knowledge of Where to Get Modern Contraceptive Methods					
Any modern method	77.5	83.8	69.4	80.4	84.2	75.7
Condoms	65.8	75.7	53.1	74.2	79.6	67.6
IUD	67.9	73.5	60.7	70.6	74.0	66.4
Oral contraceptives	45.8	55.3	33.5	61.4	67.6	54.0
Female sterilization	34.0	38.7	27.9	30.1	37.2	21.5
Spermicides	8.4	11.3	4.6	13.6	17.6	8.8
Vasectomy	9.4	12.7	5.2	4.1	5.8	1.9
Emergency contraception	2.9	4.5	0.8	3.0	4.6	1.1
Injectables	2.6	3.7	1.1	2.0	3.0	0.7
No. of Cases	7,798	4,759	3,039	6,376	3,196	3,180

Table 7.2.1 Most Important Source of Information About Contraception by Age Group and Marital Status Among Women Age 15-44 Years Who Have Heard of at Least One Method of Contraception (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

		Age Group			Marital Status		
Source	Total	15-24	25-34	35-44	Married	Previously married	Never married
Friends	38.9	39.8	38.5	38.5	37.8	36.9	42.1
Relative	19.5	20.7	18.4	19.7	19.1	18.5	20.6
Doctor	11.2	5.6	13.0	13.8	15.4	10.0	1.2
TV or radio	7.4	12.5	5.6	5.4	5.2	5.6	13.3
Partner/husband/boyfriend	6.9	3.5	7.9	8.4	9.5	7.9	0.2
Co-worker, colleagues, peers	5.0	4.2	4.7	5.8	4.3	8.0	5.9
Books	3.8	3.3	4.6	3.5	3.0	5.0	5.5
Newpapers, magazines, brochures, flyers	3.0	3.5	3.1	2.6	2.6	2.1	4.4
Mother or father	1.6	3.5	1.1	0.7	1.1	1.9	2.7
Teacher	1.1	2.1	1.2	0.3	0.4	2.2	2.6
Nurse, midwife,community health worker	0.4	0.2	0.5	0.4	0.5	0.2	0.2
Other	0.6	0.5	0.7	0.6	0.6	1.0	0.6
Does not remember	0.6	0.5	0.6	0.6	0.5	0.5	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,276	2,009	2,249	2,118	4,119	386	1,871

Table 7.2.2 Most Important Source of Information About Specific Contraceptive Methods Among Women Age 15-44 Years Who Have Heard of at Least One Method of Contraception (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

		Contraceptive Method									
Source	Total	Condom	IUD	Pill	Tubal Ligation	Spermicides	Vasectomy	Injectables	Emergency Contraception	Calendar Method	Withdrawal
Friends	38.9	41.0	38.3	39.2	30.7	34.3	9.5	24.6	23.1	45.8	39.2
Relative	19.5	11.1	24.8	19.5	17.9	17.0	2.9	4.4	5.9	28.3	19.6
Doctor	11.2	2.9	20.8	14.3	17.1	12.4	21.2	20.4	17.7	8.4	1.7
TV or radio	7.4	18.7	3.1	10.3	7.2	8.5	7.1	4.6	5.4	0.2	0.1
Partner/husband/boyfriend	6.9	14.3	0.3	0.1	0.4	1.0	0.6	0.0	0.0	0.9	30.9
Co-worker, colleagues, peers	5.0	4.0	4.3	5.7	5.1	5.3	6.9	8.5	11.7	5.2	5.3
Books	3.8	1.9	2.5	3.4	10.2	6.9	29.3	14.7	14.1	3.1	1.5
Newpapers, magazines, brochures, flyers	3.0	3.8	1.5	3.4	6.4	7.8	10.6	8.9	11.3	1.3	0.5
Mother or father	1.6	0.2	2.6	1.0	0.6	0.6	0.0	1.3	1.7	5.0	0.2
Teacher	1.1	0.5	0.9	1.0	2.4	1.3	10.4	6.1	5.7	0.7	0.5
Nurse, midwife, community health worker	0.4	0.1	0.4	0.7	0.4	0.7	0.6	0.4	0.3	0.6	0.1
Other	0.6	0.5	0.2	1.2	0.1	3.7	0.0	4.5	2.7	0.2	0.0
Does not remember	0.6	1.1	0.2	0.2	1.5	0.5	0.9	1.7	0.3	0.2	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 7.3 Opinions Regarding Contraceptive Effectiveness of Specific Methods Among Women Aged 15-44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Contraceptive Effectiveness						
Contraceptive Method*	Very Effective	Effective	Less or Not Effective	Do Not Know	Never Heard of Method	Total	No. of Cases
Tubal ligation	14.2	20.8	0.5	2.9	61.6	100.0	6,376
IUD	40.2	43.8	0.9	9.1	6.1	100.0	6,376
Oral contraceptives	12.7	54.7	2.5	11.5	18.6	100.0	6,376
Condoms	21.2	61.8	1.0	11.3	4.7	100.0	6,376
Calendar (rhythm) method	5.7	43.5	7.6	11.1	32.0	100.0	6,376
Withdrawal	3.4	37.0	5.8	8.6	45.2	100.0	6,376

*Listed in the descending order of contraceptive effectiveness when the method is used correctly and consistently (Hatcher et al., 2004).

Chapter 8

CONTRACEPTIVE USE

Since achieving independence from the Soviet Union fifteen years ago, Georgia's government has confronted major reproductive health challenges, in an effort to improve the health of Georgian women and their families. Progress has been made in providing women with access to modern contraceptives and other reproductive health services, but challenges remain in reaching the most vulnerable groups and expanding the types and quality of services provided. One objective of the 1999 and 2005 Georgia Reproductive Health Surveys was to help policymakers and program managers assess and respond to current needs.

At the end of the 1990s, only one in five Georgian couples were using modern contraceptive methods, and the extremely high rates of induced abortion appeared to be the principal determinant of fertility decline. In recent years, however, the balance has shifted away from abortion and towards contraception. Due in part to recent efforts by a number of international donors, in collaboration with governmental and nongovernmental local counterparts, both the availability of modern methods and the delivery of adequate information on modern contraception seem to be improving. Similar to Romania and Kazakhstan, where recent nationwide sample surveys have documented a steady reduction in abortion rates, abortion in Georgia is declining, while more couples are using modern contraceptive methods.

This chapter presents information on past and current use of contraceptives and sources of modern contraceptives. Reasons for not using contraception and desire to use contraceptive methods among non-users are also examined, as is contraceptive failure and discontinuation among respondents.

8.1 Ever-use of Contraceptives

Georgia is a relatively low contraceptive-use country, as demonstrated by the high percentage of women who have never used contraceptives. As shown in Table 8.1.1, 28% of all women aged 15–44 years were using a contraceptive method at the time the 2005 Reproductive Health Survey was conducted. About one in seven women (14%) had previously used a contraceptive method, but was not using any method at the time of the survey, while 58% of women declared that they had never used a contraceptive method. Thus, during the 2005 survey, 72% of Georgian women of reproductive age were found to be non-users of contraceptive methods (58% who never used contraceptives and 14% who stopped using them), which is about three percentage points lower than was found in the 1999 survey (75%) (Figure 8.1.1).

In general, 42% of all respondents aged 15–44 years had ever used a contraceptive method; only 29% had ever used a modern method and 18%, a traditional method (Table 8.1.2). Almost 6% of women had used at least one modern and one traditional method in the past. Note that users of both modern and traditional methods are counted only once in the "ever used any method" column, so the overall rate of ever-use is slightly lower than the sum of "ever-used modern methods" and "ever-used traditional methods." Ever-use of any method ranged from a high of 48% in the region of Adjara to a low of 32% in the region of Kvemo Kartli (Figure 8.1.2), and was highest among legally married women (66%) and women in consensual unions (54%) and lowest among never married women (0.3%), women aged 15–19 years (2%) and women with no living children (2%). Regardless of type of method, ever-use generally increases as number of living children, educational attainment, and socioeconomic status (SES) of the women increases. Notably, ever-use of modern methods is higher than ever-use of traditional methods for every category shown in the table.

Ever-use also increases with age, until 35–44 years (Table 8.1.3 and Figure 8.1.3). Ever-use rapidly increases when women reach 25–29 years of age, with a larger increase occurring among ever-users of modern methods compared to ever-users of traditional methods. Ever-use of modern

Figure 8.1.1 **Changes in Contraceptive Status between 1999 and 2005 Among Women Aged 15–44 Years**

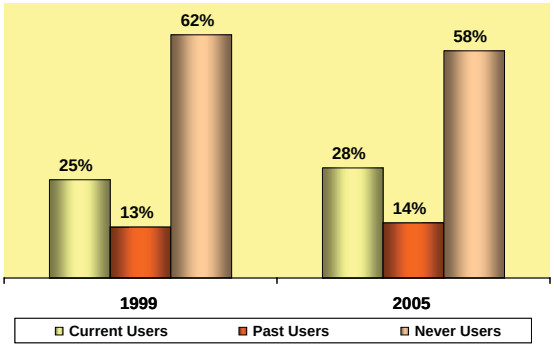


Figure 8.1.2 **Ever-use of Any Contraception among Women Aged 15–44 Years, by Region**

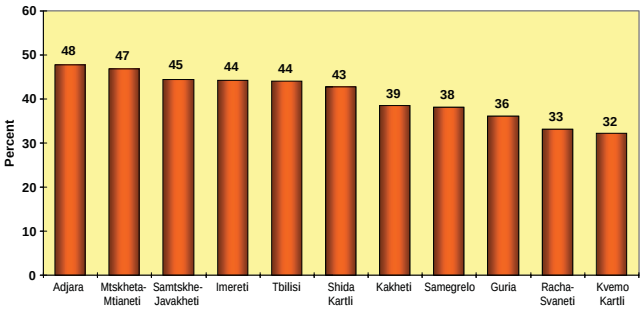
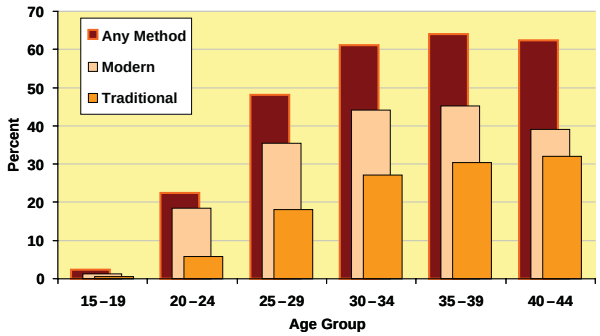


Figure 8.1.3 **Ever-use of Contraception by Type of Method by Age Group Among Women Aged 15–44 Years**

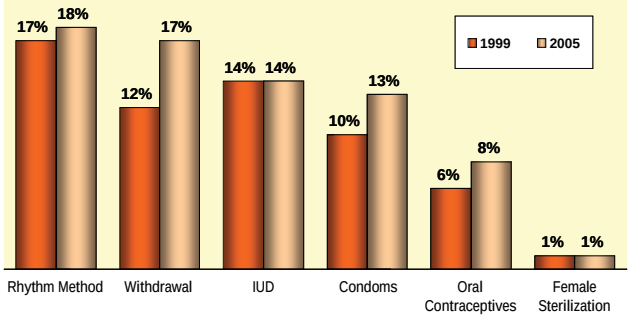


methods appears to plateau when women are in their thirties, then drops off when they are in their forties. A steady increase in ever-use of traditional methods is noted with increasing age of respondents, but ever-use of these methods never exceeds ever-use of modern methods.

Ever-use of IUDs peaks when women are 35–39 years of age, while ever-use of condoms and oral contraceptives peak when women are 30–34 years of age. The peak age for using the traditional rhythm and withdrawal methods is 35–44 years. Regardless of age, the data reveal that there has been little interest in using female sterilization or injectable contraceptives.

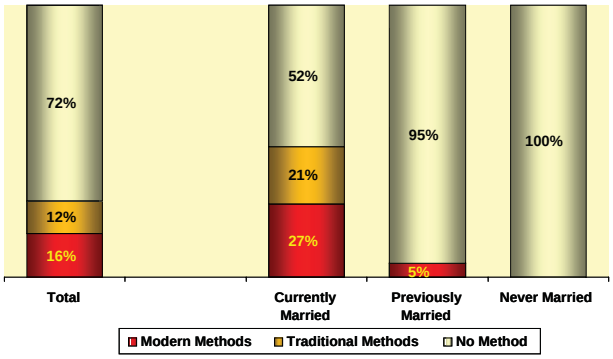
Between 1999 and 2005, the percentage of women who had ever used a male condom with a partner rose from 10% in 1999 to 13% in 2005, while the percentage who had used oral contraceptives increased from 6% to 8% (Figure 8.1.4). The percentage who had ever used an intrauterine device, spermicidal products, or female sterilization showed little to no change between 1999 and 2005.

Figure 8.1.4 **Ever-use of Specific Contraceptive Methods Among Women Aged 15–44 Years: 1999 and 2005**



In conclusion, ever-use of contraceptives had been reported by fewer than one-half of women less than 30 years of age and, in general, declined among women who have reached 40 years of age. The data suggest that the peak years of ever-use are long after women have had their desired number of children, given that Georgia's total fertility rate is only 1.6 live births per woman. Finally, ever-use of modern methods appears to be restricted to IUDs and condoms and, to a lesser extent, to oral contraceptives. Compared to 5 years ago, only ever-use of condoms and oral contraceptives increased, while ever-use of other modern methods remained essentially unchanged.

Figure 8.2.1 **Current Use of Specific Contraceptive Methods by Marital Status Among Women Aged 15–44 Years**



8.2 Current Use of Contraceptives

As mentioned earlier, 28% of all women aged 15–44 years were using a contraceptive method in the 30 days prior to the interview. The percentage was 47% among married women (defined as women legally married or in consensual union), but decreased to 5% among previously married women and to only 0.2% among never married women (Table 8.2.1 and Figure 8.2.1). In general, the

most commonly used method was the IUD, followed by withdrawal and the rhythm method (also known as the calendar method). Condoms were the fourth most common method, followed by female sterilization.

The following discussion focuses only on married women, since they represent the majority of sexually active women in Georgia and are at higher risk of unplanned pregnancies than unmarried women.

As shown in Table 8.2.2 and Figure 8.2.2, the percentage of married women aged 15–44 years who were using a contraceptive method increased from 41% in 1999 to 47% in 2005. The entire increase in prevalence can be attributed to a one-third increase in the use of modern methods, from 20% in 1999 to 27% in 2005. Most of the increase occurred among married women living in "other urban areas." Focusing on individual methods, there was a three-fold increase in the current use of oral contraceptives (from 1% to 3%), although this prevalence is still very low, while use of IUDs and condoms increased from 10% to 12% and from 6% to 9%, respectively (Figure 8.2.3). The use of female sterilization increased by less than a percentage point, from 1.6% in 1999 to 2.2% in 2005. As noted in the table, there was no increase in the current use of traditional methods between the two surveys.

Compared with other countries in the region, Georgia has the lowest overall contraceptive prevalence rate (CPR) (Figure 8.2.4). In many Eastern European countries, more than two-thirds of couples are using a contraceptive method, and in Albania, Moldova, and Russia, more than 70% are using a contraceptive method, compared to Georgia's contraceptive rate of less than 50%. While the use of traditional methods in Georgia (21%) is higher than in the Central Asian countries (ranging from 4% to 9%), it is generally lower than in the Eastern European countries and much lower than in Armenia (38%) and Azerbaijan (44%). Current use of modern contraceptives (27%), however, is lower than in most countries of the region, with the exception of Albania (8%), Armenia (22%), and Azerbaijan (12%).

Figure 8.2.2 **Current Contraceptive Status among Married Women Aged 15–44 Years by Residence: 1999 and 2005**

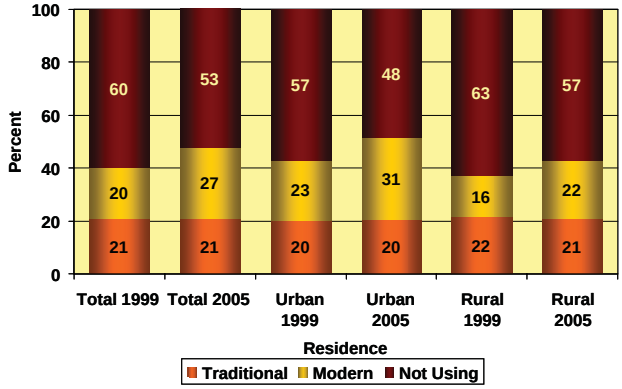


Figure 8.2.3 **Current Use of Specific Contraceptive Methods Among Married Women Aged 15–44 Years: 1999 and 2005**

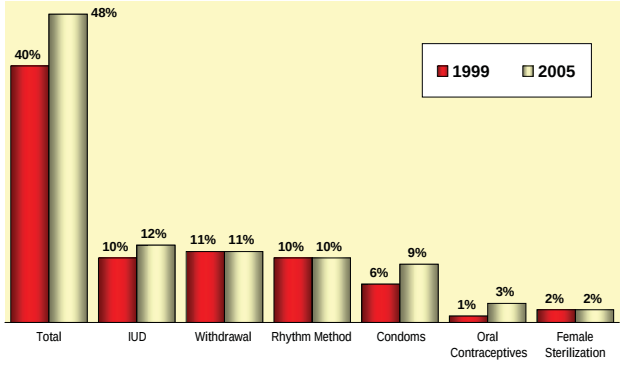
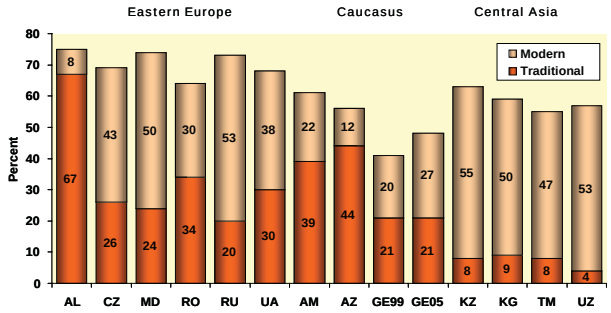


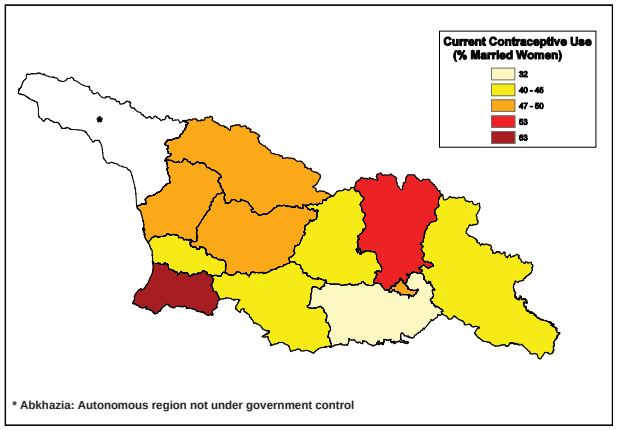
Figure 8.2.4 **Current Use of Modern and Traditional Contraception Among Married Women Aged 15–44 Years: Selected Countries in Eastern Europe and Eurasia**



Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.*
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyzstan; TM=Turkmenistan; UZ=Uzbekistan

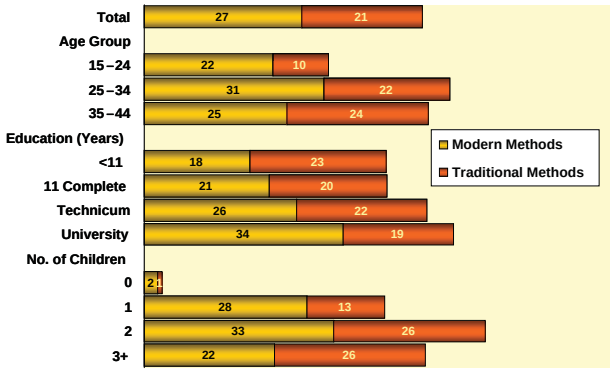
Table 8.2.3 and Figure 8.2.5 show contraceptive use among married women in Georgia, by residence and region. As expected, urban women were more likely than their rural counterparts to be current users of contraceptives. Contraceptive use was highest in the regions of Adjara (63%), Mtskheta-Mtianeti (53%), and Tbilisi (50%) and lowest in Kvemo Kartli (32%) and Kakheti (40%), but these results need to be interpreted with caution because the small sample of women interviewed in some strata yield regional estimates with large confidence intervals (see also Appendix B, Sampling Error). The most commonly used methods were the IUD (12%), withdrawal (11%), rhythm (10%), and condoms (9%). The IUD was the most commonly used method in Kakheti, Samegrelo, Imereti, and Racha-Svaneti, while the most commonly used method in Tbilisi was condoms, in Shida Kartli, Mtskheta-Mtianeti, and Kvemo Kartli, rhythm method, and in Adjara, Samtskhe-Javakheti, and Guria, withdrawal. Modern methods accounted for more than one-half of the CPR in Imereti (65%), Kakheti (65%), Tbilisi (63%), Samegrelo (62%), Mtskheta-Mtianeti (58%), and Racha-Svaneti (56%).

Figure 8.2.5 **Current Use of Any Contraception by Region Among Married Women Aged 15–44 Years**



In general, use of contraceptive methods increases with age, number of living children, educational attainment, and SES (Table 8.2.4 and Figure 8.2.6). The highest rates of contraceptive use were among women aged 30–34, women with two children, women with a university-level education, and women of high SES. Notably, women in each of these groups were more likely to be using a modern method of contraception than a traditional method. The lowest rates of contraceptive use were found among women aged 15–19, women with no living children, and Azeri women. The use of traditional methods was highest among women aged 30–44 years, women with two or more children, women with less than a secondary complete education, and women of low SES. Use of contraceptives was higher in 2005

Figure 8.2.6 **Current Use of Modern and Traditional Contraceptive Methods by Selected Characteristics Among Married Women Aged 15–44 Years**



than in 1999 for every age group except women 15–19 and women with one or more living children (Figures 8.2.7 and 8.2.8).

The prevalence of contraceptive use was higher in urban areas than in rural areas (52% vs. 43%)(Table 8.2.5). Prevalence among urban women was higher than among rural women across all background characteristics shown in the table. The most notable differences were in contraceptive use among childless women, which was much higher in urban areas than in rural areas, but still very low (6% vs. 0.1%), and among urban Azeri versus rural Azeri women (44% vs. 17%).

In summary, contraceptive use by women in legal and consensual marriages was found to be higher than among previously married and never married women. In addition to non-married women, the women least likely to be found using a contraceptive method included those aged 15–19 years, those with no living children, those with less than a secondary complete education, and Azeri women. Use was highest in the regions of Adjara and Mtskheta-Mtianeti and lowest in the regions of Kvemo Kartli and Racha-Svaneti.

At the time of the survey, almost 285,000 women aged 15–44 were currently using contraceptive methods, including 161,000 women who were using modern methods. Between 1999 and 2005, almost 68,000 women started to use supplied methods of contraception. In fact, adoption of modern contraceptives in Georgia occurred at a much faster pace than it did worldwide (Figure 8.2.9). From 1990 to 2000, use of modern methods in Georgia increased by 250%, compared to only 12% worldwide. These findings have important implications for contraceptive forecasting and the prevention of supply shortfalls, particularly at a time when donations of contraceptive supplies are decreasing.

Figure 8.2.7 **Use of Any Contraception by Age Group Among Married Women Aged 15–44 Years: 1999 and 2005**

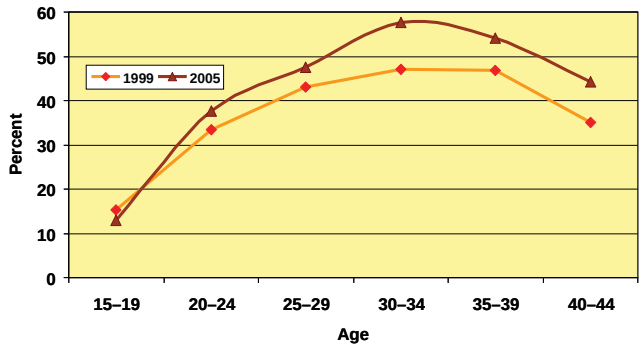


Figure 8.2.8 **Use of Any Contraception by Number of Living Children Among Married Women Aged 15–44 Years: 1999 and 2005**

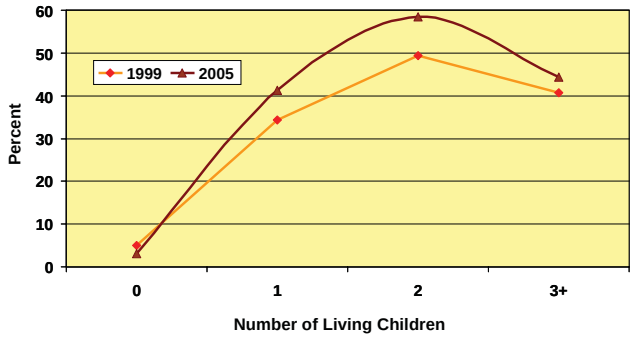
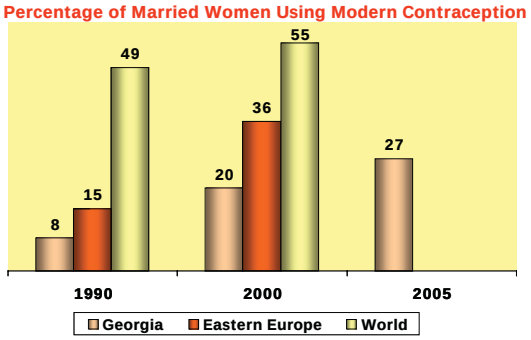


Figure 8.2.9 **Trends in the Current Use of Modern Contraception in Georgia Compared to Eastern Europe and World Average***



Source: UN Secretariat, Dept. for Economic and Social Information and Policy Analysis, 1990 and UN Population Division:, *2001 Data Sheet* ; SSSR *Vestnik Statiski,* 1991; GERHS 1999 and 2005.

8.3 Sources of Modern Contraceptive Methods

Table 8.3.1 presents the percentage of currently married users of modern contraceptive methods by source of method. Because of the heavy dependence on clinical methods, especially IUDs, the public medical sector was the principal source of modern contraceptives in Georgia (52%), followed by private pharmacies (39%). Within the public medical sector, women's consultation clinics and government hospitals with gynecology wards supplied most of the clients who have used modern contraceptives (21% and 20%, respectively). The participation of rural ambulatory clinics and polyclinics in contraceptive supply distribution was insignificant. Nationwide, the participation of private clinics or offices was low (1%). Nearly 8% of users obtained their method from "other" sources, such as partners, friends and relatives, as well as non-governmental organizations (NGOs).

The relative importance of the public medical sector as a source of contraceptive methods varied according to residence and SES. For example, while this sector was the principal source of contraceptives for users living outside of Tbilisi, women living in the capital—where the condom has become the dominant method in recent years—tended to rely on pharmacies. Reliance on the public medical sector is inversely related to SES: lower SES was associated with greater reliance on this sector as a source of modern contraceptives.

As shown in the bottom panel of the Table 8.3.1 and in Figure 8.3.1, sources varied greatly according to the contraceptive method used. The public medical sector was the principal source for only two methods: female sterilization and IUDs. Private pharmacies were the predominate source for methods that require periodic re-supply, such as oral contraceptives, condoms, and vaginal methods. Women who reported the condom as their main method of contraception mostly commonly cited pharmacies as their primary source (79%), while partners were the second most common source (19%). Less than 1% of women reported obtaining condoms via the public medical sector.

Figure 8.3.1 **Source of Supply for Modern Contraceptive Methods Among Married Women Aged 15–44 Currently Using a Method**

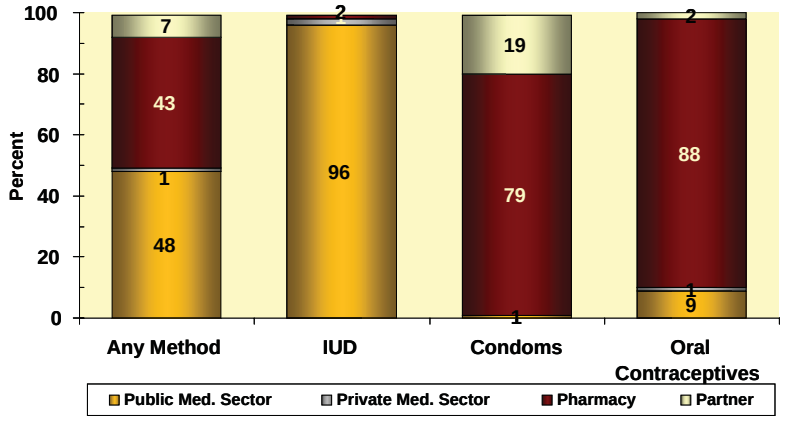
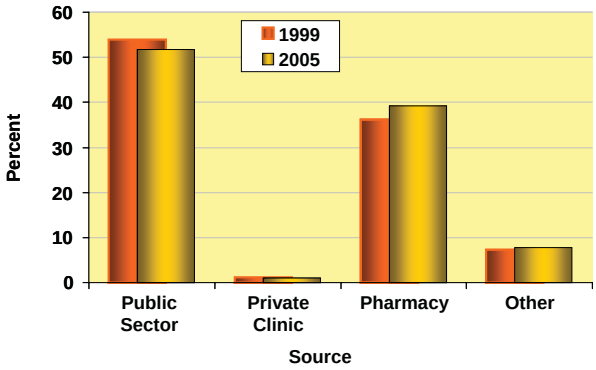


Table 8.3.2 and Figure 8.3.2 show changes in sources of modern contraceptives between 1999 and 2005. In general, the changes are small. The participation of the public medical sector decreased from 54% to 52%, while the participation of private pharmacies increased from 36% to 39%. Essentially, there was no change in the percentage of women who obtain their contraceptive methods from private clinics.

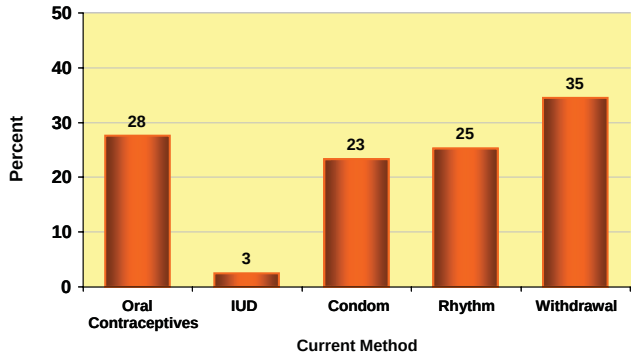
Figure 8.3.2 **Source of Supply of Modern Contraceptive Methods Among Married Women Aged 15–44 Years: 1999 and 2005**



8.4 Desire to Use a Different Contraceptive Method

All married women aged 15–44 years who were using a contraceptive method during the 30 days prior to interview were asked: "Would you prefer to use a different method of family planning from the one you are currently using?" As shown in Table 8.4.1, only 21% of the women desired to use a different method, indicating that 79% of the women were satisfied with their current method. The most frequently cited reasons women gave for dissatisfaction with their current method included inconvenience, low effectiveness/method failure resulting in pregnancy, and "I sometimes forget to use it" (data not shown). The probability of wanting to use a different method was highest among women using withdrawal (35%), oral contraceptives (28%), the rhythm method (25%), and condoms (23%) (Figure 8.4). Less than 3% of IUD users expressed a desire to use a different method.

Figure 8.4 **Percentage of Women Who Desire to Switch to Another Contraceptive Method by Current Method Among Married Women Aged 15–44 Who Are Currently Using Contraceptives**



The right panel of Table 8.4.1 shows that the most desired method among women who desired to use a different method was the IUD (75%). Few women wanted to switch to using condoms (8%), oral contraceptives (7%), or female sterilization (7%). Interestingly, no one desired to switch to using an injectable contraceptive method. The desire to use the IUD increased as age, educational attainment, and SES decreased, while the desire to use female sterilization increased with educational attainment and SES. Among women living in urban areas other than Tbilisi, 14% desired to use female sterilization. The

IUD was the overwhelming choice among respondents regardless of the number of living children. However, among women with less than two living children, there was some interest in using either oral contraceptives or condoms. Most current users of traditional expressed a desire to use the IUD: 83% and 65% of current users of withdrawal and rhythm, respectively, would prefer to use the IUD.

The principal reasons why women did not switch to their preferred method are shown in Table 8.4.2. More than a third of the women stated that they "haven't yet made up their minds" to switch to their preferred method, indicating that these women may benefit from some counseling. The second most commonly cited reason was "fear of side effects" (19%), which was particularly important for women who desired to use oral contraceptives. The third most commonly cited reason was "doctor will not prescribe" the preferred method (15%), which was cited only by women desiring to use the IUD. Cost was a factor for 15% of the women, and was an important factor for all methods shown in the table except condoms. Partner opposition was mentioned by only 5% of the women, most of whom desired to use condoms; difficulty in using condoms was also cited as a factor for not switching to them.

8.5 Users of Traditional Methods

Nearly 44% of current users of contraceptive methods use a traditional method, such as rhythm and/or withdrawal, which are the second and third most used of any contraceptive methods in Georgia. In an attempt to understand what motivates women to use these two methods, they were asked what factors were important in their decision to use a traditional method instead of a modern method. Respondents cited fear of health or side effects that may be associated with the use of modern methods; lack of knowledge about other methods; cost or availability of other methods; partner preference; medical or other person's advice against modern methods; and religious beliefs.

Over 90% of respondents mentioned that fear of or experience with side effects in using a modern method was an important or somewhat important factor (Table 8.5.1). Nearly 78% stated that they possessed little knowledge of modern methods, indicating the need for an information and education program on the advantages and disadvantages of using modern contraceptive methods. Three-fourths of the women declared that cost was a factor in not using a modern method, suggesting that the availability of subsidized contraceptive methods may eliminate an important barrier to the use of modern methods. Another factor mentioned by respondents was "difficulty in obtaining a modern method," which was mentioned by 50% of the users of traditional methods. This finding has programmatic implications in that it suggests that the geographical availability of modern methods in Georgia is not evenly distributed. Similarly, 53% of the women mentioned that they were using a traditional method on their doctor's recommendation, which suggests that modern methods may not always be brought up during the doctor-patient dialogue and that physicians may need professional updates on modern methods.

Nearly two-thirds of respondents said that they were using a traditional method because it was their husband's or partner's choice, indicating that information and education programs should focus on men as well as women. Religious beliefs were important or somewhat important for 50% of traditional method users; the rate increases to 58% among women with a university-level education.

"Lack of knowledge of modern methods" was a commonly cited reason for use of traditional methods among rural women, women aged 15–24 years, women with three or more children, women with a secondary or less education, women of low SES, and Azeri women. Similarly, the cost of modern methods was mentioned more often by rural women and women of low SES, while "difficulty in getting a modern method" was more frequently mentioned by women

with less than a secondary complete education and Azeri women. Notably, nearly 61% of women aged 15–24 stated that they were using a traditional method on their "doctor's recommendation"; this was the same group of women who were in second place in mentioning "lack of knowledge of modern methods" as a reason for use of traditional methods. This suggests a need for doctors to talk to young women about the full range of contraceptive choices available to them.

Similar reasons for not using modern methods were cited by respondents in the 1999 survey who were users of traditional methods (Figure 8.5.1). From 1999 to 2005, more women cited cost (from 67% to 75%), partner's preference (from 49% to 64%), doctor's advice (from 32% to 53%) and religious beliefs (from 23% to 50%) as important reasons for not using modern contraceptives.

Users of rhythm and withdrawal methods were also asked to compare the effectiveness of their current method to modern methods like oral contraceptives and the IUD (Table 8.5.2). Similar to other countries in the region, three-fourths of the women considered their current method more effective (27%) or equally effective (48%), compared with modern methods (Figure 8.5.2). This is the same proportion that held this belief in 1999. The only difference between the two surveys in this regard was that fewer women in 2005 considered their traditional method to be more effective (35% vs. 27%).

Focusing on the 2005 data, women aged 25–44 years, women with less than a secondary complete education, and women of high SES were most likely to consider their traditional method more effective than a modern method. Women who considered their current method to be less effective than a modern method (19%) did not vary much in terms of the variables shown in Table 8.5.2, with the exception of education level and ethnic group. As education level went up, a greater proportion of respondents considered their traditional method less effective than modern methods, increasing from 9% among women with less than a secondary complete education to more than 20% among women

Figure 8.5.1 **Most Important Reasons for Not Using Modern Contraceptives Among Women Aged 15–44 Currently Using Traditional Methods: 1999 and 2005**

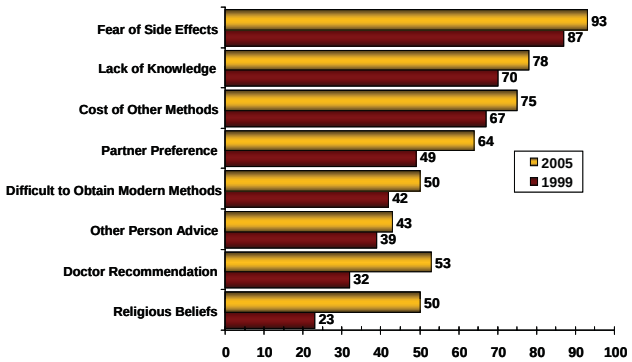
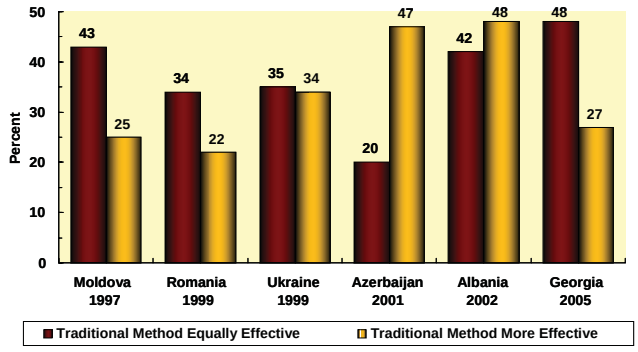


Figure 8.5.2 **Beliefs that Traditional Methods are Equally or More Effective than Modern Methods Among Women Aged 15-44: RHS Data from Selected Countries in Eastern Europe**



who attended technicum or university education. Few Azeri and Armenian women felt that their method was less effective (5% and 8% respectively) compared to Georgian women (20%).

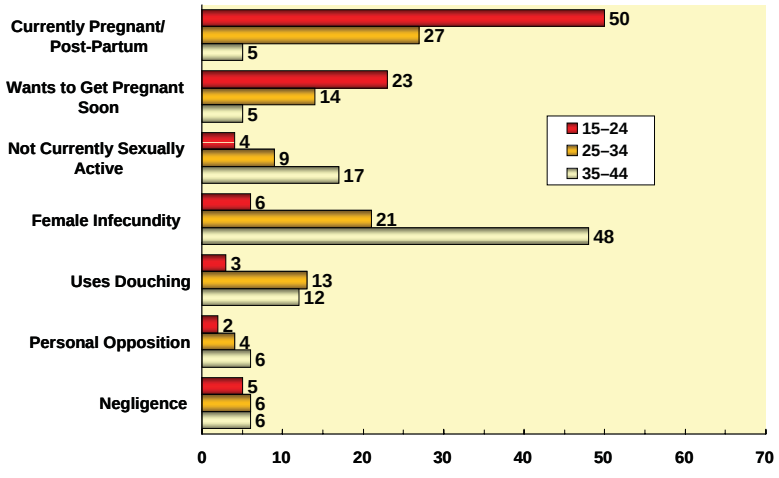
Overall, 7% of respondents did not know if their current method was more or less effective than a modern method, a percentage which increased to 13% among women aged 15–24 years, 20% among women with less than a secondary complete education, and 30% among Azeri women.

8.6 Reasons for Not Using Contraceptives

As shown in Tables 8.6.1 and 8.6.2, nearly 69% of married respondents who were not using contraceptives at the time of the survey were not doing so for reasons related to pregnancy (currently pregnant or desiring a pregnancy), fertility (believes herself to be unable to conceive), or sexual activity (not currently active). Additionally, almost 31% were not using for "other" reasons. The likelihood of not using contraceptives for reasons related to pregnancy, fertility, or sexual activity was highest in the Adjara region, among women aged 15–24 years, among women with less than two children, among women with a university level education, and among women of high SES. "Other" reasons for not using contraceptives were more frequently mentioned by women living in the region of Kvemo Kartli, among women with three or more children, and among Azeri women.

Reasons for not using a contraceptive method differed sharply by age group (Figure 8.6). For example, married women aged 15–24 years were more likely to be pregnant (31%), seeking to become pregnant (26%), or in the postpartum period (17%), while women aged 35–44 years were more likely to not be able to get pregnant (40%) or were not sexually active (16%). Similarly, women with no living children or women with only one living child were more likely to be pregnant (27%) or seeking to become pregnant (31%), while women with two or more children were more likely to be sub-fecund or infertile. A relatively high percentage of women with a university-level education were either pregnant (19%) or seeking to become pregnant (20%).

Figure 8.6 **Most Commonly Cited Reasons for Not Currently Using Contraception by Age Group Among Married Women Aged 15–44 Years**



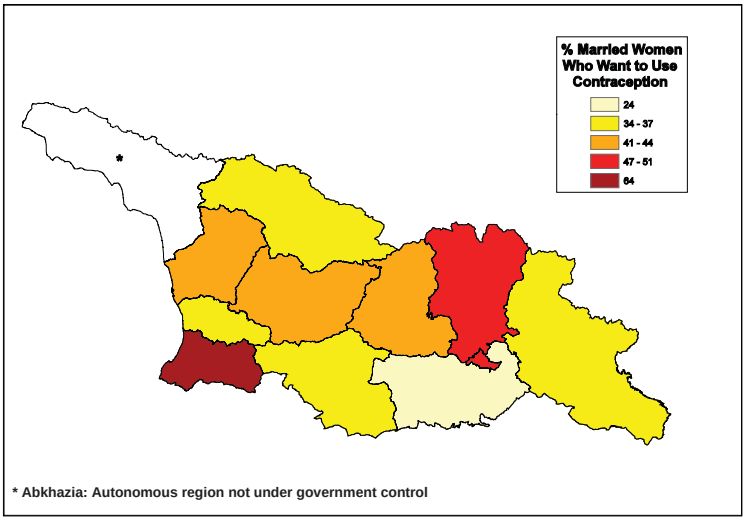
As mentioned above, almost 31% of respondents gave "other" reasons for not using contraceptives at the time of the survey. Nearly 14% said they were using vaginal douching to avoid pregnancy, while another 8% declared that they just do not think about using a contraceptive method. Only about 1% of respondents stated that their husbands or partners object to the use of contraceptives. Notably, very few women reported reasons related to contraceptive methods or family planning services as contributing to their decision not to use a method.

8.7 Intention to Use Contraceptives Among Non-users

All fecund, married respondents aged 15–44 years who were not using any contraceptive method at the time of the survey were asked if they plan to use any contraceptive method in the next 12 months or later. As Table 8.7.1 shows, 23% planned to use a contraceptive method in the next 12 months, while 19% planned to use a method sometime in the future. Thus, 42% plan to use a method relatively soon or in the future, which is 4% higher than in the 1999 survey results. As shown in Figure 8.7.1, rates of planning to use a method in the next 12 months or later varied according to region, and was highest among women living in the Adjara region and lowest among those in the Kvemo Kartli region. About one in four respondents were undecided as to whether they will use contraceptives in future, while a third of respondents declared that they do not desire to use a method at any time. The probability of not desiring to use a method is highest among women aged 35–44 years, women with three or more children, and Azeri women.

The desire to use a method in the next 12 months or at some point in the future was inversely associated with age and number of living children. For example, almost three times more respondents aged 15–24 years planned to use a method in the next 12 months or later than those aged 35–44 years, while twice as many respondents with less than two children planned to use a method compared with respondents with three or more children. In general, the proportion of respondents who plan to use a method at some point increases as the education level and SES increase. These data suggest that the family planning program in Georgia should focus its promotion efforts on young women with less than two children. Promotion

Figure 8.7.1 **Intention to Use Contraception in the Future Among Married Fecund Women Who Are Not Currently Using a Method, by Region**



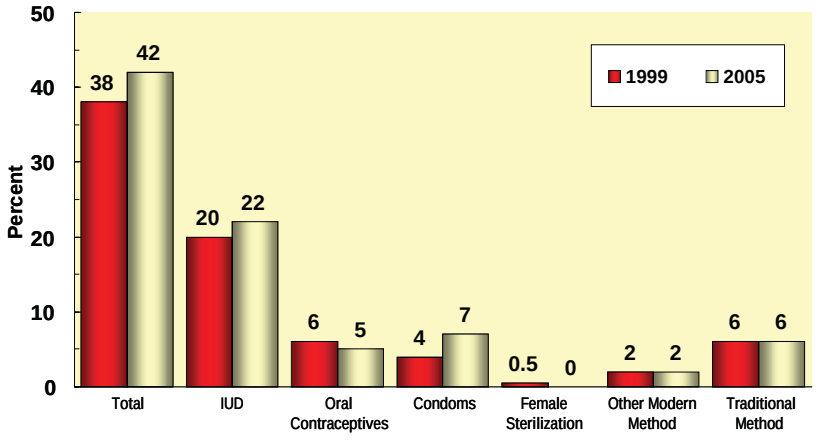
efforts should also focus on undecided women, who primarily live in the regions of Guria, Racha-Svaneti, Kvemo Kartli, Imereti, and Kakheti.

Of fecund married respondents who planned to use contraceptives in the future, the vast majority desired to use a modern method (Table 8.7.2). The most desired method was the IUD (52%), followed by condoms (17%), and oral contraceptives (12%). An additional 2% of these respondents wanted to use spermicides, while less than 1% would prefer to use female sterilization or injectable contraceptives. With regards to traditional methods, 8% of respondents planned to use the rhythm method, while 5% planned to use withdrawal. If these preferences prevail in the future, the use of the rhythm and withdrawal methods may slip to fourth and fifth place among the methods most used in Georgia, compared to their current ranking of second and third place.

Compared to 1999, the desire to use contraceptives among non-users had increased by about 5% (from 38% to 42%)(Figure 8.7.2). In both surveys, more than half of non-users who declared that they intend to use contraceptives in the future considered the IUD as the most desirable method.

Of the non-users who planned to use a modern method in the next 12 months or at some point in the future, 35% stated that they would obtain their method from a polyclinic, while 30% would obtain their method from an NGO facility (Table 8.7.3). Nearly 21% mentioned a women's consultation clinic and about 8% mentioned a government hospital. Surprisingly, less than 2% mentioned pharmacies. This mix of potential sources of contraceptive methods is radically different from the sources that current user of modern contraceptives rely on (see Table 8.4.1), especially with regards to pharmacies, government hospitals, and NGOs. These findings, however, need to be interpreted with caution. Non-users are likely to have less knowledge about modern contraception in general, including the most likely sources for them. They may also have unrealistic expectations about receiving free or subsidized contraceptive supplies or may be expressing their desire to have more accessible and affordable sources within their reach within they need them.

Figure 8.7.2 **Intention to Use Specific Methods in the Future Among Married Fecund Women Aged 15–44 Years Who Are Not Currently Using Contraception: 1999 and 2005**



8.8 Contraceptive Failure and Discontinuation

Contraceptive failure rates (i.e., the probability of becoming pregnant while using a contraceptive method) and discontinuation rates (i.e., the probability of stopping use of a contraceptive method for any reason, including getting pregnant) were calculated using information collected through the detailed month-by-month pregnancy and contraceptive use histories (Table 8.8.1). The estimates should be considered conservative because some women may have not reported pregnancies ending in abortions and if they were using contraceptives at the time of conception, the corresponding method failure would not have been not captured from their histories; thus, the true rates are probably somewhat higher than those shown in Table 8.8.1.

Monthly probabilities of failure and of discontinuing contraceptive use for all respondents who used a contraceptive method during the observed period (January 2000–July 2005) were estimated using life-table analysis. Linking these probabilities, 12-, 24-, and 36-month contraceptive failure and discontinuation rates can be calculated. These rates represent the proportion of users who stopped using their method within the first year, second year, or third year of use for any reason (the discontinuation rate) or because they became pregnant while using the method (the failure rate). The 12-, 24-, and 36-month intervals of use refer to uninterrupted use; a new interval starts when a woman begins to use a method for the first time or when she resumes its use after a period during which she had used another or no method. Because only the use of a single method can be evaluated during any month, the more effective of two methods used during the same month was recorded.

An estimated 13% of respondents became pregnant during the first year of using a method, 24% became pregnant after 2 years, and 29% became pregnant after 3 years. Failure rates varied considerably by type of contraceptive method. The IUD had the lowest failure rate at 1, 2, and 3 years: between 0.8% and 1.7% of IUD users became pregnant. The 1-year IUD failure rate was very low, comparable with the most recent data published in the literature: 0.1–2.0 failures per 100 women during the first year of typical use (Hatcher et al., 2004). Condom users reported failure rates of 7% during the first year, 16% after 2 years, and 22% after 3 years. These condom failure rates reported by Georgian respondents are lower than failure rates for typical use among US women (15%)(Hatcher et al., 2004). Similarly, the failure rate for oral contraceptives (5%) was slightly lower than previously reported failure rates for typical use (8%). The highest failure rates at 12, 24, and 36 months of use were reported by users of the rhythm method (25%, 41%, and 48%, respectively) and withdrawal (18%, 31%, and 41%, respectively), which highlights the need for increased information, education, and counseling efforts to promote correct use of more effective contraceptive methods.

Overall, 36% of respondents discontinued their method within 1 year, 56% within 2 years, and 67% within 3 years of use. About a third of discontinuations after 12 months of use (36%) were caused by method failure. As shown in Table 8.8.1, the IUD was the only method with a low discontinuation rate at 1 year (8%), but three times as many IUD users stopped using the method within 3 years (24%). Only 11% of IUD users discontinued the method because of method failure. In contrast, half of oral contraceptive users discontinued their method during the first year and only 17% continued to use oral contraceptives after 3 years, despite the low failure rate of this method. Oral contraceptive use was seldom discontinued for reasons related to method efficacy (11% during the first year of use). Condom discontinuation shows a similar pattern: 39% used the condom for less than 1 year and only 28% used it for more than 3 years. Method failure accounted for 18% of the reasons cited for condom discontinuation. Withdrawal and the rhythm method were associated with very high

discontinuation rates at 1 (39%–42%), 2 (61%–64%), and 3 years (74%–75%); method failure was cited as the reason for almost one-half of those discontinuations (45%–59%).

In addition to method failure, respondents discontinued their method for many other reasons (Table 8.8.2). After method failure, the most cited reasons for discontinuation were partner's objections or temporary absence (11% of discontinuations), negligence (8% of discontinuations), and intention to become pregnant (6% of discontinuations).

The main reason for discontinuation varied greatly with type of contraceptive method. The IUD discontinuation rate in the first year of use, the lowest among all contraceptive methods, was heavily influenced by side effects or health concerns associated with the IUD. The experience or fear of side effects was also a principal reason for discontinuing use of oral contraceptives. Women whose partners were using condoms discontinued use mainly because of partners' objections or absence. Method failure was by far the most important reason for discontinuation of withdrawal and the rhythm method.

Table 8.1.1 Contraceptive Use Status Among All Women Aged 15–44 Years by Selected Characteristics
Reproductive Health Survey: Georgia, 2005

	Contraceptive Use Status (Percentage Distribution)				
Characteristic	Never Used	Previous User	Current User	Total	No. of Cases
Total	58.0	13.5	28.4	100.0	6,376
Residence					
Urban	55.8	14.8	29.4	100.0	3,196
Rural	60.8	11.9	27.3	100.0	3,180
Region					
Kakheti	61.5	13.6	24.9	100.0	538
Tbilisi	55.7	16.7	27.6	100.0	1,431
Shida Kartli	57.2	13.2	29.5	100.0	430
Kvemo Kartli	67.6	11.9	20.5	100.0	576
Samtskhe-Javakheti	55.0	16.2	28.8	100.0	434
Adjara	52.3	8.4	39.3	100.0	490
Guria	63.8	11.2	24.9	100.0	388
Samegrelo	61.9	10.9	27.2	100.0	506
Imereti	55.7	14.6	29.7	100.0	782
Mtskheta-Mtianeti	53.2	13.7	33.2	100.0	374
Racha-Svaneti	66.9	8.8	24.3	100.0	427
Marital Status					
Legally married	33.9	18.5	47.6	100.0	3,980
Consensual union	45.9	17.1	37.0	100.0	139
Previously married	52.6	42.6	4.8	100.0	386
Never married	99.7	0.2	0.2	100.0	1,871
Age Group					
15–19	97.7	0.5	1.7	100.0	930
20–24	77.2	5.1	17.7	100.0	1,079
25–29	51.9	15.6	32.5	100.0	1,139
30–34	38.7	16.2	45.1	100.0	1,110
35–39	35.8	20.0	44.2	100.0	1,048
40–44	37.6	26.1	36.4	100.0	1,070
No. of Living Children					
0	98.2	1.2	0.6	100.0	2,299
1	44.1	20.5	35.4	100.0	1,131
2	22.6	22.0	55.4	100.0	2,168
3 or more	30.0	24.5	45.5	100.0	778
Education Level					
Secondary incomplete or less	78.1	5.8	16.1	100.0	907
Secondary complete	56.3	15.3	28.4	100.0	1,786
Technicum	46.8	17.6	35.5	100.0	1,466
University/postgraduate	56.9	13.2	29.9	100.0	2,217
Socioeconomic Status					
Low	61.7	12.7	25.6	100.0	2,277
Middle	57.6	13.8	28.6	100.0	3,028
High	52.3	14.4	33.3	100.0	1,071
Ethnic Group					
Georgian	57.2	13.3	29.5	100.0	5,545
Azeri	77.6	6.9	15.4	100.0	292
Armenian	56.4	21.4	22.3	100.0	382
Other	49.7	17.8	32.5	100.0	157

Table 8.1.2 Ever-use of Contraceptive Methods Among All Women Aged 15–44 Years by Type of Method by Selected Characteristics Reproductive Health Survey: Georgia, 2005

Characteristic	Type of Method			No. of Cases
	Any Method %	Any Modern Method %	Any Traditional Method %	
Total	41.9	29.4	18.3	6,376
Residence				
Urban	44.1	33.3	21.5	3,196
Rural	39.2	24.6	14.4	3,180
Region				
Kakheti	38.5	27.8	19.2	538
Tbilisi	44.1	36.1	23.6	1,431
Shida Kartli	42.8	26.1	24.8	430
Kvemo Kartli	32.3	22.0	14.8	576
Samtskhe-Javakheti	44.5	19.8	15.0	434
Adjara	47.7	29.4	8.5	490
Guria	36.2	21.5	13.3	388
Samegrelo	38.1	26.9	14.0	506
Imereti	44.3	31.3	19.1	782
Mtskheta-Mtianeti	46.8	33.0	26.1	374
Racha-Svaneti	33.1	23.3	14.1	427
Marital Status				
Legally married	66.0	45.9	29.3	3,980
Consensual union	54.1	40.5	19.9	139
Previously married	47.4	35.9	17.7	386
Never married	0.3	0.3	0.0	1,871
Age Group				
15–19	2.3	1.2	0.6	930
20–24	22.4	18.4	5.7	1,079
25–29	48.1	35.4	18.1	1,139
30–34	61.2	44.2	27.2	1,110
35–39	64.1	45.2	30.3	1,048
40–44	62.4	39.0	32.1	1,070
No. of Living Children				
0	1.8	1.6	0.4	2,299
1	55.7	41.9	21.9	1,131
2	77.2	54.4	37.1	2,168
3 or more	70.0	43.9	26.7	778
Education Level				
Secondary incomplete or less	21.8	11.9	6.7	907
Secondary complete	43.5	28.4	17.1	1,786
Technicum	53.1	36.9	24.5	1,466
University/postgraduate	43.1	33.7	20.9	2,217
Socioeconomic Status				
Low	38.3	22.7	13.9	2,277
Middle	42.2	30.3	18.8	3,028
High	47.7	39.4	25.0	1,071
Ethnic Group				
Georgian	42.8	30.3	19.3	5,545
Azeri	22.4	14.4	5.8	292
Armenian	42.1	23.8	11.0	382
Other	50.3	40.8	23.8	157

Table 8.1.3 Ever-use of Contraceptive Methods Among All Women Aged 15–44 Years by Method and Age Group
Reproductive Health Survey: Georgia, 2005

	Contraceptive Method										
Age Group	Rhythm %	Withdrawal %	IUD %	Condoms %	Oral Contraception %	Spermicides %	Female Sterlization %	Emergency Contraception %	Injectables %	Vasectomy %	No. of Cases
15–19	0.6	1.0	0.4	0.6	0.2	0.0	0.0	0.0	0.0	0.0	930
20–24	5.7	6.9	8.4	7.8	4.9	1.1	0.0	0.0	0.2	0.0	1,079
25–29	18.1	17.6	15.1	16.3	11.2	2.8	0.5	0.3	0.0	0.0	1,139
30–34	27.2	24.4	19.6	21.5	13.1	4.0	2.3	0.3	0.0	0.0	1,110
35–39	30.3	26.0	24.8	18.2	10.9	3.7	3.4	0.4	0.4	0.1	1,048
40–44	32.1	27.4	21.6	16.7	7.7	3.4	2.4	0.2	0.0	0.0	1,070
Total	18.3	16.6	14.4	13.0	7.6	2.4	1.4	0.2	0.1	0.0	6,376

Table 8.2.1 Current Contraceptive Use Among All Women Aged 15–44 Years by Marital Status and Method
Reproductive Health Survey: Georgia, 2005

		Marital Status		
Use and Method	Total %	Married %	Previously Married %	Never Married %
Currently Using any Method	28.4	47.3	4.8	0.2
Pill	1.9	3.2	0.5	0.0
IUD	7.0	11.6	2.0	0.0
Condom	5.3	8.7	1.0	0.2
Spermicides	0.5	0.9	0.0	0.0
Female sterilization	1.4	2.2	1.0	0.0
Emergency contraception	0.0	0.0	0.2	0.0
Injectables	0.0	0.0	0.0	0.0
Rhythm	5.7	9.5	0.0	0.0
Withdrawal	6.6	11.2	0.0	0.0
Not Currently Using	71.6	52.7	95.2	99.8
Total	100.0	100.0	100.0	100.0
No. of Cases	6,376	4,119	386	1,871

Table 8.2.2 Trends in Current Contraceptive Use Among Married Women Aged 15–44 Years by Method Reproductive Health Surveys: Georgia, 1999 and 2005

	Survey Year	
Use and Method	1999 %	2005 %
Currently Using	40.5	47.3
Modern Methods	19.8	26.6
Pill	1.0	3.2
IUD	9.7	11.6
Condom	6.3	8.7
Spermicides	0.1	0.9
Female sterilization	1.6	2.2
Injectables	0.0	0.0
Other modern	1.0	0.0
Traditional Methods	20.7	20.7
Rhythm	10.2	9.5
Withdrawal	10.5	11.2
Not Currently Using	59.5	52.7
No. of Cases	5,177	4,119

Table 8.2.3 Current Contraceptive Use Among Married Women Aged 15–44 Years by Method and by Residence and Region
Reproductive Health Survey: Georgia, 2005

		Modern Methods						Traditional Methods			
Residence and Region	Any Method %	Pill %	IUD %	Condom %	Female Sterilization %	Other Modern* %	Subtotal Modern %	Rhythm %	Withdrawal %	Subtotal Traditional %	No. of Cases
Total	47.3	3.2	11.6	8.7	2.2	0.9	26.6	9.5	11.2	20.7	4,119
Residence											
Urban	51.7	3.1	11.6	12.8	2.4	1.4	31.3	11.8	8.6	20.4	1,947
Rural	42.6	3.2	11.5	4.4	2.0	0.4	21.6	7.1	13.9	21.0	2,172
Region											
Kakheti	39.6	6.7	12.7	4.3	1.4	0.5	25.7	7.7	6.2	13.9	377
Tbilisi	50.1	2.1	7.6	18.8	1.5	1.4	31.4	14.0	4.8	18.8	841
Shida Kartli	43.6	3.5	7.8	6.4	2.9	0.3	20.9	14.7	8.0	22.7	308
Kvemo Kartli	32.4	2.1	7.7	4.9	1.1	0.2	16.1	9.9	6.4	16.3	390
Samtskhe-Javakheti	45.1	0.5	7.3	4.9	0.3	0.5	13.5	6.2	25.4	31.6	308
Adjara	63.3	2.2	18.8	4.6	1.9	2.2	29.7	5.1	28.5	33.6	335
Guria	44.9	4.0	9.2	3.7	2.9	1.5	21.3	6.6	16.9	23.5	243
Samegrelo	47.1	4.0	13.2	6.6	4.6	0.9	29.3	8.3	9.5	17.8	301
Imereti	48.1	3.6	17.3	6.1	4.0	0.3	31.3	5.7	11.1	16.8	515
Mtskheta-Mtianeti	53.0	7.4	10.4	11.4	0.7	0.7	30.5	12.8	9.7	22.5	253
Racha-Svaneti	46.6	3.0	13.9	5.6	3.0	0.8	26.3	9.4	10.9	20.3	248

* Includes spermicides and injecting contraceptives.

Table 8.2.4 Current Contraceptive Use Among Married Women Aged 15–44 Years by Method and Selected Characteristics Reproductive Health Survey: Georgia, 2005

		Modern Methods						Traditional Methods			
Characteristic	Currently Using Any Method %	Pill %	IUD %	Condom %	Female Sterilization %	Other Modern* %	Subtotal Modern %	Rhythm %	Withdrawal %	Subtotal Traditional %	No. of Cases
Total	47.3	3.2	11.6	8.7	2.2	0.9	26.6	9.5	11.2	20.7	4,119
Age Group											
15–19	13.0	1.4	2.6	1.0	0.0	0.0	5.0	3.0	5.0	8.0	156
20–24	37.7	5.5	11.9	9.3	0.0	1.1	27.8	3.6	6.3	9.9	557
25–29	47.6	4.6	13.2	11.1	0.7	0.8	30.4	5.8	11.4	17.2	829
30–34	57.6	4.3	12.6	11.2	2.6	1.0	31.7	11.4	14.5	25.9	872
35–39	54.1	2.0	13.1	8.8	4.2	1.3	29.4	12.6	12.0	24.7	841
40–44	44.3	1.2	9.6	5.9	3.0	0.6	20.3	12.6	11.4	24.0	864
No. of Living Children											
0	3.1	0.0	0.0	2.3	0.0	0.0	2.3	0.3	0.5	0.8	382
1	41.3	3.7	9.3	12.8	0.7	1.4	27.9	6.9	6.4	13.4	971
2	58.4	4.1	14.7	9.6	3.0	1.1	32.5	12.6	13.4	26.0	2,036
3 or more	48.3	1.7	12.2	4.9	3.0	0.4	22.3	9.4	16.6	26.0	730
Education Level											
Secondary incomplete or less	41.7	3.3	11.0	2.0	1.8	0.0	18.2	3.4	20.1	23.5	428
Secondary complete	41.7	2.9	10.7	5.4	1.9	0.6	21.6	7.8	12.4	20.1	1,289
Technicum	48.8	2.8	12.9	6.9	2.9	1.2	26.7	11.3	10.8	22.1	1,096
University/postgraduate	53.3	3.7	11.5	15.6	2.0	1.4	34.1	11.7	7.4	19.1	1,306
Socioeconomic Status											
Low	42.6	3.2	12.2	3.1	1.2	0.3	20.0	6.5	16.2	22.6	1,473
Middle	47.5	3.5	11.2	9.1	2.6	0.9	27.4	10.4	9.7	20.1	1,944
High	55.3	2.3	11.2	18.1	3.1	2.1	36.8	12.8	5.8	18.5	702
Ethnic Group											
Georgian	50.1	3.4	12.5	9.4	2.5	1.0	28.7	10.3	11.0	21.4	3,514
Azeri	20.8	1.1	7.7	1.6	0.3	0.0	10.7	3.2	6.9	10.1	232
Armenian	35.6	0.9	4.0	8.3	0.7	0.0	14.0	3.5	18.2	21.7	261
Other	46.0	7.0	8.7	6.3	1.2	1.4	24.6	10.9	10.6	21.4	112

*Includes spermicides and injecting contraceptives.

Table 8.2.5 Current Contraceptive Use Among Married Women Aged 15–44 Years by Residence and Selected Characteristics
Reproductive Health Survey: Georgia, 2005

			Residence			
Characteristic	Total	No. of Cases	Urban %	No. of Cases	Rural %	No. of Cases
Total	47.3	4,119	51.7	1,947	42.6	2,172
Age Group						
15–19	13.0	156	15.3	68	10.9	88
20–24	37.7	557	44.3	233	31.7	324
25–29	47.6	829	51.6	372	43.5	457
30–34	57.6	872	60.0	429	54.8	443
35–39	54.1	841	58.7	424	48.7	417
40–44	44.3	864	48.4	421	40.1	443
No. of Living Children						
0	3.1	382	5.7	188	0.1	194
1	41.3	971	45.5	570	33.3	401
2	58.4	2,036	64.1	936	52.5	1,100
3 or more	48.3	730	55.1	253	44.8	477
Education Level						
Secondary incomplete or less	41.7	428	50.3	91	39.4	337
Secondary complete	41.7	1,289	46.5	487	38.3	802
Technicum	48.8	1,096	51.1	506	46.4	590
University/postgraduate	53.3	1,306	55.0	863	48.7	443
Socioeconomic Status						
Low	42.6	1,473	47.0	353	41.2	1,120
Middle	47.5	1,944	50.3	984	43.8	960
High	55.3	702	56.2	610	47.5	92
Ethnic Group						
Georgian	50.1	3,514	52.4	1,775	47.3	1,739
Azeri	20.8	232	44.2	30	17.3	202
Armenian	35.6	261	42.5	80	31.5	181
Other	46.0	112	48.7	62	41.7	50

*Less than 25 cases.

Table 8.3.1 Source of Supply for Modern Methods by Selected Characteristics Among Married Women Aged 15–44 Years Who Are Currently Using Modern Methods (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Public Medical Sector						Private Sector		Other				
Characteristic	Subtotal Public Sector	Women's Consultation Clinics	Hospital/ Gynecology Ward	Hospital/ Maternity Ward	Rural Dispensary	Polyclinic	Clinic or Office	Pharmacy	Husband/ Partner	Friend/ Relative	Do Not Know	Total	No. of Cases
Total	51.8	21.4	20.4	8.9	0.9	0.3	1.0	39.2	6.4	1.4	0.2	100.0	1,102
Residence													
Tbilisi	28.7	18.8	5.1	3.5	0.6	0.6	1.0	60.5	7.6	1.9	0.3	100.0	273
Other urban	58.7	23.7	26.1	8.4	0.5	0.0	1.1	29.5	8.8	1.9	0.0	100.0	338
Rural	62.8	21.3	26.7	13.1	1.4	0.3	1.1	31.8	3.5	0.7	0.2	100.0	491
Age Group													
15–24	45.3	31.2	10.5	3.1	0.5	0.0	0.3	46.7	7.2	0.5	0.0	100.0	151
25–34	47.1	18.8	20.6	6.2	1.0	0.4	1.1	42.7	7.5	1.5	0.2	100.0	521
35–44	59.2	20.5	23.7	13.8	0.9	0.3	1.2	32.7	4.9	1.7	0.2	100.0	430
Education Level													
Secondary incomplete or less	73.6	22.9	32.2	18.0	0.5	0.0	0.0	22.5	4.0	0.0	0.0	100.0	78
Secondary complete	59.8	27.5	20.7	10.2	1.4	0.0	0.7	31.5	5.6	2.4	0.0	100.0	281
Technicum	57.0	17.9	29.9	7.7	0.7	0.7	2.2	35.0	5.7	0.1	0.0	100.0	291
University/postgraduate	39.8	19.5	12.1	7.2	0.7	0.2	0.7	49.5	7.7	1.9	0.4	100.0	452
Socioeconomic Status													
Low	67.9	23.8	30.5	12.0	1.2	0.4	0.7	26.5	4.2	0.6	0.0	100.0	298
Middle	49.7	22.3	17.7	8.5	1.0	0.2	1.2	40.1	7.1	1.9	0.0	100.0	543
High	39.5	17.1	15.1	6.5	0.3	0.4	1.1	50.3	7.1	1.4	0.7	100.0	261
Ethnic Group													
Georgian	51.7	21.4	20.0	9.1	0.9	0.3	1.1	39.2	6.2	1.6	0.2	100.0	1,011
Azeri	75.2	13.8	47.1	14.3	0.0	0.0	0.0	13.8	11.0	0.0	0.0	100.0	28
Armenian	39.8	21.6	16.5	0.0	1.7	0.0	0.0	51.1	9.1	0.0	0.0	100.0	34
Other	43.5	28.3	11.8	3.4	0.0	0.0	0.0	52.8	3.6	0.0	0.0	100.0	29
Modern Method Used													
Pill	9.5	5.8	3.6	0.0	0.1	0.0	1.1	87.8	0.0	1.5	0.0	100.0	144
IUD	96.9	46.8	37.2	10.2	2.0	0.7	1.4	0.8	0.0	1.0	0.0	100.0	467
Condom	1.0	0.8	0.0	0.2	0.0	0.0	0.0	77.2	19.4	1.6	0.8	100.0	363
Vaginal methods	3.3	3.3	0.0	0.0	0.0	0.0	2.6	88.6	0.0	5.5	0.0	100.0	38
Female sterilization	97.5	0.0	45.1	52.4	0.0	0.0	2.5	0.0	0.0	0.0	0.0	100.0	89
Other modern	*	*	*	*	*	*	*	*	*	*	*	100.0	1

*Less than 25 cases.

Table 8.3.2 Trends in the Supply Sources for Modern Contraceptive Methods Among Married Women Aged 15–44 Years Who Are Currently Using Modern Methods Reproductive Health Surveys: Georgia, 1999 and 2005

	Survey Year	
Source	1999	2005
	%	%
Public Medical Sector	53.9	51.8
Rural dispensary	1.2	0.9
Polyclinic	1.9	0.3
Women's consultation clinic	21.0	21.4
Govt. hospital/Gynecology ward	21.2	20.4
Govt. hospital/Maternity ward	8.6	8.9
Private clinic or office	1.1	1.0
Commercial Sales	37.1	39.2
Pharmacy	36.1	39.2
Store/kiosk	1.0	0.0
Other	7.2	7.8
Husband/partner	6.1	6.4
Friend/relative	1.1	1.4
Does not know	0.0	0.2
Total	100.0	100.0
No. of Cases	1,553	1,102

Table 8.4.1 Desire to Use a Different Contraceptive Method and Preferred Method by Selected Characteristics Among Married Women Aged 15–44 Years Who Are Currently Using Modern Methods – Reproductive Health Survey: Georgia, 2005

	Desires to Use a Different Method		Preferred Method (Percentage Distribution)								
Characteristic	%	No. of Cases	IUD	Condom	Pills	Female Sterilization	Spermicides	Rhythm	Do Not Know	Total	No. of Cases
Total	20.5	1,970	74.5	8.8	7.1	6.8	1.8	0.8	0.2	100.0	401
Residence											
Tbilisi	21.3	433	63.6	0.0	12.1	3.7	3.7	2.8	0.9	100.0	89
Other urban	17.2	578	72.5	7.5	3.7	14.2	2.1	0.0	0.0	100.0	106
Rural	22.3	959	81.6	7.0	6.1	4.5	0.6	0.2	0.0	100.0	206
Age Group											
15–24	27.7	231	76.1	0.0	4.5	8.6	0.0	0.0	0.0	100.0	59
25–34	23.7	897	75.3	7.7	7.7	4.6	2.7	1.5	0.5	100.0	207
35–44	15.7	842	72.5	9.4	7.4	8.9	1.4	0.3	0.0	100.0	135
No. of Living Children											
0–1	24.8	412	65.9	0.0	13.1	4.3	3.3	1.0	1.0	100.0	95
2	19.6	1,194	74.7	8.7	5.6	8.9	1.1	1.1	0.0	100.0	242
3+	18.6	364	85.8	5.1	3.5	3.7	1.9	0.0	0.0	100.0	64
Education Level											
Secondary incomplete or less	20.1	180	97.1	0.0	0.0	0.0	0.0	0.0	0.0	100.0	29
Secondary complete	20.8	545	79.4	6.7	8.5	2.5	1.2	1.8	0.0	100.0	109
Technicum	19.8	538	75.8	11.1	4.1	5.4	3.1	0.4	0.0	100.0	116
University/postgraduate	20.9	707	64.3	10.2	9.9	12.6	1.8	0.7	0.7	100.0	147
Socioeconomic Status											
Low	20.3	634	83.9	0.0	3.3	3.2	1.3	0.0	0.0	100.0	118
Middle	21.3	946	73.2	9.6	6.5	8.2	1.3	1.2	0.0	100.0	204
High	19.1	390	63.2	7.6	14.3	8.8	3.6	1.2	1.2	100.0	79
Current Method											
Pill	27.6	144	69.9	0.0	0.0	12.4	1.0	0.0	2.7	100.0	34
IUD	2.5	467	*	*	*	*	*	*	*	100.0	10
Condom	23.3	363	82.0	2.2	8.0	5.4	1.2	1.2	0.0	100.0	83
Female sterilization	2.1	89	*	*	*	*	*	*	*	100.0	2
Rhythm	25.3	402	64.5	15.9	10.4	5.0	4.1	0.0	0.0	100.0	107
Withdrawal	34.5	466	83.4	5.9	7.1	2.5	1.1	0.0	0.0	100.0	156
Other	19.5	39	*	*	*	*	*	*	*	100.0	9
Has Concerns About Current Method											
Yes	73.0	329	76.1	0.0	8.4	2.6	2.4	0.8	0.4	100.0	236
No	10.1	1,641	72.2	8.0	5.3	12.6	0.9	0.9	0.0	100.0	165

*Less than 25 cases.

Table 8.4.2 Most Commonly Cited Reasons for Not Using the Preferred Method by Selected Characteristics Among Married Women Aged 15–44 Years Who Are Currently Using Contraception and Who Desire to Switch to Other Methods* Reproductive Health Survey: Georgia, 2005

	Reasons for Not Using the Preferred Method (Percentage Distribution)												
Characteristic	Doctor Will Not Prescribe	Cost	Difficult to Obtain	Husband/ Partner Objects to It	Religious Reasons	Fear of Side Effects	Undecided	Difficult to Use	Fear of Surgical Procedures	Other	Do Not Know	Total	No. of Cases
Total	15.3	14.7	2.5	5.3	0.8	18.5	35.6	2.7	2.1	2.5	0.1	100.0	399
Residence													
Urban	13.4	13.1	2.0	5.4	0.5	18.1	36.8	4.4	2.5	3.5	0.2	100.0	194
Rural	17.4	16.5	3.0	5.1	1.2	18.9	34.3	0.7	1.5	1.4	0.0	100.0	205
Age Group													
15–24	7.2	6.4	3.0	4.8	0.0	4.5	67.7	6.4	0.0	0.0	0.0	100.0	59
25–34	17.0	16.1	3.4	6.3	0.6	20.5	31.4	1.8	1.1	1.7	0.2	100.0	207
35–44	16.7	16.7	1.0	4.1	1.5	22.2	26.6	2.1	4.4	4.7	0.0	100.0	133
Education Level													
Secondary incomplete or less	32.0	8.5	9.1	2.9	3.4	24.0	17.1	0.0	2.9	0.0	0.0	100.0	29
Secondary complete	13.2	20.4	0.8	3.9	0.0	10.4	50.4	0.0	0.9	0.0	0.0	100.0	108
Technicum/university	13.7	13.1	2.3	6.2	0.8	21.3	31.8	4.2	2.5	3.9	0.1	100.0	262
Preferred Method													
Pill	0.0	15.9	4.6	0.0	0.0	45.6	30.4	0.0	0.0	3.5	0.0	100.0	32
IUD	20.5	15.0	2.6	0.8	0.8	20.2	35.6	0.4	1.3	2.8	0.0	100.0	290
Condom	0.0	8.1	0.0	51.5	0.0	0.0	14.9	24.4	0.0	0.0	1.0	100.0	38
Female sterilization	0.0	17.6	0.0	1.6	3.6	3.6	57.8	0.0	15.8	0.0	0.0	100.0	27
Other	†	†	†	†	†	†	†	†	†	†	†	100.0	12

*Excludes women with female sterilization
† Less than 25 cases.

Table 8.5.1 Selected Factors that Were Important or Somewhat Important When Deciding to Use a Traditional Method Instead of a Modern Method by Selected Characteristics Among Married Women Aged 15–44 Years Currently Using Traditional Methods – Reproductive Health Survey: Georgia, 2005

	Selected Factors								
Characteristic	Fear of or Experience With Side Effects %	Little Knowledge of Modern Methods %	Cost %	Husband/Partner Choice %	Doctor's Recommendation %	Religious Beliefs %	Difficult to Get a Modern Method %	Another Person's Advice %	No. of Cases
Total	93.8	77.9	75.1	63.8	53.4	50.1	50.1	43.3	868
Residence									
Tbilisi	93.1	63.8	60.6	62.8	50.0	53.7	38.3	42.6	160
Other urban	92.8	76.1	68.5	60.7	56.6	49.1	48.5	42.9	240
Rural	94.8	85.2	85.4	66.1	52.9	49.2	56.1	43.8	468
Age Group									
15–24	95.6	86.3	73.9	64.0	60.7	45.5	55.8	40.4	80
25–34	94.3	77.4	76.2	66.6	49.6	50.3	47.3	44.1	376
35–44	93.2	77.0	74.5	61.7	55.0	50.8	51.2	43.1	412
No. of Living Children									
0–1	93.5	73.2	67.1	58.6	53.5	48.4	37.8	35.9	144
2	94.0	77.4	77.2	65.2	55.0	51.6	51.6	45.5	536
3+	93.7	82.2	75.0	63.7	49.3	47.7	53.8	42.4	188
Education Level									
Secondary incomplete or less	92.1	83.8	80.7	70.1	43.4	48.0	69.0	55.6	102
Secondary complete	96.2	82.8	81.9	61.9	55.4	45.6	56.4	41.2	264
Technicum	90.5	79.6	78.8	61.8	50.8	47.6	42.9	41.0	247
University/postgraduate	95.2	69.1	62.6	65.0	57.7	58.0	42.6	42.5	255
Socioeconomic Status									
Low	92.2	82.0	84.1	70.4	52.5	48.7	56.2	45.1	336
Middle	95.0	79.1	75.4	58.5	52.5	52.8	48.5	43.9	403
High	94.3	65.4	54.2	63.4	57.6	46.0	40.5	37.6	129
Ethnic Group									
Georgian	94.6	79.3	76.4	61.6	55.4	52.4	50.0	43.6	746
Azeri	88.8	88.4	69.9	85.2	66.0	50.9	69.0	73.5	25
Armenian	95.0	60.5	69.0	80.1	18.3	15.1	43.7	20.1	74
Other	73.4	60.9	53.0	75.0	47.6	52.2	42.5	48.4	23

Table 8.5.2 Perceived Effectiveness of Traditional Method Compared to Modern Methods by Selected Characteristics among Married Women Aged 15–44 Years Currently Using Traditional Methods – Reproductive Health Survey: Georgia, 2005

	Perceived Effectiveness (Percentage Distribution)					
Characteristic	Current Method More Effective	About Equally Effective	Current Method Less Effective	Doesn't Know/ Not Sure	Total	No. of Cases
Total	26.9	48.1	18.5	6.5	100.0	868
Residence						
Tbilisi	33.0	41.0	20.7	5.3	100.0	160
Other urban	25.2	49.2	19.5	6.1	100.0	240
Rural	25.3	50.5	17.0	7.2	100.0	468
Age Group						
15–24	17.1	50.1	19.6	13.2	100.0	80
25–34	25.6	50.7	17.5	6.2	100.0	376
35–44	29.5	45.7	19.1	5.7	100.0	412
No. of Living Children						
0–1	24.3	48.5	21.4	5.8	100.0	144
2	27.7	49.0	16.3	7.0	100.0	536
3+	26.7	45.5	22.2	5.6	100.0	188
Education Level						
Secondary incomplete or less	34.8	36.8	8.7	19.7	100.0	102
Secondary complete	24.2	52.1	18.3	5.5	100.0	264
Technicum	23.4	49.5	20.6	6.5	100.0	247
University/postgraduate	29.8	47.2	20.9	2.2	100.0	255
Socioeconomic Status						
Low	21.8	51.8	17.7	8.6	100.0	336
Middle	26.2	50.1	18.8	4.8	100.0	403
High	40.4	33.9	19.6	6.1	100.0	129
Ethnic Group						
Georgian	27.6	46.8	20.0	5.6	100.0	746
Azeri	38.1	26.9	4.8	30.1	100.0	25
Armenian	18.9	68.8	8.0	4.3	100.0	74
Other	9.9	69.3	10.4	10.4	100.0	23

Table 8.6.1 Type of Reasons for Not Currently Using Contraception by Selected Characteristics Among Married Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Type of Reason (Percentage Distribution)				
Characteristic	Reasons Related to Pregnancy, Fertility, or Sexual Activity	Other	Doesn't Know	Total	No. of Cases
Total	68.9	30.8	0.3	100.0	2,149
Residence					
Urban	73.6	26.1	0.3	100.0	936
Rural	64.7	35.0	0.4	100.0	1,213
Region					
Kakheti	60.7	38.9	0.4	100.0	223
Tbilisi	73.7	25.7	0.6	100.0	408
Shida Kartli	72.5	27.5	0.0	100.0	167
Kvemo Kartli	57.5	42.5	0.0	100.0	258
Samtskhe-Javakheti	70.9	26.6	2.5	100.0	159
Adjara	86.8	13.2	0.0	100.0	124
Guria	67.3	32.0	0.7	100.0	137
Samegrelo	64.7	35.3	0.0	100.0	163
Imereti	69.7	30.3	0.0	100.0	266
Mtskheta-Mtianeti	63.6	36.4	0.0	100.0	112
Racha-Svaneti	63.4	35.9	0.7	100.0	132
Age Group					
15–24	81.3	18.6	0.2	100.0	482
25–34	64.7	34.8	0.5	100.0	804
35–44	65.6	34.2	0.2	100.0	863
No. of Living Children					
0–1	85.8	14.0	0.2	100.0	941
2	57.8	41.9	0.2	100.0	842
3+	52.6	46.7	0.8	100.0	366
Education Level					
Secondary incomplete or less	61.2	38.4	0.4	100.0	248
Secondary complete	68.2	31.4	0.5	100.0	744
Technicum	63.3	36.4	0.3	100.0	558
University/postgraduate	77.8	22.0	0.2	100.0	599
Socioeconomic Status					
Low	64.2	35.4	0.4	100.0	839
Middle	69.7	30.0	0.3	100.0	998
High	77.6	22.1	0.3	100.0	312
Ethnic Group					
Georgian	71.8	28.1	0.1	100.0	1,757
Azeri	47.9	51.6	0.4	100.0	179
Armenian	66.2	31.3	2.5	100.0	153
Other	65.1	34.9	0.0	100.0	60

Table 8.6.2 Most Commonly Cited Reasons for Not Currently Using Contraception among Married Women Aged 15–44 Years by Selected Characteristics (Percentage Distribution) – Reproductive Health Survey: Georgia, 2005

	Reasons Related to Pregnancy, Fertility, or Sexual Activity					Other Reasons									
Characteristic	Infecundity	Desires Pregnancy	Currently Pregnant	Not Sexually Active	Postpartum/ Breastfeeding	Uses Douching	Neglected to Use	Dislike	Fear of Side Effects	Partner Objects	Cost	Other	Do Not Know	Total	No. of Cases
Total	21.3	14.4	13.6	11.6	8.0	13.7	8.3	2.6	2.3	1.2	1.0	1.8	0.3	100.0	2,149
Residence															
Urban	21.4	15.5	15.2	13.0	8.5	10.9	7.0	2.1	2.2	1.4	0.9	1.6	0.3	100.0	936
Rural	21.1	13.5	12.3	10.3	7.6	16.2	9.5	3.0	2.3	1.0	1.1	1.9	0.4	100.0	1,213
Region															
Kakheti	15.9	13.1	11.9	9.1	10.7	17.1	11.9	1.6	3.2	1.6	0.4	3.2	0.4	100.0	223
Tbilisi	18.6	17.0	17.2	13.0	7.8	6.8	7.6	3.0	3.6	1.4	1.4	1.8	0.6	100.0	408
Shida Kartli	21.8	12.3	15.6	13.3	9.5	16.1	4.3	4.3	0.9	0.5	0.5	0.9	0.0	100.0	167
Kvemo Kartli	18.7	13.0	10.8	8.3	6.7	16.8	13.7	4.1	0.6	1.6	1.9	3.8	0.0	100.0	258
Samtskhe-Javakheti	14.8	11.3	10.3	25.6	8.9	14.3	7.4	3.0	1.5	0.0	0.0	0.5	2.5	100.0	159
Adjara	30.3	16.4	20.4	9.2	10.5	6.6	3.9	0.7	1.3	0.0	0.7	0.0	0.0	100.0	124
Guria	24.0	14.7	8.7	9.3	10.7	17.3	7.3	3.3	2.0	0.0	1.3	0.7	0.7	100.0	137
Samegrelo	31.0	12.0	9.8	7.1	4.9	20.7	7.1	2.2	3.3	0.5	0.5	1.1	0.0	100.0	163
Imereti	23.0	15.0	11.7	14.3	5.7	17.3	5.7	1.3	2.3	2.0	0.7	1.0	0.0	100.0	266
Mtskheta-Mtianeti	21.4	14.3	10.7	5.0	12.1	8.6	17.1	1.4	2.1	1.4	2.9	2.9	0.0	100.0	112
Racha-Svaneti	12.0	20.4	16.2	6.3	8.5	16.2	15.5	1.4	0.7	1.4	0.0	0.7	0.7	100.0	132
Age Group															
15–24	2.0	25.9	31.3	4.9	17.2	3.8	6.8	2.1	2.3	0.6	1.0	2.0	0.2	100.0	482
25–34	10.6	17.7	15.8	10.0	10.6	15.2	8.5	2.6	3.6	1.5	1.3	2.2	0.5	100.0	804
35–44	39.8	5.8	2.6	16.3	1.1	17.8	9.1	2.8	1.2	1.2	0.8	1.3	0.2	100.0	863
No. of Living Children															
0–1	13.4	30.5	26.7	6.3	8.9	4.4	4.7	1.2	1.7	0.4	0.3	1.4	0.2	100.0	941
2.0	25.9	3.2	4.8	15.8	8.1	22.6	8.5	3.3	2.8	1.8	1.6	1.4	0.2	100.0	842
3+	29.9	0.3	1.4	15.1	5.9	17.3	16.3	4.2	2.6	1.5	1.4	3.5	0.8	100.0	366
Education Level															
Secondary incomplete	19.3	12.8	12.7	9.9	6.5	10.0	12.8	2.8	2.0	1.2	2.8	6.8	0.4	100.0	248
Secondary complete	21.1	12.6	12.1	12.7	9.6	16.1	7.3	3.3	2.1	1.0	0.6	0.8	0.5	100.0	744
Technicum	25.7	11.5	9.8	11.7	4.7	19.2	10.2	2.7	1.6	1.1	1.1	0.5	0.3	100.0	558
University/postgraduate	18.3	20.0	19.3	10.7	9.6	7.5	6.0	1.4	3.1	1.3	0.6	2.0	0.2	100.0	599
Socioeconomic Status															
Low	24.7	10.1	10.6	11.5	7.3	16.3	10.6	2.9	1.4	1.0	1.2	2.0	0.4	100.0	839
Middle	20.2	15.1	14.3	12.2	7.9	13.6	7.6	2.6	2.4	1.0	1.0	1.8	0.3	100.0	998
High	16.4	22.7	18.8	9.8	10.0	7.8	5.3	1.7	3.8	2.0	0.6	0.9	0.3	100.0	312
Ethnic Group															
Georgian	22.6	15.7	14.7	11.1	7.7	13.0	7.8	2.0	2.4	1.0	0.7	1.1	0.1	100.0	1,757
Azeri	14.6	9.0	6.7	7.3	10.3	20.8	11.8	5.3	2.3	2.4	0.5	8.5	0.4	100.0	179
Armenian	16.9	8.3	11.6	19.8	9.6	9.8	9.2	5.2	2.0	0.7	4.1	0.4	2.5	100.0	153
Other	16.5	12.5	13.0	17.9	5.3	18.2	8.3	1.7	0.0	1.7	3.3	1.8	0.0	100.0	60

Table 8.7.1 Desire to Use Contraception in the Future by Selected Characteristics Among Fecund Married Women Aged 15–44 Years Who Are Not Using Contraception Reproductive Health Survey: Georgia, 2005

	Desire to Use Contraception in the Future (Percentage Distribution)					
Characteristic	Desires to Use within 12 Months	Desires to Use Later	Does Not Desire to Use	Undecided	Total	No. of Cases
Total	22.8	19.2	33.3	24.6	100.0	1,863
Residence						
Urban	24.2	22.9	29.4	23.6	100.0	799
Rural	21.5	16.0	36.8	25.6	100.0	1,064
Region						
Kakheti	17.2	16.7	37.6	28.5	100.0	196
Tbilisi	28.6	21.9	31.1	18.3	100.0	369
Shida Kartli	23.9	20.0	33.3	22.8	100.0	144
Kvemo Kartli	15.2	8.5	45.2	31.1	100.0	224
Samtskhe-Javakheti	16.8	20.1	37.0	26.1	100.0	143
Adjara	21.7	42.5	19.2	16.7	100.0	98
Guria	25.8	10.2	26.6	37.5	100.0	116
Samegrelo	26.4	14.6	34.7	24.3	100.0	129
Imereti	25.1	18.3	27.9	28.7	100.0	222
Mtskheta-Mtianeti	23.9	23.1	36.8	16.2	100.0	98
Racha-Svaneti	20.1	14.9	32.8	32.1	100.0	124
Age Group						
15–24	26.5	33.2	8.5	31.7	100.0	474
25–34	30.1	22.2	21.6	26.1	100.0	749
35–44	12.9	6.2	62.8	18.1	100.0	640
No. of Living Children						
0–1	22.0	30.8	19.7	27.4	100.0	839
2	26.2	10.8	39.0	24.0	100.0	713
3+	17.8	7.6	55.6	19.1	100.0	311
Education Level						
Secondary incomplete or less	15.9	10.5	40.4	33.3	100.0	220
Secondary complete	21.7	16.5	33.0	28.8	100.0	647
Technicum	19.6	18.2	39.8	22.4	100.0	463
University/postgraduate	29.5	26.9	25.5	18.1	100.0	533
Socioeconomic Status						
Low	18.4	15.9	36.9	28.8	100.0	714
Middle	23.4	19.0	33.6	24.0	100.0	868
High	30.7	27.2	24.9	17.2	100.0	281
Ethnic Group						
Georgian	25.3	21.3	30.1	23.2	100.0	1,518
Azeri	7.4	9.0	57.4	26.3	100.0	160
Armenian	18.3	13.8	33.7	34.2	100.0	134
Other	16.5	8.8	38.4	36.2	100.0	51

Table 8.7.2 Preferred Contraceptive Method by Selected Characteristics Among Fecund Married Women Aged 15–44 Years Who Are Not Using Contraception and Desire to Use Contraception in the Future
Reproductive Health Survey: Georgia, 2005

	Preferred Contraceptive Method (Percentage Distribution)										
Characteristic	IUD	Condoms	Pills	Spermicides	Female Sterilization	Injectables	Rhythm	Withdrawal	Do Not Know	Total	No. of Cases
Total	52.2	16.5	11.5	2.1	0.6	0.1	7.9	5.7	3.5	100.0	786
Residence											
Tbilisi	39.4	28.3	14.2	3.5	1.3	0.0	10.2	1.8	1.3	100.0	195
Other urban	49.4	14.2	10.0	2.7	0.0	0.0	11.7	3.9	8.1	100.0	172
Rural	61.4	10.6	10.7	0.9	0.4	0.1	4.7	8.8	2.5	100.0	419
Age Group											
15–24	59.6	17.2	11.7	0.9	0.0	0.1	2.2	1.9	6.3	100.0	277
25–34	54.3	15.0	13.1	3.3	0.9	0.0	8.0	3.5	1.8	100.0	382
35–44	30.1	19.0	6.8	1.4	0.8	0.0	20.4	19.8	1.6	100.0	127
No. of Living Children											
0	52.1	19.5	15.5	1.4	0.0	0.0	2.8	0.3	8.3	100.0	171
1	55.9	17.1	9.5	2.0	0.4	0.0	8.9	3.8	2.4	100.0	255
2	50.4	15.0	11.5	2.2	0.1	0.2	9.3	9.5	1.7	100.0	269
3 or more	47.2	12.5	8.7	3.5	3.5	0.0	12.2	11.2	1.2	100.0	91
Education Level											
Secondary incomplete or less	61.9	8.7	9.3	0.0	0.0	0.0	0.6	12.2	7.4	100.0	65
Secondary complete	58.1	11.5	10.6	2.6	1.2	0.2	7.1	7.3	1.5	100.0	254
Technicum	51.0	12.9	12.3	1.8	0.0	0.0	11.5	8.3	2.2	100.0	177
University/postgraduate	46.4	23.9	12.3	2.3	0.4	0.0	8.0	1.6	5.0	100.0	290
Socioeconomic Status											
Low	53.6	14.4	10.3	1.0	0.0	0.2	6.0	11.1	3.5	100.0	258
Middle	57.3	12.0	11.8	1.6	0.9	0.0	8.4	4.5	3.5	100.0	369
High	40.1	28.8	12.6	4.5	0.6	0.0	9.4	0.9	3.3	100.0	159

Table 8.7.3 Preferred Source of Contraceptive Methods by Selected Characteristics Among Fecund Married Women Aged 15–44 Years Who Are Not Using Contraception and Desire to Use Contraception in the Future (Percentage Distribution)

	Public Medical Sector						Private Sector	Other					
Characteristic	Polyclinic	Women's Consultation Clinic	Hospital/ Gyn. Ward	Hospital/ Maternity Ward	Rural Dispensary	Village Hospital	Pharmacy	NGO	Partner/ Husband	Relative	Do Not Know	Total	No. of Cases
Total	34.5	20.6	6.2	2.2	1.0	0.8	1.9	29.8	1.9	0.5	0.6	100.0	645
Residence													
Tbilisi	37.2	6.6	1.5	0.5	0.0	0.5	2.0	48.5	1.0	1.5	0.5	100.0	170
Other urban	41.0	22.2	4.3	2.7	0.0	1.0	3.5	22.1	3.2	0.0	0.0	100.0	128
Rural	29.8	28.5	9.9	3.1	2.0	1.0	1.1	21.7	1.9	0.1	0.9	100.0	347
Age Group													
15–24	32.8	22.6	8.9	1.9	1.6	0.7	1.3	27.4	0.7	1.1	1.0	100.0	243
25–34	34.7	21.0	5.4	2.6	0.6	0.8	2.6	29.6	2.3	0.1	0.3	100.0	327
35–44	39.4	12.0	0.0	1.6	0.0	1.3	1.4	39.3	4.9	0.0	0.0	100.0	75
No. of Living Children													
0	35.7	20.5	5.7	0.6	0.0	0.5	3.6	30.3	0.4	2.0	0.6	100.0	151
1	32.2	21.5	8.5	3.6	0.7	0.0	0.9	31.0	0.9	0.0	0.7	100.0	214
2	35.7	20.7	5.0	2.3	1.8	1.0	2.3	28.2	3.0	0.0	0.1	100.0	208
3 or more	35.0	17.5	3.3	1.6	1.6	3.7	0.0	29.8	5.9	0.0	1.5	100.0	72
Education Level													
Secondary incomplete or less	27.7	22.3	15.5	4.5	4.9	4.9	2.0	18.2	0.0	0.0	0.0	100.0	52
Secondary complete	32.1	27.1	6.6	3.0	1.6	0.1	1.7	25.0	2.1	0.0	0.8	100.0	206
Technicum	45.4	17.1	4.6	1.2	0.0	1.5	0.1	27.4	2.7	0.0	0.0	100.0	137
University/postgraduate	32.0	16.9	5.1	1.7	0.2	0.3	3.0	36.9	1.8	1.3	0.8	100.0	250
Socioeconomic Status													
Low	26.1	27.0	8.9	2.3	3.2	1.2	1.8	25.5	4.0	0.0	0.1	100.0	200
Middle	41.2	21.7	6.4	1.7	0.1	0.7	1.1	24.8	1.4	0.1	0.8	100.0	307
High	30.9	10.7	2.5	3.3	0.0	0.6	3.5	45.2	0.7	1.9	0.6	100.0	138
Preferred Method													
Pill	8.3	6.3	1.8	0.5	0.3	0.0	8.2	74.7	0.0	.	0.0	100.0	97
IUD	49.2	30.0	9.0	3.4	1.5	1.1	0.6	4.5	0.0	0.1	0.7	100.0	409
Condoms/spermicides	*	*	*	*	*	*	*	*	*	*	*	100.0	133
Other	*	*	*	*	*	*	*	*	*	*	*	100.0	6

*Less than 25 cases.

Table 8.8.1 Contraceptive Failure and Discontinuation Rates After One, Two and Three Years for Selected Methods of Contraception - All Segments of Contraceptive Use Initiated Since January 2000
Reproductive Health Survey: Georgia 2005

	Failure Rates						
		Contraceptive Methods					
Duration	All Methods %	IUD %	Condom %	Pill %	Other Modern %	Rhythm %	Withdrawal %
One Year	13.2	0.8	7.0	5.2	8.2	24.5	17.8
Two Years	23.5	1.5	16.2	12.3	19.9	41.0	30.6
Three Years	29.1	1.7	21.6	14.6	23.5	47.7	41.3
No. of Segments	3,345	465	687	377	142	779	895
	Discontinuation Rates						
		Contraceptive Methods					
Duration	All Methods %	IUD %	Condom %	Pill %	Other Modern %	Rhythm %	Withdrawal %
One Year	35.9	7.5	38.9	49.3	34.2	41.6	39.1
Two Years	55.9	13.0	63.0	74.7	48.0	64.3	60.5
Three Years	66.6	23.5	72.0	83.0	55.5	75.2	74.2
No. of Segments	3,345	465	687	377	142	779	895
% Discontinuation due to Method Failure (12 months)	36.6	11.0	18.0	10.5	23.9	58.8	45.4

Table 8.8.2 Contraceptive Discontinuation Rates After One Year by Primary Reason for Discontinuing Contraception for Selected Methods of Contraception - All Segments of Contraceptive Used Initiated Since January 1994 Reproductive Health Survey: Georgia 2005

		Contraceptive Method				
Main Reason For Discontinuing Contraception*	All Methods %	IUD %	Condoms %	Oral Contraceptives %	Calendar %	Withdrawal %
Total†	35.9	7.5	38.9	49.3	41.6	
Got pregnant while using contraception	17.2	1.5	9.4	6.1	32.3	23.6
Partner's objections or absence	11.2	1.2	18.1	4.4	7.4	18.8
Negligence	7.6	0.0	4.7	5.3	14.6	9.3
Desired to become pregnant	5.6	4.5	9.7	6.3	4.6	3.8
Experienced or feared side effects	4.9	11.9	0.0	27.2	0.1	0.1
Switched to other method	2.8	0.2	4.2	1.5	4.0	2.5
Cost/Availability	2.6	0.0	6.9	7.4	0.0	0.0
Stopped to rest body/Physician Advice	2.1	3.2	0.9	8.3	1.4	0.5
Difficult or inconvenient to use	1.0	0.0	1.5	0.3	0.8	1.2
Other	0.4	0.2	0.3	1.1	0.3	0.5
No. of Cases	3345	465	687	377	779	895

* Gross discontinuation rates
† Net discontinuation rates

Chapter 9

NEED FOR CONTRACEPTIVE SERVICES

One objective of the GERHS05 was to characterize the current need and potential future demand for contraceptive services by assessing respondent fecundity and stated reproductive preferences. Taken together, current contraceptive use and the additional contraceptive use that would be required to eliminate the risk of unintended pregnancies constitute the potential future demand for family planning services, information that can be used for effective contraceptive logistics management and monitoring and evaluation of service performance.

Similar to other reproductive health surveys in the region, the GERHS05 documented recent preventive health practices among women of reproductive age in Georgia.

9.1 Potential Demand and Unmet Need for Contraception

The total potential demand for contraception is generally defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births (unmet need). Rates of unmet need for contraception are an indicator of how well current family planning programs are serving couples in need; this information can guide future programmatic efforts and ensure that a population's family planning needs are met.

Overall, the GERHS05 found that 38% of respondents had a potential future demand for contraception. Among married women, 63% were identified as having a potential future demand for contraception, including 26% of current users of modern methods, 21% of current users of traditional methods, and 16% of non users at risk of unplanned pregnancy (Table 9.1.1 and Figure 9.1.1). About one in three married women had no need for contraception because they were currently pregnant, trying to become pregnant, infecund, or unable to conceive, or they had not had intercourse recently.

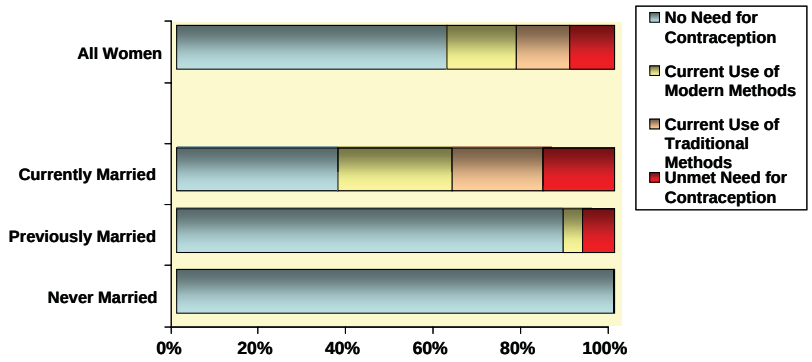
The conventional definition of unmet need includes women currently married or in consensual unions who (Bongaarts, 1991):

- Are currently sexually active (within the past month);
- Are currently exposed to the risk of pregnancy (which excludes women not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea);
- Are fecund (neither they nor their partners have any subfecundity conditions),
- Do not want to become pregnant (at the time of the interview); and
- Are not using any method of pregnancy prevention.

Alternatively, the standard formulation of unmet need can be extended to all women, not just those in union.

In addition to the unmet need for any contraception, another useful concept is the unmet need for modern contraception—an indicator that is of particular importance in countries where the use of traditional, less effective methods (e.g., withdrawal, periodic abstinence, and traditional/folk methods) is high. In such countries, the standard definition of unmet need masks a need for more effective contraception because it considers traditional method users, who tend to report high method-failure rates, as having their contraceptive needs satisfied. For these countries,

Figure 9.1.1 **Potential Demand and Unmet Need for Any Contraception by Marital Status Among Women Aged 15–44 Years**

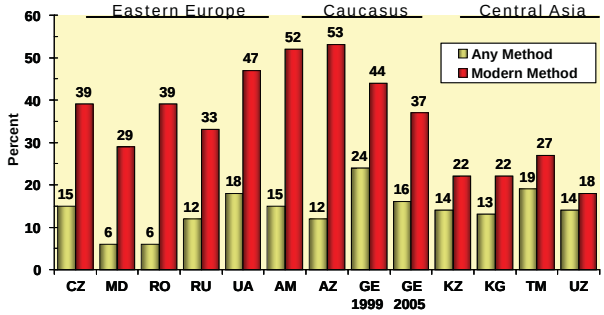


the definition of unmet need should be expanded to include users of non-supplied methods, despite the small risk of overstating the unmet need in those cases where traditional methods are used effectively.

Among those countries in Eastern Europe and the Caucasus region where population-based reproductive health or demographic health surveys have been recently conducted, Armenia and Azerbaijan had the highest unmet need for modern contraception (52%–53%), followed by Ukraine (47%), and Georgia (44%) (CDC and ORC Macro, 2003) (Figure 9.1.2). Although survey results suggest that women in these countries have a relatively low unmet need for any contraception, a significant proportion of couples—those that rely on traditional, less effective methods to prevent unplanned pregnancies—may still have unmet need for more effective modern methods of contraception. For this reason, it would be misleading to use the standard definition of unmet need for monitoring and evaluating family planning program efforts, particularly since these efforts focus on increasing use of supplied methods.

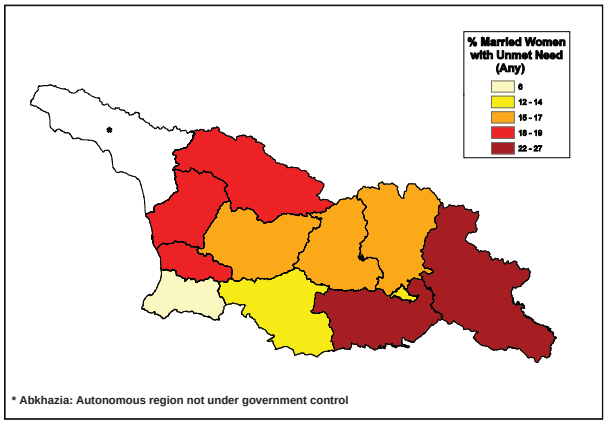
Levels of unmet need tend to be higher among married respondents, since they are more likely to be currently sexually active and have a higher risk of unintended pregnancy. In Georgia, the unmet need for contraception (using either the standard or the expanded definition) was about 50% higher among respondents in formal or consensual unions than among respondents overall (Table 9.1.2). Furthermore, some subgroups of married women exhibit much higher levels of unmet need for contraception than others. Regional levels of unmet need for any contraception among married respondents ranged from 4% in Adjara to over 18% in Kvemo-Kartli, where the second highest unmet need for modern contraception was also reported (Figures 9.1.3 and 9.1.4). Generally, levels of unmet need, particularly levels of unmet need for modern contraception, were higher among rural women than urban women and

Figure 9.1.2 **Unmet Need for Any Contraception and Unmet Need for Modern Contraception Among Married Women in Selected Countries in Eastern Europe and Eurasia**



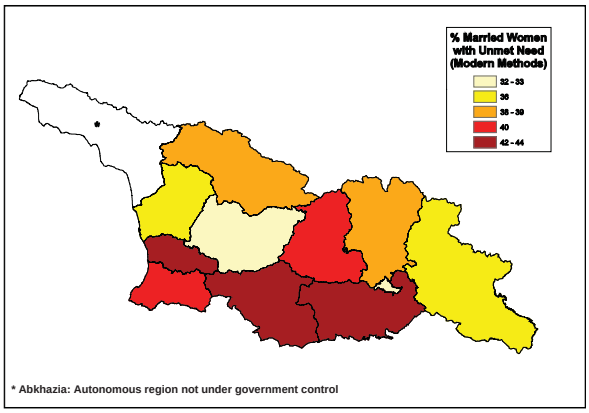
Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.*
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyzstan; TM=Turkmenistan; UZ=Uzbekistan

Figure 9.1.3 **Unmet Need for Any Contraception by Region Among Married Women Aged 15–44 Years**



* Abkhazia: Autonomous region not under government control

Figure 9.1.4 **Unmet Need for Modern Contraception by Region Among Married Women Aged 15–44 Years**



* Abkhazia: Autonomous region not under government control

increased with the number of living children (Figure 9.1.5). Respondents with secondary education or less had higher levels of unmet need than those with post-secondary education.

Between 1999 and 2005, the unmet need for modern contraception decreased from 27% to 22%. Most of the decline resulted from increased use of modern methods among couples, whose unmet need diminished by 16% (from 44% to 37%) over this time period (Figure 9.1.6). This represents an apparent decrease of 70,500 women aged 15–44 years with unmet need for modern contraception between 1999 and 2005 and could be related to the decline of unplanned pregnancies and induced abortions. Despite this decline, 22% of all women and 37% of married women continued to be at risk of unplanned pregnancy because they did not use more effective contraceptive methods

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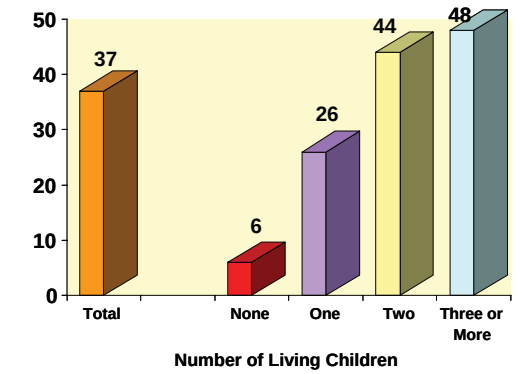
Figure 9.1.5 **Current Unmet Need for Modern Contraception by Number of Living Children Among Married Women Aged 15–44 Years**



9.2 Potential Demand for Family Planning by Fertility Preferences

In addition to measuring the potential demand for family planning services, the Reproductive Health Survey data allow for estimates of met and unmet need, based on respondents' fertility preferences. Among respondents with potential demand for any contraceptives (standard definition) or for a modern method (expanded definition), non-users of contraceptives who did not want to get pregnant right away but wanted to have children sometime in the future (including those who were undecided as to whether to have children or not) were classified as having unmet need for spacing births. Respondents who did not want (any)more children but were not doing anything to prevent pregnancy (or were using less effective traditional methods) were considered to have an unmet need for limiting births. Similarly, respondents whose contraception needs were met (users of any methods or modern methods) were classified as having their needs met for both for spacing and limiting births.

Figure 9.1.6 **Unmet Need for Modern Contraception by Marital Status Among Women Aged 15–44 Years: 1999 and 2005**

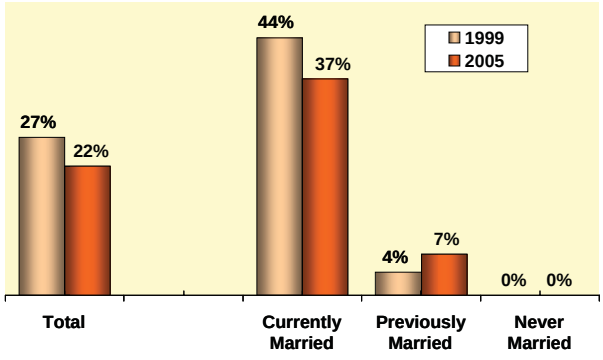
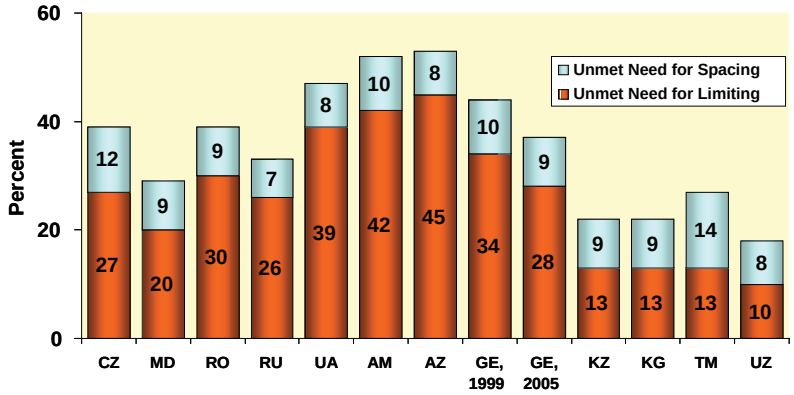


Table 9.2.1 presents comparative data for several countries in Eastern Europe and Eurasia where recent reproductive health surveys have been conducted. The surveys allow for an assessment of unmet need based on to future fertility intentions. Generally, unmet need for limiting births is higher than unmet need for spacing births, regardless of region or whether the standard or expanded? definition is used. Among women currently in union in Eastern Europe and Eurasia, the unmet need for limiting births is two to three times higher than the unmet need for spacing births, a finding that is concordant with the low ideal family size and future reproductive intentions that are typical in this region. As a result, of the total unmet need, the percentage of unmet need for limiting births ranges from 58% to 81% in Eastern Europe and from 73% to 84% in the Caucasus region. Only in Turkmenistan and Uzbekistan does the unmet need for limiting births not exceed the unmet need for spacing, but the difference is not statistically significant (Figure 9.2.1). Encouragingly, the unmet need for limiting births in Georgia declined between 1999 and 2005 by one third, while the unmet need for spacing births declined by 9%.

In the GERHS05, the contraceptive demand for limiting births was almost three times higher than the demand for spacing births (Table 9.2.2). Among respondents currently in union and using the standard definition, contraceptive use for limiting births (35%) appears to be higher than the unmet need for limiting births (12%). However, if the expanded definition is applied, the balance shifts and more married women have an unmet than a met need for modern contraceptives to effectively limit their fertility (28% vs. 18%). Also, at first glance, most of the demand for contraception in Georgia for either spacing or limiting births (74%) seems to be satisfied, but this is largely due to widespread use of traditional methods. In fact, owing to the low prevalence of long term and permanent contraceptive methods, most of the demand for methods that would effectively help couples to limit childbearing is not met. Since only 18% of women in union reported that their needs to limit childbearing were met through using modern methods and 28% still have unmet needs, of the 47% of women in union who wanted to limit fertility, only 39% had their demand for modern contraceptives satisfied. Likewise, only 49% of respondents who wanted to space births had their demand for modern methods satisfied.

Figure 9.2.1 **Unmet Need for Modern Methods Among Married Women by Future Fertility Preferences: Selected Countries in Eastern Europe and Eurasia**



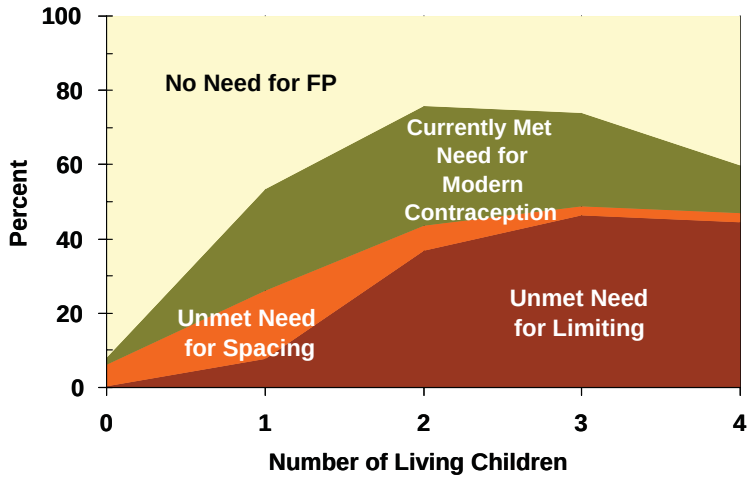
Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.*
Note: MD=Moldova; RO=Romania; RU=Russia; UA=Ukraine; AM=Armenia; AZ=Azerbaijan; GE=Georgia; KZ=Kazakhstan; KG=Kyrgyzstan; TM=Turkmenistan; UZ=Uzbekistan

Because desired fertility changes according to achieved fertility, classification of potential demand for contraception by number of living children highlights the interplay between contraceptive needs for spacing and for limiting births (Figure 9.2.2). As discussed in Chapter 4, once they are married, the majority of Georgian women want a child and often give birth within a year. Fewer than 10% of married, nulliparous, most likely young, women have any demand for family planning.

After the birth of the first child, small but equal proportions of married women have a met and unmet need for modern contraception—27% have a met need and 26% an unmet need, mostly for spacing births. After the second child, the majority of couples want to end childbearing, but fewer women (32%) have a met need and more (44%) have an unmet need, mostly for limiting births. Among couples with 3 or more children, about half have an unmet need for modern contraception, almost all of it for limiting births. However, few of these women (less than 20%) use modern contraception for this purpose. More typically, women with unmet need for limiting births will resort to abortion to achieve their preferred family size if they have an unwanted pregnancy.

Demand for birth-spacing among young, married nulliparous women, however small, suggests that family planning services may need to reevaluate current service-delivery protocols, counseling practices, and service-provider skills to fully address the needs of this cohort of potential contraception users. Similarly, a different array of methods is required by couples who need contraception for spacing births (temporary methods) compared with those who need contraception for limiting births (long-term or permanent methods). Although many women wish to limit births, sterilization is not promoted (despite permissive legislation regarding sterilization). According to Georgia's health law and patient rights law, surgical contraception-sterilization must be performed in a licensed facility; clients seeking sterilization must submit a written request and undergo contraceptive counseling, followed by a one-month waiting period (Government of Georgia 1997 and 2000).

Figure 9.2.2 **Met and Unmet Need for Family Planning Services Among Married Women by Number of Living Children**



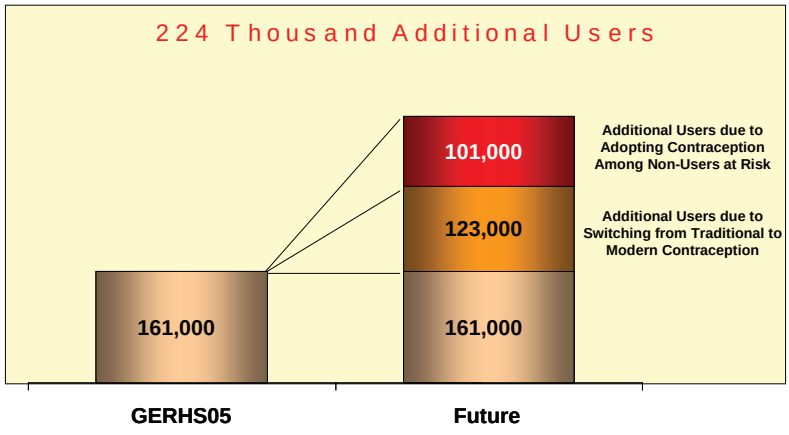
9.3 Program Implications

To ensure that efforts to satisfy the future contraceptive needs of Georgian women are effective accurate forecasting of contraceptive supply needs are needed. Estimates of future supply needs must take into account current users of modern contraceptive methods (16% or 161,000 users), as well as potential increases in demand for modern contraceptives among users of traditional methods and those currently not using any methods. Hypothetically, if all women with demand for contraceptives will use modern contraceptives, the number of users may increase from the GERHS05 figure of 161,000 users to as many as 385,000 users (224,000 additional users), assuming a population growth similar to the 2005 level (Figure 9.3). But changes in fertility preferences may generate additional users (Ross, 2002). If couples would like to have fewer children than currently documented by GERHS05, they will want to stop childbearing earlier than before and their need for contraceptive protection will extend over more subsequent years, which will elevate the overall demand for effective contraceptives.

Currently, Georgia does not have a national family planning program, and neither the state nor the private health insurance packages include family planning provisions. All family planning activities are organized with donor support (chiefly from UNFPA and USAID) and implemented by local governmental institutions and international or local NGOs. Donors support three key functions aimed at assisting family planning clinics in meeting client needs: 1) availability of a range of effective and acceptable family planning methods in family planning clinics; 2) training for family planning clinic personnel through general training programs; and 3) information dissemination and community-based education and outreach activities.

These activities, however, do not currently serve all of Georgia equally; the rural population in particular has less access to family planning information and services than urban residents, as shown in the survey results. In 2001, UNFPA initiated an outreach program in an effort to increase access to family planning and other reproductive health services among underserved populations. UNFPA equips mobile teams of physicians with vehicles, equipment, (including ultrasound

Figure 9.3 **Projected Demand for Family Planning Services to Eliminate the Risk of Unintended Pregnancy in Georgia**



scanners and generators), family planning supplies, and information materials. The UNFPA program in Georgia, which started in 1994 as a contraceptive supply project and developed into a nationwide reproductive health program during 1999–2005, will focus on improvement of quality of care and access to reproductive health services throughout the country over the next five years.

Among the most common reasons for unmet need in Georgia are lack of information, fears about contraceptive side effects, and inconvenience of services. Women with unmet need typically have low awareness of effective contraceptive methods, lack knowledge about how methods are used, and are less likely to believe that family planning services are readily accessible to them. In order to meet their needs, considerably more efforts should be made to increase contraceptive awareness through Information Education and Communication and Behavior Change Communication programs and to expand the availability of a wide array of effective, high quality, affordable contraceptive methods, including long-term and permanent methods.

Experts recommend three strategies for family planning programs that are intended to address unmet needs: a) maximize access to and quality of family planning services; b) emphasize information, education, and communication; c) focus on men as well as women (Robey et al., 1996). Also, since unmet need is concentrated among women who are pregnant unintentionally or who have recently given birth, efficient strategies should include post-abortion and postpartum counseling and integration of family planning services with other services for new mothers and young children.

Given that a larger share of the unmet need in Georgia is among rural women, those less educated or less affluent, and those with two or more children, family planning services will need to expand their reach to improve access to services among these populations. To optimize efforts, family planning services should prioritize subgroups based on need, identify and address barriers to health service delivery, and implement programs that are best suited to provide appropriate information and services. For example, to best meet the needs of rural women, availability of services in remote areas must be increased through expansion of the number of providers, types of services, and facilities where these services are offered. USAID and its partners currently support the strategy of integrating family planning services with primary health care services (PHCs). Traditionally, PHCs in Georgia have been under-funded, under-staffed and under-utilized. Currently, rates of utilization of PHCs are low, which prevents maintenance of a full schedule of services and may lead to deterioration of knowledge and skills among PHC health personnel. PHCs also often lack necessary equipment and supplies. For these reasons, patients may perceive PHCs to be of low quality and may bypass them altogether and self-refer to polyclinics and hospitals to seek higher quality care, despite the added expenses in terms of travel, time, and out-of-pocket costs. To address this situation, investments by international donors and the World Bank are being used to rebuild and equip PHC facilities, and model PHC clinics have been established to demonstrate how to improve availability and quality of integrated, accessible medical services and establish community-based outreach programs.

Satisfying the unmet need for modern contraception in Georgia will require a substantial increase in programmatic and financial support, as current levels of support are insufficient. Currently, the majority of contraceptive services are paid for through donor contributions and consumer payments, while government family planning subsidies remain limited. To better meet the demand for family planning services, the donor community needs to work with the Georgian government to support a broad combination of public and private-sector family planning services, with emphasis on quality of care and cost-effectiveness.

Table 9.1.1 Demand for Family Planning (FP) Services, by Marital Status and Age Group Among All Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

		Marital Status			Age Group		
Demand for FP Services	Total	Married	Previously Married	Never Married	15–24	25–34	35-44
No Demand	61.7	36.7	88.4	99.7	86.7	49.3	45.5
Never had sexual intercourse	34.6	0.0	0.0	99.4	69.7	20.8	8.8
Not currently sexually active*	8.8	6.6	82.3	0.3	2.0	9.2	15.9
Currently pregnant or post-partum	7.1	11.9	0.4	0.0	9.9	9.3	2.0
Seeking to get pregnant †	3.4	5.5	1.7	0.0	4.0	4.2	1.8
Infecund/subfecund ‡	7.8	12.7	4.0	0.0	1.1	5.8	17.0
Potential Demand	38.3	63.3	11.6	0.2	13.3	50.5	54.6
Met Need	28.2	46.9	4.4	0.2	9.3	38.1	39.8
Current users of a modern method	16.0	26.3	4.4	0.2	6.6	22.5	20.2
Current users of a traditional method	12.2	20.6	0.0	0.0	2.7	15.6	19.6
Unmet Need of Any Contraception (Nonusers at risk of unintended pregnancy)	10.1	16.4	7.2	0.0	4.0	12.4	14.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unmet Need of Modern Contraception §	22.3	37.0	7.2	0.0	6.7	28.0	34.4
No. of Cases	6,376	4,119	386	1,871	2,009	2,249	2,118

* Within the past month.

† Want to get pregnant right away; includes 68 respondents who answered "when God wants."

‡ Sterilization surgery for noncontraceptive reasons, medical conditions that preclude pregnancy, infertile partners, and menopause.

§ Includes nonusers at risk of unintended pregnancy and current users of traditional contraceptive methods.

Table 9.1.2 All Women and Married Women Aged 15–44 Years in Need of Any or a More Effective Modern Contraceptive Methods Reproductive Health Survey: Georgia, 2005

	All Women			Married Women		
	Any Method %	Modern Method %	No. of Cases %	Any Method %	Modern Method %	No. of Cases %
Total	10.1	22.3	6,376	16.4	37.0	4,119
Residence						
Urban	7.8	19.0	3,196	13.0	33.2	1,947
Rural	12.9	26.4	3,180	19.8	40.9	2,172
Region						
Kakheti	14.0	22.8	538	22.1	36.0	377
Tbilisi	7.9	17.8	1,431	13.7	32.4	841
Shida Kartli	12.1	27.5	430	16.8	39.6	308
Kvemo Kartli	18.2	28.5	576	26.6	42.9	390
Samtskhe-Javakheti	7.8	27.8	434	12.2	43.5	308
Adjara	3.9	24.7	490	6.3	39.9	335
Guria	10.8	23.9	388	18.4	41.9	243
Samegrelo	10.5	20.6	506	18.4	35.9	301
Imereti	10.0	20.1	782	16.3	32.9	515
Mtskheta-Mtianeti	9.7	23.7	374	15.1	37.6	253
Racha-Svaneti	10.0	20.4	427	18.8	38.7	248
Age Group						
15–19	1.5	2.5	930	10.6	18.5	156
20–24	6.7	11.1	1,079	14.6	24.3	557
25–29	11.8	23.4	1,139	16.9	34.1	829
30–34	13.0	32.9	1,110	16.2	42.0	872
35–39	14.3	34.0	1,048	16.8	41.4	841
40–44	15.3	34.9	1,070	17.6	41.7	864
Number of Living Children						
0	0.9	1.0	2,299	5.3	6.0	382
1	12.0	23.4	1,131	12.6	26.0	971
2	17.0	41.3	2,168	17.8	43.7	2,036
3 or more	21.4	45.7	778	22.6	48.4	730
Education						
Secondary incomplete or less	8.7	17.7	907	21.6	45.0	428
Secondary complete	12.7	26.2	1,786	18.3	38.3	1,289
Technicum	14.2	30.3	1,466	18.7	41.0	1,096
University/postgraduate	6.3	16.7	2,217	10.9	29.9	1,306
Socioeconomic Status						
Low	12.1	25.6	2,277	19.8	42.5	1,473
Middle	10.1	22.0	3,028	16.3	36.3	1,944
High	6.7	17.7	1,071	10.2	28.6	702
Ethnicity						
Georgian	8.9	21.2	5,545	14.5	35.7	3,514
Azeri	31.0	38.5	292	41.1	51.3	232
Armenian	11.1	24.5	382	17.3	38.7	261
Other	10.8	26.5	157	16.0	39.4	112

Table 9.2.1 Unmet Need for Contraception, by Future Fertility Preferences Among Currently Married Women of Reproductive Age*
Eastern Europe and Eurasia: A Comparative Report

	Unmet Need for Any Contraception†			Unmet Need for Modern Contraception			Unmet Need for Limiting	
Region and Country	Total %	For Spacing %	For Limiting %	Total %	For Spacing %	For Limiting %	Any Method %	Modern Method %
Eastern Europe								
Czech Rep., 1993	14.6	3.9	10.7	38.9	11.9	27.0	73	69
Moldova, 1997	5.9	2.5	3.4	28.9	9.3	19.6	58	68
Romania, 1999	5.6	1.7	3.9	39.2	9.4	29.8	70	76
Russia, 1999‡	11.5	2.4	9.1	32.5	7.0	25.5	79	78
Ukraine, 1999	17.5	3.4	14.1	47.2	8.1	39.1	81	83
Caucasus								
Armenia, 2000	15.0	4.0	11.0	52.0	10.0	42.0	73	81
Azerbaijan, 2001	11.5	1.8	9.7	53.3	8.2	45.1	84	85
Georgia, 1999	23.8	5.7	18.1	44.1	9.9	34.2	76	78
Georgia, 2005	16.3	4.3	12.0	36.9	8.6	28.3	74	77
Central Asia								
Kazakhstan, 1999	15.0	6.0	9.0	22.0	9.0	13.0	60	59
Kyrgyz Rep., 1997	13.0	5.0	8.0	22.0	9.0	13.0	62	59
Turkmenistan, 2000	19.0	11.0	8.0	27.0	14.0	13.0	42	48
Uzbekistan, 1996	14.0	7.0	7.0	18.0	8.0	10.0	50	56

* Considered to be 15–44 years in RHS and 15–49 years in DHS survey.

† Women using folk methods or lactation amenorrhea method were classified as having unmet need for contraception.

‡ Data for Russia pertain to three primarily urban areas (Ivanovo Oblast, Perm and Yekaterinburg cities).

Source: Serbanescu et al. in *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report.* CDC and ORC/Macro, 2003

Table 9.2.2 Met and Unmet Need for Family Planning (FP) Services Among All Women and Among Women in Union Aged 15–44 According to Their Future Fertility Preferences Reproductive Health Survey: Georgia, 2005

	All Women		Women In Union	
	Any Method %	A Modern Method %	Any Method %	A Modern Method %
Total Demand for FP	38.4	38.4	63.4	63.5
Demand for spacing	10.3	10.3	16.9	16.9
Demand for limiting	28.1	28.1	46.5	46.6
Met Need For FP (Users)	28.3	16.1	47.1	26.6
For spacing	7.6	5.0	12.6	8.3
For limiting	20.7	11.1	34.5	18.3
Unmet Need For FP (Non-Users)	10.1	22.3	16.3	36.9
For spacing	2.7	5.3	4.3	8.6
For limiting	7.4	17.0	12.0	28.3
Demand Satisfied	73.7	41.9	74.3	41.9
For spacing	73.8	48.5	74.6	49.1
For limiting	73.7	39.5	74.2	39.3
No. of Cases	6,376	6,376	4,119	4,119

Chapter 10

CONTRACEPTIVE COUNSELING

For years after the break-up of the Soviet Union in 1991, Georgia did not have a specific population policy, although regulations enacted during the Soviet era were retained. The "Law on Health Care," adopted on December 10, 1997 (MoLHSA, 1997), acknowledged the right of citizens to decide freely for themselves the number and spacing of children through artificial termination of pregnancy and other methods, and permitted the production, importation, and dissemination of contraceptives. However, this law did not sufficiently address policy changes to actively promote contraception. Georgia's family planning program, which has been in place since the mid-1990s, has been mainly driven by several UNFPA- and USAID-supported projects, which aim to promote contraceptive security, increase awareness of contraception, and train providers in contraceptive technologies. For example, since 1997, UNFPA, has provided training in family-planning counseling to over 800 reproductive health service providers, and since 2001, it has also provided on-the-job counseling training to UNFPA-supported mobile team health professionals that provide outreach reproductive health services. The recent increase in contraceptive use and decrease in reliance on abortion are likely indicators of the slow but sure impact of such projects.

Family planning counseling, however, is currently available only through specialized facilities (gynecology and reproductive health service clinics) that are primarily located in urban areas, and is mostly offered as part of postpartum or post-abortion care. Thus, Georgia has a great need for new policies that will allow integration of counseling and other reproductive health services at the primary care level. An important recommendation of a recent review of Georgia's reproductive health policies and laws—initiated by the USAID in collaboration with MoLHSA in 2004—was to integrate family planning services and counseling into the basic reproductive health package offered at the primary health care level (CoReform Project, , 2005).

In addition, the review recommended that a wider range of service providers, including general practitioners, pediatricians, and nurses, be trained and certified to provide family planning services, including counseling. As part of the ongoing Primary Health Care Reform Project (which is supported by the World Bank, Britain's Department for International Development, and the European Union), the training curriculum for general practitioners includes a module on family planning counseling and service provision. Approximately 200 general practitioners who have already completed or are undergoing the re-training courses will be able to provide family planning services. Additionally, a group of primary health care professionals have been trained to provide these services at the most basic level of the primary care system on a pilot basis, under a special waiver granted by the MoLHSA to the USAID-funded Healthy Women in Georgia project.

10.1 Client-Provider Communications Regarding Family Planning

Most family planning services in Georgia are provided by Ob/Gyns and "reproductologists" (physicians who have received extra training related to reproductive issues), both of whom traditionally have little expertise in providing client-oriented family planning counseling. Under a recent MoLHSA initiative, primary health care physicians in two regions (Imereti and Kakheti) were given special training in client-centered family planning counseling and were authorized to provide such counseling in rural ambulatory clinics. The results of this initiative to improve physician training will be assessed in follow-up program evaluation activities.

The GERHS05 included a series of questions to characterize typical interactions between family planning providers and their clients. Specifically, the survey asked about the extent to which health professionals provided basic family planning information and services to women who had used a modern contraceptive method or had an abortion or a birth during the five years prior to the interview.

Respondents who had used at least one modern contraceptive method in the previous five years were asked who had advised them to use their most recent modern method and, if the advice came from a health care provider (e.g., a physician, nurse, or midwife), what topics were covered during family planning counseling. Most respondents were advised

by a gynecologist to use their current or most recent modern method (61%) (Table 10.1 and Figure 10.1.1). As shown in Figure 10.1.2, contraceptive counseling by gynecologists is quite common in Eastern Europe.

Respondents who did not receive medical advice started using their last method at the suggestions of a partner (18%) or friend (9%), at their own counsel (7%), or at the suggestion of a relative (4%). In each of these cases, any potential family planning counseling would have been bypassed. In only 1% of cases was the choice of method made at the suggestion of a pharmacist.

The source of advice varied widely by the last modern contraceptive method used. Almost all IUD users and women with tubal ligation had chosen their method based on the advice of a heath care provider (96% and 89%, respectively), but only 8% of condom users were advised by a physician, nurse, or midwife. Most women who had used condoms did so because their partners suggested it (39%) or because they decided to do so themselves. Among women who used oral contraceptives, 70% were advised by a health care provider to do so; the second most important source of advice was a friend (12%). Most spermicide users initiated use at the recommendation of a pharmacist (29%) or a friend (29%).

During provider-client interactions, 62% of women received general information about other contraceptive methods (Figure 10.1.3); 59% were counseled about the effectiveness of the chosen method compared with other methods; 80% reported that the provider had explained possible side effects of the method chosen; and 77% reported that they were told what to do if they experienced side effects (Table 10.1, bottom panel). Overall, 54% of women received comprehensive counseling (e.g., information about all methods, effectiveness and side effects, and what to do when warning signs occur); rates were higher in urban areas (58%) than in rural areas (48%). The content of contraceptive counseling varied also by

Figure 10.1.1 **Source of Advice for Most Recently Used Contraceptive Method Among Women Aged 15–44 Years Who Had Used a Modern Method within the Last 5 Years**

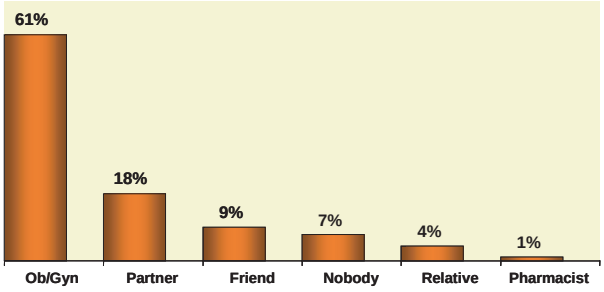


Figure 10.1.2 **Contraceptive Counseling by an Ob/Gyn at Commencement of a Modern Method Recent Survey Estimates in Eastern Europe**

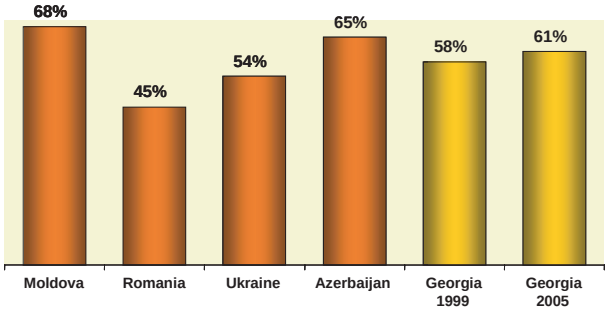
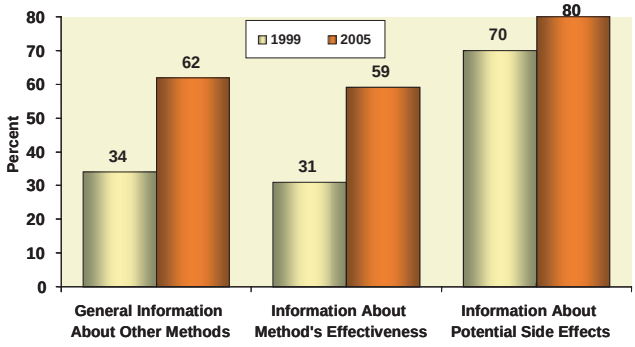


Figure 10.1.3 **Trends in Type of Counseling Received Among Women Aged 15–44 Years Who Had Used a Modern Method within the Last 5 Years**



the method chosen. IUD users were more likely to be counseled about effectiveness and side effects than users of other contraceptive methods; tubal ligation users were least likely to receive counseling, especially information about other methods (39%) or contraceptive effectiveness (35%) (Table 10.1). Women who used hormonal contraception were most likely to have received medical advice about other methods (76%) and about contraceptive effectiveness (71%). Overall, condom users and women who have undergone tubal ligation were the least likely to receive comprehensive counseling (33% and 31%, respectively), whereas users of oral contraceptives were the most likely (65%).

Between 1999 and 2005, general counseling about contraceptive methods and information about contraceptive effectiveness had almost doubled; counseling regarding potential side effects, already very prevalent, had increased by 14% (Figure 10.1.3).

Interactions between family planning providers and their clients and the messages conveyed during those interactions can ensure sustained and correct use of contraceptive methods, as well as client satisfaction with services. The client-health provider interaction is an important opportunity for reproductive health promotion and counseling on risk behaviors. Improvements in family planning competency at the primary health care level are also urgently needed. To address these needs, the Reproductive Health Policy Working Group (see also Chapter 1) is working to develop a comprehensive Reproductive Health Policy for Georgia. The policy will lay out guiding principles and key practical steps to enable MoLHSA and other concerned government agencies and partner organizations to meet priority maternal and child health goals. Family planning service provision is one of the main components of the above-mentioned document, one objective of which is to improve availability and quality of family planning services at the primary care level.

10.2 Satisfaction With Counseling Services

Respondents who used a modern method in the last five years were asked about their satisfaction with the service provider (Table 10.2). Only 34% were very satisfied and 52%, satisfied. About one in 10 women was somewhat satisfied, while 3% were dissatisfied. Satisfaction with counseling services at the time of choosing the last modern method varied little by respondent background characteristics. IUD users were most likely and condom users were least likely to be very satisfied with the counseling services (39% vs. 18%).

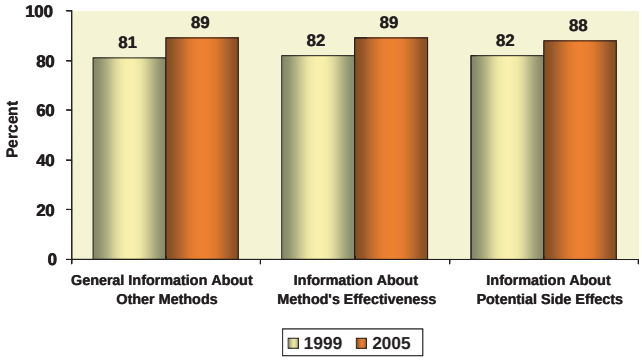
Women who were counseled about all birth control methods at the time of making their contraceptive decision were more likely to be very satisfied with counseling than those who did not receive complete information (40% vs. 25%). Similarly, women who received counseling about method specific effectiveness were more likely to be satisfied with counseling than those that didn't (41% vs. 24%) as were women who received counseling about side effects (38% vs. 19%). Overall, women who received comprehensive counseling were almost twice as likely to be very satisfied compared to those who received only partial information. Compared to 1999, the percentage of

women who were very satisfied or satisfied with specific counseling information had increased in each category (Figure 10.2).

10.3 Post-abortion and Post-partum Counseling

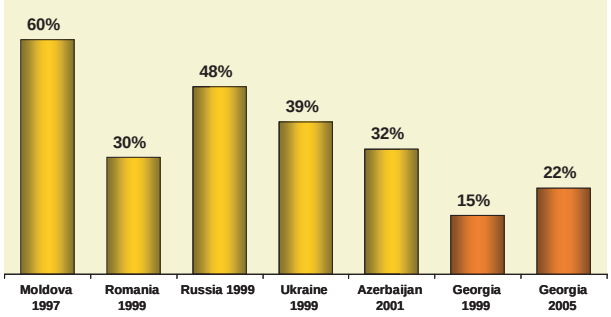
As discussed in Chapters 4 and 5, almost two-thirds of fecund women in union do not want any (more) children and a very high number resort to legal abortion to delay or avoid having children. Women who decide to end their pregnancies in abortion and do not adopt an effective contraceptive method afterwards are likely to be at high risk for another unintended pregnancy during the immediate post-abortion period. They represent an important target audience for family planning counseling. A wide range of contraceptive methods, together with accurate information, and/or referral for ongoing family planning services should be made available and accessible to all women who have undergone abortions; both abortion providers and family planning service providers should be able to offer contraceptive counseling and services as soon as possible after an abortion.

Figure 10.2 **Percentage of Women Aged 15–44 Years Who Were Very Satisfied or Satisfied with Specific Types of Counseling ReceivedAmong Women Who Had Used a Modern Method within the Last 5 Years**



In GERHS05, all respondents who had an abortion in the last five years were asked if they 1) received any family planning advice either before or after the abortion procedure; 2) received any contraceptive method or a prescription for any method; and 3) were referred to a family planning facility following the procedure. Similar to other countries of the region, only a minority of Georgian women received information about contraceptive methods before or after an abortion (15% in 1999 and 22% in 2005) (Figure 10.3.1). In contrast, Moldova and Russia showed much higher rates of counseling: 60% and 48%, respectively.

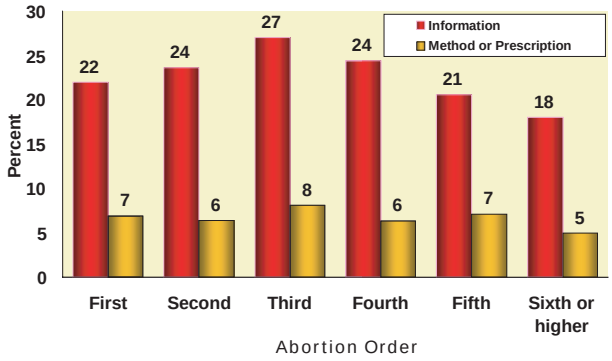
Figure 10.3.1 **Receipt of Contraceptive Information at the Time of an Abortion on Request in the Last 5 Years: Recent Survey Estimates in Eastern Europe**



Although 22% of respondents with a history of at least one abortion on request in the last five years reported receiving contraceptive counseling around the time of the abortion, only 12% of these (3% of all women with a history of abortion in the past five years) received

a contraceptive method to prevent future unintended pregnancies. Receipt of contraception information was inversely correlated with age and directly correlated with education and SES. Receipt of contraceptive supplies was very low across all subgroups. Women in urban areas, particularly Tbilisi (31%), were more likely than rural residents (17%) to receive pre- or post- abortion information about contraception (Table 10.3.1). Unfortunately, receipt of contraception counseling did not vary significantly by the abortion order (Figure 10.3.2). On the contrary, women with many repeat abortions (six or more) were slightly less likely to receive contraceptive information, supplies, or prescription for supplies than women with fewer abortions.

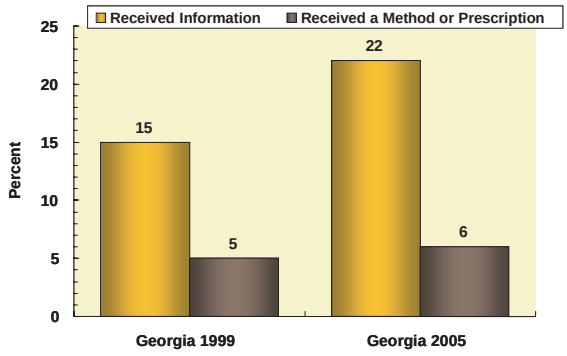
Figure 10.3.2 **Receipt of Contraceptive Information, Methods, or Prescription at the Time of an Abortion on Request by Abortion Order Among Women Aged 15–44 Years Who Had Abortions within the Last 5 Years**



Compared to 1999, more women reported receipt of contraceptive information in 2005 (22%), but the proportion who had received a contraceptive method or prescription remained very low (6% and 5%) (Figure 10.3.3).

These findings demonstrate a great need to improve and expand availability of counseling, referrals, and provision of contraceptives at the time of the abortion procedure. This will require more rigorous oversight of adherence to current regulations concerning provision of family planning advice and services post-abortion. Additionally, systems must be in place to support full integration of family planning services at facilities where abortion is provided. Client education may also facilitate changes in their perceptions of and expectations for abortion services, which may increase demand for counseling, referrals, and provision of contraceptive methods.

Figure 10.3.3 **Receipt of Contraceptive Counseling at the Time of an Abortion on Request: 1999 and 2005**



Contraceptive counseling was not much more prevalent during perinatal health care visits (Table 10.3.2). Only about one in four women (26%) who gave birth in the last five years and had at least one prenatal care visit reported receiving family planning information as a component of the prenatal consultation. Similarly, only one in three women who

received postpartum care in the last five years reported contraceptive counseling on that occasion. Since only 22% of women had received any postnatal care, the actual prevalence of contraceptive counseling after birth was much lower (7%). Compared to 1999, rates of contraceptive counseling during prenatal care have increased (from 20% to 26%), as have rates of such counseling during postnatal care visits (from 20% to 31%)(Figure 10.3.4).

A wealth of evidence has shown that longer pregnancy and birth intervals are associated with numerous health and nutrition benefits for both mother and child, and may play a significant role in reducing maternal and infant mortality and morbidity and attaining Millennium Development Goals. The care of women during pregnancy and after birth provides a unique opportunity to discuss birth spacing and offer contraceptive information and supplies. Current efforts in Georgia to expand the role of general practitioners in primary health care and to promote integration of family planning counseling with other health services at this level (i.e., postpartum and post-abortion counseling) are likely extend the reach of contraceptive information and supplies, improve birth intervals, and avoid unintended pregnancies.

Figure 10.3.4 **Receipt of Contraceptive Counseling at the Time of Prenatal or Postnatal Care: 1999 and 2005**

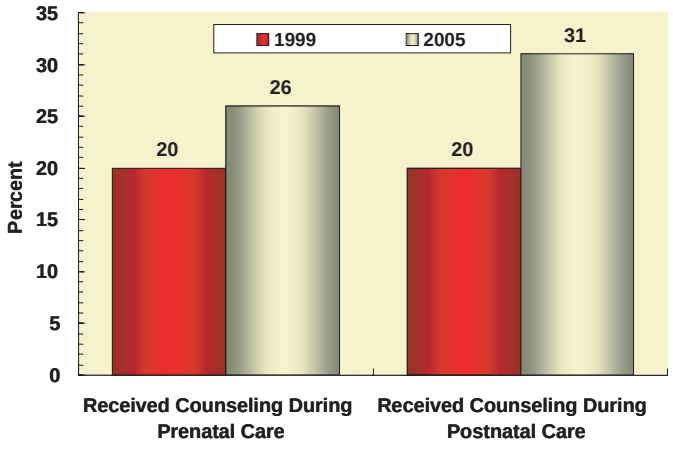


Table 10.1 Percentage of Women Aged 15–44 Years Who Had Used a Modern Contraceptive Method Within the Last 5 Years, by Who Advised Them to Use a Specific Method and by the Type of Counseling Received from a Health Care Provider, by Residence and by Method – Reproductive Health Survey: Georgia, 2005

	Residence			Supplied Method				
Person Who Advised User of Method	Total	Urban	Rural	Contraceptives	IUD	Condoms	Female Sterilization	Other Modern
Ob/Gyn*	61.3	54.5	72.3	69.0	97.0	11.5	92.0	54.1
Partner/husband	17.6	21.2	11.8	0.0	0.0	50.2	2.0	0.0
Friend	9.1	10.8	6.2	12.5	0.7	17.6	0.0	22.0
Nobody	6.9	8.7	3.8	4.3	1.2	14.9	5.9	4.7
Relative	4.0	3.5	4.8	10.1	1.0	5.2	0.0	8.2
Pharmacist	1.1	1.1	1.0	3.1	0.0	0.7	0.0	11.1
Nurse/midwife	0.1	0.1	0.2	0.9	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,473	843	630	235	583	505	93	57
Type of Counseling	Total†	Urban	Rural	Pills	IUD	Condoms	Female Sterlization	Other Modern
General information about other methods	62.0	65.1	58.3	76.5	61.3	60.5	41.5	67.0
Information about method's effectiveness	59.4	62.9	54.9	71.9	59.1	58.8	37.0	67.0
Information about possible side effects	80.5	81.5	79.2	80.0	87.2	59.9	55.2	64.9
What to do if side effects occur	77.5	78.6	76.2	80.1	84.9	50.4	48.5	57.3
Comprehensive	53.5	57.8	48.1	65.3	55.8	33.1	31.3	54.0
No. of Cases	905	457	448	162	565	60	87	31

* Includes also 4 women advised by general practitioners.

† Includes only women who were advised by a health professional (an Ob/Gyn, general practitioner, nurse, or midwife).

Table 10.2 Satisfaction with Family Planning Services Among Women Who Have Received Contraceptive Counseling in the Last 5 Years Reproductive Health Survey: Georgia, 2005

Characteristic	Degree of Satisfaction			No. of Cases
	Very Satisfied %	Satisfied %	Somewhat Satisfied %	
Total	34.2	51.9	11.2	905
Residence				
Urban	36.2	50.5	11.7	457
Rural	31.7	53.6	10.6	448
Age Group				
15–24	26.2	52.1	17.8	120
25–34	30.9	56.8	10.7	410
35–44	40.2	47.0	9.4	375
Region				
Kakheti	29.2	57.5	8.8	107
Tbilisi	39.1	44.7	13.7	168
Shida Kartli	33.8	52.1	14.1	62
Kvemo Kartli	30.3	59.1	7.6	59
Samtskhe-Javakheti	47.5	40.0	7.5	35
Adjara	40.8	47.6	6.8	83
Guria	38.6	49.1	10.5	49
Samegrelo	33.0	45.4	17.5	86
Imereti	26.4	61.3	11.7	147
Mtskheta-Mtianeti	34.4	60.7	4.9	53
Racha-Svaneti	45.2	46.8	6.5	56
Education				
Secondary incomplete or less	33.6	60.2	3.7	78
Secondary complete	34.2	50.6	10.1	243
Technicum	31.1	55.1	12.4	258
University/postgraduate	36.7	48.3	13.1	326
Socioeconomic Status				
Low	33.5	53.0	10.2	280
Middle	34.6	51.1	11.4	453
High	34.3	52.0	12.2	172
Method Used				
Pills	21.6	51.4	22.1	162
IUD	39.4	51.3	6.7	565
Condoms	17.9	60.3	20.1	60
Female sterilization	35.9	50.2	12.8	87
Other modern	21.8	54.7	23.5	31
Counseled About All Methods				
No	24.5	57.6	14.8	350
Yes	40.1	48.4	9.0	555
Counseled About Method Effectiveness				
No	23.7	57.5	15.1	375
Yes	41.4	48.0	8.6	530
Counseled About Possible Side Effects				
No	19.4	57.0	18.7	180
Yes	37.8	50.6	9.4	725
Comprehensive Counseling				
No	23.9	58.7	13.9	434
Yes	43.1	46.0	8.9	471

Table 10.3.1 Selected Family Planning Services Offered at the Time of Legally Performed Abortions by Selected Characteristics Among Women Who Have Had at Least One Abortion in the Last 5 Years – Reproductive Health Survey: Georgia 2005

	Contraception Counseling			Distribution of Contraceptive Methods, Prescriptions for Methods, or Referrals			
Characteristic	Total %	Before Abortion %	After Abortion %	Method Distributed	Offered Prescription %	Offered Referral %	Cases
Total	21.8	4.1	10.0	2.6	3.7	0.7	3,103
Residence							
Urban	26.7	4.5	12.4	2.8	5.0	0.7	1,445
Rural	16.8	3.6	7.6	2.4	2.5	0.6	1,658
Residence							
Tbilisi	30.7	4.2	15.0	1.8	6.2	0.5	683
Other urban	22.5	4.9	9.7	3.8	3.7	0.9	762
Rural	16.8	3.6	7.6	2.4	2.5	0.6	1,658
Age Group							
15–24	30.2	4.0	11.8	4.4	5.7	0.8	357
25–34	23.7	5.0	11.3	3.1	3.8	0.8	1,727
35–44	16.4	2.7	7.6	1.3	3.0	0.5	1,019
Education							
Secondary incomplete or less	18.8	2.1	11.3	3.4	4.7	0.4	353
Secondary complete	18.8	4.2	7.3	2.3	2.5	1.1	1,039
Technicum/university	24.2	4.4	11.3	2.6	4.3	0.5	1,711
Socioeconomic Status							
Low	16.7	3.6	6.6	2.1	3.0	0.5	1,126
Middle	22.4	4.5	11.2	2.6	3.6	0.8	1,466
High	30.5	3.7	13.9	3.5	5.4	0.7	511
Ethnicity							
Georgian	24.0	4.3	11.2	2.9	4.4	0.7	2,593
Azeri	8.4	1.4	4.1	1.4	0.0	0.7	244
Armenian	9.1	2.5	2.8	1.2	0.0	0.3	182
Other	27.8	10.8	9.6	0.0	5.1	0.0	84
Order of Abortion							
First	22.0	4.5	9.9	3.3	3.6	0.8	643
Second	23.6	3.9	10.8	2.3	4.1	0.7	542
Third	27.0	5.2	12.0	4.5	3.6	1.5	446
Fourth	24.4	5.8	10.4	2.1	4.2	0.6	331
Fifth	20.6	3.9	8.8	4.8	2.3	0.2	255
Sixth or Higher	18.0	2.8	9.0	1.0	4.0	0.4	886

Table 10.3.2 Family Planning Counseling Offered During Prenatal Care and Postnatal Care Among Women with a Live Birth in the Last 5 Years Who Received Perinatal Health Services, by Selected Characteristics
Reproductive Health Survey: Georgia 2005

	Contraception Counseling During Prenatal Care		Contraception Counseling During Postnatal Care	
Characteristic	%	No. of Cases	%	No. of Cases
Total	25.6	1,917	30.6	404
Residence				
Urban	30.2	872	33.3	215
Rural	20.9	1,045	26.9	189
Residence				
Tbilisi	35.3	387	25.5	95
Other urban	25.4	485	40.1	120
Rural	20.9	1,045	26.9	189
Age Group				
15–24	21.8	635	31.3	121
25–34	28.1	1,017	29.8	228
35–44	26.4	265	32.8	55
Education				
Secondary incomplete or less	13.7	227	17.8	34
Secondary complete	20.9	628	31.0	111
Technicum/university	30.8	1,062	32.1	259
Socioeconomic Status				
Low	19.0	739	28.1	126
Middle	26.4	866	32.2	175
High	36.4	312	30.9	103
Birth Order				
First	25.7	884	27.0	199
Second	27.1	704	37.1	147
Third or more	22.2	329	27.2	58

Table 9.2.2 Met and Unmet Need for Family Planning (FP) Services Among All Women and Among Women in Union Aged 15–44 According to Their Future Fertility Preferences Reproductive Health Survey: Georgia, 2005

	All Women		Women In Union	
	Any Method %	A Modern Method %	Any Method %	A Modern Method %
Total Demand for FP	38.4	38.4	63.4	63.5
Demand for spacing	10.3	10.3	16.9	16.9
Demand for limiting	28.1	28.1	46.5	46.6
Met Need For FP (Users)	28.3	16.1	47.1	26.6
For spacing	7.6	5.0	12.6	8.3
For limiting	20.7	11.1	34.5	18.3
Unmet Need For FP (Non-Users)	10.1	22.3	16.3	36.9
For spacing	2.7	5.3	4.3	8.6
For limiting	7.4	17.0	12.0	28.3
Demand Satisfied	73.7	41.9	74.3	41.9
For spacing	73.8	48.5	74.6	49.1
For limiting	73.7	39.5	74.2	39.3
No. of Cases	6,376	6,376	4,119	4,119

Chapter 11

OPINIONS ABOUT CONTRACEPTION

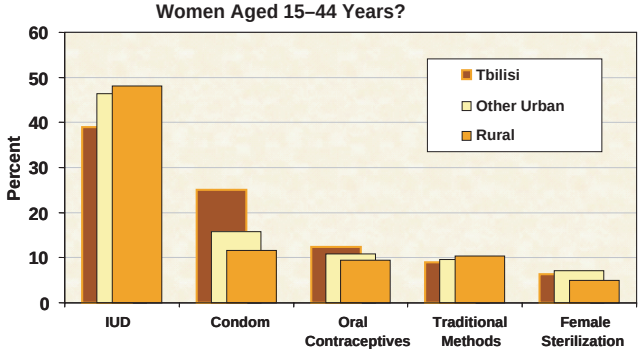
GERHS05 survey results show that virtually all Georgian women of reproductive age have heard of at least one method of contraception. However, although the overall level of awareness of contraceptives is very high, knowledge about the effectiveness of specific contraceptive methods, especially modern methods, is much lower, as is knowledge of how to use modern or traditional methods correctly. Moreover, use of contraceptives remains relatively low in Georgia, with only 47% of married women using any contraceptive method. Thus, it is important to know in more detail what reproductive-aged women in Georgia think about contraceptives, since their opinions and fears about contraceptives ultimately influence their contraceptive practices.

11.1 Opinions on Method Effectiveness

All respondents aged 15–44 years were shown a list of 12 contraceptive methods and were asked to identify the most effective method (Table 11.1 and Figure 11.1). In Table 11.1, contraceptive methods are listed from left to right according to their actual use-effectiveness in preventing a pregnancy; tubal ligation/female sterilization has the highest use-effectiveness, while withdrawal has the lowest. Notably, if all of the respondents had correct knowledge about use-effectiveness, 100% would have named tubal ligation as the most effective method; however, only 6% named it as the most effective method.

The IUD, which is ranked second in terms of actual use-effectiveness, was ranked highest in effectiveness by 45% of the respondents. Similarly, condoms are ranked fourth in actual use-effectiveness, but were considered by 16% of the respondents to be the most effective method, putting this method in second place in respondent-rated effectiveness. In terms of both actual effectiveness and respondent-rated effectiveness, oral contraceptives are ranked third. Despite low actual effectiveness, respondents overall ranked the rhythm method as the fourth most effective method. As for the "other" category, which included Norplant, emergency contraception, injectable contraceptives, and vasectomy, all very highly effective methods, only 0.1% of the respondents recognized this category of methods as being most effective. The accuracy of the ranking of the various methods did not improve significantly as respondent educational level increases.

Figure 11.1 Opinions Regarding Which is the Most Effective Contraceptive Method by Residence Among Women Aged 15–44 Years?

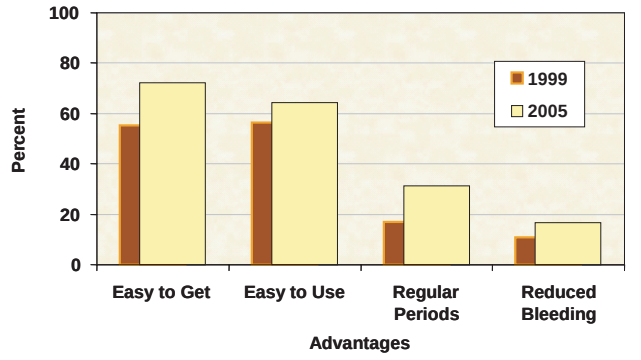


Overall, 11% of the women did not have an opinion on which method is the most effective; percentages were significantly higher among women aged 15–19 years (25%), those with low educational attainment (26%), and Azeri women (47%). In sum, incorrect information or lack of information about the various contraceptive methods appears to be widespread, indicating the need for improved information and education programs in the country.

11.2 Opinions on Advantages and Disadvantages of the Pill and the IUD

Respondents who had heard of oral contraceptives and the IUD were asked to agree or disagree with several statements referring to advantages and disadvantages of each of these methods. As shown in Table 11.2.1 and Figure 11.2.1, 72% of respondents agreed that the pill is "easy to get," while 64% agreed that it is "easy to use." They were less likely to agree that the pill makes menstrual periods more regular (31%)

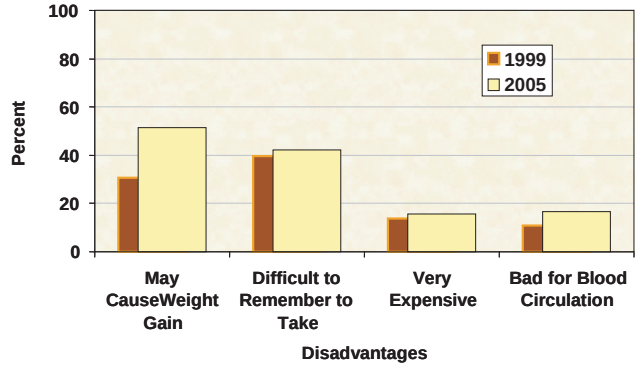
Figure 11.2.1 Opinions Regarding the Advantages Associated with Using Oral Contraceptives Among Women Aged 15–44 Who Have Heard of Oral Contraceptives: 1999 and 2005



and reduces menstrual bleeding (17%). In general, the percentage of women correctly identifying the advantages of the pill increased as place of residence becomes more urban and as educational attainment and SES increased. As shown in Figure 11.2.1, more women in 2005 correctly agreed with the statements on the advantages associated with pill use than 1999 survey respondents.

About 52% of respondents agreed with the statement that the pill may cause weight gain, while 42% agreed with the statement that remembering to take the pill every day is difficult. Only 15.8% agreed that the pill is very expensive, while 15% agreed that the use of the pill is "bad for blood circulation." Women more likely to correctly identify the disadvantages associated with use of oral contraceptives include women living in urban areas, older women, and women with higher educational attainment and SES. As shown in Figure 11.2.2, a slight increase in awareness of the disadvantages associated with pill use (especially weight gain) occurred between the 1999 and 2005 surveys.

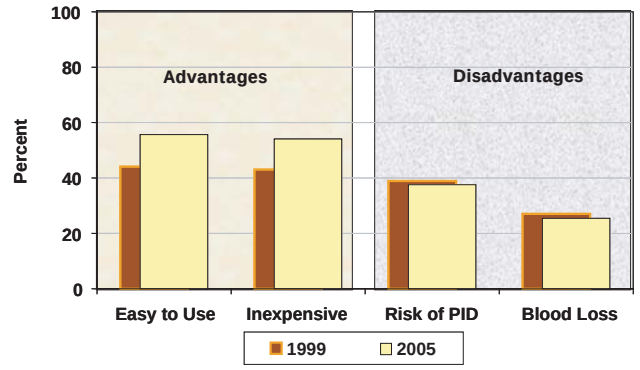
Figure 11.2.2 **Opinions Regarding the Disadvantages Associated with Using Oral Contraceptives Among Women Aged 15–44 Who Have Heard of Oral Contraceptives: 1999 and 2005**



Turning to the IUD, 56% of respondents agreed with the statement that the IUD is "easy to use" (compared with 44% in 1999) while 54% agreed with the statement that it is "relatively inexpensive" (compared with 43% in 1999) (Table 11.2.2 and Figure 11.2.3). Nearly 38% of respondents agreed that IUD use increases the risk of pelvic inflammatory disease, while one in four agreed that the IUD increases blood loss during menses.

Awareness of the advantages of using an IUD was higher among ever-married women and increased with age and, up to a certain point, with educational attainment. Awareness of the disadvantages of using an IUD was also higher among ever-married women and urban residents, and as educational attainment and SES increased. Compared to 1999, however, awareness of IUD advantages had substantially increased, while awareness of this method's disadvantages did not change significantly (Figure 11.2.3).

Figure 11.2.3 **Opinions Regarding the Advantages and Disadvantages Associated with Using the IUD Among Women Aged 15–44 Who Have Heard of the IUD: 1999 and 2005**



11.3 Opinions on Risks of Contraceptive Use

The low rates of modern contraceptive use in Georgia may be due in part to perception of risks to a woman's health associated with contraceptive use. Respondents aged 15–44 years were asked to evaluate the degree of risk to a woman's health associated with the use of five modern contraceptive methods and abortion on request. (Findings are summarized in Table 11.3.1 and Figures 11.3.1 and 11.3.2; more detail is provided in Tables 11.3.2 through 11.3.7.)

The perceived risk was lowest for condoms and highest for abortion on request (Table 11.3.1). More than half of respondents believe that there is medium to high risk associated with oral contraceptive and IUD use, although 12% of respondents believed that there is low risk associated with the use of oral contraceptives and 20% believed that there is low risk associated with the IUD. A high proportion of women did not know if oral contraceptives, tubal ligation, or injectables pose a risk to a woman's health (30%, 67%, and 99%, respectively). This is likely due in part to the fact that many of these women had never heard of these methods.

Ever-users of a given method were more likely to rate that method as low risk than never-users (Tables 11.3.2 through 11.3.5). Also, the percentage of women who were unable to rate the health risks of every method ("don't know") decreased as age, educational attainment, and SES increased and was lower among urban residents than rural residents. Older women and more educated women had the highest rates of perception of risk for every contraceptive method shown.

Finally, as shown in Table 11.3.6, 57% of respondents considered abortion to pose a "high risk" to a woman's health, which is six percentage points higher than in 1999. The probability of believing that abortion is a high-risk procedure increases as the educational attainment of the women increases, as shown in

Figure 11.3.1 Opinions Regarding the Level of Health Risk Associated with Using Selected Contraceptive Methods Among Women Aged 15–44 Years

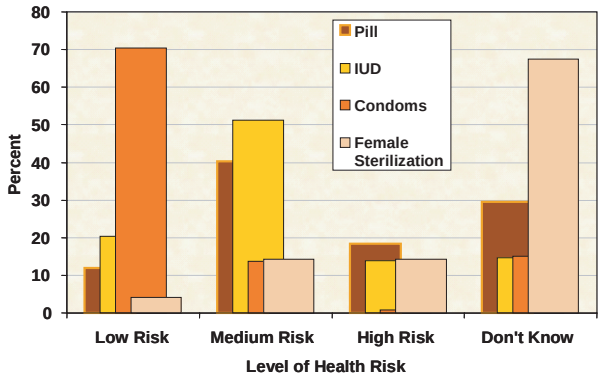


Figure 11.3.2 Opinions Regarding the Level of Health Risk Associated with Using Abortion on Request by Education Among Women Aged 15–44 Years

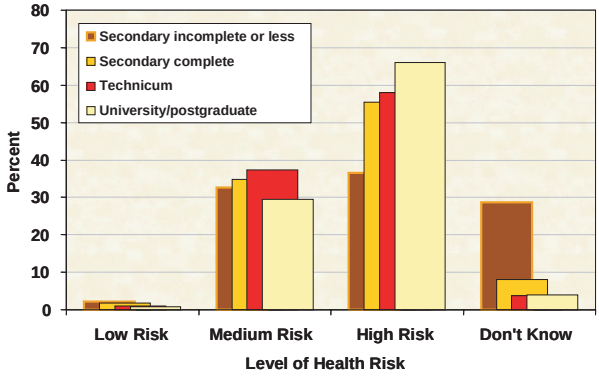


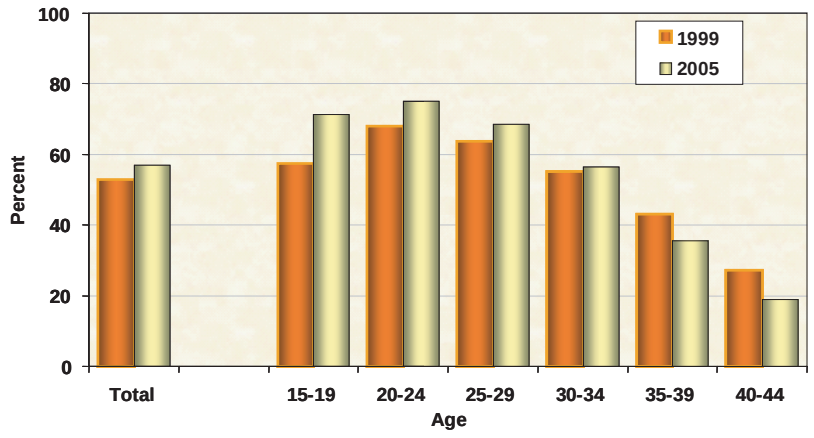
Figure 11.3.2, and is higher among urban residents than rural residents. The increased awareness that abortion poses risks to a woman's health may lead to greater use of modern contraceptives. However, the results shown in Table 11.3.6 suggest that more efforts are needed to increase awareness of the risks of abortion among younger and less educated women, as well as Azeri women.

11.4 Desire for More Information on Contraceptive Methods

To reduce reliance on abortion in Georgia, overall contraceptive use must be increased, more effective modern contraceptive methods must predominate, and information and services must be provided to women to ensure correct and consistent use of contraceptives. GERHS05 data confirm that women want to know more about contraception. As shown in Table 11.4.1 and Figure 11.4.1, 57% of respondents want more information.

As shown in Figure 11.4.1, desire for more information in 2005 (55%) was about the same as in 1999 (53%). In both surveys, a greater percentage of women under the age of 30 indicated a desire for more information on contraceptives, compared to those 30 or older in both surveys. However, in 2005, more women aged 15–29 were interested in receiving information about contraceptives than women of the same age group in 1999, whereas the interest among older women had slightly declined. As the number of living children of the respondents increases, the desire for more information decreases (Table 11.4.1). Encouragingly, women who have never used contraception were more interested in receiving additional information on contraception than ever-users. Similarly, young adult women, never-married women, and those with no living children (characteristics which are highly correlated), expressed high rates of interest in using contraception.

Figure 11.4.1 **Desire to Receive More Information about Contraception among Women Aged 15–44 Years: 1999 and 2005**



Among women who indicated an interest in receiving more information, 53% considered a gynecologist to be the best source of information, followed by 20% who named television or radio broadcasting as the best source (primarily TV), and 14% who thought that newspapers and magazines are the best source (Table 11.4.2 and Figure 11.4.2). Taken together, broadcasting and print media can be combined into a single category, the "mass media" category; 34% of respondents believe that the mass media are the best source of information on contraception. An additional 5% cited books, while 3% mentioned friends and 2%, a current contraceptive user. Interestingly, only 10 women mentioned a nurse or a midwife, and only 5 mentioned a general practitioner. Not surprisingly, three out of four women believe that information about contraceptive methods should be broadcast on radio or television (Table 11.4.3). Respondents least likely to be in agreement with this information strategy include women aged 35–44 years, women with low educational attainment, and Azeri women. From a practical point of view, although it is encouraging that women in Georgia welcome more information about contraception through mass media, it is worrisome that they do not consider nurses and general practitioners as reliable sources. Efforts to increase knowledge and use of effective contraceptive methods may fall short if women do not rely on health professionals for family planning advice.

Figure 11.4.2 **Opinions Regarding the Best Source of Information about Contraception Among Women Aged 15–44 Years Who Would Like to Receive More Information: 1999 and 2005**

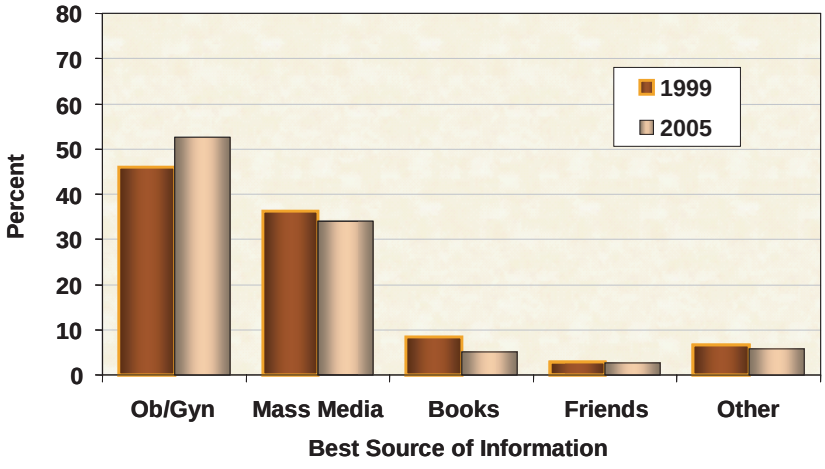


Table 11.1 Opinions Regarding Which Contraceptive Method Is the Most Effective by Selected Characteristics Among All Women Aged 15–44 Years (Percentage Distribution) – Reproductive Health Survey: Georgia, 2005

	Method of Contraception											
Characteristic	Female Sterilization	IUD	Pill	Condom	Spermicides	Other Modern*	Rhythm	Withdrawal	None of Them	Don't Know	Total	No. of Cases
Total	5.9	45.1	10.6	16.4	0.8	0.1	6.3	3.4	0.6	10.6	100.0	6,376
Residence												
Tbilisi	6.4	38.9	12.4	25.1	1.2	0.2	7.8	1.1	0.4	6.6	100.0	1,431
Other urban	7.1	46.4	10.8	15.8	1.4	0.2	6.7	2.9	0.6	8.0	100.0	1,765
Rural	4.9	48.1	9.4	11.6	0.2	0.0	5.1	5.2	0.8	14.6	100.0	3,180
Marital Status												
Married	6.4	48.1	9.6	13.5	1.3	0.2	8.9	5.6	0.8	5.7	100.0	4,119
Previously married	8.7	46.2	13.6	16.4	0.5	0.0	5.1	1.8	1.0	6.9	100.0	386
Never married	4.6	40.0	11.8	21.5	0.1	0.1	2.0	0.0	0.3	19.6	100.0	1,871
Age Group												
15–19	1.6	38.5	10.7	22.2	0.0	0.0	0.7	0.6	0.3	25.4	100.0	930
20–24	3.5	47.0	11.8	20.3	0.5	0.3	2.6	1.3	0.2	12.4	100.0	1,079
25–34	7.7	46.1	11.8	15.8	1.3	0.1	6.7	4.0	0.7	5.7	100.0	2,249
35–44	8.0	47.0	8.7	11.7	1.0	0.2	11.0	5.6	0.9	5.8	100.0	2,118
Number of Living Children												
0	4.5	41.4	11.6	21.4	0.2	0.2	1.9	0.1	0.3	18.5	100.0	2,299
1	6.8	44.8	10.2	19.8	1.8	0.0	6.9	2.9	1.0	5.8	100.0	1,131
2	7.1	47.1	11.4	11.4	1.1	0.2	11.2	6.0	0.6	4.1	100.0	2,168
3 or more	6.7	53.5	6.1	7.9	1.1	0.0	7.7	8.9	1.5	6.7	100.0	778
Education Level												
Secondary incomplete or less	2.4	39.8	7.9	15.0	0.0	0.0	2.2	5.5	0.7	26.5	100.0	907
Secondary complete	4.0	49.9	9.9	13.5	0.7	0.0	6.1	4.6	0.9	10.2	100.0	1,786
Technicum	7.2	49.2	10.0	13.0	0.9	0.1	8.2	4.3	0.8	6.4	100.0	1,466
University/postgraduate	8.3	41.4	12.8	21.5	1.3	0.3	7.0	1.0	0.3	6.0	100.0	2,217
Socioeconomic Status												
Low	4.6	48.4	10.1	11.7	0.2	0.1	4.4	5.7	0.8	14.0	100.0	2,277
Middle	6.1	45.8	10.7	16.9	0.9	0.1	7.0	2.4	0.7	9.5	100.0	3,028
High	7.9	37.6	11.3	24.0	1.7	0.2	7.9	1.7	0.3	7.3	100.0	1,071
Ethnic Group												
Georgian	6.5	45.8	11.2	17.3	0.9	0.1	6.7	3.0	0.5	7.9	100.0	5,545
Azeri	0.5	37.1	2.5	4.0	0.0	0.0	3.7	3.0	2.2	47.0	100.0	292
Armenian	2.4	39.4	5.8	16.9	0.3	0.0	1.8	11.9	0.8	20.7	100.0	382
Other	4.2	50.8	15.7	12.6	2.1	1.2	5.7	1.6	0.2	6.0	100.0	157

*Other Modern includes Norplant, emergency contraception, injectables, and vasectomy.

Table 11.2.1 Opinions Regarding the Advantages and Disadvantages of Using Oral Contraceptives by Selected Characteristics Among Women Aged 15–44 Years Who Have Ever Heard of Oral Contraceptives (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Advantages				Disadvantages				
Characteristic	**Easy to** Get	Easy to Use	Regular Periods	Reduced Bleeding	May Cause Weight Gain	Difficult to Remember to Take	Very Expensive	Bad for Blood Circulation	No. of Cases
Total	72.2	64.4	31.2	16.6	51.5	42.3	15.8	15.1	5,260
Residence									
Tbilisi	81.1	72.2	35.8	18.5	58.0	46.9	18.5	18.3	1,329
Other urban	73.9	61.3	31.6	17.8	53.2	42.7	15.4	14.8	1,539
Rural	64.2	60.9	27.5	14.3	45.3	38.6	14.0	12.9	2,392
Marital Status									
Married	74.3	66.2	34.0	19.0	54.8	47.3	18.5	16.8	3,592
Previously married	77.3	62.7	34.6	18.8	53.6	46.5	13.1	17.6	341
Never married	66.5	60.8	24.5	11.0	43.7	30.6	10.4	10.9	1,327
Age Group									
15–19	61.6	57.6	21.1	9.5	37.3	29.4	8.6	10.0	523
20–24	72.0	66.6	29.1	13.6	48.3	36.8	12.4	11.2	848
25–34	76.6	66.5	33.6	19.6	55.5	44.3	17.4	16.2	2,018
35–44	71.8	63.8	33.5	17.7	54.1	47.6	18.3	17.7	1,871
Education Level									
Secondary incomplete or less	60.5	55.2	17.8	9.8	31.4	34.7	11.3	8.9	457
Secondary complete	67.5	61.0	29.3	14.2	48.2	39.9	16.0	12.2	1,412
Technicum	71.2	65.4	31.1	17.5	51.1	44.6	18.3	15.3	1,312
University/postgraduate	78.6	68.4	35.9	19.3	58.7	44.4	15.2	18.4	2,079
Socioeconomic Status									
Low	62.7	58.8	26.0	13.0	43.7	39.1	14.7	10.4	1,661
Middle	73.9	65.1	30.4	16.1	52.1	41.3	15.4	14.8	2,600
High	81.4	70.7	40.4	22.8	60.8	49.2	18.2	22.1	999
Ethnic Group									
Georgian	72.7	64.4	31.3	16.8	52.0	42.6	15.7	15.4	4,807
Azeri	56.1	53.4	23.2	13.6	31.5	30.4	6.0	6.6	114
Armenian	62.9	67.4	24.9	9.6	44.6	40.7	22.8	10.3	216
Other	81.9	74.2	45.0	23.0	63.3	46.8	19.4	19.3	123

Table 11.2.2 Opinions Regarding the Advantages and Disadvantages of Using the IUD by Selected Characteristics Among Women Aged 15–44 Years Who Have Ever Heard of the IUD (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

	Advantages		Disadvantages		
Characteristic	Easy to Use	Is Relatively Inexpensive	Increases the Risk of PID*	May Increase Blood Loss	No. of Cases
Total	55.8	54.0	37.5	25.3	6,034
Residence					
Tbilisi	55.5	58.0	47.5	32.5	1,396
Other urban	56.0	54.3	34.3	24.5	1,712
Rural	55.9	51.3	33.3	21.2	2,926
Marital Status					
Married	64.8	64.1	43.4	30.5	4,007
Previously married	60.0	58.0	45.5	32.9	373
Never married	38.1	34.2	25.0	14.0	1,654
Age Group					
15–19	32.5	31.5	20.3	10.2	747
20–24	48.9	46.0	31.8	20.5	1,014
25–34	62.8	59.8	40.6	26.4	2,199
35–44	63.9	63.4	45.7	33.9	2,074
Education Level					
Secondary incomplete or less	38.3	38.1	22.9	11.7	700
Secondary complete	56.4	50.6	34.2	22.2	1,702
Technicum	63.5	60.2	40.3	28.9	1,437
University/postgraduate	57.1	58.6	43.6	30.3	2,195
Socioeconomic Status					
Low	51.7	46.3	29.7	19.1	2,080
Middle	57.9	56.4	38.7	26.2	2,906
High	57.7	61.6	47.8	33.7	1,048
Ethnic Group					
Georgian	56.2	54.5	37.1	25.3	5,373
Azeri	45.2	43.8	26.0	16.0	185
Armenian	53.9	51.7	52.8	28.0	327
Other	59.7	55.8	39.2	32.3	149

*Pelvic Inflammatory Disease

Table 11.3.1 Opinions Regarding the Degree of Risk to a Woman's Health From Using Selected Family Planning Methods Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Degree of Risk					
Method	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Pill	12.0	40.2	18.3	29.5	100.0	6,376
IUD	20.3	51.3	13.8	14.6	100.0	6,376
Condoms	70.5	13.7	0.8	15.0	100.0	6,376
Female sterilization	4.1	14.2	14.3	67.4	100.0	6,376
Injectables	0.1	0.9	0.4	98.6	100.0	6,376
Abortion on request	1.3	33.1	56.6	9.0	100.0	6,376

Table 11.3.2 Opinions Regarding the Level of Health Risk Associated With Using Oral Contraceptives by Selected Characteristics Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Level of Health Risk Associated with Using the Pill					
Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	12.0	40.2	18.3	29.5	100.0	6,376
Residence						
Tbilisi	11.5	47.9	23.7	16.9	100.0	1,431
Other urban	12.1	43.9	18.0	26.0	100.0	1,765
Rural	12.1	33.3	15.2	39.3	100.0	3,180
Marital Status						
Married	12.3	43.9	22.7	21.1	100.0	4,119
Previously married	12.0	40.5	23.6	23.8	100.0	386
Never married	11.3	33.8	9.9	45.0	100.0	1,871
Age Group						
15–19	11.8	23.2	6.4	58.6	100.0	930
20–24	11.9	40.2	14.5	33.4	100.0	1,079
25–34	13.6	45.0	23.1	18.3	100.0	2,249
35–44	10.6	45.4	22.6	21.5	100.0	2,118
Education Level						
Secondary incomplete or less	7.8	19.9	7.6	64.7	100.0	907
Secondary complete	13.5	36.9	16.8	32.7	100.0	1,786
Technicum	12.8	45.7	19.1	22.4	100.0	1,466
University/postgraduate	12.2	48.9	23.9	15.0	100.0	2,217
Socioeconomic Status						
Low	13.2	30.3	14.8	41.7	100.0	2,277
Middle	11.3	43.6	19.0	26.0	100.0	3,028
High	11.3	49.9	22.8	16.0	100.0	1,071
Ethnic Group						
Georgian	12.2	43.4	19.2	25.1	100.0	5,545
Azeri	5.6	9.2	5.2	79.9	100.0	292
Armenian	6.5	21.4	18.0	54.1	100.0	382
Other	27.8	32.7	12.8	26.8	100.0	157
Ever Used Oral Contraceptives						
No	10.3	39.7	18.1	31.9	100.0	5,835
Yes	31.4	46.8	20.9	0.9	100.0	541

Table 11.3.3 Opinions Regarding the Level of Health Risk Associated With Using the IUD by Selected Characteristics
Among Women Aged 15–44 Years (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

	Level of Health Risk					
Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	20.3	51.3	13.8	14.6	100.0	6,376
Residence						
Tbilisi	18.6	55.0	17.3	9.2	100.0	1,431
Other urban	20.9	54.3	12.1	12.6	100.0	1,765
Rural	20.9	47.3	12.7	19.0	100.0	3,180
Marital Status						
Married	23.1	53.3	15.6	8.0	100.0	4,119
Previously married	20.2	50.6	17.2	11.9	100.0	386
Never married	15.6	48.1	10.0	26.2	100.0	1,871
Age Group						
15–19	13.3	42.6	9.0	35.0	100.0	930
20–24	22.9	48.3	12.2	16.6	100.0	1,079
25–34	22.7	54.5	14.6	8.1	100.0	2,249
35–44	20.6	55.0	16.5	7.9	100.0	2,118
Education Level						
Secondary incomplete or less	15.8	37.8	7.8	38.6	100.0	907
Secondary complete	22.2	49.4	14.4	14.0	100.0	1,786
Technicum	23.1	54.7	14.8	7.4	100.0	1,466
University/postgraduate	19.2	57.1	15.4	8.2	100.0	2,217
Socioeconomic Status						
Low	21.1	47.1	11.8	20.0	100.0	2,277
Middle	20.2	53.4	13.8	12.7	100.0	3,028
High	19.1	54.1	17.4	9.5	100.0	1,071
Ethnic Group						
Georgian	20.9	54.3	13.5	11.3	100.0	5,545
Azeri	14.8	22.3	8.1	54.9	100.0	292
Armenian	8.8	36.9	24.0	30.3	100.0	382
Other	35.0	40.6	13.2	11.2	100.0	157
Ever Used IUD						
No	16.4	52.5	14.1	17.0	100.0	5,394
Yes	43.6	44.2	11.9	0.3	100.0	982

Table 11.3.4 Opinions Regarding the Level of Health Risk Associated With Using Condoms by Selected Characteristics Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Level of Health Risk					
Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	70.5	13.7	0.8	15.0	100.0	6,376
Residence						
Tbilisi	78.0	12.4	0.8	8.8	100.0	1,431
Other urban	73.4	14.3	1.1	11.2	100.0	1,765
Rural	64.3	14.1	0.6	21.0	100.0	3,180
Marital Status						
Married	73.2	14.2	0.8	11.7	100.0	4,119
Previously married	72.3	15.0	0.5	12.1	100.0	386
Never married	65.6	12.6	0.8	20.9	100.0	1,871
Age Group						
15–19	57.4	13.9	1.2	27.5	100.0	930
20–24	71.9	12.5	0.3	15.3	100.0	1,079
25–34	75.2	13.7	0.7	10.5	100.0	2,249
35–44	72.9	14.3	0.9	11.9	100.0	2,118
Education Level						
Secondary incomplete or less	50.2	11.8	1.1	36.9	100.0	907
Secondary complete	67.9	15.5	1.2	15.4	100.0	1,786
Technicum	73.0	15.9	0.4	10.7	100.0	1,466
University/postgraduate	80.6	12.0	0.5	7.0	100.0	2,217
Socioeconomic Status						
Low	63.4	15.6	0.7	20.3	100.0	2,277
Middle	73.0	12.7	0.7	13.6	100.0	3,028
High	77.5	13.1	0.9	8.5	100.0	1,071
Ethnic Group						
Georgian	74.7	14.0	0.7	10.7	100.0	5,545
Azeri	17.1	10.6	0.6	71.7	100.0	292
Armenian	53.8	12.3	2.5	31.4	100.0	382
Other	74.8	15.3	0.0	9.9	100.0	157
Ever Used Condoms						
No	67.8	14.6	0.8	16.8	100.0	5,507
Yes	88.9	7.8	0.6	2.8	100.0	869

Table 11.3.5 Opinions Regarding the Level of Health Risk Associated With Using Female Sterilization by Selected Characteristics Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Level of Health Risk					
Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	4.1	14.2	14.3	67.4	100.0	6,376
Residence						
Tbilisi	6.3	14.8	20.8	58.1	100.0	1,431
Other urban	4.1	19.4	15.5	61.1	100.0	1,765
Rural	2.8	10.7	9.7	76.9	100.0	3,180
Marital Status						
Married	4.6	16.9	16.9	61.6	100.0	4,119
Previously married	5.5	15.6	21.5	57.4	100.0	386
Never married	3.0	9.4	8.6	78.9	100.0	1,871
Age Group						
15–19	0.9	3.5	4.5	91.1	100.0	930
20–24	3.5	11.1	11.0	74.5	100.0	1,079
25–34	4.8	17.9	18.1	59.3	100.0	2,249
35–44	5.6	18.6	18.1	57.6	100.0	2,118
Education Level						
Secondary incomplete or less	0.6	3.4	4.4	91.7	100.0	907
Secondary complete	2.0	10.1	10.3	77.6	100.0	1,786
Technicum	4.7	17.2	16.6	61.5	100.0	1,466
University/postgraduate	7.0	20.7	20.7	51.6	100.0	2,217
Socioeconomic Status						
Low	2.1	9.8	8.5	79.7	100.0	2,277
Middle	3.8	15.2	16.1	64.9	100.0	3,028
High	8.4	20.0	20.4	51.2	100.0	1,071
Ethnic Group						
Georgian	4.6	15.5	15.2	64.6	100.0	5,545
Azeri	0.0	2.5	1.7	95.9	100.0	292
Armenian	0.1	7.0	8.7	84.2	100.0	382
Other	3.5	8.5	20.7	67.3	100.0	157
Ever Used Female Sterilization						
No	3.6	13.7	14.4	68.3	100.0	6,283
Yes	39.8	54.6	5.1	0.6	100.0	93

Table 11.3.6 Opinions Regarding the Level of Health Risk Associated With Using Abortion on Request by Selected Characteristics Among Women Aged 15–44 Years (Precentage Distribution) Reproductive Health Survey: Georgia, 2005

	Level of Health Risk					
Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	1.3	33.1	56.6	9.0	100.0	6,376
Residence						
Tbilisi	1.3	27.6	65.2	5.9	100.0	1,431
Other urban	0.6	33.5	59.4	6.5	100.0	1,765
Rural	1.8	36.1	49.7	12.4	100.0	3,180
Marital Status						
Married	1.4	37.2	57.5	4.0	100.0	4,119
Previously married	1.7	29.6	64.1	4.7	100.0	386
Never married	1.2	26.6	53.8	18.3	100.0	1,871
Age Group						
15–19	2.2	26.2	45.6	26.0	100.0	930
20–24	0.6	31.1	58.6	9.7	100.0	1,079
25–34	1.0	35.1	59.6	4.4	100.0	2,249
35–44	1.6	36.2	59.0	3.2	100.0	2,118
Education Level						
Secondary incomplete or less	2.2	32.6	36.5	28.6	100.0	907
Secondary complete	1.8	34.7	55.5	8.0	100.0	1,786
Technicum	0.9	37.4	57.9	3.8	100.0	1,466
University/postgraduate	0.8	29.4	66.0	3.9	100.0	2,217
Socioeconomic Status						
Low	1.7	35.9	49.8	12.7	100.0	2,277
Middle	1.1	32.9	58.2	7.8	100.0	3,028
High	1.2	28.5	65.1	5.2	100.0	1,071
Ethnic Group						
Georgian	1.0	33.6	58.6	6.8	100.0	5,545
Azeri	5.3	28.7	29.8	36.2	100.0	292
Armenian	2.6	25.6	53.0	18.7	100.0	382
Other	2.7	40.4	48.5	8.4	100.0	157
Ever Used Any Method						
No	1.6	29.4	54.6	14.4	100.0	3,488
Yes	1.0	38.2	59.3	1.5	100.0	2,888

Table 11.4.1 Desire for More Information About Contraceptive Methods by Selected Characteristics Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	Desire for More Information				
Characteristic	Yes	No	Don't Know	Total	No. of Cases
Total	54.7	42.3	3.0	100.0	6,376
Residence					
Tbilisi	54.1	43.9	2.0	100.0	1,431
Other urban	58.1	39.7	2.1	100.0	1,765
Rural	53.0	42.8	4.2	100.0	3,180
Marital Status					
Married	49.8	48.4	1.8	100.0	4,119
Previously married	27.7	69.3	2.9	100.0	386
Never married	67.6	27.3	5.2	100.0	1,871
Age Group					
15–19	71.4	22.6	6.0	100.0	930
20–24	75.1	21.9	3.0	100.0	1,079
25–34	62.7	35.3	2.0	100.0	2,249
35–44	26.6	71.0	2.4	100.0	2,118
Number of Living Children					
0	67.1	28.2	4.8	100.0	2,299
1	59.4	39.1	1.5	100.0	1,131
2	44.0	54.2	1.8	100.0	2,168
3 or more	33.7	63.9	2.4	100.0	778
Education Level					
Secondary incomplete or less	51.3	41.9	6.8	100.0	907
Secondary complete	54.2	43.5	2.3	100.0	1,786
Technicum	47.4	49.5	3.0	100.0	1,466
University/postgraduate	61.1	37.0	1.9	100.0	2,217
Socioeconomic Status					
Low	51.1	45.0	3.9	100.0	2,277
Middle	56.7	40.4	2.9	100.0	3,028
High	56.3	42.0	1.7	100.0	1,071
Ethnic Group					
Georgian	57.4	39.9	2.7	100.0	5,545
Azeri	22.5	68.8	8.7	100.0	292
Armenian	45.0	52.6	2.4	100.0	382
Other	48.1	46.7	5.3	100.0	157
Ever Used Any Method					
No	58.9	36.8	4.2	100.0	3,488
Yes	48.8	49.8	1.4	100.0	2,888

Table 11.4.2 Opinions Regarding the Best Source of Information About Contraceptive Methods by Selected Characteristics Among Women Aged 15–44 Years Who Desire More Information (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

	Best Source of Information about Contraceptive Methods								
Characteristic	Gynecologist	Radio/TV	Newspapers/ Magazines	Books	Friends/ Peers	Contraceptive User	Other or Unknown	Total	No. of Cases
Total	52.7	20.0	14.0	5.0	2.6	2.0	3.7	100.0	3,502
Residence									
Tbilisi	54.6	14.2	15.4	7.5	1.7	1.4	5.2	100.0	774
Other urban	52.8	20.6	13.9	4.6	3.4	2.3	2.4	100.0	995
Rural	51.4	23.1	13.2	3.7	2.6	2.3	3.7	100.0	1,733
Marital Status									
Married	64.8	14.9	12.2	2.7	1.7	1.7	2.1	100.0	2,129
Previously married	46.3	22.4	16.3	5.1	1.6	2.1	6.3	100.0	107
Never married	37.8	26.3	16.1	7.8	3.8	2.5	5.6	100.0	1,266
Age Group									
15–19	40.0	26.2	13.6	6.6	4.3	2.4	6.9	100.0	682
20–24	52.6	18.8	14.6	5.5	2.1	2.5	3.8	100.0	808
25–34	60.8	16.9	11.8	4.3	1.5	2.1	2.5	100.0	1,403
35–44	54.2	19.3	18.4	3.3	3.0	0.7	1.2	100.0	609
Education Level									
Secondary incomplete or less	41.7	28.3	12.3	5.3	3.6	2.5	6.4	100.0	470
Secondary complete	56.8	21.5	10.9	3.1	2.1	2.9	2.6	100.0	972
Technicum	54.4	19.8	14.5	4.2	2.6	1.3	3.2	100.0	700
Universitypostgraduate	53.3	15.8	16.5	6.5	2.6	1.6	3.6	100.0	1,360
Socioeconomic Status									
Low	48.3	25.9	13.6	4.2	2.7	2.1	3.2	100.0	1,176
Middle	53.3	18.8	14.1	5.2	2.6	2.0	3.9	100.0	1,727
High	58.3	13.5	14.4	5.6	2.3	2.0	3.9	100.0	599
Employment Status									
Working	51.4	18.2	17.8	5.3	2.7	1.5	3.0	100.0	686
Not working	53.0	20.4	13.1	4.9	2.6	2.2	3.9	100.0	2,816
Ethnic Group									
Georgian	52.8	19.7	14.3	5.2	2.7	2.0	3.4	100.0	3,188
Azeri	71.2	14.8	2.4	3.9	0.0	3.9	3.9	100.0	69
Armenian	42.9	29.1	11.0	1.8	2.4	3.8	9.0	100.0	171
Other	47.9	21.6	18.4	2.5	2.3	0.0	7.2	100.0	74
Ever Used Any Method									
No	45.8	23.0	14.5	6.1	3.3	2.6	4.7	100.0	2,023
Yes	64.3	15.0	13.2	3.1	1.5	1.0	2.0	100.0	1,479

Table 11.4.3 Opinions Regarding Whether Information about Contraceptive Methods Should be Broadcast on Radio or Television by Selected Characteristics Among Women Aged 15–44 Years (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

	"Should Information about Contraceptive Methods be Broadcast?"				
Characteristic	Yes	No	Don't Know	Total	No. of Cases
Total	76.0	19.2	4.8	100.0	6,376
Residence					
Tbilisi	75.4	21.8	2.8	100.0	1,431
Other urban	83.0	14.3	2.7	100.0	1,765
Rural	72.0	20.7	7.3	100.0	3,180
Marital Status					
Married	75.8	19.2	5.0	100.0	4,119
Previously married	72.2	22.0	5.7	100.0	386
Never married	77.0	18.7	4.3	100.0	1,871
Age Group					
15–19	74.8	19.5	5.7	100.0	930
20–24	79.9	15.9	4.2	100.0	1,079
25–34	80.0	16.4	3.6	100.0	2,249
35–44	70.7	23.5	5.7	100.0	2,118
Education Level					
Secondary incomplete or less	62.2	25.8	12.0	100.0	907
Secondary complete	77.6	18.1	4.2	100.0	1,786
Technicum	77.0	18.3	4.7	100.0	1,466
University/postgraduate	80.5	17.6	1.9	100.0	2,217
Socioeconomic Status					
Low	71.0	20.7	8.3	100.0	2,277
Middle	78.0	18.8	3.2	100.0	3,028
High	80.2	17.5	2.3	100.0	1,071
Employment Status					
Working	77.8	18.6	3.6	100.0	1,422
Not working	75.5	19.4	5.1	100.0	4,954
Ethnic Group					
Georgian	79.3	17.2	3.5	100.0	5,545
Azeri	33.0	39.8	27.2	100.0	292
Armenian	64.3	31.5	4.2	100.0	382
Other	77.4	18.4	4.2	100.0	157
Ever Used Any Method					
No	73.9	20.3	5.7	100.0	3,488
Yes	78.8	17.7	3.5	100.0	2,888

Chapter 12

REPRODUCTIVE HEALTH KNOWLEDGE AND OPINIONS

This chapter explores opinions about ideal family size, knowledge of the menstrual cycle and the contraceptive effect of breastfeeding, and attitudes and opinions toward induced abortion among Georgian women. The latter topic is of particular importance, since Georgia has a long tradition of relying on abortion to control fertility. The lack of widespread availability of modern contraception and relatively high use of traditional, less effective methods is largely responsible for the continued high rates of abortion and its acceptability in Georgia.

12.1 Ideal Family Size

All respondents aged 15–44 years were asked, "In your opinion, how many children in general should a young family have in Georgia?" Table 12.1 shows that 74% of respondents stated that a young family should have two or three children, with 46% favoring three children, well above the total fertility rate for Georgia. About 10% of respondents stated that a young couple should have as many children as possible, while 4% stated that a young family should have as many children as God gives.

The overall mean ideal number of children was 2.8, which is the same as was found in the 1999

Reproductive Health Survey. In 2005, there were no significant differences between urban and rural women or between age groups, nor did the figure vary according to educational attainment and SES. The only group with a mean stated ideal number of children higher than three (3.2) was women with three or more living children.

12.2 Knowledge of the Menstrual Cycle

As shown in Table 8.2.1, approximately 21% of married women use a traditional method of contraception, such as withdrawal, the rhythm method, or a combination of both. To use the rhythm method successfully, couples need to know when during the menstrual cycle a woman is most likely to get pregnant.

As shown in Table 12.2, only 48% of the respondents correctly stated that the highest risk of becoming pregnant is halfway between the two menstrual periods, compared to 44% in the 1999 survey. Level of knowledge is highest in urban areas and among ever-married women, and increases with age, educational attainment, and SES. Women residing in Imereti had the highest level of knowledge (58%) while those in Samtskhe-Javakheti and Guria reported the lowest level of knowledge on this topic (35% in each region)(Figure 12.2.1). Women aged 15–19 years, never-married women, women with no living children, women with less education, and Azeri women were less likely to know when the risk of getting pregnant was highest. Overall, 27% of respondents did not know when the risk is higher, while 9% said that a woman can get pregnant anytime during the menstrual cycle. Slightly more than one-third of all respondents fell into one of these two response categories.

Figures 12.2.2 and 12.2.3 show that the percentage of respondents who accurately knew when a woman

Figure 12.2.1 **Correct Knowledge of When a Woman is Most Likely to Become Pregnant During the Menstrual Cycle, by Region**

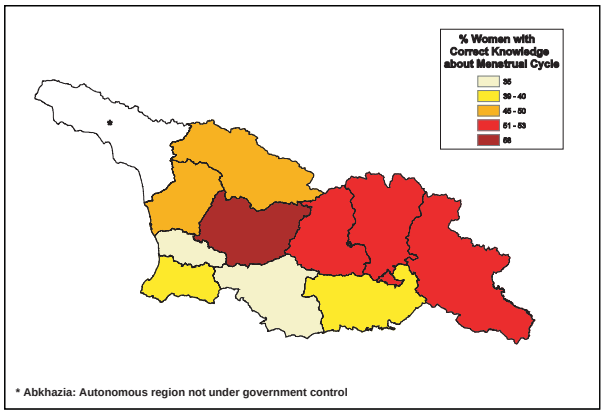


Figure 12.2.2 **Correct Knowledge of When a Woman is Most Likely to Become Pregnant During the Menstrual Cycle by Education: 1999 and 2005**

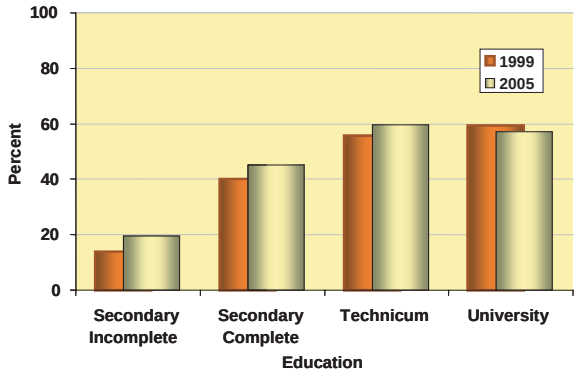
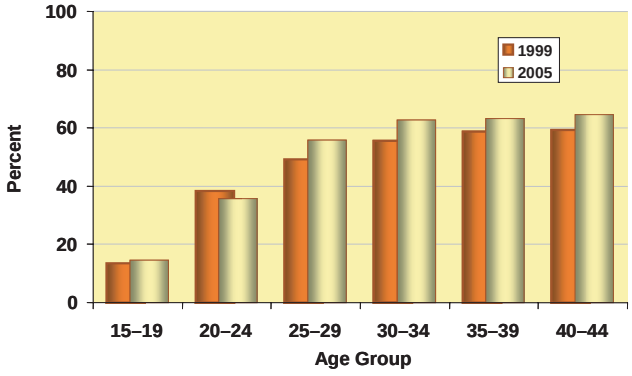


Figure 12.2.3 **Correct Knowledge of When a Woman is Most Likely to Become Pregnant During the Menstrual Cycle by Age Group: 1999 and 2005**

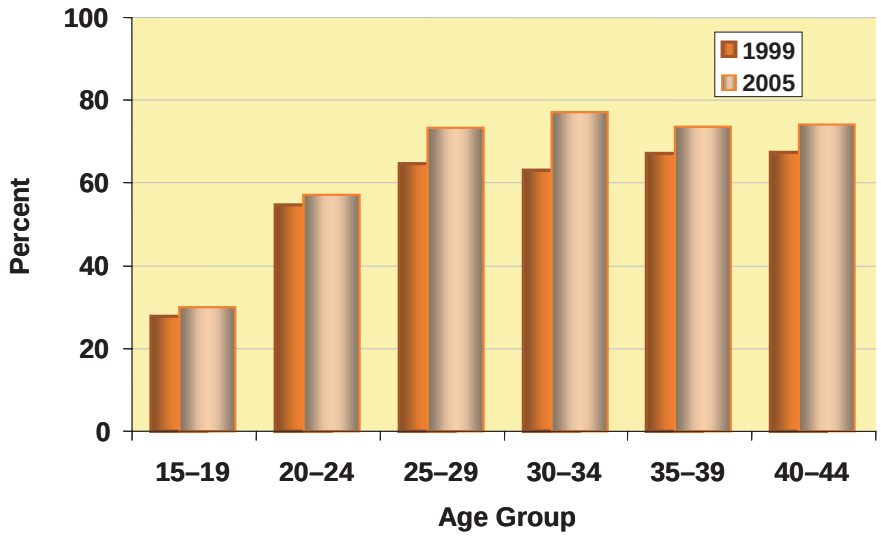


is most likely to get pregnant did not increase substantially between the 1999 and 2005 surveys for any of the educational levels and age groups shown in the figures. Disturbingly, less than 60% of women with a university-level education and less than 40% of women aged 20–24 knew when the risk of getting pregnant is highest, reflecting a need for improvements in sex education efforts.

12.3 Knowledge of the Contraceptive Effect of Breastfeeding

All respondents aged 15–44 years were asked whether breastfeeding increases, decreases or has no effect on a woman's chance of becoming pregnant. Nearly two-thirds (63%) correctly stated that there is a lower risk of getting pregnant during breastfeeding (Table 12.3). About 19% did not know what the effect of breastfeeding has on fertility, while 17% stated that it has no effect. In general, women's knowledge of the contraceptive effect of breastfeeding increased with age (Figure 12.3), number of living children, and educational attainment, but did not vary by SES. Figure 12.3 illustrates the need for more sex education, primarily among women aged 15–24 years. As shown in the table, young, never-married women with no children, as well as less educated women, are more likely to have no knowledge of the contraceptive effect of breastfeeding.

Figure 12.3 **Correct Knowledge That Breastfeeding Decreases a Woman's Chance of Becoming Pregnant by Age Group: 1999 and 2005**



12.4 Opinions on the Acceptability of Abortion

Opinions of abortion were explored by asking respondents whether "a woman should always have the right to make personal decisions about her pregnancy, including whether or not to have an abortion." Respondents who disagreed that induced abortion should be an option for pregnancy resolution under any circumstance were also asked whether an abortion should be permitted under certain circumstances (Table 12.4.1).

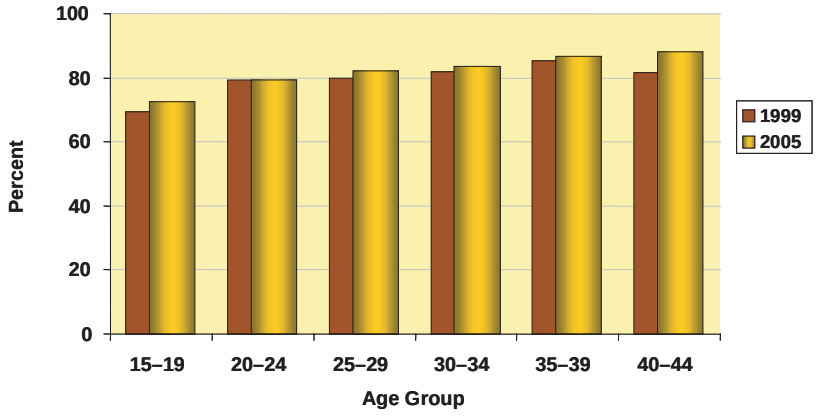
Overall, 82% of respondents aged 15–44 years agreed that a woman should always have the right to decide about her pregnancy, including resorting to abortion. Less than 2% of women opposed pregnancy termination under any circumstance, while 16% agreed with the acceptability of abortion under certain circumstances. The corresponding figures from the 1999 survey were 2.5 percentage points lower for beliefs that abortion is always acceptable (Figure 12.4.1), while beliefs that it may be acceptable only under certain circumstances were 3 percentage points higher (19% in 1999 vs. 16% in 2005).

Women who were less accepting of abortion under any circumstance included those aged 15–19 years (72%), never-married women (74%), and those living in Tbilisi (75%). The few women most likely to say that abortion is never acceptable were women aged 15–24 years (2%–3%), never married women (3%), women with no living children (3%), women with a secondary incomplete or less education (3%), and Armenian women (4%).

Figure 12.4.1 shows the percentage of women who agreed that abortion is always acceptable, by age, according to the 1999 and 2005 surveys. Between the two surveys, there was a slight increase in the acceptability of abortion in all age groups except one—20–24 year olds.

Table 12.4.2 shows the level of approval for abortion under certain circumstances among those women who said that abortion is not always acceptable. Over 75% of the women thought that life-threatening health problems of the mother and physical deformities of the fetus were considered acceptable reasons for abortion, while another 57% thought abortion was acceptable if the pregnancy would endanger a woman's health. Only one-third of the women thought abortion to be

Figure 12.4.1 **Percentage of Women Aged 15–44 Years Who Believe That Abortion is Always Acceptable by Age Group: 1999 and 2005**



acceptable when the pregnancy resulted from rape. The lowest levels of acceptability of abortion were in cases where the couple desires no children or no more children (19%), when the couple cannot afford to have a child or another child (18%) or when the pregnant woman is not married (15%).

Figure 12.4.2 shows the percentage of respondents in 1999 and in 2005 who agreed that abortion is acceptable under certain circumstances. Between the two surveys, there was a slight decrease in the acceptability of abortion for each of the circumstances discussed in the previous paragraph, with the largest decrease associated with the circumstance of pregnancy endangering a woman's health.

Acceptability of abortion under certain circumstances increases with age and number of living children (Table 12.4.3). Thus, among respondents who did not feel abortion was acceptable in all circumstances, older women and women with more children were more likely to approve of abortion under certain circumstances than younger women and women with fewer children. Interestingly, across all circumstances, university-educated women tend to be conservative on the issue of abortion, but not as conservative as women with a secondary incomplete or less education. Finally, never-married women are less likely to approve of abortion than ever-married women, whether they viewed abortion as always acceptable or acceptable under certain circumstances.

Probing further the possibility of abortion under certain circumstances, all respondents aged 15–44 years were asked, "If a woman had an unwanted pregnancy, what should she do?" As shown in Table 12.4.4, 55% of respondents said that the woman should have an abortion, while 42% said the woman should give birth and keep the baby. Only 1.4% said that the woman should give birth and give the baby up for adoption. Women less likely to mention abortion as an option included never-married women, women aged 15–24 years, and women with no living children. As mentioned previously, these three variables are highly correlated. These women favored "keeping the baby."

Figure 12.4.2 **Circumstances Under Which Abortion is Acceptable among Women Aged 15–44 Who Said That Abortion is Not Always Acceptable: 1999 and 2005**

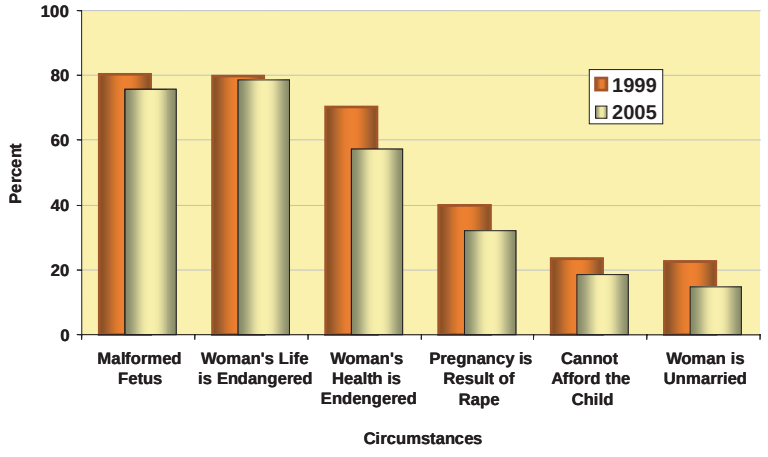
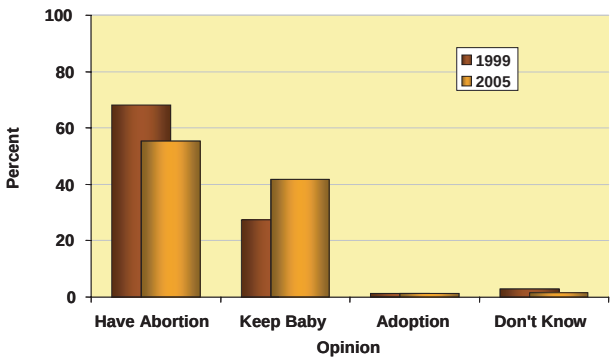


Figure 12.4.3 shows that a higher percentage of respondents in 2005 than in 1999 said that the woman should give birth and keep the baby. In contrast, a lower percentage of the 2005 respondents compared to the 1999 respondents said that the woman should have an abortion.

Figure 12.4.3 **Opinions Regarding What a Woman Should Do if a Pregnancy is Unwanted Among Women Aged 15–44 Years: 1999 and 2005**

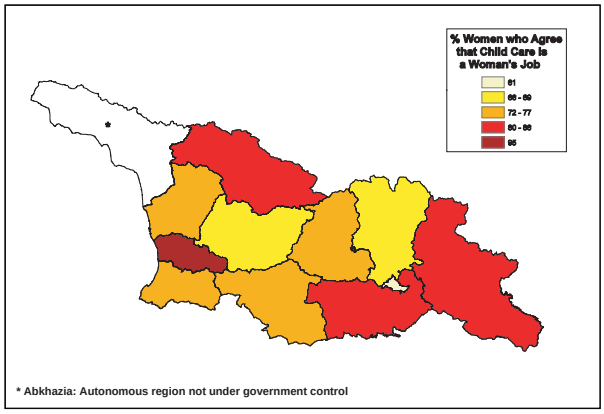


12.5 Attitudes and Opinions Toward Family and Reproductive Roles

Overall, 81.5% of respondents aged 15–44 years agreed that "all people should marry" (Table 12.5.1). Previously married women were less likely to endorse universal marriage (72%), compared to married women (84%) and never-married women (79%). Among ethnic groups, Azeri women were most likely to endorse universal marriage (91%). The biggest differences in endorsement of universal marriage were seen between women living in Tbilisi (64%) versus those outside Tbilisi (88%), and women with high SES (70%) versus women with low SES (88%).

Overall, 73% of respondents agreed that "child care is a woman's job." The subgroups of women who showed the highest rates of endorsement of this statement were women residing in Guria (Figure 12.5.1), rural women, women with three or more children, women with lower educational attainment or SES, and Azeri women.

Figure 12.5.1 **Percentage of Women Aged 15–44 Who Agreed with the Statement That "Child Care is a Woman's Job," by Region**



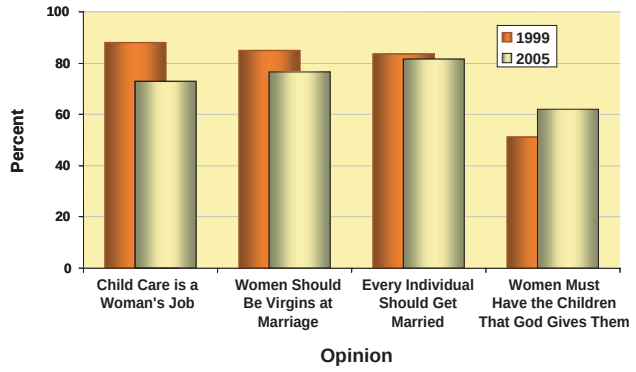
More than three-fourths of respondents (77%) agreed that "a woman must be a virgin at marriage." The highest rates of endorsement of this conservative view were among rural women (88%), women with three or more children (87%), women with the lowest level of educational attainment (88%), women of low SES (87%), and Azeri women (95%).

Over 60% of respondents agreed that "women should have as many children as God gives them." This traditional attitude is slightly more prevalent among

never-married women (64%), women aged 15–24 years (65%), women with no living children (65%), and rural women (64%).

As shown in Figure 12.5.2, a lower percentage of respondents in 2005 than in 1999 agreed that "child care is a woman's job" and that "a woman must be a virgin at marriage." In contrast, a higher percentage of the 2005 respondents compared to the 1999 respondents agreed that "women should have as many children as God gives them." Agreement with the statement "all people should marry" did not change significantly.

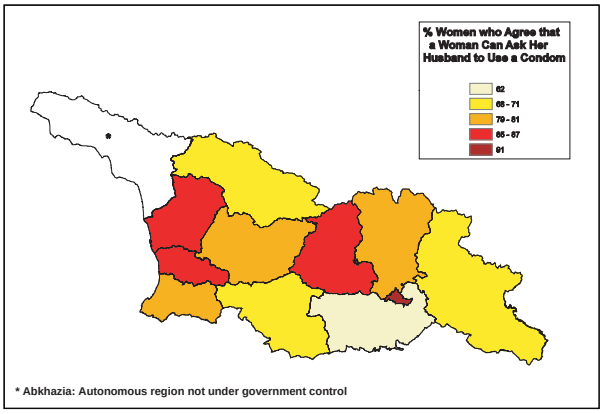
Figure 12.5.2 **Agreement with Various Statements on Reproductive Norms Among Women Aged 15–44 Years: 1999 and 2005**



Three new opinion questions (on risk of pregnancy at first intercourse, refusal of sex if a husband has an STI, and acceptability of asking a husband to use a condom if he has an STI), were added to the 2005 survey. As shown on the right panel of Table 12.5.1, the vast majority of respondents (89%) agreed that "a woman can become pregnant the first time she has sexual intercourse." The subgroups of women least likely to agree with this statement were those with a secondary incomplete or lower education (78%).

A majority of respondents also agreed that "a woman can refuse sex with her husband if he has an STI" (85%) and that "a woman can ask her husband to use a condom when they have sex if he has an STI" (80%). Never-married women, women aged 15–24 years, women with a secondary incomplete or less education, and Azeri women were the least likely to agree with these two statements. Almost all women residing in Tbilisi (91%) agreed that "a woman can ask her husband to use a condom…", whereas only 62% of women in Kvemo-Kartli agreed with this statement (Figure 12.5.3).

Figure 12.5.3 **Percentage of Women Aged 15–44 Who Agreed that "a Woman Can Ask Her Husband to Use a Condom if He Has an STI," by Region**



Finally, respondents aged 15–44 years were asked, "Who do you think should decide how many children a couple should have?" The vast majority of respondents (92%) said that the man and the woman should make that decision jointly (Table 12.5.2).

Table 12.1 Opinions Regarding the Ideal Number of Children for a Young Family in Georgia by Selected Characteristics Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Ideal Number of Children (Percentage Distribution)										Mean No. of Children	
Characteristic	0–1	2	3	4	5 or More	As Many as God Gives	As Many as Possible	Not Sure	Total	No. of Cases	Mean	No. of Cases*
Total	1.2	28.1	46.0	9.0	1.1	3.9	9.5	1.1	100.0	6,376	2.8	5,398
Residence												
Tbilisi	1.9	26.8	47.2	9.7	1.3	3.8	9.2	0.1	100.0	1,431	2.8	1,244
Other urban	1.3	31.0	43.6	8.6	0.9	4.7	9.3	0.6	100.0	1,765	2.7	1,472
Rural	0.8	27.2	46.7	8.8	1.2	3.5	9.7	2.0	100.0	3,180	2.8	2,682
Marital Status												
Married	1.0	27.0	48.7	9.0	1.3	3.0	9.5	0.5	100.0	4,119	2.8	3,541
Previously married	2.6	25.0	47.5	10.3	1.3	2.6	10.4	0.3	100.0	386	2.8	332
Never married	1.4	30.5	41.0	8.8	0.9	5.9	9.3	2.2	100.0	1,871	2.7	1,525
Age Group												
15–19	0.8	34.7	39.6	8.3	0.9	5.0	7.6	3.1	100.0	930	2.7	772
20–24	1.4	32.1	45.6	7.6	1.1	2.9	8.1	1.1	100.0	1,079	2.7	937
25–34	1.6	27.7	47.5	7.3	0.7	4.0	10.3	0.9	100.0	2,249	2.7	1,896
35–44	1.0	22.7	48.4	11.8	1.7	3.9	10.5	0.2	100.0	2,118	2.9	1,793
Number of Living Children												
0	1.4	30.1	42.1	8.3	0.8	6.1	9.1	2.1	100.0	2,299	2.7	1,871
1	2.2	33.1	46.8	5.5	0.9	2.4	8.9	0.2	100.0	1,131	2.7	989
2	0.6	31.0	46.0	8.8	0.8	1.9	10.4	0.5	100.0	2,168	2.8	1,873
3 or more	0.7	8.2	57.7	16.5	3.3	3.6	9.5	0.6	100.0	778	3.2	665
Education Level												
Secondary incomplete or less	0.8	28.0	42.5	9.1	1.1	4.2	10.0	4.3	100.0	907	2.8	725
Secondary complete	1.2	29.3	45.0	9.7	1.4	3.4	9.0	1.0	100.0	1,786	2.8	1,535
Technicum	1.2	28.0	47.5	8.9	1.1	3.0	10.0	0.3	100.0	1,466	2.8	1,252
University/postgraduate	1.5	27.5	47.4	8.5	0.9	4.8	9.3	0.2	100.0	2,217	2.8	1,886
Socioeconomic Status												
Low	1.0	28.3	46.5	9.1	1.4	4.1	8.6	1.2	100.0	2,277	2.8	1,942
Middle	1.3	28.1	45.5	9.1	1.1	3.6	10.1	1.2	100.0	3,028	2.8	2,549
High	1.5	27.9	46.3	8.7	0.8	4.5	9.7	0.7	100.0	1,071	2.8	907
Ethnic Group												
Georgian	1.3	27.8	46.5	8.8	1.1	4.2	9.6	0.7	100.0	5,545	2.8	4,702
Azeri	0.3	27.2	44.3	13.7	2.3	3.1	4.2	4.8	100.0	292	2.9	259
Armenian	0.7	30.5	41.0	6.6	1.1	2.6	12.9	4.5	100.0	382	2.7	296
Other	2.0	36.8	41.0	10.0	0.3	0.2	9.0	0.6	100.0	157	2.7	141

* Excludes 978 women who gave non-numeric answers.

Table 12.2 Opinions Regarding When a Woman is most Likely to Become Pregnant During Her Menstrual Cycle by Selected Characteristics Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	When is a Woman Most Likely to Become Pregnant? (Percent Distribution)							
Characteristic	Just Before Her Period Starts	During Her Period	Right After the Period Ends	Halfway Between Her Periods	Anytime	Don't Know	Total	No. of Cases
Total	1.9	0.4	14.0	48.2	8.7	26.7	100.0	6,376
Residence								
Tbilisi	2.3	0.4	17.7	52.9	8.7	18.0	100.0	1,431
Other urban	2.3	0.6	15.0	49.5	7.5	25.2	100.0	1,765
Rural	1.5	0.3	11.2	44.7	9.5	32.8	100.0	3,180
Marital Status								
Married	2.0	0.6	14.4	61.6	7.8	13.7	100.0	4,119
Previously married	1.2	0.0	16.8	59.3	7.8	14.8	100.0	386
Never married	2.0	0.2	12.9	23.6	10.5	50.9	100.0	1,871
Age Group								
15–19	2.1	0.3	10.6	14.6	12.7	59.6	100.0	930
20–24	2.0	0.3	16.8	35.8	12.2	32.8	100.0	1,079
25–34	2.1	0.5	15.0	59.1	7.0	16.3	100.0	2,249
35–44	1.7	0.5	13.5	63.9	6.2	14.3	100.0	2,118
Number of Living Children								
0	2.1	0.4	13.3	27.1	10.1	47.1	100.0	2,299
1	1.7	0.2	16.4	61.4	9.4	11.0	100.0	1,131
2	2.0	0.7	14.4	65.2	6.7	11.0	100.0	2,168
3 or more	1.7	0.3	12.5	59.5	8.4	17.7	100.0	778
Education Level								
Secondary incomplete or less	1.7	0.0	9.2	19.5	14.3	55.2	100.0	907
Secondary complete	2.0	0.5	14.9	45.1	9.2	28.2	100.0	1,786
Technicum	2.0	0.5	15.0	59.6	6.5	16.5	100.0	1,466
University/postgraduate	1.9	0.5	14.9	57.1	7.1	18.3	100.0	2,217
Socioeconomic Status								
Low	1.4	0.2	12.3	41.4	9.1	35.6	100.0	2,277
Middle	2.2	0.6	15.1	49.6	8.6	24.0	100.0	3,028
High	2.4	0.5	14.3	57.5	8.4	16.9	100.0	1,071
Ethnic Group								
Georgian	2.0	0.5	14.7	50.8	7.4	24.6	100.0	5,545
Azeri	1.8	0.0	9.1	18.1	19.9	51.2	100.0	292
Armenian	1.2	0.0	7.6	33.2	20.0	38.0	100.0	382
Other	1.8	0.0	15.1	54.9	6.5	21.7	100.0	157

Table 12.3 Opinions Regarding Whether Breastfeeding Increases, Decreases, or Has No Effect on a Woman's Chances of Becoming Pregnant by Selected Characteristics Among Women Aged 15-44 Years Reproductive Health Survey: Georgia, 2005

	How Does Breastfeeding Affect a Woman's Chance of Getting Pregnant? (Percent Distribution)					
Characteristic	Increases the Chance	Decreases the Chance	Has No Effect	Don't Know	Total	No. of Cases
Total	1.0	63.1	17.1	18.8	100.0	6,376
Residence						
Tbilisi	2.1	59.3	22.3	16.4	100.0	1,431
Other urban	0.9	67.5	14.2	17.5	100.0	1,765
Rural	0.4	62.8	15.9	21.0	100.0	3,180
Marital Status						
Married	1.1	76.1	16.4	6.4	100.0	4,119
Previously married	0.3	72.3	18.0	9.4	100.0	386
Never married	0.9	39.5	18.1	41.5	100.0	1,871
Age Group						
15-19	0.4	30.0	17.5	52.1	100.0	930
20-24	1.3	57.2	20.1	21.3	100.0	1,079
25-34	1.0	75.2	14.5	9.3	100.0	2,249
35-44	1.1	73.9	17.7	7.3	100.0	2,118
Number of Living Children						
0	1.0	41.8	18.1	39.0	100.0	2,299
1	1.3	76.1	17.2	5.5	100.0	1,131
2	0.8	79.6	15.5	4.1	100.0	2,168
3 or more	1.2	76.4	17.6	4.9	100.0	778
Education Level						
Secondary incomplete or less	0.3	38.2	18.3	43.2	100.0	907
Secondary complete	1.0	66.4	16.8	15.8	100.0	1,786
Technicum	0.9	73.0	15.4	10.7	100.0	1,466
University/postgraduate	1.4	66.2	17.8	14.6	100.0	2,217
Socioeconomic Status						
Low	0.2	61.1	16.5	22.2	100.0	2,277
Middle	1.1	64.9	16.9	17.2	100.0	3,028
High	2.2	62.6	18.8	16.3	100.0	1,071
Ethnic Group						
Georgian	1.1	64.5	17.1	17.3	100.0	5,545
Azeri	0.3	47.3	16.1	36.3	100.0	292
Armenian	0.0	57.4	17.3	25.3	100.0	382
Other	1.8	61.2	19.6	17.4	100.0	157

Table 12.4.1 Opinions Regarding the Acceptability of Abortion by Selected Characteristics Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

Characteristic	Acceptability of Abortion (Percent Distribution)				Total	No. of Cases
	Always Acceptable	Acceptable Under Certain Circumstances	Never Acceptable	Don't Know		
Total	81.7	15.9	1.8	0.6	100.0	6,376
Residence						
Tbilisi	74.9	23.3	1.8	0.1	100.0	1,431
Other urban	84.4	13.4	1.8	0.5	100.0	1,765
Rural	84.2	13.1	1.7	1.0	100.0	3,180
Age Group						
15-19	72.4	22.8	3.3	1.5	100.0	930
20-24	79.3	17.7	2.4	0.5	100.0	1,079
25-34	82.8	15.4	1.2	0.6	100.0	2,249
35-44	87.3	11.6	1.0	0.1	100.0	2,118
Marital Status						
Married	86.5	12.0	1.3	0.2	100.0	4,119
Previously married	80.6	18.1	0.8	0.4	100.0	386
Never married	73.8	22.3	2.7	1.3	100.0	1,871
Number of Living Children						
0	74.0	22.3	2.7	1.1	100.0	2,299
1	83.0	14.8	1.8	0.3	100.0	1,131
2	88.0	11.0	0.7	0.3	100.0	2,168
3 or more	90.3	8.5	1.2	0.0	100.0	778
Education Level						
Secondary incomplete or less	78.6	16.5	2.5	2.3	100.0	907
Secondary complete	84.8	13.1	1.7	0.4	100.0	1,786
Technicum	85.8	13.2	0.9	0.1	100.0	1,466
University/postgraduate	78.3	19.5	2.0	0.2	100.0	2,217
Socioeconomic Status						
Low	83.1	13.9	1.9	1.2	100.0	2,277
Middle	81.7	16.1	1.9	0.3	100.0	3,028
High	79.3	19.1	1.3	0.3	100.0	1,071
Ethnic Group						
Georgian	81.8	16.2	1.6	0.3	100.0	5,545
Azeri	79.7	12.5	2.0	5.8	100.0	292
Armenian	81.0	15.5	3.6	0.0	100.0	382
Other	83.7	14.0	2.3	0.0	100.0	157

Table 12.4.2 Acceptability of Abortion Under Selected Circumstances Among Women Aged 15–44 Years Who Do Not Believe That Abortion Is Always Acceptable (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

Circumstance	Acceptable	Not Acceptable	Depends	Don't Know	Total	No. of Cases
If pregnancy endangers woman's life	78.5	14.6	3.3	3.5	100.0	1,098
If the child might be born deformed	75.8	16.5	3.7	4.1	100.0	1,098
If pregnancy endangers woman's health	57.2	28.1	10.5	4.2	100.0	1,098
If pregnancy resulted from rape	32.1	47.8	9.2	10.9	100.0	1,098
If the couple desires no (more) children	19.2	67.5	5.6	7.7	100.0	1,098
If the couple cannot afford to have a(nother) child	18.4	67.6	6.6	7.4	100.0	1,098
If the woman is not married	14.8	70.1	6.1	8.9	100.0	1,098

Table 12.4.3 Circumstances Under Which It Is Acceptable for a Woman to Have an Abortion by Selected Characteristics Among Women Aged 15–44 Years Who Do Not Believe That Abortion Is Always Acceptable
Reproductive Health Survey: Georgia, 2005

	Circumstances Under Which It Is Acceptable for a Woman to Have an Abortion							
Characteristic	Woman's Life Endangered %	Fetus Deformed %	Woman's Health Endangered %	Pregnancy Resulted From Rape %	Desires No (More) Children %	Cannot Afford Child %	Woman Unmarried %	No. of Cases
Total	78.5	75.8	57.2	32.1	19.2	18.4	14.8	1,098
Residence								
Tbilisi	80.9	78.4	61.4	30.5	25.0	19.7	10.8	340
Other urban	79.5	77.0	54.5	34.0	18.7	21.7	15.5	266
Rural	75.7	72.5	54.8	32.5	14.0	15.1	18.3	492
Age Group								
15–24	74.8	70.9	52.1	27.6	12.5	12.0	12.8	458
25–34	80.6	79.7	60.5	34.1	21.6	22.3	16.3	365
35–44	83.8	81.1	63.8	39.2	30.2	27.0	17.4	275
Marital Status								
Married	80.9	79.4	61.4	35.7	24.2	24.5	19.1	568
Previously married	86.6	85.8	61.1	42.6	31.0	27.9	8.9	69
Never married	75.5	71.3	53.0	27.7	13.3	11.8	11.8	461
Number of Living Children								
0	75.6	72.0	53.2	27.8	13.0	11.5	12.2	566
1	80.5	78.3	59.9	37.7	24.4	24.0	14.3	192
2	83.9	81.9	62.2	37.1	27.3	27.8	20.4	262
3 or more	83.9	84.6	70.8	42.0	37.5	38.5	23.0	78
Education Level								
Secondary incomplete or less	69.0	67.4	46.2	28.1	7.2	10.2	15.6	181
Secondary complete	76.4	74.7	52.9	32.5	18.8	19.2	17.6	263
Technicum	85.5	80.6	66.9	42.9	26.9	26.0	17.8	200
University/postgraduate	81.3	78.3	60.8	29.5	21.8	18.7	11.8	454
Socioeconomic Status								
Low	76.1	74.0	57.8	36.6	16.6	17.8	20.7	382
Middle	78.7	75.3	57.0	31.6	20.0	19.7	14.3	506
High	81.8	79.6	56.6	26.4	21.4	16.5	7.2	210
Ethnic Group								
Georgian	80.3	78.1	58.2	32.2	19.9	19.5	13.1	949
Azeri	47.7	51.9	42.0	26.9	17.2	10.4	29.2	54
Armenian	79.9	65.7	59.4	39.4	7.7	12.7	28.6	70
Other	86.0	71.3	50.4	23.9	25.5	10.8	10.6	25

Table 12.4.4 Opinions Regarding What a Woman Should Do If She Has an Unwanted Pregnancy by Selected Characteristics Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	What Should a Woman Do If She Has an Unwanted Pregnancy? (Percent Distribution)					
Characteristic	Have an Abortion	Give Birth and Keep the Baby	Give Birth and Give the Baby Up for Adoption	Don't Know	Total	No. of Cases
Total	55.3	41.7	1.4	1.6	100.0	6,376
Residence						
Tbilisi	55.9	40.6	2.7	0.8	100.0	1,431
Other urban	53.6	43.8	1.2	1.4	100.0	1,765
Rural	56.0	40.9	0.8	2.2	100.0	3,180
Marital Status						
Married	64.4	33.6	1.1	0.8	100.0	4,119
Previously married	62.0	36.6	0.6	0.8	100.0	386
Never married	38.6	56.3	2.1	3.1	100.0	1,871
Age Group						
15-24	43.4	52.1	1.7	2.9	100.0	2,009
25-34	59.1	38.4	1.4	1.1	100.0	2,249
35-44	65.0	33.1	1.2	0.7	100.0	2,118
Number of Living Children						
0	38.3	56.7	2.2	2.8	100.0	2,299
1	58.4	39.4	0.9	1.3	100.0	1,131
2	69.9	28.6	0.8	0.6	100.0	2,168
3 or more	71.5	26.6	1.1	0.8	100.0	778
Education Level						
Secondary incomplete or less	48.7	45.4	1.3	4.7	100.0	907
Secondary complete	57.1	40.5	1.4	1.1	100.0	1,786
Technicum	63.5	34.4	1.3	0.7	100.0	1,466
University/postgraduate	51.9	45.2	1.6	1.2	100.0	2,217
Socioeconomic Status						
Low	56.0	40.2	1.1	2.7	100.0	2,277
Middle	54.6	42.7	1.6	1.1	100.0	3,028
High	55.7	41.7	1.7	1.0	100.0	1,071
Ethnic Group						
Georgian	54.0	43.2	1.6	1.2	100.0	5,545
Azeri	60.1	30.9	0.3	8.7	100.0	292
Armenian	68.3	30.1	0.0	1.6	100.0	382
Other	63.1	34.4	0.0	2.5	100.0	157

Table 12.5.1 Agreement with Selected Statements on Gender and Reproductive Norms by Selected Characteristics Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Agreement With Statements on Gender and Reproductive Norms							
Characteristic	All People Should Marry %	Women Must be Virgins at Marriage %	Child Care is a Woman's Job %	Women Must Have the Children That God Gives Them %	A Woman Can Get Pregnant at First Sex %	A Woman Can Refuse Sex if Her Husband Has an STI %	A Woman Can Ask Her Husband to Use a Condom if He Has an STI %	No. of Cases
Total	81.5	76.6	72.8	62.1	89.3	85.4	80.4	6,376
Residence								
Tbilisi	64.0	52.7	61.1	58.8	90.1	92.8	90.8	1,431
Other urban	87.9	80.9	71.1	61.8	90.2	88.0	84.8	1,765
Rural	87.9	88.1	80.8	64.2	88.2	79.3	71.5	3,180
Marital Status								
Married	83.7	79.7	75.2	60.8	93.6	91.5	86.0	4,119
Previously married	71.9	59.5	74.2	62.2	94.3	92.5	87.1	386
Never married	79.4	74.1	68.4	64.4	81.1	73.8	69.7	1,871
Age Group								
15–24	83.0	78.2	72.8	64.8	82.9	74.9	70.2	2,009
25–34	80.0	71.9	71.1	60.9	92.6	90.8	85.7	2,249
35–44	81.2	79.2	74.3	60.2	93.2	92.0	86.8	2,118
Number of Living Children								
0	80.0	73.9	69.5	65.1	81.9	76.6	72.5	2,299
1	77.6	67.7	70.2	62.5	94.1	92.9	89.8	1,131
2	83.1	80.6	74.6	58.2	94.6	91.2	86.1	2,168
3 or more	87.6	87.2	82.6	61.3	94.1	90.3	80.5	778
Education Level								
Secondary incomplete or less	85.3	88.0	82.5	64.6	78.2	60.6	52.5	907
Secondary complete	85.4	82.9	77.5	64.1	90.6	86.0	79.4	1,786
Technicum	83.6	82.3	70.2	57.8	92.4	90.9	86.3	1,466
University/postgraduate	75.4	62.8	66.1	62.0	91.5	93.1	90.7	2,217
Socioeconomic Status								
Low	88.2	86.9	81.0	65.6	90.3	79.8	71.2	2,277
Middle	81.2	76.4	71.1	60.5	87.9	86.8	82.7	3,028
High	69.8	58.3	62.0	59.8	90.6	92.1	91.7	1,071
Ethnic Group								
Georgian	81.3	75.3	71.2	63.4	89.7	88.4	84.6	5,545
Azeri	91.1	94.6	91.6	63.6	85.8	41.0	24.5	292
Armenian	75.8	83.8	82.3	43.7	82.5	78.5	66.5	382
Other	78.7	67.5	69.4	52.1	97.2	89.0	82.5	157

Table 12.5.2 Opinions Regarding Who Should Decide How Many Children a Couple Will Have by Selected Characteristics Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	Who Should Decide How Many Children a Couple Will Have? (Percent Distribution)					
Characteristic	The Woman	The Man	Both	Don't Know	Total	No. of Cases
Total	5.5	1.9	92.1	0.5	100.0	6,376
Residence						
Tbilisi	4.8	0.8	94.0	0.4	100.0	1,431
Other urban	5.2	1.0	93.3	0.5	100.0	1,765
Rural	6.1	3.0	90.3	0.7	100.0	3,180
Marital Status						
Married	5.2	2.0	92.4	0.4	100.0	4,119
Previously married	8.3	0.8	90.9	0.0	100.0	386
Never married	5.5	1.8	91.8	0.9	100.0	1,871
Age Group						
15–24	4.8	2.3	92.1	0.8	100.0	2,009
25–34	6.1	1.6	91.9	0.4	100.0	2,249
35–44	5.7	1.7	92.3	0.4	100.0	2,118
Number of Living Children						
0	5.5	1.9	91.8	0.9	100.0	2,299
1	6.2	1.7	91.8	0.3	100.0	1,131
2	5.6	1.6	92.5	0.3	100.0	2,168
3 or more	4.2	2.6	92.9	0.3	100.0	778
Education Level						
Secondary incomplete or less	5.0	4.0	88.9	2.1	100.0	907
Secondary complete	5.1	2.2	92.4	0.2	100.0	1,786
Technicum	5.9	1.1	92.6	0.4	100.0	1,466
University/postgraduate	5.7	1.0	93.1	0.2	100.0	2,217
Socioeconomic Status						
Low	5.1	3.0	91.1	0.8	100.0	2,277
Middle	6.0	1.3	92.3	0.4	100.0	3,028
High	5.0	1.1	93.4	0.5	100.0	1,071
Ethnic Group						
Georgian	5.8	1.2	92.6	0.4	100.0	5,545
Azeri	1.4	13.5	82.0	3.2	100.0	292
Armenian	2.9	2.8	93.5	0.9	100.0	382
Other	7.3	0.0	92.7	0.0	100.0	157

Chapter 13

WOMEN'S HEALTH

Despite recent advancements in prevention, diagnosis, and treatment, gynecologic malignancies continue to be a leading cause of death in women of reproductive age in both the developed and developing world. Among reproductive-system cancers, breast and cervical cancers are the most common. A substantial proportion of these cancers in Eastern Europe are detected at an advanced and incurable stage as a result of lack of services; women's lack of awareness or reluctance to access preventive care services; provider's lack of interest, time, or expertise for health promotion; and a health system that generally allocates its limited resources to curative care rather than prevention. For cancer therapy to be highly effective, diagnosis and treatment must start early.

Generally, Eastern European women face barriers to preventive health services, primarily a lack of awareness about screening tests and failure on the part of health providers to recommend the tests. Among the range of preventive services, access to routine gynecologic exams and cervical cancer screening is particularly deficient.

Tobacco and alcohol use are also serious and growing health risks for women in Eastern Europe. A recent worldwide review estimated that smoking prevalence was highest in Europe and Central Asia, (53% among men and 16% among women). Globally, among female smokers aged 15–49 years, more than 40% young adults (Jha et al., 2002). In addition to lung cancer and cardiovascular diseases, smoking poses specific risks to women, including increased risk of cervical cancer and, among older women, increased risk for heart disease associated with taking the

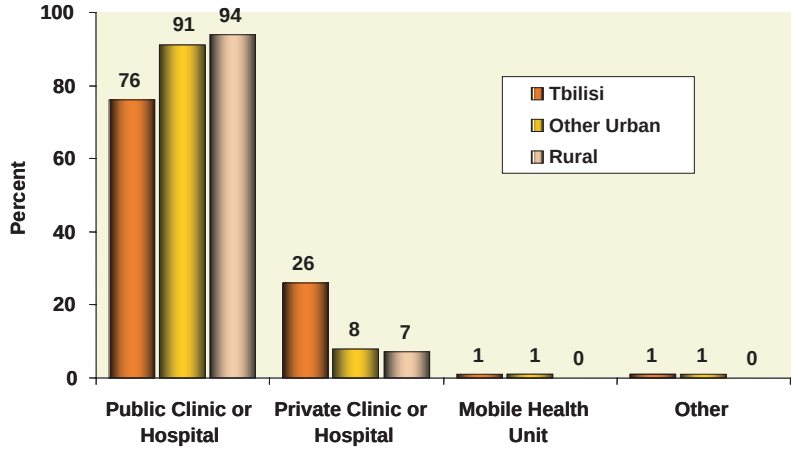
contraceptive pill. It also affects women's reproductive health by increasing the risk of early menopause, miscarriage, and low birth-weight babies. Women are more sensitive than men to the toxic effects of alcohol because gender differences in body structure and chemistry cause women to absorb more alcohol and take longer to break it down and remove (Ashley et al., 1977; Urbano-Marquez et al., 1995). In addition to more pronounced toxicity to the liver, brain, and heart, excessive drinking in women is associated with specific reproductive health problems (e.g., disruption of menstrual cycling, increased risk of infertility, miscarriage, stillbirth, premature delivery, and birth defects, and a linear increase in breast cancer incidence) and with other high-risk behaviors, such as having unprotected sex and multiple sexual partners (Naimi et al., 2003a; Smith-Warner et al., 1998; Wilsnack et al., 1984).

To examine these health issues, the GERHS05 included questions regarding recent preventive health practices (including routine gynecologic exams, breast self-exam, and cervical cancer screening), other health behaviors (i.e., cigarette smoking and alcohol use), and self reported health conditions.

13.1 Utilization of Health Care Services

The interaction between client and health provider is an important opportunity for health promotion and disease prevention. During patient encounters, health care providers can provide general health counseling and advice for risk behavior change. Patients' attitudes and behaviors regarding health care visits are important determinants of whether they receive health counseling and routine screening, including cervical and breast cancer screening. The GERHS05 included a series of questions that explored health care-seeking behaviors and barriers to health care among women of childbearing age. Only one in four respondents reported that they had visited a health care facility (either for treatment or for preventive services, including family planning) during the 12 months preceding the interview (Table 13.1.1). Of those who had at least one health visit, the majority (88%) attended governmental health clinics (either ambulatory clinics or hospitals). Only 13% of women with recent health visits obtained care in the private sector, and less than 1% obtained care from mobile health units (Figure 13.1.1). Urban residents, including

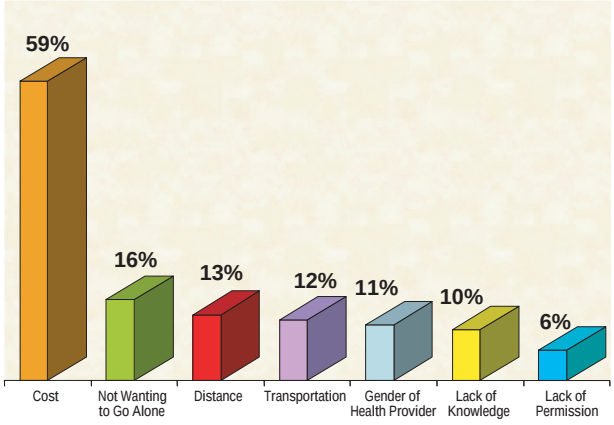
Figure 13.1.1 **Type of Health Care Facility Visited by Residence?Among Women Aged 15–44 Years Who Had Used Medical Care in the Past Year**



those residing in Tbilisi, and women aged 25–34 years (the group with the highest demand for both antenatal care and family planning services) were more likely to seek health care. Likelihood of a health visit in the past 12 months increased directly with respondent SES and was lowest for women with secondary incomplete or lower education level.

More than half of respondents (59%) reported that the cost of health care services was the most important deterrent in seeking health care for either preventive or curative purposes (Table 13.1.2 and Figure 13.1.2). Not wanting to go alone, distance to the health facility, gender of the health care provider, and lack of transportation were other important self-perceived barriers to health care. There were no important differences among those who reported having or not having health care visits in the past 12 months.

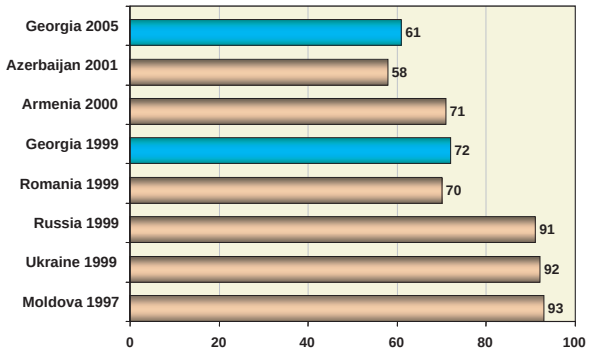
Figure 13.1.2 **Most Commonly Cited Barriers to Medical Care Among Women Aged 15–44**



13.2 Prevalence of Routine Gynecologic Visits

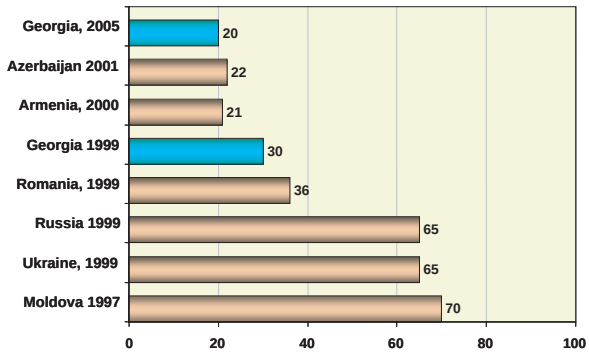
In the United States and Western Europe, women are recommended to have a routine gynecologic examination every year after age 18, or starting earlier if the woman is sexually experienced. In several countries of Eastern Europe and the Caucasus region, a substantial proportion of sexually experienced women reported that they had never had routine gynecologic exams, or they had not had such exams in the last 12 months. Prevalence of routine exams within the last year was higher in Eastern Europe (with the exception of Romania) than in the Caucasus region (Figures 13.2.1 and 13.2.2). Surveys conducted in the early 2000s showed that the Caucasus region had particularly low rates of recent exams: 21% in Armenia, 22% in Azerbaijan, and 30% in Georgia. The most recent survey in Georgia showed a further decline in routine gynecologic exams in Georgia from 30% in 1999 to 20% in 2005. Given that screening for cervical and breast cancer is generally provided or prescribed during routine gynecologic visits, a low

Figure 13.2.1 **Prevalence of Routine Gynecologic Visits Among Sexually Experienced Women Aged 15–44 Years: Selected Countries in Eastern Europe***



* Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eu rasia: A Comparative Report*

Figure 13.2.2 **Prevalence of Routine Gynecologic Visits during the Past Year among Sexually Experienced Women Aged 15–44 Years Selected Countries in Eastern Europe***



* Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eu rasia: A Comparative Report*

frequency of such visits will inevitably have an impact on early detection and treatment of gynecologic cancers. The low prevalence of routine gynecologic exams also has a substantial negative effect on family planning counseling and health education.

Rural residents, young adult women (aged 15–24 years), those with lower levels of educational attainment, those with low SES, and Azeri women were least likely to have had preventive gynecologic exams (Table 13.2). Women using a modern method of contraception were more likely to have had a gynecologic exam than nonusers.

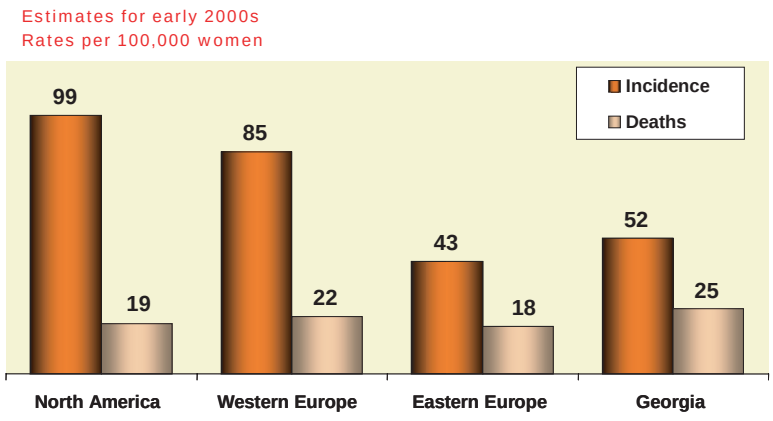
Routine gynecologic exams are recommended for all women of reproductive age, and preventive screening practices (e.g., pap smear tests and counseling for breast self-exams), as well as counseling for family planning and STD prevention, should be part of these exams. Survey findings show that health exams are not performed routinely, if they are performed at all, and annual rates of screening are quite low. Sustained public education campaigns and changes in health care provider practices (e.g., more emphasis on preventive than curative approaches) are essential steps in reducing death and disability associated with gynecologic cancers and with health risk behaviors.

13.3 Breast Self-examination

Each year, over a million women worldwide are diagnosed with breast cancer. Breast cancer is the most common cancer among women, representing 21% of all female cancers (Parkin et al., 2001). The age-standardized incidence rate of reported new cases of breast cancer in Georgia for 1998–2000 (51.8 new cases per 100,000 women) is slightly higher than the Eastern Europe average, but it is lower than the average in North America, the region with the highest incidence rate in the world (Ferlay et al., 2004) (Figure 13.3.1). Notably, although there are almost twice as many detected cases of breast cancer in North America as in Georgia, only one-fifth of cases are fatal, compared to about half in Georgia. According to the National Center for Disease Control, the crude breast cancer incidence rates in Georgia increased between 2000 and 2004 by 36%. At the end of 2004, 7,892 women were living with breast cancer, including 4,036 (51%) who had been diagnosed with the disease for at least 5 years (NCDC, 2006).

Age-standardized mortality in Georgia, at 25.1 deaths from cancer per 100,000 women, is slightly higher than in industrialized countries, reflecting high rates of delayed detection and treatment. Although mortality

Figure 13.3.1 **Breast Cancer Incidence and Mortality, by Region**



Note: Rates are age-standardized, meaning they permit international comparison in spite of varying age structures.
Source: J. Ferlay et al., International Agency for Research on Cancer, World Health Organization, GLOBOCAN 2002 Database, 2004.

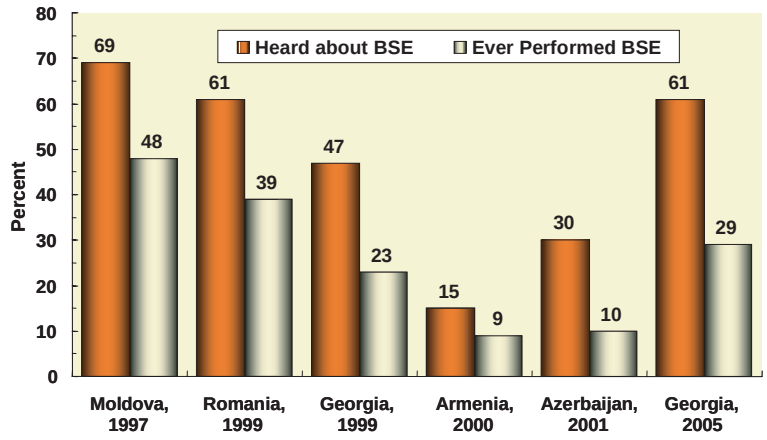
due to breast cancer has remained relatively stable in the industrialized countries, the mortality rate in Georgia has recently been on the rise (NCDC, 2006).

Currently available practices for detecting breast cancer include breast self-examination (BSE), clinical breast examination (CBE), and mammography, which is the most effective way to detect breast cancer in its earliest, most treatable stage. BSE is a very simple self-care procedure that can detect early modifications of the breast and can be performed by women in the privacy of their homes after minimal instruction. The American Cancer Society recommends monthly BSE for women after age 20 as a supportive detection system to be used in conjunction with clinical breast examinations and mammography (American Cancer Society, 2005). The purpose of BSE is to facilitate health awareness and detection of changes in the breast over time. Appropriate follow-up by a physician should be made available and accessible to women who detect breast changes through self-examination.

GERHS05 assessed levels of awareness about BSE and how often respondents performed BSE. Overall, 61% of sexually experienced women in Georgia had ever heard about this technique, but only 29% had ever performed BSE (Table 13.3). Awareness of BSE was higher among urban than rural residents and among women in Tbilisi and in Mtskheta-Mtianeti; it increased with age, educational attainment, and SES. Awareness of BSE was higher among women who underwent routine gynecological exams than among those who had never made such visits. It was also higher among women who use modern contraception. Levels of both awareness and practice of BSEs were lower in Georgia than in other countries in Eastern Europe, but higher than in Azerbaijan and Armenia, where women were also least likely to be aware of or to practice BSE (Figure 13.3.2).

Similar results were documented by a Knowledge, Attitudes, and Practices (KAP) survey on breast cancer conducted by John Snow International (JSI) in 2002 in the Imereti region (Berdzuli, 2003). The KAP study found that 71% of women aged 30-65 years had never done BSE, and 77% had never had CBE performed by health care provider. Virtually all women interviewed (96%) had never had a mammogram and most of them (67%) claimed they had never been advised by a health care provider to get a mammogram. JSI used study findings to design educational and behavior change interventions among women and health care providers to improve breast cancer awareness and early detection practices in the region.

Figure 13.3.2 **Awareness and Experience with Breast Self-Exam (BSE) Among Sexually Experienced Women Aged 15–44 Years: Selected Countries in Eastern Europe***



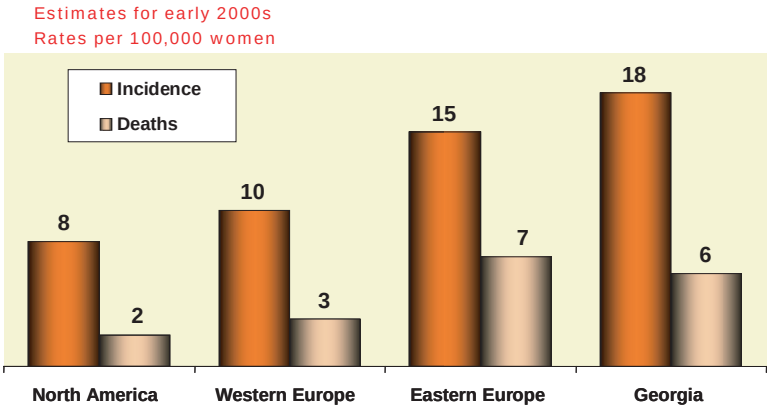
•Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report;*

13.4 Cervical Cancer Screening

Cervical cancer is the second most common cancer of women, with over 493,000 new cases diagnosed each year worldwide (Ferlay et al., 2004). The major risk factors for cervical cancer include early age at initiation of sexual activity, multiple sexual partners, infection with human papillomavirus (HPV), and cigarette smoking. Both the age-adjusted incidence (17.5 new cases of cervical cancer per 100,000 women) and the age-adjusted mortality (5.9 deaths due to cervical cancer per 100,000 women) reported in Georgia for 1998–2000 are similar to overall estimates in Eastern Europe , but they are higher than those in industrialized countries (Ferlay et al., 2004) (Figure 13.4.1). According to NCDC cervical cancer surveillance data, the crude cervical cancer incidence has increased by 68% between 2000 and 2004, while, as discussed below, screening practices remained basically unchanged (NCDC, 2006).

While primary prevention of cervical cancer focuses mainly on modification of sexual behavior, the newly introduced HPV vaccine, and cessation of tobacco use, secondary prevention occurs through screening, using the Papanicolaou (Pap) smear test. Pap smear tests can find cervical cancer at an early stage, when it is most curable, or even prevent the disease, if precancerous lesions found during the test are treated. Experts recommend that women who are sexually active or 18 years of age or older should have a Pap smear test at least once every 3 years, with the option of reducing the frequency of screening in women over age 65 who have been regularly screened with normal results (U.S. Preventive Services Task Force, 1996). Published recommendations of the European Union allow for longer intervals between screening (up to 5 years) and stipulate that screening should not be offered to women younger than age 20. For resource-poor settings, they define a core age group of women aged 30–60 years who should be the primary target of Pap smear screening (Advisory Committee on Cancer Prevention, 2000). Among preventive care services, cervical cancer screening in Eastern Europe is particularly deficient. Unlike typical practices in many industrialized countries, including the United States, Pap smear tests in Eastern Europe are performed only by gynecologists. Pregnant women often receive cervical cancer screening during antenatal care, but given the low fertility rates in the region, this type of care provides little opportunity for periodic Pap tests.

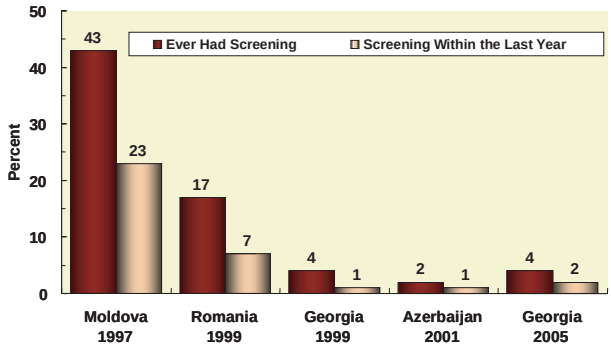
Figure 13.4.1 **Cervical Cancer Incidence and Mortality, by Region**



Note: Rates are age-standardized, meaning they permit international comparison in spite of varying age structures.
Source: J. Ferlay et al., International Agency for Research on Cancer, World Health Organization, GLOBOCAN 2002 Database, 2004.

To estimate the extent of cervical screening in the general population, the two Georgia Reproductive Health Surveys included questions to determine if the respondents had ever had a Pap smear test and, if so, when they had had their most recent test. Similar to studies in other countries of the region, in both surveys only a small fraction of sexually experienced Georgian women aged 15–44 years reported ever having had a Pap smear test, and less than 2% of respondents had had a test during the past 12 months (Figure 13.4.2). The proportion of sexually experienced women who reported having had a Pap smear test did not change between 1999 and 2005. The prevalence of cervical cancer screening was generally very low and thus does not allow the study of potential determinants of this preventive practice in Georgia (Table 13.4). It is worth mentioning, however, that virtually all women who reported Pap smear testing had had at least one routine gynecologic exam, though only 7% of women who had ever had a gynecologic exam were ever screened for cervical cancer.

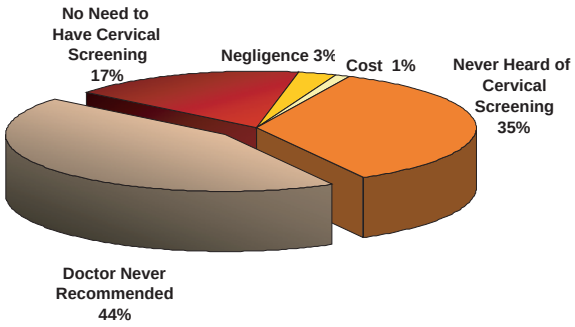
Figure 13.4.2 **Prevalence of Cervical Cancer Screening Tests Among Sexually Experienced Women Aged 15–44 Years: Selected Countries in Eastern Europe***



* Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*

The most important reasons for not having a test among sexually experienced women were lack of recommendation of the test by a health provider (44%), lack of awareness of cervical cancer screening (35%), and a belief that cervical cancer screening is unnecessary (17%)(Figure 13.4.3). These findings demonstrate the need in Georgia for sustained health promotion campaigns for the public and changes in health care provider practices, in order to improve cervical cancer screening rates.

Figure 13.4.3 **Most Commonly Cited Reasons for Never Having Had a Cervical Cancer Screening Test Among Sexually Experienced Women Aged 15–44 Years**



Many deaths from breast and cervical cancer could be avoided in Georgia by increasing access to cancer screening and treatment services and implementing public education and outreach strategies that will reach underserved women. Because health care referral is one of the most common means by which women learn about and undergo breast and cervical cancer screening, physicians who provide primarily gynecological services in a variety of health care settings need to be well informed about breast and cervical cancer screening guidelines. Marketing

materials geared toward health care professionals should inform clinicians about screening services as well as how and where to refer patients.

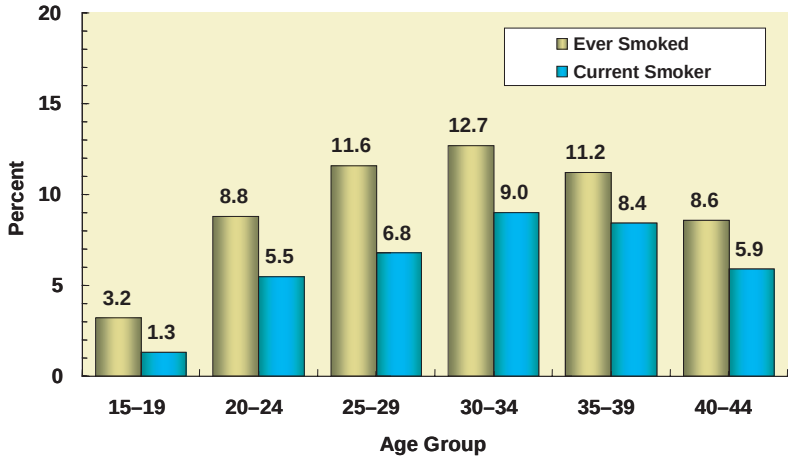
13.5 Cigarette Smoking

Tobacco contains potent human carcinogens that have been shown to be related to many cancers, including those of the respiratory and digestive tracts, bladder, cervix and kidney. Worldwide, cigarette smoking accounts for 87% of lung cancer deaths and 30% of all cancer deaths. Smoking is also a risk factor for atherosclerosis, 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 has been linked to low birth-weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome, and infant respiratory problems (DiFranza and Lew, 1996).

GERHS05 included the following questions for determining cigarette-smoking status: "Have you ever tried cigarette smoking?"; "Have you smoked at least 100 cigarettes in your entire life?"; and "During the last 30 days, did you smoke every day, almost every day, some days, or not at all?" Additional questions explored the number of cigarettes smoked by current smokers and the age of smoking initiation. Almost one in ten Georgian women (9%) reported smoking at least 100 cigarettes (i.e., ever-smokers), including 6% who smoked daily or almost daily during the 30 days preceding the survey (i.e., current smokers) (Table 13.5).

Respondents residing in urban areas, particularly in Tbilisi, were significantly more likely than rural respondents to be past or current smokers. Smoking rates were lowest among young adults and peaked among 30–34 year olds (Figure 13.5). Previously married women, who as a group are older, were most likely to smoke. Smoking rates increased with educational attainment of women and with SES. Respondents who were currently employed were more likely than those not employed to have ever smoked and to be current smokers. Similar findings were documented by the 1999 RHS in Georgia and the Living Conditions, Lifestyles and Health Study, an European Union-funded cross-sectional survey conducted in 2001–2003 in eight newly independent states in the region, including Georgia (Gilmore et al., 2004).

Figure 13.5 **Lifetime and Current Smoking Prevalence Rates by Age Group among Women Aged 15–44 Years**



On a positive note, Georgia ratified the WHO Framework Convention on Tobacco Control at the beginning of 2006. This framework is the first international legal instrument designed to promote national action and global cooperation to curb the tobacco epidemic. The treaty stipulates internationally accepted tobacco control measures that are to be implemented within eight years after a country has ratified the framework: health warnings on tobacco packaging (at least 30% of the display area), followed by a complete ban of tobacco advertising; protection of people from second-hand smoke in all indoor workplaces and public places; increased tobacco taxes; clear indication of origin and final destination market, in order to discourage smuggling; and incorporation of tobacco cessation services into national health programs (The Framework Convention Alliance, 2006).

13.6 Alcohol Use

Women absorb and metabolize alcohol differently than men and are more vulnerable to alcohol's long-term health effects. Heavy drinking is associated with a number of chronic health conditions, including liver disease, cancer, cardiovascular disease, and neurological damage, as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder. Binge drinking has been most commonly associated with unintentional injuries (e.g., motor vehicle crashes), violence (homicide, suicide, child abuse, and domestic violence), alcohol poisoning, hypertension, myocardial infarction, sexually transmitted diseases, meningitis, and poor control of diabetes (Naimi et al., 2003b). Alcohol abuse among pregnant women has additional significance because of its potential harm to the fetus. No amount of alcohol is safe to drink during pregnancy and there is a linear relationship between the quantity of alcohol used and the chances of birth defects (fetal alcohol syndrome) or physical and mental developmental problems. Research also suggests that women who drink alcohol while pregnant are more likely to have pregnancies that end in miscarriage, stillbirth, and premature delivery (Wilsnack et al., 1984; Kesmodel et al., 2002).

Eastern European nations have a long tradition of producing and drinking alcoholic beverages. Georgia grows grape wines in all of its regions, both for internal consumption and export. Although alcohol consumption is perceived to be high in Georgia, there are no periodic estimates, since the former tracking system, which was based on data on state-controlled sales, has yet to be replaced with other assessment tools. The 1999 RHS and the 2001–2003 multi-country Living Conditions, Lifestyles and Health surveys are the only other population-based sources of data on alcohol use among Georgians (Serbanescu et al., 2001b; Pomerleau et al., 2005)

In GERHS05, alcohol use was measured by asking each respondent how frequently they drank, how many drinks they had had at any given occasion during the past three months, and how often they drank that amount. Respondents who had consumed at least one drink every day or almost every day were defined as "current drinkers"; those who consumed alcohol in excess of one drink per day, on average, were defined as "current frequent drinkers"; and those who consumed five or more drinks in a row at any given time during the three months preceding the survey were defined as "episodic heavy drinkers" or binge drinkers. Because alcohol consumption data are self-reported, they might be subject to reporting biases, especially among pregnant respondents who may have been aware that alcohol use in any quantity during pregnancy is not advised.

On average, 24% of women have used alcohol (current drinkers), but only 4% of women reported that they consumed it daily or almost daily (current frequent drinkers) during the three months preceding the survey (Table 13.6). Almost one in two current drinkers reported at least one episode of binge drinking. Drinking was directly correlated with age

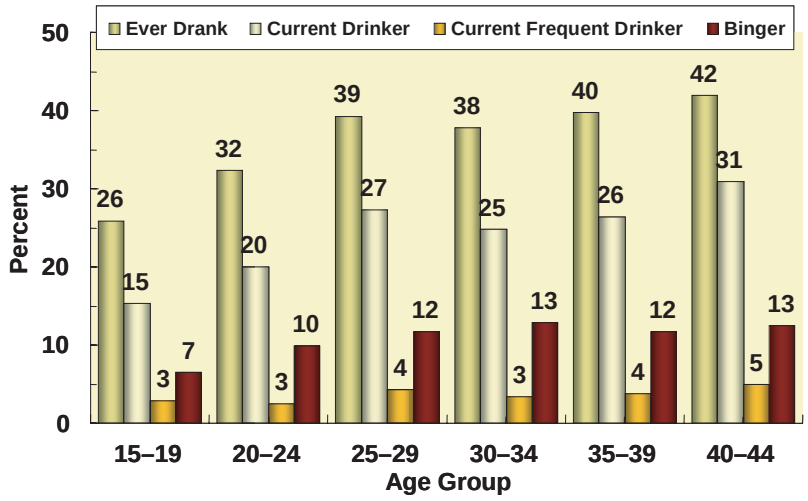
(Figure 13.6). Current frequent drinking and episodic heavy drinking were both less common among rural residents, residents of the southern region (where most of the Azeri population lives), women with lower educational attainment, and women of Azeri or Armenian descent, and more common among women who reside in urban areas, particularly in Tbilisi, and among respondents who had at least completed secondary education

13.7 Prevalence of Selected Health Problems

All respondents were asked, "Has a doctor or other health care provider ever told you that you have (selected health problems)?" The health problems listed were diabetes, anemia, high blood pressure, and rubella. In addition, the prevalence of pelvic inflammatory disease (PID) was assessed by asking respondents if they "had ever been treated for an infection of the fallopian tubes, uterus, or ovaries, also called pelvic infection?" Results are shown in Table 13.7.

Survey results should be considered minimum estimates of the true prevalence of these health problems in the population of women of childbearing age. The real prevalence is probably much higher because self-reporting of health conditions is influenced by access to health care facilities, the client-provider interaction, and respondent ability to accurately recall medical diagnoses. Thus, the self-reported occurrence of health problems among different subgroups should be interpreted with caution because background characteristics may affect both access to the health care system and accuracy of reporting. Furthermore, these are lifetime estimates; they do not reflect current health status and cannot be temporally associated with other events. For all these reasons, the survey data on health problems among women should serve only as proxy estimates in the absence of official statistics based on medical records or hospital discharge data.

Figure 13.6 **Current Drinking Prevalence Rates by Age Group Among Women Aged 15–44 Years**



The most commonly reported condition among respondents of reproductive age was PID: 19% of all respondents, 29% of currently married respondents, and 28% of those aged 35–44 years had been told by a doctor that they had PID. PID was nonexistent among women who had never had sexual intercourse, and it was almost nonexistent among adolescent women, who are least likely to be sexually experienced. PID levels among adolescent (aged 15–19 years) and young adult (aged 20–24 years) women were lower than among women older than age 24, after controlling for the absence of sexual experience (data not shown). Rates of ever having had PID increased with age among sexually experienced women, which is to be expected because older women have been exposed for a longer period to the risk of genital infections, which are associated with PID.

Other health conditions were reported as follows: almost 1 in 8 respondents reported that she had been told by a doctor that she had high blood pressure; 11% reported anemia; 3% had been diagnosed with rubella; and 1% had been told that they had diabetes. Generally, women living in urban areas, particularly Tbilisi, and those with the highest educational attainment and SES were more likely to report diagnosis of any health condition, probably due to better access to health information and health services.

Because many of the health conditions explored in GERHS05 could be pregnancy-related or could be more likely to be detected during pregnancy, additional questions explored if each health problem, with the exception of PID, was only diagnosed during pregnancy. Figure 13.7 shows the proportion of women who had even been pregnant and had ever been told about selected health conditions only during the pregnancy. Most women with pregnancy experience found out about their health problems while they were pregnant, either because the health condition was pregnancy-related or because there is a greater likelihood of seeking preventive health care during pregnancy than while not pregnant.

Figure 13.7 **Self-Reports of Ever Being Diagnosed with Selected Health Conditions and Being Diagnosed During Pregnancy Among Women Aged 15–44 Who Have Ever Been Pregnant**

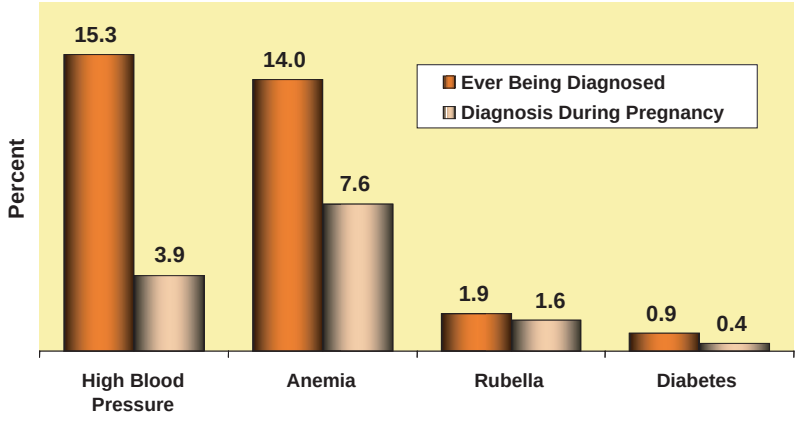


Table 13.1.1 Use of Health Care and Type of Health Facility Visited During the Last 12 Months Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Use of Health Care		Type of Health Facility				
Characteristic	%	No. of Cases	Public Medical Sector %	Private Clinic or NGO %	Mobile Health Unit %	Other %	No. of Cases
Total	25.2	6,376	87.6	13.5	0.4	0.4	1,701
Residence							
Urban	26.9	3,196	82.9	17.9	0.6	0.6	882
Rural	23.2	3,180	94.2	7.3	0.1	0.1	819
Region							
Kakheti	20.8	538	93.5	10.9	0.0	0.0	122
Tbilisi	30.3	1,431	75.7	26.1	0.9	0.5	436
Shida Kartli	27.7	430	94.1	6.5	0.7	0.7	127
Kvemo Kartli	21.7	576	93.8	5.6	0.0	0.0	138
Samtskhe-Javakheti	22.8	434	96.2	3.0	0.0	0.0	110
Adjara	24.1	490	96.3	3.7	0.0	0.0	129
Guria	28.8	388	88.7	14.2	0.0	0.0	116
Samegrelo	22.1	506	94.0	5.2	0.0	0.0	113
Imereti	22.9	782	92.2	9.2	0.0	1.4	192
Mtskheta-Mtianeti	23.9	374	81.6	20.2	0.9	0.0	92
Racha-Svaneti	28.2	427	86.8	11.1	6.9	0.0	126
Age Group							
15–19	17.8	930	83.2	17.8	1.5	1.3	183
20–24	26.1	1,079	92.3	8.6	0.3	0.6	294
25–29	31.2	1,139	87.8	15.1	0.0	0.3	366
30–34	29.8	1,110	85.4	14.2	0.1	0.3	330
35–39	26.0	1,048	86.3	15.3	0.1	0.0	272
40–44	22.5	1,070	89.3	10.9	0.8	0.0	256
Education							
Secondary incomplete or less	15.3	907	89.7	12.6	0.4	0.6	154
Secondary complete	26.2	1,786	90.4	9.8	0.7	0.8	487
Technicum	25.7	1,466	90.0	11.8	0.3	0.0	387
University/postgraduate	28.9	2,217	83.7	17.3	0.4	0.3	673
Socioeconomic Status							
Low	20.1	2,277	94.3	6.4	0.1	0.2	513
Middle	26.5	3,028	87.2	13.5	0.5	0.3	836
High	31.5	1,071	80.5	21.8	0.7	0.7	352
Ethnicity							
Georgian	25.2	5,545	86.9	14.1	0.5	0.5	1,479
Azeri	23.0	292	97.7	3.4	0.0	0.0	71
Armenian	22.6	382	92.7	7.3	0.0	0.0	96
Other	37.4	157	84.0	19.7	0.0	0.0	55

Table 13.1.2 Self-Perceived Barriers to Health Care Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

Characteristic	Cost %	Not Wanting to Go Alone %	Distance %	Gender of the Health Provider %	Lack of Transportation %	Not Knowing Where to Go %	Not Getting Permission to Go %	No. of Cases
Total	58.9	15.7	12.6	11.6	11.3	10.0	6.2	6,376
Residence								
Urban	49.5	12.6	4.0	10.2	3.4	6.9	3.8	3,196
Rural	70.3	19.6	23.1	13.2	21.0	13.9	9.1	3,180
Region								
Kakheti	68.8	17.2	12.7	13.7	10.4	12.7	3.9	538
Tbilisi	45.3	15.2	2.5	11.9	2.1	7.0	3.7	1,431
Shida Kartli	67.6	16.3	17.0	8.9	14.9	11.1	5.6	430
Kvemo Kartli	68.2	25.9	23.1	17.0	23.9	17.1	9.1	576
Samtskhe-Javakheti	70.7	17.2	30.2	10.7	28.8	13.6	5.2	434
Adjara	51.6	17.4	12.0	13.3	10.5	12.0	15.3	490
Guria	81.0	22.5	34.2	10.6	33.9	17.0	7.4	388
Samegrelo	57.7	9.6	4.6	4.8	4.8	4.3	4.0	506
Imereti	62.5	7.6	12.1	9.8	7.9	6.8	3.8	782
Mtskheta-Mtianeti	69.3	18.9	28.2	12.8	25.8	12.6	8.2	374
Racha-Svaneti	69.9	15.5	37.2	9.2	37.6	10.2	4.1	427
Age Group								
15–19	52.5	30.3	13.6	26.2	12.7	17.0	17.0	930
20–24	51.1	20.2	11.8	11.8	9.9	10.5	5.1	1,079
25–29	59.6	13.9	12.5	8.1	11.6	7.4	3.4	1,139
30–34	62.3	11.3	10.6	8.0	10.0	7.9	3.3	1,110
35–39	61.4	7.7	12.6	6.2	12.5	8.0	2.9	1,048
40–44	67.8	7.9	14.2	6.5	11.2	8.0	3.4	1,070
Number of Living Children								
0	52.3	23.2	11.2	17.5	10.3	12.1	9.5	2,299
1	53.6	12.1	10.3	7.6	8.8	7.4	3.3	1,131
2	65.0	9.6	13.2	7.6	11.9	8.3	3.5	2,168
3 or more	72.7	10.7	18.8	6.9	16.6	10.8	5.4	778
Education								
Secondary incomplete or less	64.2	31.1	20.6	27.4	19.2	20.8	17.8	907
Secondary complete	66.6	16.0	17.0	10.8	15.8	12.1	5.8	1,786
Technicum	63.3	9.3	11.1	7.5	10.1	7.3	3.6	1,466
University/postgraduate	47.6	12.2	6.3	7.3	4.9	5.0	2.7	2,217
Socioeconomic Status								
Low	76.5	19.1	22.1	14.2	20.5	16.1	9.8	2,277
Middle	55.4	14.7	9.2	11.1	7.9	7.3	4.7	3,028
High	35.4	12.2	3.9	7.8	3.2	5.6	3.1	1,071
Employment								
Working	51.8	9.0	8.1	6.1	7.0	5.4	2.2	1,422
Not working	60.8	17.5	13.8	13.0	12.5	11.3	7.2	4,954
Ethnicity								
Georgian	57.2	14.1	10.4	10.5	9.0	8.4	5.5	5,545
Azeri	72.1	27.2	26.0	26.0	25.3	28.8	15.9	292
Armenian	72.4	31.2	35.9	16.6	35.4	14.6	7.5	382
Other	61.7	15.1	13.1	8.7	12.8	17.5	4.8	157
Ever Had Gynecologic Exam								
Yes	61.8	10.6	12.8	7.1	11.4	6.8	3.2	2,880
No	56.7	19.6	12.5	14.9	11.3	12.4	8.4	3,496
Had a Health Care Visit Last Year								
Yes	62.8	13.4	12.2	8.1	10.8	7.5	3.9	1,701
No	57.6	16.5	12.8	12.7	11.5	10.9	6.9	4,675

Table 13.2 Time of Last Routine Gynecologic Exam, by Selected Characteristics Among Women Aged 15–44 Years Who Had Ever Had Sexual Intercourse Reproductive Health Survey: Georgia, 2005

	Time of Last Routine Gynecologic Exam				
Characteristic	During the Past 12 Months %	Within 1–3 Years %	More than 3 Years Ago %	Never Had %	No. of Cases
Total	20.4	19.3	21.7	38.5	4,517
Residence					
Urban	22.4	21.7	22.2	33.7	2,188
Rural	18.3	16.7	21.2	43.9	2,329
Region					
Kakheti	17.4	16.5	23.4	42.8	405
Tbilisi	24.9	22.9	18.5	33.6	952
Shida Kartli	18.6	20.1	26.4	34.9	341
Kvemo Kartli	17.2	18.5	19.1	45.2	432
Samtskhe-Javakheti	24.0	19.2	19.9	36.8	328
Adjara	18.3	15.6	28.2	37.8	350
Guria	17.6	20.6	24.0	37.8	266
Samegrelo	15.5	16.5	24.8	43.2	336
Imereti	23.0	20.1	18.9	38.0	550
Mtskheta-Mtianeti	18.1	19.3	23.0	39.6	280
Racha-Svaneti	16.3	14.3	14.7	54.7	277
Age Group					
15–19	23.1	2.1	0.2	74.7	161
20–24	27.1	15.9	3.4	53.5	580
25–29	29.8	20.8	10.6	38.9	885
30–34	21.8	22.9	21.9	33.5	962
35–39	15.9	22.0	28.4	33.8	939
40–44	12.6	17.9	36.9	32.6	990
Number of Living Children					
0	31.9	9.4	8.4	50.3	440
1	21.9	20.1	14.7	43.3	1,131
2	20.1	20.9	25.5	33.5	2,168
3 or more	13.4	19.6	28.5	38.5	778
Education					
Secondary incomplete or less	15.4	11.8	17.0	55.8	461
Secondary complete	19.1	18.0	22.1	40.8	1,402
Technicum	19.4	19.3	26.2	35.0	1,208
University/postgraduate	24.1	22.9	19.3	33.7	1,446
Socioeconomic Status					
Low	14.8	17.1	23.4	44.7	1,649
Middle	21.5	19.0	21.6	37.8	2,102
High	28.2	24.3	18.7	28.8	766
Ethnicity					
Georgian	20.6	19.5	22.6	37.3	3,857
Azeri	19.1	12.9	13.0	55.0	243
Armenian	20.3	20.0	17.2	42.5	284
Other	19.3	25.7	23.5	31.4	133
Current Use of Contraception					
Modern	23.2	26.4	23.6	26.8	1,121
Traditional	15.6	19.3	24.5	40.6	868
No method	20.8	16.3	20.0	42.9	2,528

Table 13.3 Awareness of Breast Self-Examination (BSE) and Frequency of BSE, by Selected Characteristics Among Women Aged 15–44 Years Who Had Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2005

	Awareness of BSE	Frequency of BSE (Percentage Distribution)					
Characteristic	%	Every Month	Every 2–5 Months	Every 6–12 Months or	Never Had	Total	No. of Cases
Total	60.7	11.5	7.1	10.3	71.1	100.0	4,517
Residence							
Urban	73.9	16.0	9.2	12.7	62.1	100.0	2,188
Rural	46.1	6.6	4.7	7.7	81.0	100.0	2,329
Region							
Kakheti	48.8	5.1	3.1	11.1	80.6	100.0	405
Tbilisi	79.5	21.2	12.2	12.5	54.2	100.0	952
Shida Kartli	57.9	6.8	6.5	9.9	76.8	100.0	341
Kvemo Kartli	46.0	7.4	8.4	9.0	75.2	100.0	432
Samtskhe-Javakheti	30.7	6.1	2.3	1.0	90.5	100.0	328
Adjara	58.0	6.0	4.4	8.3	81.4	100.0	350
Guria	51.4	9.1	5.7	4.7	80.4	100.0	266
Samegrelo	59.2	7.8	2.1	13.7	76.5	100.0	336
Imereti	62.4	13.8	6.1	11.4	68.7	100.0	550
Mtskheta-Mtianeti	71.3	13.9	11.8	9.1	65.3	100.0	280
Racha-Svaneti	60.3	10.0	6.3	10.7	73.0	100.0	277
Age Group							
15–19	28.3	1.1	2.3	1.1	95.5	100.0	161
20–24	43.2	6.0	2.3	4.8	86.9	100.0	580
25–29	59.5	9.3	6.6	8.8	75.3	100.0	885
30–34	64.8	12.4	9.2	11.6	66.8	100.0	962
35–39	68.7	15.1	7.8	12.5	64.7	100.0	939
40–44	66.0	14.2	8.4	12.9	64.5	100.0	990
Education							
Secondary incomplete or less	32.9	2.1	2.4	7.2	88.3	100.0	461
Secondary complete	46.9	7.3	5.1	6.1	81.5	100.0	1,402
Technicum	66.6	11.8	7.9	12.4	67.9	100.0	1,208
University/postgraduate	77.9	18.4	9.7	13.7	58.2	100.0	1,446
Socioeconomic Status							
Low	43.2	5.9	3.3	7.5	83.2	100.0	1,649
Middle	65.4	11.5	8.2	11.6	68.8	100.0	2,102
High	81.8	22.1	11.4	12.3	54.1	100.0	766
Employment							
Working	79.4	17.4	9.2	16.1	57.4	100.0	1,025
Not working	55.4	9.9	6.5	8.7	74.9	100.0	3,492
Ethnicity							
Georgian	66.4	12.7	7.7	11.4	68.2	100.0	3,857
Azeri	11.5	0.3	0.7	1.1	97.9	100.0	243
Armenian	28.5	7.0	3.3	3.4	86.2	100.0	284
Other	63.2	11.7	10.0	10.8	67.6	100.0	133
Current Use of Contraception							
Modern	74.1	14.9	7.9	13.3	64.0	100.0	1,121
Traditional	58.6	10.7	7.7	11.4	70.1	100.0	868
No method	55.6	10.4	6.5	8.7	74.4	100.0	2,528
Ever Had Gynecologic Exam							
Yes	68.9	15.4	8.6	13.0	63.0	100.0	2,731
No	47.6	5.4	4.6	6.1	83.9	100.0	1,786

Table 13.4 History of Cervical Cancer Screening, by Selected Characteristics Among Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse Reproductive Health Survey: Georgia, 2005

	Time of Most Recent Cervical Cancer Screening (Percentage Distribution)					
Characteristic	During the Past 12 Months	Within 1–3 Years	More than 3 Years Ago	Never Had	Total	No. of Cases
Total	1.6	1.0	1.7	95.8	100.0	4,517
Residence						
Urban	1.7	1.3	2.3	94.6	100.0	2,188
Rural	1.4	0.6	1.0	97.0	100.0	2,329
Region						
Kakheti	0.4	0.2	0.7	98.7	100.0	405
Tbilisi	1.4	2.1	2.5	93.9	100.0	952
Shida Kartli	1.5	0.7	1.0	96.9	100.0	341
Kvemo Kartli	2.3	0.4	0.8	96.6	100.0	432
Samtskhe-Javakheti	1.8	0.8	0.8	96.7	100.0	328
Adjara	0.9	0.5	2.5	96.1	100.0	350
Guria	1.4	0.3	0.7	97.6	100.0	266
Samegrelo	2.1	0.5	4.1	93.3	100.0	336
Imereti	2.4	1.1	0.5	96.0	100.0	550
Mtskheta-Mtianeti	0.9	1.2	1.5	96.4	100.0	280
Racha-Svaneti	0.3	0.7	0.7	98.3	100.0	277
Age Group						
15–19	0.0	0.0	0.0	100.0	100.0	161
20–24	0.7	0.5	0.2	98.6	100.0	580
25–29	1.8	0.7	0.3	97.2	100.0	885
30–34	1.5	0.9	1.7	95.9	100.0	962
35–39	2.4	1.2	3.5	92.9	100.0	939
40–44	1.4	1.6	2.1	94.9	100.0	990
Education						
Secondary incomplete or less	0.6	0.4	0.2	98.7	100.0	461
Secondary complete	1.1	0.5	1.3	97.1	100.0	1,402
Technicum	1.9	1.2	1.5	95.4	100.0	1,208
University/postgraduate	2.0	1.5	2.6	93.9	100.0	1,446
Socioeconomic Status						
Low	0.6	0.6	1.3	97.5	100.0	1,649
Middle	2.2	0.6	1.6	95.6	100.0	2,102
High	1.7	2.6	2.8	92.9	100.0	766
Ethnicity						
Georgian	1.7	1.0	1.8	95.5	100.0	3,857
Azeri	0.7	0.4	.	98.9	100.0	243
Armenian	0.2	0.4	1.8	97.7	100.0	284
Other	1.0	3.7	2.3	93.1	100.0	133
Ever Had Gynecologic Exam						
Yes	2.5	1.6	2.7	93.2	100.0	2,731
No	0.1	0.1	0.0	99.9	100.0	1,786

Table 13.5 Percentage of Women Aged 15–44 Years Who Have Ever Smoked and Who Currently Smoke by Selected Characteristics Reproductive Health Survey: Georgia 2005

Characteristic	Cigarette Use		No. of Cases
	Ever smoked	Current Smoker	
Total	9.1	5.9	6,376
Residence			
Tbilisi	23.7	15.2	1,431
Other urban	7.7	5.4	1,765
Rural	1.2	0.8	3,180
Region			
Kakheti	1.8	1.2	538
Tbilisi	23.7	15.2	1,431
Shida Kartli	2.9	1.8	430
Kvemo Kartli	3.5	1.5	576
Samtskhe-Javakheti	1.0	0.5	434
Adjara	7.5	6.7	490
Guria	2.7	0.8	388
Samegrelo	2.5	2.0	506
Imereti	4.0	2.4	782
Mtskheta-Mtianeti	5.0	2.1	374
Racha-Svaneti	3.1	2.0	427
Age Group			
15–24	5.9	3.3	2,009
25–34	12.1	7.9	2,249
35–44	9.8	7.0	2,118
Marital Status			
Married	7.3	4.5	4,119
Previously married	24.3	19.3	386
Never married	9.7	6.2	1,871
Education			
Secondary incomplete or less	1.6	0.7	907
Secondary complete	5.8	3.9	1,786
Technicum	6.5	4.8	1,466
University	16.8	10.7	2,217
Socioeconomic Status			
Low	2.9	1.8	2,277
Middle	8.6	6.1	3,028
High	21.8	13.1	1,071
Ethnicity			
Georgian	9.9	6.5	5,545
Azeri	0.3	0.3	292
Armenian	5.1	2.7	382
Other	9.2	6.6	157
Employment			
Working	16.1	11.7	1,422
Not working	7.2	4.4	4,954

Table 13.6 Percentage of Women Aged 15–44 Years Who Used Alcohol During the Previous Three Months by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Alcohol Use During the Past Three Months				
Characteristic	Ever Drank	Current Drinkers	Current Frequent Drinkers	Episodic Heavy Drinkers	No. of Cases
Total	35.8	23.9	3.6	10.7	6,376
Residence					
Urban	39.7	26.1	4.5	12.8	3,196
Rural	31.1	21.2	2.5	8.2	3,180
Region					
Kakheti	34.4	21.6	1.4	10.0	538
Tbilisi	44.6	27.4	4.2	16.0	1,431
Shida Kartli	33.2	21.7	3.1	10.3	430
Kvemo Kartli	31.3	16.8	1.8	11.5	576
Samtskhe-Javakheti	11.2	5.5	1.6	1.7	434
Adjara	33.1	22.5	3.1	3.6	490
Guria	29.2	11.5	1.6	9.8	388
Samegrelo	35.7	28.0	5.4	5.8	506
Imereti	36.4	31.6	5.5	12.2	782
Mtskheta-Mtianeti	36.3	26.3	5.3	10.7	374
Racha-Svaneti	34.8	24.1	2.7	15.7	427
Age Group					
15–24	28.9	17.6	2.7	8.1	2,009
25–34	38.5	26.1	3.8	12.3	2,249
35–44	40.9	28.8	4.4	12.1	2,118
Marital Status					
Married	34.7	23.6	3.4	10.1	4,119
Previously married	40.9	27.4	6.2	13.4	386
Never married	36.8	23.7	3.6	11.4	1,871
Education Level					
Secondary incomplete or less	18.1	12.4	1.8	4.9	907
Secondary complete	35.9	24.2	3.5	9.2	1,786
Technicum	36.6	25.2	4.0	11.8	1,466
University	43.5	28.1	4.3	13.9	2,217
Socioeconomic Status					
Low	32.3	22.4	3.1	8.0	2,277
Middle	36.0	23.2	4.2	11.8	3,028
High	41.7	28.1	3.1	13.0	1,071
Ethnicity					
Georgian	38.8	26.0	4.0	11.8	5,545
Azeri	3.6	3.1	0.0	0.1	292
Armenian	18.9	10.5	0.4	3.8	382
Other	33.9	20.2	3.0	10.0	157
Employment					
Working	44.7	31.9	4.9	12.2	1,422
Not working	33.4	21.7	3.3	10.3	4,954

Table 13.7 Percentage of Women Aged 15–44 Years Who Have Ever Been Told by a Doctor That They Have Selected Health Problems by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Selected Health Problems					
Characteristic	PID	High Blood Pressure	Anemia	Rubella	Diabetes	No. of Cases
Total	18.5	11.6	10.5	2.6	0.7	6,376
Residence						
Urban	19.0	11.7	12.8	3.0	0.7	3,196
Rural	17.9	11.4	7.7	2.0	0.7	3,180
Region						
Kakheti	12.5	7.7	5.4	0.6	0.3	538
Tbilisi	19.3	13.4	15.8	5.0	1.1	1,431
Shida Kartli	23.7	12.7	15.4	1.6	0.5	430
Kvemo Kartli	17.6	7.9	9.2	1.5	0.1	576
Samtskhe-Javakheti	19.1	9.5	11.0	2.1	0.2	434
Adjara	18.4	11.2	4.0	2.1	0.1	490
Guria	21.7	13.1	9.6	1.2	0.2	388
Samegrelo	19.6	12.7	5.4	1.3	1.6	506
Imereti	17.4	11.6	10.5	2.1	0.8	782
Mtskheta-Mtianeti	21.0	19.1	12.2	1.5	0.2	374
Racha-Svaneti	11.5	13.3	11.4	3.9	1.8	427
Age Group						
15–24	4.9	3.9	6.7	3.3	0.2	2,009
25–34	24.3	11.2	14.5	1.8	0.6	2,249
35–44	28.1	20.5	11.0	2.5	1.4	2,118
Marital Status						
Married	28.8	14.8	13.9	1.6	0.9	4,119
Previously married	23.6	17.6	10.7	4.5	1.1	386
Never married	0.0	5.2	4.7	3.8	0.3	1,871
Education						
Secondary incomplete or less	7.4	6.7	3.6	2.0	0.3	907
Secondary complete	19.4	12.3	9.2	2.5	0.8	1,786
Technicum	25.4	16	10.3	2.2	0.9	1,466
University	18.7	10.6	14.9	3.1	0.7	2,217
Socioeconomic Status						
Low	16.6	11.7	6.9	1.8	0.7	2,277
Middle	19.2	11.7	11.6	2.7	0.9	3,028
High	20.1	11.2	14.5	3.6	0.2	1,071
Ethnicity						
Georgian	18.9	11.8	10.8	2.8	0.7	5,545
Azeri	12.3	6.1	6.5	0.6	0.0	292
Armenian	18.6	10.9	9.4	1.8	1.3	382
Other	17.8	17.4	10.9	2.0	1.2	157
Employment						
Working	20.9	13.6	11.2	3.3	0.9	1,422
Not working	17.8	11.1	10.3	2.4	0.6	4,954

Chapter 14

FAMILY LIFE EDUCATION

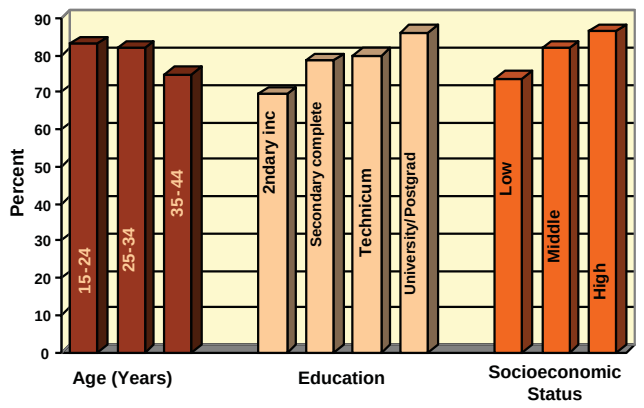
Increased rates of premarital intercourse, the threat of increasing rates of HIV/AIDS infections, and other related changes in sexual and reproductive health behaviors, as well as increases in the amount of sexual content in the media, have sparked public debate about sex education in Eastern Europe. Although research has shown that school-based sex education is an important component of a broader prevention effort to reduce rates of adolescent pregnancy and STIs, such education is largely absent in the region, and sexual health is often a taboo topic. Elements of reproductive biology are taught in high school in the biology and human anatomy classes, but none of the former USSR countries have national policies related to comprehensive school-based sex education. To assess the need for more information about sex education in schools, as well as linkages with reproductive health, the CDC-assisted reproductive health surveys conducted in Eastern Europe and former Soviet Union have been collecting data on this topic since the mid-1990s.

14.1 Opinions About Family Life Education in Schools

Similar to surveys conducted in Moldova, Romania, and Azerbaijan, as well as the 1999 RHS in Georgia, one of the objectives of the GERHS05 was to examine whether reproductive-age women support the concept of school-based sex education (termed “family life education” in the region) and to explore their opinions about the best age to start such education. If presented

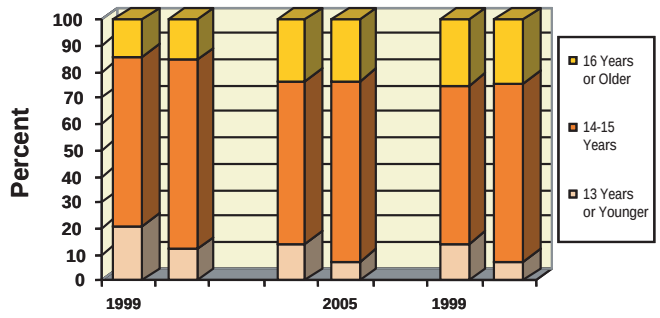
effectively, such information could help to initiate open discourse on age-appropriate education on sexuality and health and alleviate fears that parents may have regarding school-based education on sexual issues. In 2005, the large majority of respondents (80%) supported sex education in schools—although more respondents were supportive in 1999 (85%). In 2005, respondents were asked about their support of specific sex education topics, including "how pregnancy occurs" (supported by 80% of respondents), sexually transmitted infections (79%), and contraception (78%) (Table 14.1.1 and Figure 14.1.1). Support for any sex education in schools in the current survey was strongest among women who live in urban areas (84%), have one or no children (85% and 84%), and are more educated (86% of those with university/ postgraduate education), and was weakest among older women (75% of 35–44-year-olds), women with lower SES (74%), and Azeri women (40%).

Figure 14.1.1 **Support for Family Life Education in Schools**



Respondents who believe sex education should be taught in schools were asked specifically about the best age to begin teaching specific topics (Tables 14.1.2 and 14.1.3). Overall, women responded that education about "how pregnancy occurs" should happen at later ages than they did in the 1999 survey (Figure 14.1.2): Only 12% felt that it should start before age 14, compared to 21% in 1999; 73% felt it should start between 14–15 years of age (64% in 1999), and 16% at 16 years or older (14% in 1999). Similar trends were found for other topics. In 1999, 14% of respondents believed courses about contraception and about sexually transmitted infections should begin by age 13. In 2005, only 8% of respondents believed the topic of contraception should be introduced at age 13, and 7% believed the topic of sexually transmitted infections should be introduced at age 13. However, in both 1999 and 2005, the majority of respondents felt that ages 14–15 were the best for introducing these topics.

Figure 14.1.2 **Perceived Best Age to Start Family Life Education About Specific Topics**



Certain subgroups tended to be more conservative about the best age to introduce sex education topics. Among the minority of Azeri women who supported sex education in schools, between a quarter and a

third felt that waiting until age 16 years or later was the most appropriate for introducing courses on "how pregnancy occurs" (28%), contraception (32%), and sexually transmitted infections (32%). Notably, these proportions were higher than among other ethnic groups, despite the fact that Azeri young women report sexual experience at earlier ages (as will be discussed in Chapter 15).

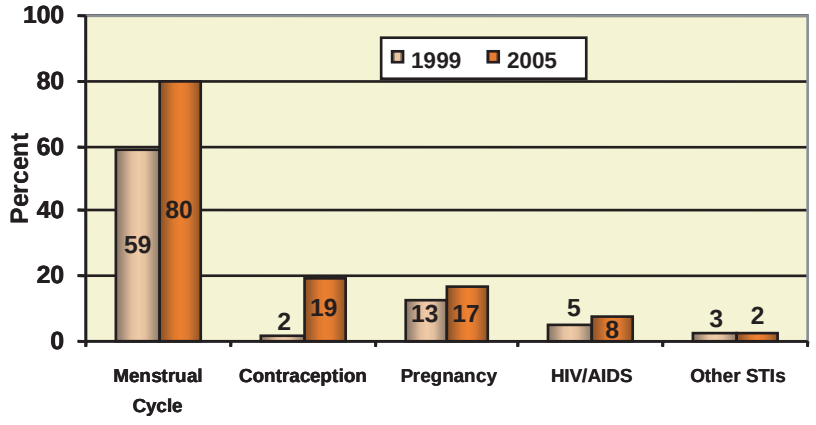
14.2 Discussions About Sex Education Topics With Parents

To assess family-based exposure to sex education topics, 15–24 year old respondents were asked about conversations with parents regarding selected sex and reproductive health topics before they reached age 18. Topics explored included the menstrual cycle, how pregnancy occurs, contraceptive methods, HIV/AIDS, and other STIs. Since the data for 15–17 year olds are truncated, due to the fact that they have not yet reached age 18, the data for this age group should be considered minimum estimates only.

Eighty-one percent of all young women surveyed had spoken with a parent about at least one sex education topic (Table 14.2). The majority reported having had discussions about menstrual cycles, while many fewer had had discussions about family planning (19%), how pregnancy occurs (17%), HIV/AIDS (8%), and other sexually transmitted infections (2%). While these proportions are fairly low, they represent noticeable increases from the previous survey for discussions about the menstrual cycle and contraception (Figure 14.2.1).

Table 14.2 also shows variations in reporting by various characteristics. The proportion of young women who had discussed HIV/AIDS with a parent was higher among residents of Tbilisi (17%), women with higher SES (16%), and women with a university education (19%), when compared to their counterparts.

Figure 14.2.1 **Family Life Education Topics Discussed with a Parent Before Reaching Age 18, Among Young Women Aged 15-24**

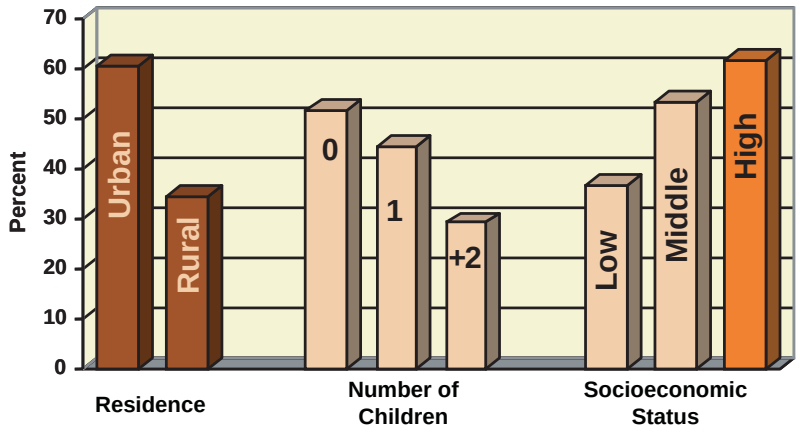


14.3 Family Life Education in Schools

The school system is an institution to which most young people are connected, and it provides an important opportunity to deliver consistent and accurate information about sexual health issues. It also provides an environment where young people can talk with well-informed adults about issues that are important to their reproductive development. Respondents between the ages of 15 and 24 were asked if they received formal or informal sex education in school before age 18. Respondents were asked specifically about reproductive health-related topics such as female and male reproductive biology, the menstrual cycle, how pregnancy occurs, contraceptive methods, and sexually transmitted infections, including HIV/AIDS. As with the data on discussions with parents about sex, the data on school-based education for 15–17 year olds are truncated, since these respondents had not yet reached age 18. Consequently, results for this age group should be considered to be minimum estimates only.

Table 14.3 shows the proportion of young women who reported having had school-based lectures on the topics mentioned above. Similar to the 1999 survey, slightly less than half (49%) of respondents between the ages of 15 and 24 reported having had at least one school-based course that addressed sex education topics. Respondents living in urban areas were significantly more likely to have had such courses than those living in rural areas (61% vs. 35%) (Figure 14.3.1). Rates of exposure to school-based sex education also varied widely by region, ranging from 30% of young women in Racha-Svaneti to 74% in Guria. Socioeconomic status was also a factor: only 36% of respondents with low SES reported having had any sex education in school, compared to 54% of middle-SES and 62% of high-SES respondents. Ethnicity was also a factor: while respondents of most ethnicities reported rates of 45% to 52%, only 10% of Azeri young women were exposed to any sex education topics in school.

Figure 14.3.1 **Selected Characteristics of Young Women Who Received Any Family Life Education in School Before Reaching Age 18**



The specific sex education topics that young women were exposed to most were female reproductive biology (44%), male reproductive biology (42%), the menstrual cycle (37%), and how pregnancy occurs (25%). Only a small proportion of young women reported receiving courses about sexually transmitted infections (11%), HIV/AIDS (3%), and contraception (2%). As shown in Table 14.3, for every sex education topic addressed in the survey, greater proportions of young women with no sexual experience reported exposure in comparison to their sexually experienced counterparts. Exposure also varied by type of residence: more urban respondents were exposed to each of the various topics than rural respondents. When comparing these results with 1999 survey data, there was a slight decrease among all young women in exposure to school-based information on HIV/AIDS (from 5% to 3%), despite an increase in exposure to information regarding other sexually transmitted infections (from 2% to 11%) (Figure 14.3.2). There has also been a decrease in reported school-based education on how pregnancy occurs (from 32% to 25%), but a slight increase in reported education on contraception (from 1% to 2%). Exposure to all other topics, in general, were reported at the same levels as the prior survey. As with the 1999 survey, the majority of young women were still not being exposed to any sex education topics in school.

Figure 14.3.2 **Percentage of Young Women who Had School-Based Education on Specific Family Life Education Topics Before Age 18**

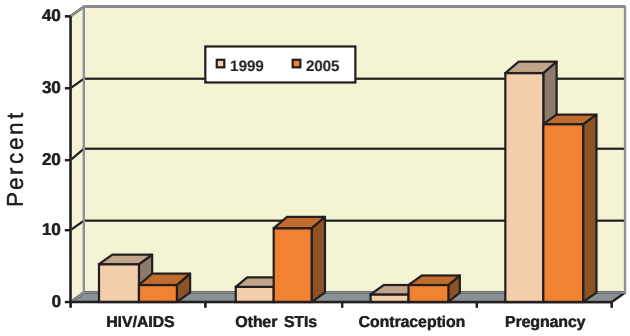
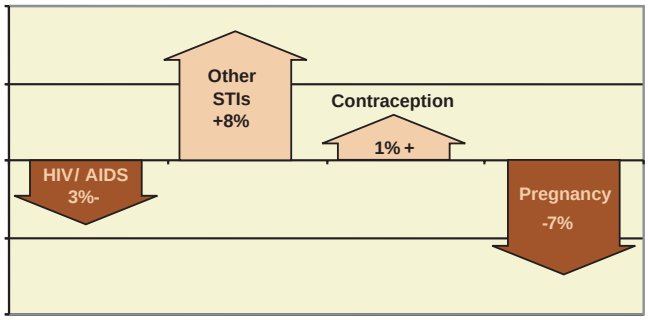


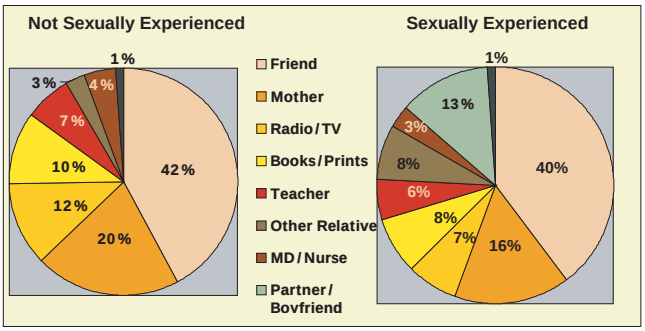
Figure 14.3.2 **Percentage-Point Change in Proportion of Young Women Who Had a School-based Course on Specific FLE Topics: 1999 and 2005**



14.4 Sources of Information on Sexual Matters

When asked who they felt has been the most important source of information on sexual matters, young women most often stated that it was a friend (42%)(Table 14.4 and Figure 14.4). Nearly one in five stated that it was their mother (19%) and 10% cited radio or television as their most important source. This order of frequency varied somewhat depending on whether or not the respondent was sexually experienced. Most sexually experienced young women considered a friend (40%) or their mother (16%) to be their most important source, but the third largest proportion (13%) described their

Figure 14.4 **Most Important Source of Information About Sexual Matters by Sexual Experience Among Women Aged 15-24 Years**



partner/boyfriend as most important. This difference likely reflects the fact that most sexually experienced young women in Georgia are married, and therefore might be more likely to discuss sexual matters with their husband than an unmarried and/or inexperienced young woman would with a boyfriend. The order also varied by ethnicity, with Armenian respondents citing their mother (30%) as a slightly more important source of information than friends (29%).

Reported information sources also varied by residence. While most women in either urban or rural settings cited friends as their most important source, rural respondents were more likely to do so (46%) than urban respondents (38%). A slightly higher proportion of urban women reported that their mother was their most important source (21%) than did rural women (17%).

14.5 Impact on Knowledge about Fertility Issues and Contraception

In order to assess the relationship between exposure to school-based or parental sex education and respondents' knowledge of reproduction, respondents 15 to 24 years of age were asked 1) when conception is most likely to occur during the menstrual cycle; 2) whether breastfeeding increases, decreases, or has no effect on a woman's risk of getting pregnant; and 3) whether or not it is possible to get pregnant at first sexual intercourse. Responses are categorized in Table 14.5 by whether or not the respondent discussed these topics with a parent or was taught about them in school.

Only a fourth of all young women were able to correctly identify the most fertile period (halfway between periods) during a woman's menstrual cycle. Despite being given multiple choices, the largest proportions of young women responded that they "don't know," including the majority of those who had not discussed the menstrual cycle with a parent (54%) and those who had not been taught about the menstrual cycle in school (51%). Exposure to school-based courses and discussions about the menstrual cycle with parents was associated with fewer "don't know" responses and more correct responses; however, the proportion of young women with correct knowledge remained low (29% among those with school-based exposure and 26% among those that had discussed the menstrual cycle with a parent). Correct knowledge of the most likely time to become pregnant increased with age. It also varied by type of residence. Accurate knowledge of when conception is most likely to occur is important to a couple's ability to assess the risk of pregnancy during unprotected intercourse, and is therefore one indicator of the potential to prevent unintended pregnancies.

Large proportions of young women correctly identified that breastfeeding lowers a woman's risk for becoming pregnant, a finding which may be related to the high prevalence of breastfeeding in Georgia. Those who had received information from a parent on how pregnancy occurs were more likely to know about the contraceptive effect of breastfeeding (49% vs. 42%), but no difference in correct responses were found between those who were or were not taught about it in school (43% each). A sizeable proportion of respondents incorrectly stated that breastfeeding has no effect on pregnancy risk. Interestingly, this mistake was more common among young women who had discussed "how pregnancy occurs" with a parent or received instruction on this topic in school (24% in both cases) than it was among their counterparts without similar exposure to information on how pregnancy occurs (17% of those who hadn't talked about it with parents and 18% of those who hadn't been educated about it in school).

The overwhelming majority of young women were aware of the possibility of getting pregnant during a woman's first sexual intercourse, especially if they had discussed how pregnancy occurs with a parent (94%) or had been exposed to the topic in a school-based course (89%). This knowledge increased with age group, with 73% of 15–17 year olds, 81% of 18-19 year olds, and 90% of 20–24 year olds giving the correct response.

Table 14.1.1 Percentage of Women Aged 15–44 Years Who Agree That Selected Sex Education Topics Should Be Taught in School Reproductive Health Survey: Georgia, 2005

	Family Life Education Topics				
Characteristic	Any Family Life Education	How Pregnancy Occurs	Sexually Transmitted Infections (STIs)	Contraception	No. of Cases
Total	80.0	80.0	78.8	78.0	6,376
Residence					
Urban	84.0	84.0	83.1	81.9	3,196
Rural	75.2	75.2	73.5	73.1	3,180
Region					
Kakheti	81.1	81.1	79.6	79.0	538
Tbilisi	82.0	82.0	81.2	79.8	1,431
Shida Kartli	80.1	80.1	78.1	77.4	430
Kvemo Kartli	69.7	69.7	69.1	67.3	576
Samtskhe-Javakheti	80.0	79.8	75.2	75.9	434
Adjara	74.5	74.5	74.5	74.1	490
Guria	77.1	77.1	69.9	71.8	388
Samegrelo	82.9	82.7	82.4	81.2	506
Imereti	86.8	86.8	85.6	84.9	782
Mtskheta-Mtianeti	78.8	78.8	78.8	78.8	374
Racha-Svaneti	85.7	85.7	84.7	84.7	427
Age Group					
15–24	83.0	83.0	82.0	81.6	2,009
25–34	82.0	82.0	80.6	79.8	2,249
35–44	74.9	74.9	73.5	72.2	2,118
Number of Living Children					
0	83.8	83.8	82.8	82.4	2,299
1	84.7	84.7	83.3	82.9	1,131
2	76.9	76.9	75.7	74.3	2,168
3+	69.1	69.1	67.2	66.0	778
Education					
Secondary incomplete or less	69.6	69.6	68.6	68.3	907
Secondary complete	78.6	78.6	76.7	75.7	1,786
Technicum	79.9	79.8	78.7	78.0	1,466
University/postgraduate	86.1	86.1	85.2	84.3	2,217
Socioeconomic Status					
Low	73.7	73.7	71.6	71.0	2,277
Middle	82.0	82.0	81.4	80.2	3,028
High	86.6	86.6	85.7	85.1	1,071
Ethnicity					
Georgian	82.8	82.8	81.7	80.9	5,545
Azeri	39.6	39.6	39.1	37.9	292
Armenian	73.6	73.6	69.8	69.2	382
Other	80.5	80.5	79.3	79.3	157
Employment					
Working	81.9	81.9	80.8	80.0	1,422
Not working	79.5	79.5	78.3	77.4	4,954

Table 14.1.2 Perceived Best Age to Start Family Life Education on "How Pregnancies Occur" and on Contraceptive Methods Among Women Aged 15–44 Years Who Agreed with Sex Education in School (Percentage Distribution)
Reproductive Health Survey: Georgia, 2005

	Best Age to Start Courses on "How Pregnancies Occur"					Best Age to Start Courses on Contraception				
Characteristic	≤13	14–15	16+	Total	No. of Cases	≤13	14–15	16+	Total	No. of Cases
Total	12.0	72.5	15.6	100.0	5,130	7.6	68.7	23.8	100.0	4,988
Residence										
Urban	13.3	72.0	14.7	100.0	2,711	8.9	67.8	23.3	100.0	2,644
Rural	10.1	73.1	16.8	100.0	2,419	5.7	69.8	24.4	100.0	2,344
Region										
Kakheti	11.0	74.9	14.1	100.0	428	6.1	73.9	20.0	100.0	417
Tbilisi	15.1	69.6	15.3	100.0	1,177	10.2	67.1	22.6	100.0	1,146
Shida Kartli	2.7	77.1	20.1	100.0	349	1.4	67.0	31.6	100.0	337
Kvemo Kartli	11.9	70.4	17.7	100.0	395	6.1	69.1	24.8	100.0	378
Samtskhe-Javakheti	17.5	68.9	13.6	100.0	350	13.6	70.5	15.9	100.0	330
Adjara	11.5	71.4	17.1	100.0	362	6.9	62.8	30.4	100.0	360
Guria	3.7	79.0	17.2	100.0	308	2.0	72.4	25.6	100.0	287
Samegrelo	10.4	71.9	17.7	100.0	416	4.7	65.7	29.6	100.0	408
Imereti	12.2	76.6	11.2	100.0	682	8.4	74.3	17.2	100.0	667
Mtskheta-Mtianeti	9.3	70.4	20.3	100.0	295	5.9	65.1	29.1	100.0	295
Racha-Svaneti	21.2	68.5	10.3	100.0	368	15.9	67.4	16.6	100.0	363
Age Group										
15–24	13.4	72.9	13.7	100.0	1,677	9.0	70.9	20.1	100.0	1,647
25–34	11.9	71.2	17.0	100.0	1,839	7.6	66.7	25.7	100.0	1,788
35–44	10.3	73.2	16.5	100.0	1,614	5.7	67.9	26.3	100.0	1,553
Number of Living Children										
0	13.5	72.0	14.5	100.0	1,928	9.4	69.2	21.5	100.0	1,897
1	11.8	74.8	13.4	100.0	962	6.8	71.8	21.4	100.0	939
2	9.9	72.1	18.0	100.0	1,691	6.0	67.0	27.0	100.0	1,630
3+	11.9	71.4	16.7	100.0	549	5.8	66.0	28.2	100.0	522
Education										
Secondary incomplete or less	9.1	74.3	16.7	100.0	621	6.9	68.5	24.6	100.0	607
Secondary complete	13.0	73.0	14.0	100.0	1,402	6.6	71.1	22.4	100.0	1,346
Technicum	10.5	72.0	17.4	100.0	1,186	7.0	67.0	26.0	100.0	1,153
University/postgraduate	13.2	71.6	15.2	100.0	1,921	8.8	68.0	23.2	100.0	1,882
Socioeconomic Status										
Low	10.8	72.3	16.8	100.0	1,695	6.0	69.1	24.9	100.0	1,625
Middle	11.8	72.9	15.3	100.0	2,509	7.2	69.1	23.8	100.0	2,452
High	14.1	71.6	14.3	100.0	926	10.9	67.2	21.9	100.0	911
Ethnicity										
Georgian	12.0	72.8	15.1	100.0	4,619	7.6	68.9	23.5	100.0	4,507
Azeri	14.5	57.3	28.2	100.0	109	2.9	64.7	32.4	100.0	104
Armenian	6.8	74.2	19.0	100.0	277	5.7	68.9	25.5	100.0	254
Other	18.2	70.6	11.3	100.0	125	13.7	64.0	22.3	100.0	123

Table 14.1.3 Perceived Best Age to Start Family Life Education about STIs Among Women Aged 15–44 Years Who Agreed with Sex Education in School Reproductive Health Survey: Georgia, 2005

	Best Age to Start Courses on STIs (Percentage Distribution)				
Characteristic	≤13	14–15	16+	Total	No. of Cases
Total	7.4	68.3	24.2	100.0	5,028
Residence					
Urban	8.7	67.5	23.8	100.0	2,677
Rural	5.7	69.4	24.9	100.0	2,351
Region					
Kakheti	5.3	73.5	21.2	100.0	421
Tbilisi	10.1	66.6	23.2	100.0	1,165
Shida Kartli	1.4	67.3	31.3	100.0	341
Kvemo Kartli	6.1	68.9	25.0	100.0	390
Samtskhe-Javakheti	13.8	70.4	15.8	100.0	326
Adjara	6.8	62.6	30.6	100.0	362
Guria	2.0	71.9	26.0	100.0	279
Samegrelo	4.8	64.7	30.5	100.0	413
Imereti	8.2	73.9	17.8	100.0	673
Mtskheta-Mtianeti	5.9	64.8	29.3	100.0	295
Racha-Svaneti	15.5	67.4	17.1	100.0	363
Age Group					
15–24	9.0	70.4	20.7	100.0	1,651
25–34	7.5	66.8	25.7	100.0	1,803
35–44	5.5	67.3	27.2	100.0	1,574
Number of Living Children					
0	9.2	68.7	22.1	100.0	1,902
1	6.9	71.0	22.0	100.0	945
2	5.8	66.8	27.3	100.0	1,654
3+	5.6	66.2	28.2	100.0	527
Education					
Secondary incomplete or less	6.7	69.0	24.3	100.0	608
Secondary complete	6.7	70.4	22.9	100.0	1,356
Technicum	7.0	66.3	26.7	100.0	1,164
University/postgraduate	8.5	67.7	23.8	100.0	1,900
Socioeconomic Status					
Low	5.9	68.9	25.2	100.0	1,631
Middle	7.1	68.7	24.3	100.0	2,480
High	10.7	66.6	22.7	100.0	917
Ethnicity					
Georgian	7.5	68.5	24.0	100.0	4,545
Azeri	2.8	65.7	31.5	100.0	107
Armenian	6.0	67.8	26.2	100.0	253
Other	13.7	64.0	22.3	100.0	123

Table 14.2 Percentage of Young Adult Women Aged 15–24 Years Who Discussed Selected Family Life Education Topics with a Parent Before They Reached Age 18 Reproductive Health Survey: Georgia, 2005

	Family Life Education Topic						
Characteristic	Any Topic	Menstrual Cycle	Contraceptive Methods	How Pregnancy Occurs	HIV/ AIDS	Other STIs	No. of Cases
Total	81.4	79.9	19.0	17.0	7.8	2.2	2,009
Residence							
Urban	83.3	81.2	21.6	18.6	12.4	3.7	990
Rural	79.2	78.3	15.9	14.9	2.1	0.5	1,019
Region							
Kakheti	83.2	82.8	14.7	19.8	0.4	0.0	189
Tbilisi	79.9	76.9	23.8	22.4	17.2	6.9	447
Shida Kartli	77.9	77.9	18.4	9.8	1.8	1.2	116
Kvemo Kartli	72.7	72.3	18.4	11.0	2.8	0.4	201
Samtskhe-Javakheti	84.6	84.6	26.3	20.1	7.3	0.8	163
Adjara	78.7	77.1	11.5	10.7	9.1	0.0	163
Guria	88.6	88.1	21.9	4.5	4.5	0.0	127
Samegrelo	87.6	83.6	14.1	14.1	8.5	2.3	134
Imereti	89.2	88.9	19.6	21.7	1.2	0.0	239
Mtskheta-Mtianeti	73.4	69.5	18.2	13.6	7.1	1.3	108
Racha-Svaneti	88.3	85.6	15.6	14.4	3.9	2.8	122
Age Group							
15–17	84.0	83.2	17.9	17.8	9.0	2.6	515
18–19	81.0	79.4	19.1	18.1	7.7	2.9	415
20–24	80.0	78.1	19.7	15.9	7.1	1.7	1,079
Number of Living Children							
0	82.0	80.6	19.1	16.9	8.5	2.6	1,466
1	83.9	81.9	19.5	18.3	6.3	1.3	356
2	69.4	66.9	16.8	14.5	2.2	0.6	173
3+	*	*	*	*	*	*	14
Education							
Secondary incomplete or less	78.4	77.0	14.5	14.0	5.6	0.7	578
Secondary complete	83.4	82.5	17.1	16.8	5.0	2.3	629
Technicum	86.3	85.8	22.7	19.9	9.7	2.4	217
University/postgraduate	81.1	78.4	24.4	19.2	12.0	3.7	585
Socioeconomic Status							
Low	79.6	77.8	16.2	14.1	3.1	1.1	741
Middle	81.9	81.0	20.0	16.9	8.2	1.7	952
High	83.8	81.1	22.1	22.6	16.0	6.0	316
Ethnicity							
Georgian	83.1	81.6	19.1	17.4	8.3	2.2	1,701
Azeri	65.2	65.2	18.8	14.4	0.0	0.7	114
Armenian	74.2	73.3	16.6	13.7	5.5	2.8	151
Other	83.8	74.6	25.2	17.4	17.7	5.6	43
Sexually Experienced							
No	81.6	80.4	19.1	16.9	9.1	2.8	1,268
Yes	81.0	78.7	19.0	17.1	4.8	1.1	741
Religious Attendance							
Monthly	85.3	83.8	23.2	20.9	13.6	4.1	709
Less than monthly	86.1	84.0	26.2	21.5	5.9	1.0	284
Holidays only	80.3	78.8	14.4	13.0	4.8	1.5	737
Never	69.9	68.6	12.5	11.6	1.4	0.3	279

* less than 25 cases

Table 14.3 Percentage of Young Adult Women Aged 15–24 Years Who Were Taught Family Life Education Topics in School Before They Reached Age 18 Reproductive Health Survey: Georgia, 2005

Characteristic	Family Life Education Topics								No. of Cases
	Any Topic	Female Reproductive Biology	Male Reproductive Biology	Menstrual Cycle	How Pregnancy Occurs	Other STDs	HIV/ AIDS	Contraception	
Total	48.9	43.8	41.8	36.8	24.9	10.5	2.5	2.3	2,009
Residence									
Urban	60.7	54.1	51.1	43.7	30.6	15.6	3.8	3.4	990
Rural	34.5	31.3	30.4	28.3	18.0	4.4	0.8	1.0	1,019
Region									
Kakheti	33.3	30.4	28.9	22.0	11.0	0.4	0.4	0.0	189
Tbilisi	69.6	59.3	55.0	54.3	34.6	19.6	6.6	6.1	447
Shida Kartli	49.1	43.6	44.8	40.5	28.8	1.2	0.0	0.6	116
Kvemo Kartli	38.7	36.2	33.3	31.9	20.9	3.2	1.8	1.4	201
Samtskhe-Javakheti	41.7	41.3	41.3	40.9	18.1	12.4	0.4	1.2	163
Adjara	36.8	33.2	33.2	22.1	20.2	14.2	0.0	0.0	163
Guria	73.6	72.1	71.1	62.7	57.2	11.4	2.5	4.5	127
Samegrelo	46.9	40.7	37.9	26.0	26.6	13.6	1.1	0.6	134
Imereti	38.3	36.4	34.9	27.1	17.8	4.8	1.2	1.2	239
Mtskheta-Mtianeti	51.3	44.2	43.5	38.3	20.8	11.7	3.2	1.9	108
Racha-Svaneti	30.0	24.4	22.2	22.8	11.7	2.8	1.1	0.0	122
Age Group									
15–17	49.3	41.4	39.7	38.1	24.6	12.2	1.6	1.5	515
18–19	50.8	46.2	43.7	36.4	26.0	12.5	5.1	3.5	415
20–24	47.9	44.3	42.2	36.1	24.7	8.7	1.9	2.3	1,079
Number of Living Children									
0	51.6	46.0	43.8	38.9	25.6	11.8	2.9	2.7	1,466
1	44.4	39.8	37.3	32.0	25.0	6.3	1.3	1.3	356
2	29.1	28.5	28.5	23.9	16.5	5.2	0.0	0.0	173
3+	*	*	*	*	*	*	*	*	14
Education									
Secondary incomplete or less	39.3	34.1	32.1	29.7	20.4	7.9	1.1	1.2	578
Secondary complete	45.7	40.0	39.2	34.2	22.9	10.4	2.8	2.6	629
Technicum	48.1	42.7	40.5	36.0	19.6	12.4	0.4	0.3	217
University/postgraduate	62.3	58.0	54.6	46.9	33.3	12.9	4.3	3.8	585
Socioeconomic Status									
Low	36.5	33.3	31.2	27.2	19.1	5.1	0.5	0.8	741
Middle	53.5	48.0	45.9	41.3	26.1	13.3	2.8	2.6	952
High	61.7	53.8	51.9	43.9	33.3	14.3	5.5	4.6	316
Ethnicity									
Georgian	52.0	46.7	44.5	38.3	26.2	11.3	2.6	2.5	1,701
Azeri	9.5	8.3	8.0	7.5	6.2	0.0	0.0	0.0	114
Armenian	45.3	41.0	39.2	42.0	27.4	9.2	1.8	2.4	151
Other	50.2	41.1	37.3	46.5	19.5	14.0	7.4	1.9	43
Sexually Experienced									
No	51.7	45.6	43.6	38.8	25.4	12.6	3.0	2.7	1,268
Yes	42.6	39.7	37.7	32.2	23.8	5.8	1.3	1.4	741
Religious Attendance									
Monthly	61.6	54.1	52.3	43.3	30.6	16.7	4.1	4.0	709
Less than monthly	56.2	53.0	50.0	43.3	24.0	9.2	2.6	2.0	284
Holidays only	42.4	38.3	35.6	33.7	23.4	7.9	1.7	1.5	737
Never	25.0	22.0	21.4	21.4	15.0	2.1	0.0	0.2	279

* Less than 25 cases.

Table 14.4 Most Important Source of Information About Sexual Matters Among Young Adult Women Aged 15–24 Years, by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Most Important Source of Information (Percentage Distribution)										
Characteristic	Friend	Mother	Radio/ TV	Books/ Prints	Teacher	Other Relative	Doctor/ Nurse	Partner/ Boyfriend	Other	Total	No. of Cases
Total	41.6	19.1	10.4	9.4	6.5	4.2	4.1	3.9	0.9	100.0	2,009
Residence											
Urban	38.3	20.6	12.2	10.8	7.9	2.5	4.7	2.3	0.8	100.0	990
Rural	45.6	17.3	8.3	7.6	4.9	6.3	3.3	5.8	1.0	100.0	1,019
Region											
Kakheti	56.4	14.3	5.9	6.6	4.8	7.3	0.7	3.7	0.4	100.0	189
Tbilisi	31.9	21.5	12.4	14.7	10.2	0.9	5.8	1.4	1.2	100.0	447
Shida Kartli	32.5	23.3	20.2	15.3	2.5	.	2.5	3.7	0.0	100.0	116
Kvemo Kartli	40.1	22.3	11.0	6.0	3.5	9.9	0.4	5.3	1.4	100.0	201
Samtskhe-Javakheti	37.1	23.9	3.1	4.2	3.9	1.2	12.4	12.0	2.3	100.0	163
Adjara	40.3	18.6	11.1	7.1	5.9	10.7	0.4	5.1	0.8	100.0	163
Guria	20.4	23.4	13.4	16.9	12.9	3.5	0.0	9.5	0.0	100.0	127
Samegrelo	38.4	19.2	7.9	8.5	15.3	4.5	0.0	5.6	0.6	100.0	134
Imereti	61.1	12.3	9.0	3.9	1.5	1.5	8.7	1.2	0.6	100.0	239
Mtskheta-Mtianeti	51.3	15.6	7.1	7.1	2.6	0.6	12.3	3.2	0.0	100.0	108
Racha-Svaneti	62.2	5.6	7.2	14.4	1.7	2.8	1.1	2.2	2.8	100.0	122
Age Group											
15–17	38.6	23.4	13.8	7.1	6.3	3.3	5.2	1.0	1.3	100.0	515
18–19	46.5	17.8	9.8	7.4	7.2	3.4	4.4	2.8	0.7	100.0	415
20–24	41.2	17.0	8.6	11.6	6.4	5.1	3.2	6.1	0.7	100.0	1,079
Number of Living Children											
0	42.5	19.9	11.5	10.0	6.5	3.3	4.3	1.0	0.9	100.0	1,466
1	38.9	16.7	7.7	7.0	7.1	5.4	3.5	13.2	0.5	100.0	356
2	37.2	15.5	4.0	6.4	5.8	10.4	2.9	16.5	1.3	100.0	173
3+	*	*	*	*	*	*	*	*	*	*	14
Education											
Secondary incomplete or less	38.4	21.9	11.4	6.5	6.9	5.4	3.8	4.3	1.4	100.0	578
Secondary complete	45.6	18.4	9.2	7.4	5.9	4.6	3.3	4.9	0.6	100.0	629
Technicum	41.1	16.1	6.7	11.5	9.7	3.2	6.9	4.9	0.0	100.0	217
University/postgraduate	41.1	17.8	11.9	13.5	5.7	3.0	4.1	2.0	0.9	100.0	585
Socioeconomic Status											
Low	44.9	15.7	10.6	7.0	4.4	6.8	3.5	5.8	1.4	100.0	741
Middle	41.6	19.1	9.6	9.9	7.7	3.5	4.6	3.3	0.6	100.0	952
High	35.0	25.7	12.2	12.7	7.5	1.0	3.8	1.6	0.6	100.0	316
Ethnicity											
Georgian	42.0	19.0	11.2	10.0	6.8	3.4	4.3	2.8	0.6	100.0	1,701
Azeri	47.4	13.8	1.4	5.9	2.6	17.4	0.6	7.6	3.3	100.0	114
Armenian	29.1	30.0	10.3	5.2	6.4	1.6	2.5	13.4	1.4	100.0	151
Other	43.0	7.5	8.1	6.6	7.4	7.0	7.6	7.2	5.6	100.0	43
Sexually Experienced											
No	42.3	20.4	12.0	10.1	6.9	2.7	4.4	0.1	1.0	100.0	1,268
Yes	39.7	16.1	6.9	7.7	5.6	7.5	3.2	12.5	0.7	100.0	741
Religious Attendance											
Monthly	37.3	23.4	10.3	11.3	8.2	1.4	5.5	1.5	1.0	100.0	709
Less than monthly	49.3	13.9	11.2	9.7	4.8	3.9	2.3	5.0	0.0	100.0	284
Holidays only	44.4	14.2	10.6	9.8	7.6	4.3	4.8	3.8	0.5	100.0	737
Never	38.9	23.9	9.7	3.1	1.6	11.3	0.3	9.0	2.3	100.0	279

* Less than 25 cases.

Table 14.5 Knowledge Among Young Adult Women Aged 15–24 Years Regarding Selected Reproductive Health Issues by Whether or Not Specific Family Life Education Topics Were Discussed with a Parent or Learned in School and by Age Group Reproductive Health Survey: Georgia, 2005

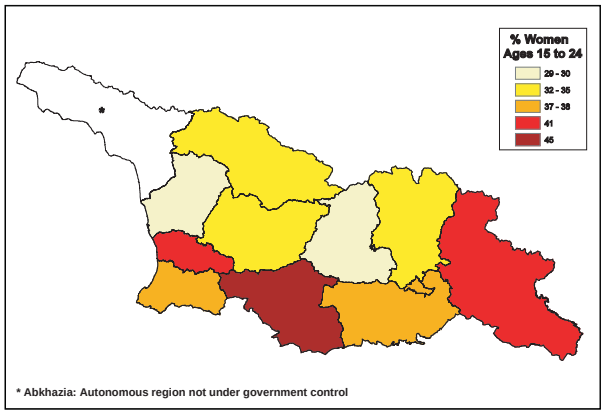
		Exposure to Family Life Education				Age Group		
Reproductive Health Issue	Total	Discussed Menstrual Cycle With a Parent		Taught about Menstrual Cycle in School		15–17	18–19	20–24
		No	Yes	No	Yes			
Most Likely Time to Become Pregnant During Menstrual Cycle	%	%	%	%	%	%	%	%
Halfway	24.9	20.4	26.1	22.5	29.2	8.5	23.3	35.8
Before period	16.0	11.4	17.1	15.6	16.6	11.1	15.6	19.1
Anytime	12.5	14.6	12.0	11.1	14.9	14.1	10.8	12.2
Do not know	46.6	53.6	44.9	50.8	39.4	66.3	50.2	32.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of cases	2,009	396	1,613	1,263	746	515	415	1,079
Risk of Getting Pregnant While Breastfeeding	Total	Discussed "How Pregnancy Occurs" With a Parent		Taught about "How Pregnancy Occurs" in School		15–17	18–19	20–24
		No	Yes	No	Yes			
	%	%	%	%	%	%	%	%
Lower risk	43.2	42.0	49.2	43.4	42.8	25.0	37.2	57.2
Has no effect	18.8	17.7	23.9	17.1	23.7	17.3	17.9	20.1
Higher risk	0.8	0.8	0.9	0.8	0.8	0.5	0.2	1.3
Do not know	37.1	39.4	26.0	38.6	32.7	57.2	44.7	21.3
Possibility of Getting Pregnant at First Intercourse	Total	Discussed "How Pregnancy Occurs" With a Parent		Taught about "How Pregnancy Occurs" in School		15–17	18–19	20–24
		No	Yes	No	Yes			
	%	%	%	%	%	%	%	%
Possible	82.9	80.7	93.9	80.8	89.2	73.4	80.8	89.7
Not possible	3.8	4.1	2.7	3.7	4.4	4.2	3.2	3.9
Do not know	13.2	15.3	3.4	15.5	6.4	22.3	16.0	6.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of cases	2,009	1,688	321	1,505	504	515	415	1,079

Chapter 15

SEXUAL AND CONTRACEPTIVE EXPERIENCE OF YOUNG ADULTS

As with the other reproductive health surveys conducted in the region, the GERHS05 included a module that was administered to adolescent and young adult women aged 15-24 years to assess their sexual and reproductive behaviors, particularly the risk for unplanned pregnancy and sexually transmitted infections. Young adult women are an important group to consider when assessing reproductive health issues in Georgia, especially given that they make up over a third of the survey population in most regions (Figure 15.1). This chapter explores survey findings regarding young adult women's sexual experiences, contraceptive use, and sexual partners—all of which can be particularly valuable information for planning reproductive health strategies and sex education for young people.

Figure 15.1 **Proportion of Respondents who were Young Adults (15-24 years old) by Region**



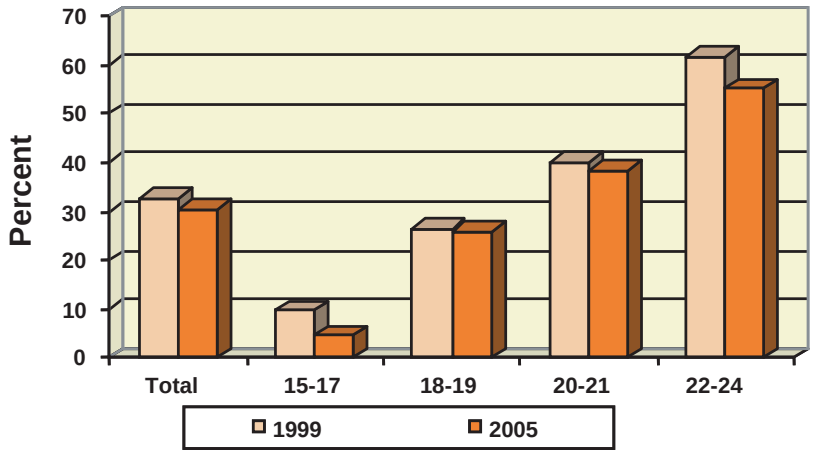
15.1 Sexual Experience

Less than a third of respondents aged 15–24 years reported being sexually experienced (defined as having ever had sexual intercourse), which reflects a slight decrease since the 1999 survey (33% to 30%). Young women in rural areas reported higher levels of being sexually experienced than urban women, as did Azeri respondents compared to young women of other ethnicities, most likely due to earlier typical age of marriage (Table 15.1.1) Young women in all four age groups reported lower rates of being sexually experienced than their counterparts in 1999 (shown in Table 15.1.2 and Figure 15.1.1). However, except for the difference between 15–17-year-olds in 1999 and 2005 (p=0.05), the difference is not statistically significant. There was also little or no gap between first union and first intercourse in 2005, suggesting that any decrease in rates of sexual experience could be partially explained by the growing proportion of young women who are delaying marriage. The proportion of 20–24-year-olds who had ever been married has dropped by 9% since the last survey (48% in 2005 compared to 53% in 1999). The rates of premarital sexual experience remained very low among all young women (2.5%) in 2005, suggesting that almost all sexual experience occurred within marriage. However, this may also be because some sexually experienced respondents were unwilling to report sexual activity, due to social norms against adolescent sexual activity in Georgia.

Table 15.1.3 shows that reported rates of sexual experience among young women was higher among rural residents (35%) than urban residents (27%), which is likely due primarily to the tendency to marry at younger ages in rural areas. This finding was principally true for 20–24-year-old women. Educational attainment was also a factor among women in this age group: There was an inverse relationship between level of educational attainment and sexual experience (Table 15.1.4). Rates of being sexually experienced ranged from 72% among the least educated women in this age group (incomplete secondary or less) to 45% among technicum-educated women and 34% among women with a university education.

Consistent with the low contraceptive prevalence detailed in Chapter 8, only 3% of sexually experienced young women ages 15–24 reported that they or their partner used contraception at the woman's first

Figure 15.1.1 **Sexual Experience Among Women Aged 15-24 Years by Age Group**



intercourse, which may be attributable in part to limited availability of sexual education programs and family planning services, including the absence of targeted family planning services for young adults. Education programs addressing sexual and reproductive health issues are not included in school curricula, and there is a perception among some officials that this type of education may promote sexual activity among adolescents.

Of those who did not use contraception, the main reasons given were the desire to get pregnant (78%), not thinking about using a method (14%), and not knowing about contraception (5%) (Table 15.1.5). The main reason for nonuse of contraceptives at first intercourse varied slightly by marital status, but the desire to get pregnant was the primary reason for both unmarried and married young women (Figure 15.1.2). Among young women whose first intercourse was premarital, 65% said that desire to get pregnant was the primary reason for not using contraceptives, while the second most frequently reported reason was that the intercourse was unexpected (16%). Over half (57%) of women reporting premarital sex indicated that they had been dating their partner for at least one year; it may be that many of these respondents believed marriage was imminent and therefore wanted to get started on their families. Among those whose first intercourse was marital, 79% cited a desire for pregnancy while 14% did not think about contraceptives.

Figure 15.1.2 **Most Commonly Cited Reasons Given by Young Women for Not Using Contraceptives at First Sexual Intercourse When it Was Classified as Marital**

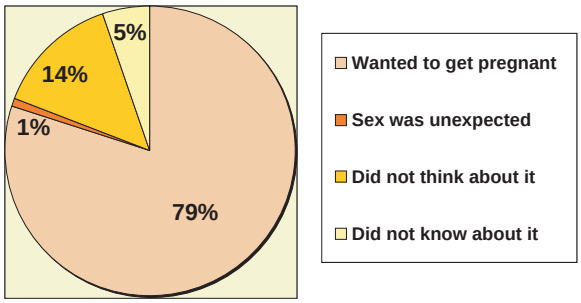
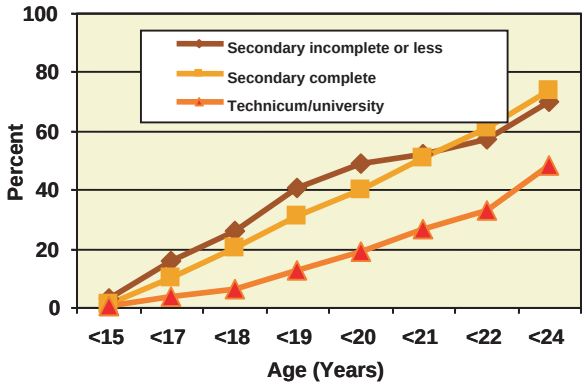


Figure 15.2.1 **Percentage of Young Adult Women Who Became Sexually Experienced Before Selected Ages, by Educational Attainment**



15.2 First Sexual Intercourse

The respondents' date (month and year) of first sexual intercourse, birth date, and age at time of the interview were all recorded to calculate age at first sexual intercourse. The life table estimates in Table 15.1.1 show that less than 2% of young women reported having had sexual intercourse by age 15, and only 46% had had sexual intercourse by age 22. Age at first intercourse varied widely across educational attainment (Figure 15.2.1). By age 24, only 48%

of young women with a technicum or university education have had sexual intercourse, compared to more than 70% of less educated women. Age at first intercourse also varied by ethnicity. Over half (58%) of Azeri women and 45% of Armenian women reporting having had sexual intercourse before age 20 (Figure 15.2.2). In comparison, Georgian women tend to delay sexual intercourse longer, with a majority delaying sex until after age 22. Although there is an inverse relationship between age at first sexual intercourse and socioeconomic status, the difference is less pronounced by age 22 and disappears by age 24. As is the case in many countries, young women in rural areas tend to have their first sexual experience at earlier ages than urban women. Differences among these groups are most likely due to variations in typical age at marriage.

As shown in Table 15.2.1, partnering sexually with older men was relatively common for young women in Georgia. Forty-one percent of all sexually experienced young women had their first sexual experience with a partner who was six or more years older. This was even more frequently the case among young women residing in rural areas (46%), where the age gap between partners was the widest (Figure 15.2.3). Rates were lower among sexually experienced urban respondents: 30% of young women in Tbilisi and 39% of their counterparts in other urban areas reported having first intercourse with a partner who was six or more years older. Overall, young women whose first intercourse occurred before age 18 more frequently reported having partners who were six or more years older (47%); however, they reported partners ten or more years older with similar frequency as young women who were 20–24 years old at first intercourse (14% and 13% respectively). This finding is particularly striking among young women who had first intercourse at the youngest ages (13–15 years old), the largest proportion of whom had partners who were six or more years older (39%) (Figure 15.2.4). More married women tended to have first sexual partners that were within three years of age (36%) than did unmarried women (23%).

Figure 15.2.2 **Percentage of Young Adult Women Who Became Sexually Experienced before Given Ages, by Ethnic Group**

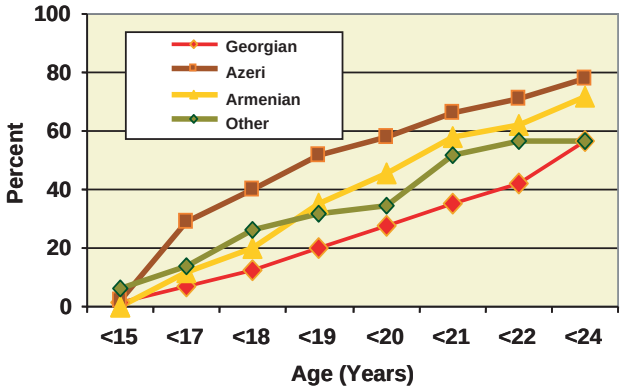


Figure 15.2.3 **Age Difference Between Partners at First Sexual Intercourse, by Respondent's Age at First Intercourse and by Residence**

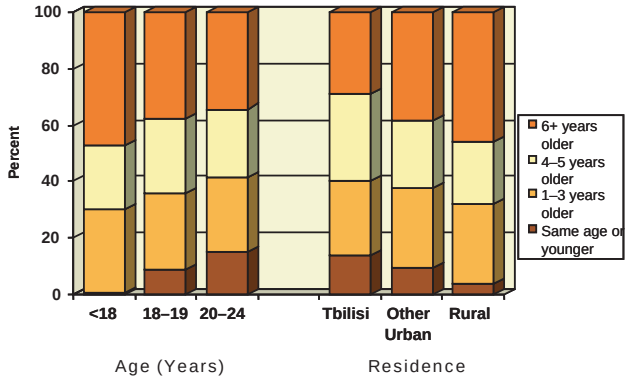
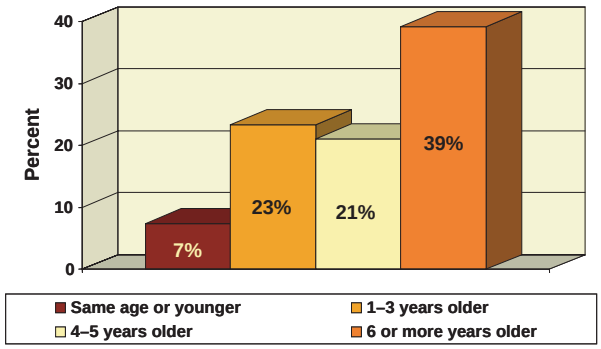


Figure 15.2.4 **Age Difference Between Partners at First Sexual Intercourse Among Young Women Whose First Intercourse Occurred Between Ages 13 and 15**



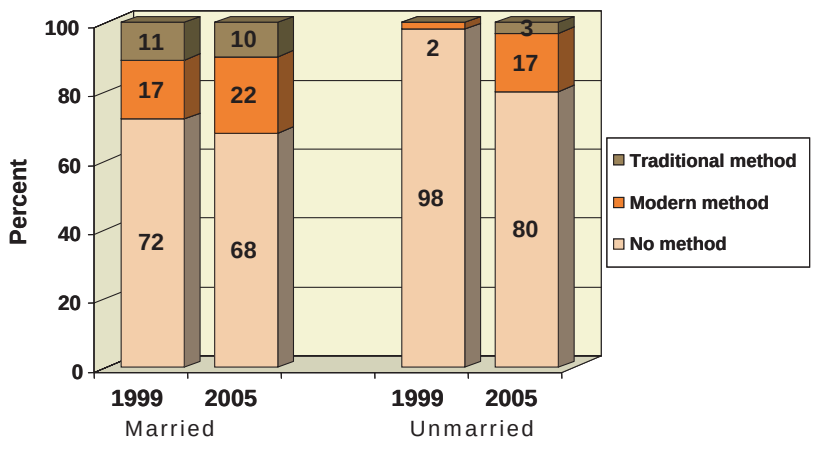
Since the majority of young women were married at the time of their first sexual intercourse, partners at first sexual intercourse were primarily husbands (91%) (Table 15.2.2). This was true regardless of type of residence, educational attainment, SES, or ethnic group. Among young women whose first experience was premarital, 80% described their partner as being a boyfriend or fiancé. Young women were also asked how long they had been dating their partner before they engaged in their first sexual experience. Whether the first sexual experience was reported as marital or premarital, a large proportion of young women reported dating their partner less than one year before initiating sexual activity (44% and 40%, respectively) (Table 15.2.3).

15.3 Current Sexual Activity

To determine the proportion of young women exposed to the risk of pregnancy at the time of the survey, information was gathered on current sexual activity, based on the date of last sexual intercourse (Table 15.3.1). Most sexually experienced women reported current sexual activity, with 61% of married women having had intercourse within the last 30 days prior to their interview. Slightly more than a third (34%) of married young women and 4% of previously married young women were identified as currently pregnant, postpartum, or breastfeeding.

Figure 15.3.1 and Table 15.3.2 show that rates of contraceptive use at last intercourse increased among young women in Georgia since the last survey, most noticeably among unmarried women (from 2% in 1999 to 20% in 2005). Yet despite increased contraceptive use in this group, rates are still lower than among married women (32%). Types of contraception used at most recent sexual intercourse by marital status and age groups are displayed in Table 15.3.2. Thirty-two percent of married women reported using a modern method (22%) or traditional method (10%) at last sexual intercourse. The youngest group of married women (15–19 years) reported lower rates of contraceptive use at most recent sexual intercourse, compared to 20–24-year-olds (13% versus 38%). Unlike the older group (20–24 years), a larger

Figure 15.3.1 **Trends in Contraceptive Use at Last Sexual Intercourse, by Marital Status Among Young Women Aged 15–24 Years**



proportion of married adolescents (15–19) relied on traditional methods (8%) rather than modern methods (5%). This suggests there may be a lack of information about and/or access to modern contraceptives among married adolescents. Among unmarried young women who use contraceptives, 85% used modern methods, principally condoms.

Multiple lifetime partners were only rarely reported by sexually experienced young women (Table 15.3.3). Eighty-nine percent reported having one partner in the last three months, while the remaining 11% reported having no sexual partners in the last three months. Ninety-eight percent of young women reported one partner in their lifetime, leaving only 2% who had had two or more partners in their lifetime. One of every seven previously married women reported two or more partners.

15.4 Opinions and Attitudes About Condoms and Condom Use

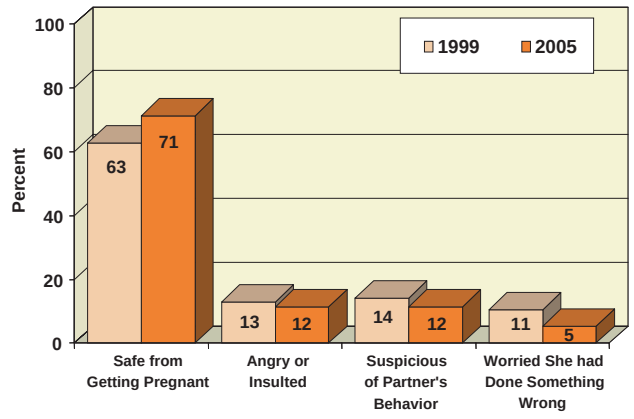
Sexually experienced young women were categorized based on whether or not they had ever used condoms (ever-users and never-users) and asked about the extent to which they agreed or disagreed with statements related to condom use (Table 15.4.1). Most sexually experienced respondents who had ever used condoms agreed that using condoms with a new partner is a smart idea (86%) and that women should ask their partners to use condoms (81%). In contrast, only 53% of sexually experienced young women who had never used condoms agreed that using condoms with a new partner is a good idea, and only 20% agreed that women should ask their partners to use condoms. Never-users of condoms more frequently reported being uncertain about these statements (selecting "don't know" as opposed to agreeing or disagreeing). Interestingly, a slightly higher proportion of ever-users (46%) than never-users (43%) agreed that condoms are not necessary if you know your partner.

As shown in Table 15.4.2, discussions about condom use among sexually experienced young women and their partners were infrequent, with only 23% having ever talked about condoms with a partner. However, 86% of women who have ever used condoms talked with their partner about using condoms, compared with only 12% who have never used condoms. The proportion of young women who had ever talked to their partner about using condoms varied based on age group, education, and residence. The proportion increased with age and education. Twenty-six percent of young women aged 20–24, compared to 11% of young women aged 15–19, had discussed condom use with their partner. Similarly, 33% of young women with technicum or university education had conversations about condoms, compared to 20% of young women who had completed secondary school and 9% of young women who had an incomplete secondary education or less. Twelve percent of young women in rural areas, 23% in urban areas outside of Tbilisi and 49% in Tbilisi reported having had conversations with partners about condom use.

Sexually experienced young women were asked if they agreed with specific statements about their partner or husband wanting to use a condom. Seventy-one percent stated that using a condom would make them feel safe from getting pregnant (Table 15.4.3). This is a 9% increase from 1999, suggesting a growing confidence in this method among young women in Georgia. This sentiment varied somewhat by various characteristics. Eighty-four percent of urban women would feel safe from getting pregnant compared to 61% of rural women. Feeling safe from pregnancy with condom use generally increased with educational attainment; only 50% of young women with incomplete secondary or less education reporting feeling safe, compared to 72% of young women with complete secondary education and over 80% of respondents with technicum (82%) and university (81%) education. This feeling was very prevalent among those who were ever-users of condoms (92%) and women who had spoken to partners about condom use (94%). When asked if condom use made them feel safe from getting STDs, including HIV/AIDS, 67% of young women agreed that it did. Again,

there were disparities based on certain characteristics, with higher rates of agreement among urban women (80%), women aged 20–24 (70%), ever-users of condoms (87%), and those who had talked to a partner about using condoms (88%). Young women were also asked how they would react to a partner's suggestion of condom use; 12% of young women said they would be insulted or angry, 12% would feel suspicious that her partner might be sleeping with other women, and 5% would feel like her partner had done something wrong. This may suggest a slight decrease in stigma surrounding condom use because a lower percentage of women agreed with those statements in 2005 than in 1999 (Figure 15.4.1).

Figure 15.4.1 How Respondent Would Feel if Partner Wanted to Use a Condom

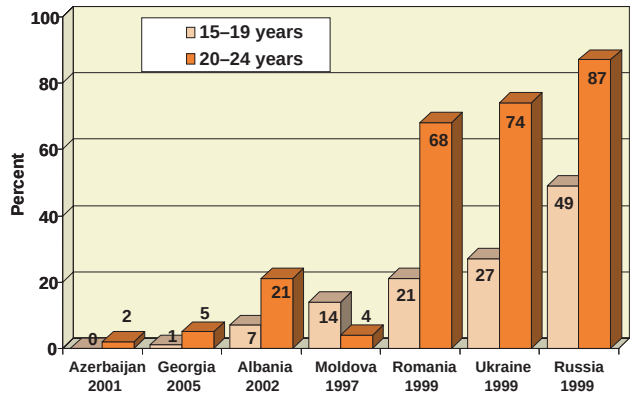


15.5 Regional Comparisons

Sexual experiences of young adults vary throughout Eastern Europe, particularly in terms of premarital sex and contraceptive use. These differences are illustrated in Table 15.5.1 and Figure 15.5.1, which present data from surveys conducted in the past decade in Albania, Moldova, Russia, Romania, Ukraine, Azerbaijan, and Georgia. Russia has the highest level of reported premarital sexual experience (71%), followed by Ukraine (48%) and Romania (44%). As is consistent with the traditionally conservative Caucasus region, rates were lowest in Azerbaijan (1%) and Georgia (3%).

Noticeable differences between Georgia and other Eastern European countries can also be seen in contraceptive use. Contraceptive use at first premarital sexual experience was as high as 57% in Romania; however, only 3% of young women in Georgia reported contraceptive use. This proportion remained steady since 1999, suggesting that little progress has been made in this area in Georgia. However, in 2006, UNFPA launched the European Commission/UN Population Fund (EC/UNFPA)-funded Reproductive Health Initiative for Youth in South Caucasus (RHIYC) project, which is a large-scale, multi-partner initiative aimed at making sustainable improvement in the

Figure 15.5.1 Premarital Sexual Experience Among Young Adult Women, by Age Group Selected Countries in Eastern Europe and Caucasus



sexual and reproductive health and rights of the most vulnerable young populations in Georgia, Armenia, and Azerbaijan. Using best practices from around the world, RHIYC is designed to meet the needs of youth ages 15 to 24, and aims to reach at least 50% of the region's 2,850,000 youth. The objectives are to inform, educate, and communicate with youth about their sexual and reproductive health and rights; improve availability of and access to quality youth-friendly sexual and reproductive health services; and strengthen inter-country collaboration and networking on young adult sexual and reproductive health issues.

Table 15.1.1 Age at First Sexual Intercourse and Percentage of Women Aged 15–24 Years Who Reported Sexual Experience, by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Age at First Sexual Intercourse (Life Table Estimates)					Sexual Experience		
Characteristic	<15	<18	<20	<22	<24	Had Intercourse	Never Had Intercourse	No. of Cases
Total	1.5	15.0	30.6	45.5	59.1	30.3	69.7	2,009
Residence								
Urban	1.5	11.6	25.6	40.1	53.6	26.6	73.4	990
Rural	1.5	19.2	36.7	52.3	65.7	34.7	65.3	1,019
Education								
Secondary incomplete or less	3.0	26.4	48.9	57.3	70.3	18.5	81.5	578
Secondary complete	1.3	20.6	40.4	61.2	73.9	43.1	56.9	629
Technicum/university	0.5	6.5	19.4	33.3	48.3	29.9	70.1	802
Socioeconomic Status								
Low	2.5	19.5	34.9	46.6	57.5	29.6	70.4	741
Middle	1.0	14.6	29.1	45.7	56.7	30.7	69.3	952
High	0.6	7.6	26.6	41.8	64.1	30.6	69.4	316
Ethnicity								
Georgian	1.5	12.5	27.4	42.1	56.5	27.8	72.2	1,701
Azeri	2.0	40.1	58.0	70.9	78.1	55.2	44.8	114
Armenian	0.0	19.9	45.3	62.3	71.7	38.3	61.7	151
Other	6.4	26.1	34.4	56.3	56.3	38.5	61.5	43

Table 15.1.2 Reported Sexual Experience of Young Women Aged 15-24 years by Marital Status at Time of First Sexual Experience by Age Group at Time of Survey Reproductive Health Survey: Georgia 2005

Current Age	Reported Sexual Experience			Marital Status at First Intercourse		
	No Sexual Experience %	Sexual Experience %	Total %	After Marriage %	Before Marriage %	No. of Cases
Total (15-24)	69.5	30.5	100.0	28.0	2.5	2,009
15-17	95.3	4.7	100.0	4.6	0.1	515
18-19	73.5	26.5	100.0	25.0	1.5	415
20-21	61.5	38.5	100.0	35.3	3.3	410
22-24	44.6	55.4	100.0	50.1	5.3	669

Table 15.1.3 Reported Sexual Experience of Young Women Aged 15-24 years by Marital Status at Time of First Sexual Experience by Residence Reproductive Health Survey: Georgia 2005

	Reported Sexual Experience (Percentage Distribution)				
	No Sexual Experience	After Marriage	Before Marriage	Total	No. of Cases
Total	69.5	28.0	2.5	100.0	2,009
15-19	86.3	13.1	0.7	100.0	930
20-24	51.8	43.8	4.4	100.0	1,079
Urban					
Total	73.4	24.7	1.9	100.0	990
15-19	87.9	11.5	0.6	100.0	463
20-24	58.4	38.3	3.3	100.0	527
Rural					
Total	64.8	32.0	3.2	100.0	1,019
15-19	84.3	14.9	0.7	100.0	467
20-24	43.4	50.7	5.9	100.0	552

Table 15.1.4 Reported Sexual Experience of Young Women Aged 15-24 years by Marital Status at Time of First Sexual Experience by Education Reproductive Health Survey: Georgia 2005

	Reported Sexual Experience (Percentage Distribution)				
	No Sexual Experience	After Marriage	Before Marriage	Total	No. of Cases
Total	69.5	28.0	2.5	100.0	2,009
15-19	86.3	13.1	0.7	100.0	930
20-24	51.8	43.8	4.4	100.0	1,079
Secondary Incomplete or Less					
Total	81.5	17.4	1.1	100.0	578
15-19	91.5	8.5	0.1	100.0	460
20-24	27.9	65.2	6.8	100.0	118
Secondary Complete					
Total	56.4	39.6	4.0	100.0	629
15-19	77.4	20.5	2.1	100.0	266
20-24	38.6	55.8	5.6	100.0	363
Technicum					
Total	65.1	31.1	3.9	100.0	217
15-19	89.0	9.5	1.5	100.0	48
20-24	54.9	40.2	4.9	100.0	169
University/Postgraduate					
Total	71.2	26.7	2.0	100.0	585
15-19	83.2	16.8		100.0	156
20-24	66.1	31.0	2.9	100.0	429

Table 15.1.5 Most Commonly Cited Primary Reasons for Not Using Contraception at First Sexual Intercourse by Marital Status at First Sexual Intercourse Reproductive Health Survey: Georgia 2005

		Marital Status at First Intercourse (Percentage Distribution)	
	Total	Marital	Premarital
Reason			
Wanted to get pregnant	77.8	78.9	64.5
Did not think about using a method/negligence	13.5	13.7	14.1
Did not know about contraception	5.1	5.1	5.7
Sex was not expected	2.0	0.9	15.7
Respondent was against it	0.4	0.5	0.0
Partner was against it	0.2	0.2	0.0
Thought it was a safe time of the month	0.1	0.1	0.0
Thought that contraceptive methods are harmful	0.1	0.1	0.0
Respondent afraid of partner's reaction	0.1	0.1	0.0
Respondent was too embarrassed to use a method	0.1	0.1	0.0
Do not remember/do not know	0.3	0.3	0.0
Total	100.0	100.0	100.0
No. of cases	737	675	62

Table 15.2.1 Age Difference Between Partners at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24 Years (Percentage Distribution) Reproductive Health Survey: Georgia 2005

	Age Difference Between Partners						
Characteristic	Partner Same Age or Younger	Partner 1–3 Years Older	Partner 4–5 Years Older	Partner 6–9 Years Older	Partner 10 or More Years Older	Total	No. of Cases
Total	7.4	27.6	24.5	28.2	12.3	100.0	741
Residence							
Tbilisi	13.5	25.6	31.4	22.4	7.1	100.0	121
Other urban	9.5	28.0	23.6	27.8	11.2	100.0	196
Rural	3.9	28.1	22.4	30.7	14.8	100.0	424
Age at First Sex							
< 18	1.3	28.7	23.2	33.2	13.6	100.0	319
18–19	8.6	27.2	26.3	28.3	9.6	100.0	217
20–24	15.1	26.4	24.4	20.8	13.3	100.0	205
Marital Status at First Sex							
Not married	1.4	21.4	30.5	28.2	18.5	100.0	64
Married	7.9	28.2	23.9	28.3	11.7	100.0	677

Table 15.2.2 Relationship to Partner at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24 (Percentage Distribution) Reproductive Health Survey: Georgia 2005

	Relationship to Partner at First Intercourse								
	Husband	Fiancé	Boyfriend	Friend	Acquaintance	Just Met	Other	Total	No. of Cases
Total	91.1	3.2	4.0	0.6	0.9	0.3	0.0	100.0	741
Residence									
Tbilisi	89.7	4.5	3.2	0.6	1.3	0.6	0.0	100.0	121
Other urban	94.6	0.9	2.9	1.1	0.5	0.0	0.0	100.0	196
Rural	89.8	3.9	4.9	0.2	0.9	0.3	j	100.0	424
Age at First Sex									
< 18	89.2	4.4	3.4	0.7	2.0	0.3	0.0	100.0	319
18–19	93.0	2.2	3.2	0.9	0.2	0.4	0.2	100.0	217
20–24	91.8	2.5	5.7	0.0	0.0	0.0	0.0	100.0	205
Marital Status at First Sex									
Not married	0.0	35.6	44.8	6.3	9.7	3.0	0.5	100.0	64
Married	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	677
Education									
Secondary incomplete or less	93.9	1.0	1.9	0.0	3.2	0.0	0.0	100.0	150
Secondary complete	89.4	4.7	4.5	0.7	0.3	0.3	0.1	100.0	316
Technicum/university	91.6	2.5	4.4	0.7	0.3	0.3	0.0	100.0	275
Socioeconomic Status									
Low	92.9	3.2	3.2	0.3	0.5	0.0	0.0	100.0	282
Middle	89.4	3.0	5.3	0.9	0.7	0.6	0.1	100.0	347
High	92.1	3.5	2.2	0.0	2.2	0.0	0.0	100.0	112
Ethnicity									
Georgian	89.7	3.9	4.3	0.7	1.1	0.3	0.1	100.0	578
Azeri	98.9	1.1	0.0	0.0	0.0	0.0	0.0	100.0	75
Armenian	96.6	0.0	3.4	0.0	0.0	0.0	0.0	100.0	67
Other	*	*	*	*	*	*	*	*	21

* Less than 25 cases.

Table 15.2.3 Duration of Dating Before First Sexual Intercourse Among Sexual Experienced Young Women Aged 15–24 by Marital Status at First Sex Reproductive Health Survey: Georgia 2005

		Marital Status at First Sex (Percentage Distribution)	
Duration of Dating Before First Intercourse	Total	Premarital	Marital
< 1 Month	6.1	9.5	5.8
1-3 Months	15.5	16.2	15.4
4-11 Months	18.8	17.9	18.9
1 Year	22.6	20.0	22.8
2-5 Years	27.9	23.8	28.2
6+ Years	8.8	12.7	8.5
Did not respond	0.3	0.0	0.3
Total	100.0	100.0	100.0
No. of cases	739	62	677

Table 15.3.1 Current Sexual Activity Status Among Young Adult Women Aged 15-24 Years by Current Marital Status and by Age Group Reproductive Health Survey: Georgia 2005

		Marital Status			Age Group	
Sexual Activity Status	Total %	Married %	Previously married %	Never married %	15-19 %	20-24 %
Never had intercourse	69.5	0.0	0.0	99.8	86.3	51.8
Within 30 Days	18.2	61.8	6.5	0.2	6.6	30.5
1-3 months	0.7	1.7	12.7	0.1	0.1	1.3
4-12 months	0.8	2.1	19.7	0.0	0.3	1.4
>1 year	0.9	0.7	57.6	0.0	0.2	1.6
No response	0.0	0.1	0.0	0.0	0.0	0.1
Currently pregnant	6.3	21.4	3.5	0.0	4.4	8.2
Postpartum or breastfeeding	3.5	12.1	0.0	0.0	2.2	5.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	2,009	713	25	1,271	930	1,079

Table 15.3.2 Use of Contraception at Most Recent Sexual Intercourse, by Current Marital Status and Age Group Among Sexually Experienced Young Women Aged 15–24 Years Reproductive Health Survey: Georgia 2005

		Marital Status			
Contraceptive Method	All Young Women	Currently Married			Not Currently Married
		Total	Age Group		Total
			15–19	20–24	
Any Method	31.3	31.8	12.9	37.7	19.7
Modern Methods	21.9	22.2	4.9	27.4	16.7
Oral Contraceptives	4.2	4.4	1.4	5.4	0.0
IUD	9.5	9.8	2.5	12.1	2.6
Condoms	7.3	7.0	1.0	8.8	14.1
Spermicides	0.9	0.9	0.0	1.2	0.0
Traditional Methods	9.4	9.7	7.9	10.2	3.1
Calendar (rhythm) Method	3.5	3.6	3.0	3.7	3.1
Withdrawal	5.8	6.1	4.9	6.5	0.0
No Method	68.7	68.2	87.1	62.3	80.3
Total	100.0	100.0	100.0	100.0	100.0
No. of Cases	741	713	156	557	28

Table 15.3.3 Number of Sexual Partners Reported in Last Three Months and Lifetime PartnersCurrent Marital Status Reported by Sexually Experienced Young Women Aged 15–24 Years Reproductive Health Survey: Georgia 2005

		Marital Status		
Number of Sexual Partners	Total %	Married %	Previously Married %	Never Married %
In the Last Three Months				
None	10.6	7.8	80.8	*
One	89.4	92.2	19.2	*
Two or more	0.0	0.0	0.0	*
Total	100.0	100.0	100.0	*
Lifetime				
One	98.2	99.1	86.9	*
Two or more	1.8	0.9	13.1	*
Total	100.0	100.0	100.0	*
No. of cases	741	713	25	3

*Less than 25 cases.

Table 15.4.1 Beliefs About Condoms and Condom Use by Condom Experience Among Sexually Experienced Women Aged 15–24 Years Reproductive Health Survey: Georgia 2005

	Ever Users (N=96)				Never Users (N=645)			
Belief	Agree	Disagree	Don't Know	Refused	Agree	Disagree	Don't Know	Refused
Using condoms with a new partner is a smart idea	85.5	1.7	12.8	0.0	52.3	10.2	31.4	6.1
Women should ask their partners to use condoms	80.5	11.0	8.5	0.0	20.2	41.7	31.9	6.2
It is easy to discuss using a condom with a prospective partner	44.5	33.2	22.3	0.0	10.1	48.2	35.2	6.5
Using condoms is not necessary if you know your partner	46.3	44.4	8.4	0.9	42.6	22.7	28.8	5.9
Condoms diminish sexual enjoyment	37.4	52.7	8.4	1.5	5.0	7.8	79.4	7.8
It is embarrassing to ask for condoms in family planning clinics or pharmacies	10.0	78.9	11.1	0.0	19.4	46.6	28.3	5.7
Same condom can be used more than once	5.5	89.8	4.7	0.0	1.3	72.2	20.5	5.9
People who use condoms sleep around a lot	0.9	93.5	5.6	0.0	2.3	66.2	25.3	6.2

Table 15.4.2 Percentage of Women Who Have Ever Talked to a Partner About His Using Condoms by Condom Experience Among Sexually Experienced Women 15-24 Years of Age
Reproductive Health Survey: Georgia 2005

Characteristic	All Sexually Experienced Women		Women Who Have Ever Used Condoms		Women Who Have Never Used Condoms	
	%	N	%	N	%	N *
Total	22.8	739	85.6	96	12.2	643
Residence						
Tbilisi	49.4	121	92.3	40	27.9	81
Other urban	23.2	195	74.6	26	14.0	169
Rural	12.3	423	86.0	30	6.9	393
Age Group						
15-19	11.4	160	†	11	7.2	149
20-24	26.2	579	86.8	85	13.8	494
Education						
Secondary incomplete or less	9.1	150	†	12	6.6	138
Secondary complete	19.9	315	90.5	30	10.3	285
Technical school/university	32.5	274	89.8	54	17.5	220

* Excludes 2 cases without information.

† Less than 25 cases.

†

Table 15.4.3 Agreement with Specific Statements Regarding Partner/Husband's Desire to Use a Condom Among Sexually Experienced Young Women Aged 15-24 Years Reproductive Health Survey: Georgia 2005

Characteristic	Would Feel Safe From Getting Pregnant %	Would Feel Safe From Getting STD/HIV/AIDS %	Would Feel Insulted or Angry %	Would Be Suspicious That He May Sleep Around %	Would Feel Like I had Done Something Wrong %	No. of Cases*
Total	71.3	67.1	11.5	11.5	5.4	741
Residence						
Urban	83.4	79.9	13.7	12.3	5.4	317
Rural	60.0	55.3	9.5	10.7	5.5	424
Region						
Tbilisi	82.7	80.8	12.8	9.6	5.1	121
Other urban	84.0	79.2	14.3	14.3	5.6	196
Rural	60.0	55.3	9.5	10.7	5.5	424
Age Group						
15-19	61.9	58.8	12.4	10.6	9.6	161
20-24	74.1	69.7	11.3	11.8	4.2	580
Marital Status						
Currently married or in union	71.1	67.1	11.4	11.5	5.4	713
Not currently married or in union	75.2	67.4	13.6	11.1	6.8	28
Education						
Secondary incomplete or less	49.6	39.0	13.1	8.7	9.2	150
Secondary complete	71.5	68.7	10.6	14.3	4.1	316
Technicum	81.5	77.5	16.8	10.9	1.5	92
University/postgraduate	81.4	79.6	9.7	9.5	6.4	183
Condom Use						
Ever users	91.7	86.6	8.1	11.4	8.3	96
Never users	67.9	63.9	12.1	11.5	5.0	645
Ever Talked to a Partner About Using Condom						
Yes	94.6	89.0	8.4	10.7	4.2	154
No	64.8	61.1	12.5	11.8	5.8	585

* Excludes 2 cases missing information.

Table 15.5.1 Percentage of Young Women Aged 15-24 Years Reporting Premarital Sexual Experience and Contraceptive Use at First Premarital Sexual Experience (PSE) Among Women Aged 15-24 Years Reproductive Health Survey, Eastern Europe: 1997-2005

		Percentage of Young Women Reporting PSE			Percentage of Contraceptive Use at First PSE		
Country	Year of RHS	15-24	15-19	20-24	Total	Modern Methods	Traditional Methods
Albania	2002	14	7	21	91	7	84
Moldova	1997	26	14	40	33	14	19
Russia*	1999	71	49	87	46	33	12
Romania	2004	44	21	68	57	50	7
Ukraine	1999	48	27	74	47	30	16
Azerbaijan	2001	1	†	2	3	3	0
Georgia	2005	3	1	5	3	3	0

* Three oblasts: Ivanovo, Ekaterinburg and Perm

† Less than 0.5%

Chapter 16

SEXUALLY TRANSMITTED INFECTIONS OTHER THAN HIV/AIDS

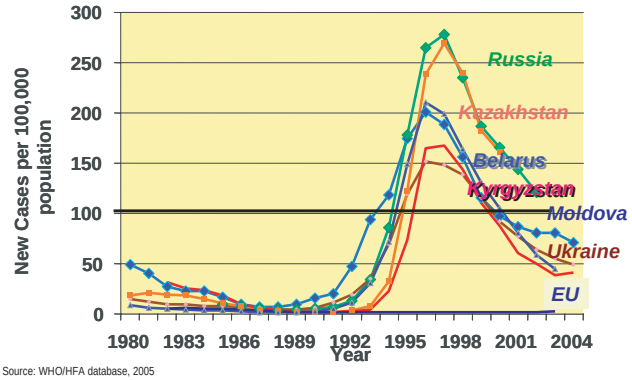
Worldwide, over 340 million curable and many more incurable sexually transmitted infections (STIs) occur annually (WHO, 2001). An estimated 31 million curable STIs (syphilis, gonorrhea, Chlamydia, and trichomoniasis) occur every year in North America and Western Europe, and an additional 22 million cases occur in Eastern Europe and Central Asia (WHO, 2001). Women suffer more frequent and severe long-term consequences from STIs than men: Chlamydial and gonococcal infections are important causes of pelvic inflammatory disease, ectopic pregnancy, and infertility. Although human papillomavirus can cause genital warts in both men and women, infection in women is associated with genital cancers, primarily cervical cancer. An STI during pregnancy can lead to premature rupture of membranes, premature labor, and postpartum endometritis. Left untreated, syphilis infection during pregnancy can result in fetal death, stillbirth, perinatal death, or severe abnormalities and system disorders in infected infants (Brunham et al., 1990). It has been estimated that 30%–40% of excess preterm births and infant deaths are secondary to STDs, including bacterial vaginosis (Goldenberg et al., 1997). The impact of these diseases is heightened by their potential to increase susceptibility to and the spread of HIV infection.

In industrialized countries, screening for STIs is widely recommended, but such policies are largely nonexistent in Georgia, due in part to budgetary constraints. Current incidence and prevalence estimates, based on clinically symptomatic cases diagnosed through specialized health care services, are seriously underreported and have limited generalizability. Thus, little information is available regarding STI awareness and disease burden in the general population in Georgia. The 1999 and 2005 Reproductive Health Surveys conducted in Georgia documented STI knowledge, attitudes, perception of risk, prevalence of testing for STIs, and experience of STI symptoms among a representative sample of sexually active women of reproductive age to facilitate STI prevention and management policy recommendations.

16.1 STIs in Georgia and the Former Soviet Union

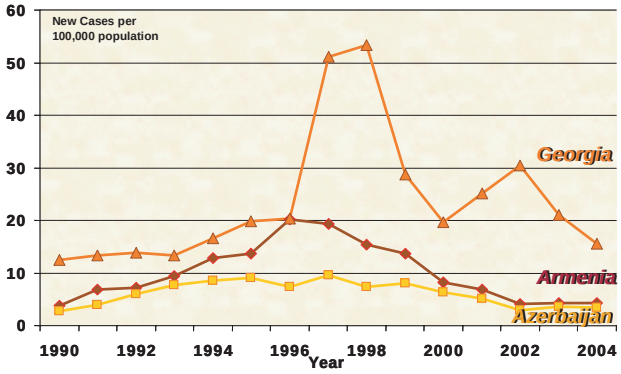
During the past 15 years, sexually transmitted infections have become a major public health problem in Georgia and the other countries that were formerly part of the Soviet Union. Many of these countries have experienced major epidemics of STIs, particularly syphilis. The reported incidence of new cases of syphilis in several former Soviet countries increased 45- to 165-fold between 1990–1998; the steepest recorded increases were reported in Kazakhstan (from 1.4 to 231.4 new cases per 100,000), Kyrgyzstan (from 2 to 144.4 new cases per 100,000), Belarus (from 2.7 to 164 new cases per 100,000), and the Russian Federation (from 5.3 to 225.6 per 100,000) (Figure 16.1.1) (WHO, 2005a). Syphilis incidence rates declined to around 50–120 per 100,000 population after 1998, but were still 25–50 times higher than the 2004 European Union average of 2.4 new cases per 100,000. The rates in the countries of the Caucasus region, though following a similar pattern, remained low by comparison (Figure 16.1.2) (WHO, 2005a). This trend of sharply increasing syphilis rates is most obvious in Georgia, which has the highest syphilis

Figure 16.1.1 **Syphilis Incidence per 100,000 Population in Eastern Europe, Central Asia and European Union: 1980–2004**



Source: WHO/HFA database, 2005

Figure 16.1.2 **Syphilis Incidence per 100,000 Population Caucasus Countries: 1990–2004**

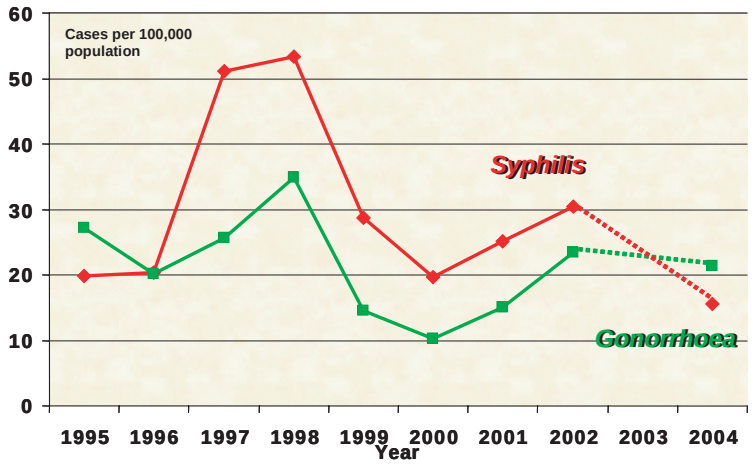


Source: WHO/HFA database, 2005

incidence rate among the Caucasus countries. The incidence rate in Georgia registered an almost threefold increase between 1995 and 1998, from 20 per 100,000 population to 53 per 100,000, and declined thereafter to 21 per 100,000 in 2003 and 16 per 100,000 in 2004. The reported incidence of gonorrhea followed a similar pattern: It increased in 1996, reached a peak in 1998 (35 new cases per 100,000 population), and declined thereafter to stabilize around 20 new cases per 100,000 in 2002–2004 (Figure 16.1.3) (WHO, 2005a). During the peak in syphilis incidence in 1997–1998, an alarming number of babies were born with congenital syphilis (29 cases per 100,000 in 1997 and 27 cases per 100,000 in 1998, corresponding to an incidence rate of 55 cases per 100,000 live births in 1997 and 54 cases per 100,000 live births in 1998), reflecting an increase in the prevalence of untreated syphilis among pregnant women. Most of the increases in syphilis and gonorrhea rates that occurred in 1997–1998 coincided with the implementation of a new government program providing free STI diagnostic services (and occasionally treatment) through dermatovenereology (DV) services and gynecologic wards. The recent decline in reported incidence coincides with substantial funding cuts and discontinuation of mass-screening in 1999, and thus may be due to subsequent under-diagnosis and underreporting of cases.

The existing system of STI reporting and treatment in Georgia was inherited from the Soviet era. STI cases are managed and reported exclusively by DV clinics. The DV system includes 58 regional DV cabinets, 29 regional clinics (including 15 located in regional hospitals), and a national research institute, the National Institute of Skin and Venereal Diseases, which is primarily responsible for all aspects of diagnosis, treatment, data collection, and reporting of STIs. Patients seen in maternity or other clinics that require diagnosis, treatment, or follow-up are referred to the DV system. Reporting of syphilis, gonorrhea, chlamydia, mycoplasma, genital herpes, and trichomoniasis is mandatory by law and is based on cases registered by physicians. Each of these diagnoses must be confirmed by laboratory testing or other means prior to treatment and reporting: syphilis requires serologic testing, gonorrhea requires bacteriologic testing, trichomonas and chlamydia diagnoses are made based on microscopic examination, mycoplasma by culture, and genital herpes by clinical examination. Because of limited resources, however, few DV clinics have the ability to provide a wide array of laboratory testing and

Figure 16.1.3 **Syphilis and Gonorrhea Infections Newly Diagnosed per 100,000 Population in Georgia: 1995–2004**



Source: WHO/HFA database, 2005

treatment. Treatment schedules are obsolete, long, and based on inpatient treatment, especially treatment for syphilis (Schouten E, 1999).

STI reporting is believed to be seriously affected by the general lack of resources that has plagued health care services in Georgia during the past decade. Even with adequate laboratory resources, the statistics reported by STI surveillance reflect only those patients who seek medical care, thus underreporting those with asymptomatic STIs, those who get treatment from providers outside the DV system, those who use self-treatment or no treatment, and those with limited access to medical care. Because STIs are frequently asymptomatic or their symptoms are often non-specific and episodic, infected individuals may not seek diagnosis and treatment; thus, surveillance systems based solely on case-notification reports substantially underestimate the real magnitude of STI rates in a population.

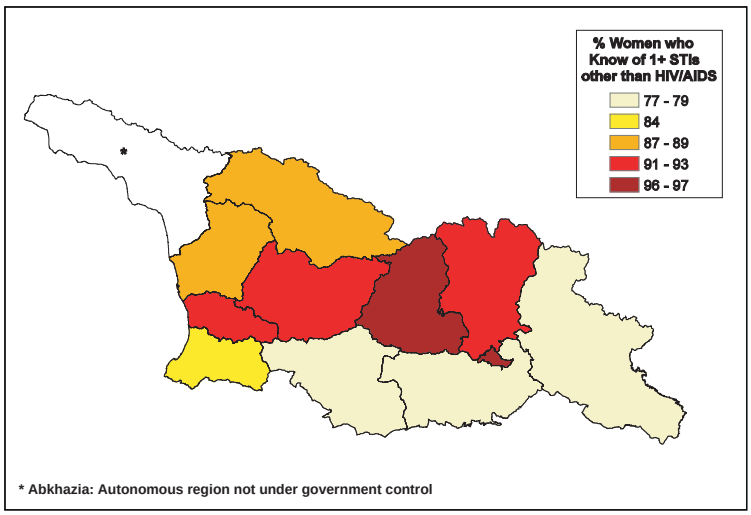
Currently, the publicly funded STI program in Georgia supports active case-finding only through syphilis screening for pregnant women during prenatal care and for a very limited number of high-risk groups (Curatio International Foundation, 2002). Under the newly enacted health care reforms, fewer women are seeking prenatal care early and only four prenatal care visits are offered free of charge, reducing the chance of active case-finding and early treatment of syphilis among pregnant women.

16.2 Awareness of STIs

Respondents aged 15–44 years were asked if they had ever heard of seven specific STIs that are common in Georgia. As shown in Table 16.2, 89% had heard of at least one STI. Awareness of at least one STI was highest in the urban areas of the country (94%), among women 25–44 years of age (over 94%), and was more than 95% in Shida Kartli and Tbilisi regions (Figure 16.2.1), as well as among women with high educational attainment (97%) and high SES (96%). Lower levels of awareness were found among women living in the regions of Kvemo Kartli and Kakheti (77% in each), and among Azeri women (45%).

Levels of awareness of specific infections ranged from a high of 82% for yeast infections to a low of 7% for genital warts (the most easily recognized sign of genital human papilloma virus infection). Awareness was particularly poor for Chlamydia, herpes virus, and human papilloma virus infections: between 64% to

Figure 16.2.1 **Awareness of at Least one STI Among Women Aged 15-44 Years, by Region**

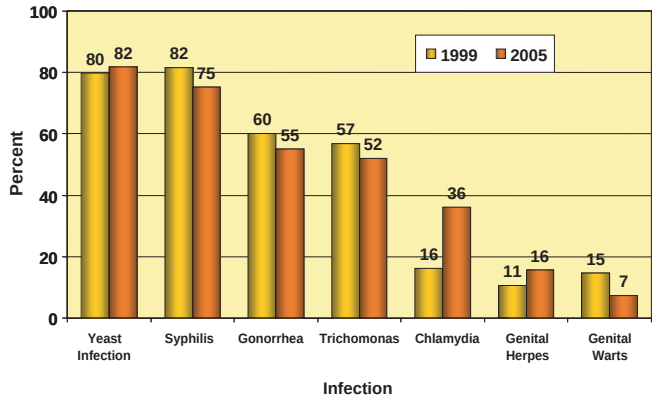


93% of respondents had never heard of these diseases. Only 75% of respondents had heard of syphilis, and 55%, of gonorrhea. Generally, urban residence, older age, higher educational attainment, and higher SES, as well as sexual experience, were associated with higher levels of awareness of the individual STIs.

RHS data were analyzed to compare awareness of specific STIs in1999 and 2005 (Figure 16.2.2). Of the seven types of STIs shown, awareness increased slightly between surveys for only three STIs (yeast infections, Chlamydia, and genital herpes). Awareness of syphilis, gonorrhea, trichomoniasis, and genital warts decreased between surveys.

Two major reasons for lack of STI awareness are that many of these infections are asymptomatic, and that a powerful social stigma around having an STI prevents open discussions about this topic. Survey results have shown that many sexually active women do not know the names of some of the most common and potentially damaging STIs and, by implication, are not tested or treated for them. Consequently, they may place themselves or their partners at risk during sexual activity.

Figure 16.2.2 **Awareness of Selected STIs Among Women Aged 15–44 Years: 1999 and 2005**

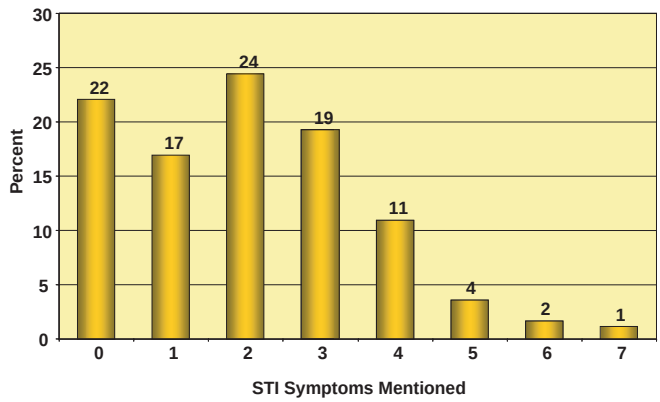


16.3 Awareness of Symptoms Associated with STIs

Women aged 15–44 years who were aware of at least one STI were asked, without prompting, to list the symptoms that a woman with an STI might present. A score to rate awareness of STI symptoms was calculated based on the number of correct STI symptoms cited by respondents. Awareness of a specific correct symptom spontaneously mentioned was given a value of +1, while lack of it a value of 0; possible scores ranged from 0 to 10 or higher.

As shown in Table 16.3.1 and Figure 16.3, 22% of women were unable to mention any symptoms, suggesting that they were completely unaware about how STIs may affect a woman's health. On average, women of reproductive age in Georgia mentioned

Figure 16.3 **Awareness of STI Symptoms Among Women Aged 15–44 Years**



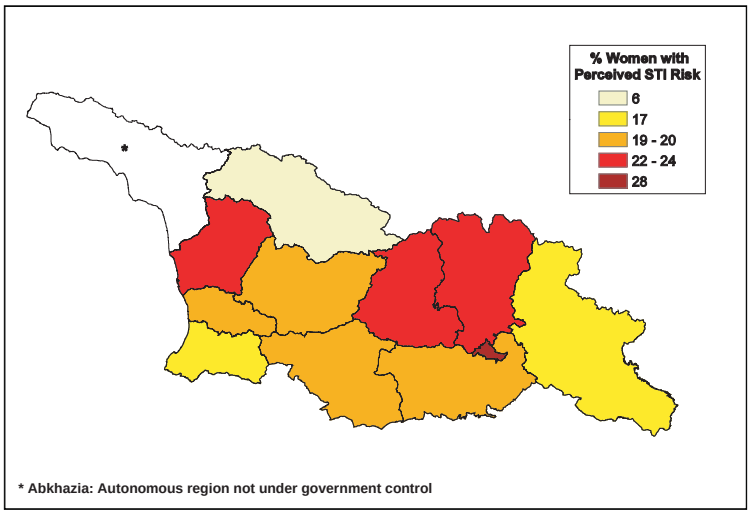
two STI symptoms; 17% mentioned one symptom, 24% mentioned two, 19% mentioned three, and 17% mentioned four or more. Rural women were more likely than urban women to not mention any symptoms (30% vs. 16%). The percentage of respondents who could not spontaneously mention any symptoms increased as age, educational attainment, and SES decreased. More than half of Azeri women (58%) did not mention any symptoms.

The most commonly mentioned symptoms included vaginal discharge (55%), genital itching (35%), foul smelling discharge (34%), and abdominal pain (33%) (Table 16.3.2). In contrast, the least mentioned symptoms include difficulty in getting pregnant (6%) and weight loss (3%). In general, the ability to mention a specific symptom increased with age and educational attainment.

16.4 Self-perceived Risk of Contracting a STI

Respondents aged 15–44 years who were aware of at least one STI symptom were asked to rate their own risk of contracting an STI; 75% perceived that they are not at risk of contracting a STI, while 22% believe that they have some risk, including 19% who believe that their risk is very low (Table 16.4). The percentage of women who perceive themselves to be at some risk of acquiring a STI is highest among women living in the regions of Tbilisi (30%), Shida Kartli (28%), and Mtskheta-Mtianeti (28%) (Figure 16.4). In general, the probability of perceiving to be at risk of acquiring an STI increases with educational attainment and SES. Only 3% of respondents stated that they do not know what their risk is of contracting a STI.

Figure 16.4 **Percent of Women Aged 15-44 Who Believe They Have Some Risk of Contracting an STI, by Region**



* Abkhazia: Autonomous region not under government control

16.5 Self-Reported STI Testing

Table 16.5.1 shows self-reported STI testing for each of the seven STIs. Overall, 38% of sexually experienced women aged 15–44 years reported being tested for at least one STI other than HIV/AIDS. As shown in Figure 16.5.1, testing for at least one STI is highest in the regions of Tbilisi (62%), Imereti (48%), and Mtskheta-Mtianeti (43%). Urban women (48%), women 25–34 years of age (37% to 44%), women with high educational attainment (51%) and high SES (57%), and those with two or more lifetime sexual partners were more likely to report STI testing (47%).

The STIs most often tested for included yeast infections (31%) and trichomoniasis (22%), followed by syphilis (45%), Chlamydia (9%), and gonorrhea (7%). With the exception of syphilis, rates of getting test for these infections were highest among women with two or more lifetime sexual partners. As shown in Table 16.5.1, viral STIs such as genital herpes and genital warts are very seldom tested for in Georgia.

Figure 16.5.2 compares the percentage of sexually experienced women aged 15–44 years who were ever tested for selected STIs in the 1999 and 2005 Reproductive Health Surveys. With the exception of genital warts, testing for STIs increased during the interval between the two surveys, including an 8% increase in testing for yeast infections, a 5% increase in testing for syphilis, and a 6% increase in testing for Chlamydia.

Respondents were also asked whether they had received their test results (Table 16.5.2). More than 90% of respondents who were tested for a yeast infection, trichomoniasis, Chlamydia, and genital herpes had received the results of their last test. In contrast, only 70% of respondents who were tested for syphilis or gonorrhea had received the results of their last test. Because of the relatively small sample size, there were no statistically significant variations among subgroups in receipt of STI test results.

Figure 16.5.1 **Percent of Sexually Experienced Women Who Have Ever Been Tested for an STI, by Region**

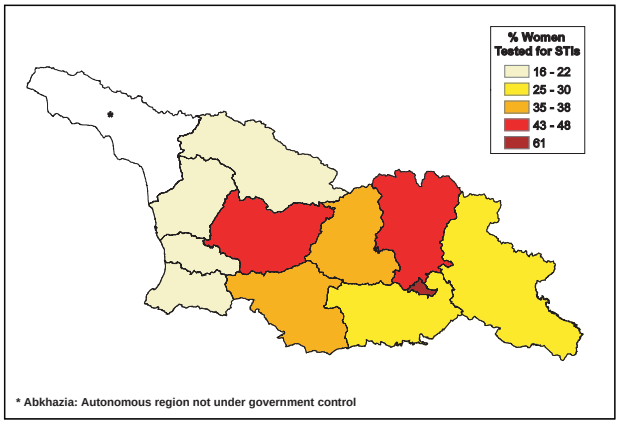
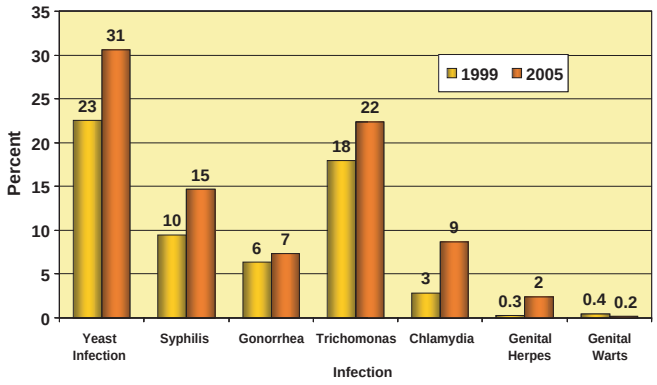


Figure 16.5.2 **Prevalence of STI-Testing Among Women Aged 15–44 Years: 1999 and 2005**



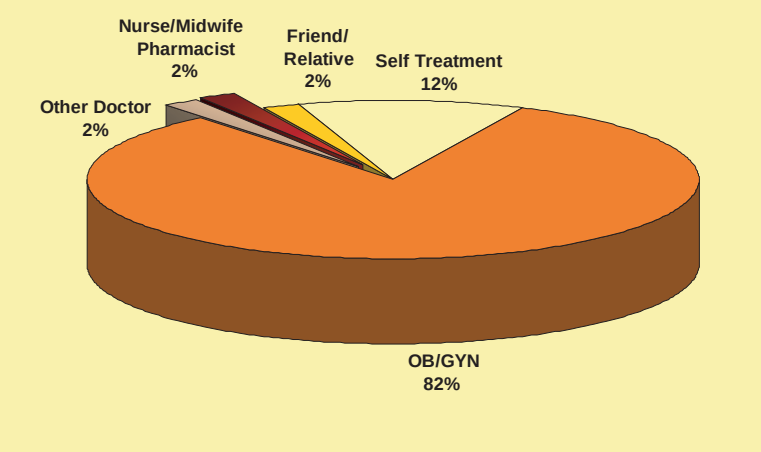
16.6 Self-reported STI symptoms

To estimate the prevalence of STI symptoms in the general population, the GERHS05 included a series of questions about whether the respondents experienced any of five symptoms associated with STIs during the 12 months prior to interview. As shown in Table 16.6.1, 18% of sexually experienced women aged 15–44 years reported a vaginal discharge with a bad smell during this time period. An additional 13% reported itching or burning in the genital area; 10%, burning pain upon urination; 7%, pain during sexual intercourse; and 4%, sores, ulcers, or warts in the genital area. In general, the probability of presenting one or more of these symptoms increases as the age of respondents increases.

Of respondents who presented one or more STI symptoms during the 12 months prior to interview, 46% sought treatment (Table 16.6.2). The probability of seeking treatment increases as respondent educational attainment and SES increases. Of those women who sought treatment, the vast majority (83%) were treated by an OB/GYN, while 12% self-treated their STI symptoms (Table 16.6.3 and Figure 16.6).

Respondents with STI symptoms during the 12 months prior to interview were asked why they did not seek treatment (Table 16.6.4); 61% did not seek treatment because they could not afford to pay for the services or treatment. This reason was particularly important for women outside of Tbilisi, older women, and women of lower educational attainment and was inversely related to SES. Overall, 15% of respondents declared that their symptoms disappeared over time, including 27% of respondents with a university education and 32% of those with high SES. Interestingly, 9% of respondents did not seek treatment because they did not think that their symptoms were due to an STI, while 5% did not seek treatment because they were afraid of knowing the diagnosis.

Figure 16.6 **Person Who Provided STI Treatment Among Sexually Experienced Women Aged 15–44 Years Who Sought Treatment for STI Symptoms**



16.7 Sources of Information on STIs

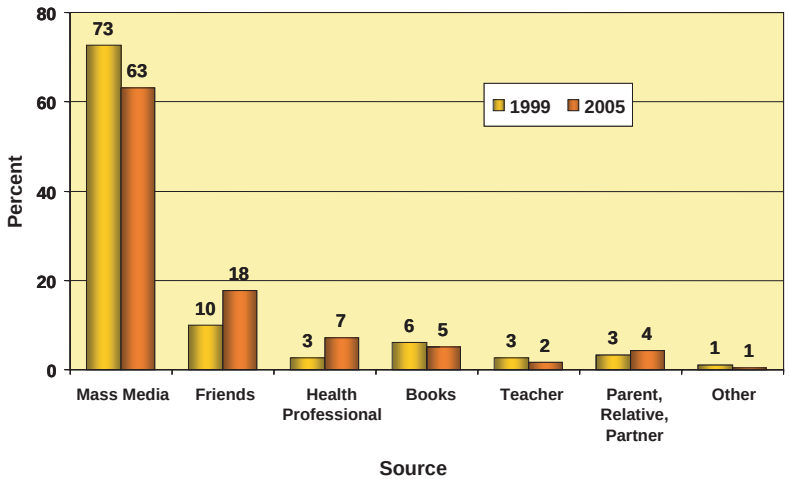
Women who were aware of at least one type of STI were asked, "What has been your most important source of information about STIs, including AIDS?" As shown in Table 16.7.1, nearly 55% of the respondents stated that television was their principal source of information, followed by friends, colleagues, and peers (18%), newspapers, magazines and brochures (8%), and doctors, nurses, and pharmacists (7%). Another 5% mentioned specialty books. Less than 1% of respondents mentioned radio. The data suggest that parents play a very minor role in providing information about STIs. In regions where television is a less important source of information, friends, colleagues, and peers become more important, as do newspapers, magazines, and brochures.

Principal sources of information about STIs shifted between the 1999 and 2005 Reproductive Health Surveys (Figure 16.7.1): Mass media (television, radio, newspapers, magazines, and brochures) lost importance during the interval between the two surveys, while friends, colleagues, and peers, as well as doctors, nurses, and pharmacists became more important sources of information.

Finally, all respondents aged 15–44 years were asked, "In the past 6 months, have you seen or heard any public announcements or advertisements on television or radio, or read in any newspaper or magazine, about STIs other than HIV/AIDS?" As shown in Table 16.7.2, 72% had not heard, seen, or read any messages on STIs other than HIV/AIDS during the 6 months prior to interview. Rates of exposure to any message were highest in Tbilisi (47%) and overall among urban residents (36%), and increased with educational attainment and SES. Sources of messages varied: 8% of respondents saw an announcement or an advertisement on television during the 6-month period, while 3% read a message in a newspaper or magazine, and less than 1% heard an announcement on the radio.

If we only examine information broadcasted via television and radio, exposure to messages via television in the 6 months prior to the survey more than doubled in 2005 compared to 1999 (from 6%

Figure 16.7.1 **Principal Source of Information About STIs Among Women Aged 15-44 Years: 1999 and 2005**



to 13%) and exposure to radio and TV messages increased from 0.4% to 2.0%, but the overwhelming majority of women aged 15–44 in both surveys had not been exposed to messages on STIs via radio or television (Figure 16.7.2).

In conclusion, primary and secondary STI prevention must be made a public health priority in Georgia. Primary prevention aims to decrease the prevalence and morbidity of STIs through promoting healthy lifestyle behaviors. Secondary prevention (e.g., targeted chlamydia and gonorrheal infections screening) could reduce the incidence of pelvic inflammatory disease and infertility, congenital syphilis, and the risk of HIV/AIDS transmission.

To achieve both primary and secondary STI prevention goals, the public must be equipped with accurate knowledge, which can then be translated into informed choices and appropriate decision-making. Because of scarce and competing health resources, STI prevention and education needs should become a focal component of the overall strategy for STI control. Preventive efforts should include dissemination of information on means of transmission of all STIs, including HIV/AIDS, and promotion of safer sex and risk-reduction practices. Children and youth should be educated from an early age, before a pattern of risky sexual behaviors can begin. Age-appropriate comprehensive school-based programs for educating young adults about STIs are urgently needed. Information Education and Communication efforts should continue during adulthood; family planning clinics are a prime venue for health promotion activities for sexually active clients. Only when they are equipped with accurate information and unbiased by social stigma will sexually active individuals be able to make informed and responsible decisions about safer sexual practices and about seeking testing and treatment.

Figure 16.7.2 **Recent Exposure to Radio or TV Messages on STIs All Women Aged 15–44 Years: 1999 and 2005**

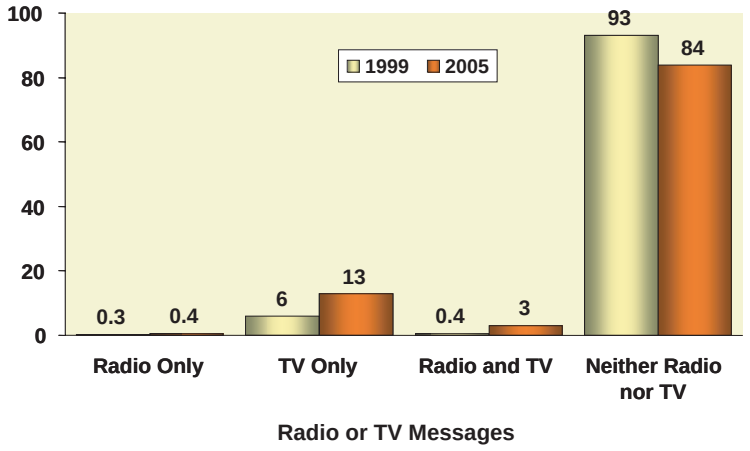


Table 16.2 Awareness of STIs Other than HIV/AIDS by Selected Characteristics Among Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

Characteristic	Total %	Selected STIs: Yeast Infection %	Syphilis %	Gonorrhea %	Trichomoniasis %	Chlamydia %	Genital Herpes %	Genital Warts %	No. of Cases
Total	88.5	81.9	75.2	55.0	52.1	36.2	15.7	7.4	6,376
Residence									
Urban	94.4	88.2	82.4	63.7	62.1	46.8	21.5	10.4	3,196
Rural	81.4	74.3	66.5	44.4	39.8	23.3	8.7	3.7	3,180
Region									
Kakheti	77.2	71.8	63.8	49.3	42.7	27.5	9.8	4.5	538
Tbilisi	96.9	92.1	87.1	71.8	70.8	59.7	29.3	14.0	1,431
Shida Kartli	95.5	88.2	80.4	52.7	56.2	30.6	13.2	4.7	430
Kvemo Kartli	76.5	70.7	64.2	48.0	46.7	31.5	11.9	5.4	576
Samtskhe-Javakheti	79.1	60.0	71.9	45.5	38.3	9.7	6.7	4.0	434
Adjara	83.8	76.8	66.1	39.3	32.7	21.7	8.2	5.4	490
Guria	90.8	80.2	84.0	47.6	32.9	19.2	8.4	1.8	388
Samegrelo	87.3	83.5	70.3	47.1	40.4	28.7	9.6	4.6	506
Imereti	92.2	84.9	75.7	54.5	56.0	32.5	13.1	5.7	782
Mtskheta-Mtianeti	92.6	83.4	78.2	64.5	59.0	37.0	13.4	4.8	374
Racha-Svaneti	89.4	83.8	70.1	47.9	38.6	30.1	9.2	3.3	427
Age Group									
15–19	70.4	61.3	40.6	19.0	19.9	11.3	6.2	3.5	930
20–24	85.8	77.8	66.9	44.7	40.9	28.3	13.4	5.7	1,079
25–34	94.4	89.2	85.4	65.4	62.9	46.3	19.9	8.1	2,249
35–44	94.9	89.1	90.0	71.2	66.3	45.1	18.4	9.7	2,118
Education Level									
Secondary incomplete or less	63.1	53.8	38.6	19.0	16.9	8.0	1.8	1.2	907
Secondary complete	87.4	79.4	71.1	45.3	43.0	22.8	7.4	3.0	1,786
Technicum	95.3	88.1	87.5	68.0	63.9	41.4	15.5	7.5	1,466
University/postgraduate	97.2	93.2	88.2	71.4	68.4	56.7	28.8	13.6	2,217
Socioeconomic Status									
Low	80.7	71.6	63.3	40.1	35.4	18.4	5.0	1.9	2,277
Middle	91.2	85.2	79.1	59.0	56.7	39.1	17.0	7.6	3,028
High	96.2	92.8	87.5	72.1	71.0	61.4	32.0	16.7	1,071
Ethnic Group									
Georgian	92.1	86.1	77.8	57.6	54.7	38.7	16.9	8.0	5,545
Azeri	45.4	34.4	37.0	20.0	18.8	7.9	1.9	1.9	292
Armenian	73.4	60.7	67.4	42.4	38.9	19.5	9.0	2.6	382
Other	88.1	79.6	81.6	63.1	56.5	43.6	16.0	7.6	157
Sexual Experience									
No	80.7	72.1	58.0	37.2	34.8	23.6	12.5	5.9	1,859
Yes	92.7	87.1	84.4	64.4	61.2	42.8	17.4	8.1	4,517

Table 16.3.1 Awareness of STI Symptoms Spontaneously Mentioned by Selected Characterisitcs Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Number of Symptoms Spontaneously Mentioned (Percentage Distribution)						
Characteristic	0	1	2	3	4 or More	Total	No. of Cases
Total	22.0	16.9	24.4	19.3	17.3	100.0	6,376
Residence							
Urban	16.0	15.2	26.0	21.7	21.2	100.0	3,196
Rural	29.5	19.0	22.5	16.4	12.6	100.0	3,180
Region							
Kakheti	25.5	17.0	23.8	21.3	12.4	100.0	538
Tbilisi	8.9	16.8	26.7	23.5	23.9	100.0	1,431
Shida Kartli	20.7	17.6	19.4	18.8	23.6	100.0	430
Kvemo Kartli	28.5	18.7	24.3	18.2	10.3	100.0	576
Samtskhe-Javakheti	41.7	15.0	10.9	10.2	22.2	100.0	434
Adjara	32.4	19.8	26.1	12.4	9.1	100.0	490
Guria	20.9	18.0	26.0	20.0	15.2	100.0	388
Samegrelo	27.3	17.3	24.4	18.8	12.2	100.0	506
Imereti	22.3	13.4	26.3	19.7	18.3	100.0	782
Mtskheta-Mtianeti	23.1	14.3	18.9	20.6	23.2	100.0	374
Racha-Svaneti	21.7	20.4	29.5	21.9	6.5	100.0	427
Age Group							
15–19	39.4	25.6	21.4	8.4	5.3	100.0	930
20–24	25.3	21.1	23.3	17.8	12.5	100.0	1,079
25–34	16.8	14.1	25.4	22.0	21.7	100.0	2,249
35–44	15.3	12.4	25.9	23.8	22.8	100.0	2,118
Education Level							
Secondary incomplete or less	43.4	23.6	20.2	7.8	5.1	100.0	907
Secondary complete	27.0	18.2	23.7	17.7	13.3	100.0	1,786
Technicum	15.6	14.6	25.9	23.0	21.0	100.0	1,466
University/postgraduate	12.2	14.2	26.1	23.7	23.8	100.0	2,217
Socioeconomic Status							
Low	32.7	18.5	22.9	16.2	9.5	100.0	2,277
Middle	18.9	16.7	25.5	19.2	19.8	100.0	3,028
High	10.5	14.6	24.5	25.3	25.0	100.0	1,071
Ethnic Group							
Georgian	19.4	16.9	25.4	19.9	18.2	100.0	5,545
Azeri	57.8	16.1	14.5	9.2	2.4	100.0	292
Armenian	32.4	18.9	17.3	19.8	11.8	100.0	382
Other	16.1	15.0	25.8	18.0	25.0	100.0	157
Sexual Experience							
No	31.3	22.7	22.4	13.8	9.9	100.0	1,859
Yes	17.2	13.9	25.5	22.2	21.3	100.0	4,517

Table 16.3.2 Awareness of Specific STI Symptoms Spontaneously Mentioned by Selected Characteristics Among Women Aged 15–44 Years Reproductive Health Survey: Georgia, 2005

	Symptoms										
Characteristic	Vaginal Discharge %	Genital Itching %	Foul Smelling Discharge %	Abdominal Pain %	Burning Pain on Urination %	Redness in Genital Area %	Genital Sores, Ulcers or Warts %	Swelling in Genital Area %	Hard to Get Pregnant %	Weight Loss %	No. of Cases
Total	55.4	34.7	34.2	32.8	16.0	9.4	6.8	6.1	6.0	2.8	6,376
Residence											
Urban	61.9	41.1	39.4	33.3	18.4	12.0	8.6	7.8	6.3	3.5	3,196
Rural	47.6	26.8	27.9	32.1	13.1	6.4	4.7	4.1	5.7	2.0	3,180
Region											
Kakheti	48.9	28.5	32.6	28.4	20.2	8.3	5.4	5.1	5.7	1.4	538
Tbilisi	66.0	47.4	42.5	33.6	21.3	15.0	10.6	10.0	6.4	4.9	1,431
Shida Kartli	60.7	33.2	38.4	32.6	17.6	9.4	10.9	5.1	8.9	2.7	430
Kvemo Kartli	44.4	30.5	27.0	29.9	9.4	8.0	8.1	5.8	2.4	1.9	576
Samtskhe-Javakheti	44.1	18.1	26.2	39.1	20.9	5.9	5.0	2.2	3.8	0.2	434
Adjara	47.4	30.1	22.5	30.3	6.6	6.3	1.0	3.0	4.6	2.2	490
Guria	50.9	35.2	23.9	26.4	16.4	9.4	10.8	6.5	9.6	5.7	388
Samegrelo	55.7	33.3	28.8	35.1	6.9	5.6	1.6	4.3	5.4	1.5	506
Imereti	57.1	29.9	40.2	36.3	18.7	6.6	4.9	5.3	7.7	1.8	782
Mtskheta-Mtianeti	56.7	28.8	38.7	33.8	22.5	10.3	9.5	6.1	10.5	2.5	374
Racha-Svaneti	48.7	26.6	26.8	28.0	12.7	10.8	4.3	4.9	3.3	6.7	427
Age Group											
15–19	31.0	18.1	16.0	29.1	7.1	4.6	2.5	2.4	4.8	2.1	930
20–24	48.5	29.0	28.8	31.5	12.6	8.3	5.9	4.9	6.6	2.8	
25–34	63.5	40.3	40.0	32.2	19.8	11.9	8.2	8.2	6.3	2.5	1,079
35–44	65.6	41.9	42.0	36.0	19.5	10.5	8.5	7.0	6.1	3.5	2,249
Education Level											2,118
Secondary incomplete or less	28.5	17.1	16.5	26.9	9.0	3.4	1.0	2.3	3.4	2.1	907
Secondary complete	51.4	28.1	29.0	33.5	10.9	7.4	6.1	4.8	5.9	2.2	
Technicum	64.0	40.4	41.4	34.3	19.4	9.9	6.7	6.3	5.6	2.6	1,786
University/postgraduate	66.0	44.5	42.1	33.9	21.3	13.6	10.2	8.8	7.6	3.7	1,466
Socioeconomic Status											2,217
Low	44.6	24.6	25.1	31.1	12.1	5.6	3.6	3.2	4.8	1.6	2,277
Middle	58.8	36.8	37.4	33.4	17.0	10.0	7.3	6.8	6.3	3.0	
High	67.0	47.7	42.8	34.1	20.9	15.0	11.6	9.9	7.5	4.3	3,028
Ethnic Group											1,071
Georgian	57.8	36.6	36.1	32.7	16.9	9.8	7.1	6.5	6.4	3.0	5,545
Azeri	23.4	10.8	10.9	26.3	4.6	1.9	1.6	1.6	1.7	0.3	
Armenian	47.5	26.6	21.7	35.6	10.5	8.2	7.0	3.0	3.2	1.4	292
Other	56.3	34.3	42.7	41.5	23.9	13.8	7.1	9.8	7.3	3.3	382
Sexual Experience											157
No	41.2	26.1	22.6	29.1	11.4	7.0	4.4	4.1	5.8	2.6	1,859
Yes	63.0	39.2	40.3	34.7	18.5	10.7	8.1	7.2	6.2	2.9	
	63.0	39.2	40.3	34.7	18.5	10.7	8.1	7.2	6.2	2.9	4,517

Table 16.4 Self-Perceived Risk of Contracting a STI by Selected Characteristics Among Women Aged 15–44 Years Who Are Aware of at Least One Type of STI Reproductive Health Survey: Georgia, 2005

	Self-Perceived Risk (Percentage Distribution)						
Characteristic	High Risk	Moderate Risk	Low Risk	No Risk at All	Doesn't Know	Total	No. of Cases*
Total	0.3	2.9	18.8	74.9	3.0	100.0	5,667
Residence							
Urban	0.3	3.8	20.7	72.5	2.8	100.0	3,039
Rural	0.4	1.7	16.1	78.5	3.3	100.0	2,628
Region							
Kakheti	0.4	1.0	15.3	80.3	3.0	100.0	411
Tbilisi	0.2	5.2	22.7	69.5	2.4	100.0	1,396
Shida Kartli	0.2	1.3	22.7	71.8	4.0	100.0	413
Kvemo Kartli	1.1	3.6	14.1	78.3	2.9	100.0	438
Samtskhe-Javakheti	0.9	2.4	15.3	74.0	7.4	100.0	354
Adjara	0.2	2.2	14.7	80.6	2.3	100.0	416
Guria	0.2	1.4	16.9	79.7	1.8	100.0	353
Samegrelo	0.0	0.6	23.2	73.4	2.9	100.0	438
Imereti	0.1	2.6	16.8	77.7	2.8	100.0	719
Mtskheta-Mtianeti	0.0	1.8	19.8	71.8	6.6	100.0	346
Racha-Svaneti	0.0	0.7	4.8	91.6	2.9	100.0	383
Age Group							
15–19	0.2	0.5	8.2	84.8	6.3	100.0	651
20–24	0.1	2.9	17.5	75.5	3.8	100.0	922
25–34	0.3	3.9	22.3	71.2	2.4	100.0	2,105
35–44	0.4	3.1	20.7	74.0	1.8	100.0	1,989
Education Level							
Secondary incomplete or less	0.5	0.9	13.0	79.0	6.6	100.0	552
Secondary complete	0.5	1.9	13.7	80.3	3.5	100.0	1,556
Technicum	0.4	3.1	19.0	75.0	2.4	100.0	1,393
University/postgraduate	0.0	4.1	23.9	69.9	2.0	100.0	2,166
Socioeconomic Status							
Low	0.5	1.7	12.7	81.5	3.6	100.0	1,844
Middle	0.2	2.9	19.6	74.7	2.6	100.0	2,785
High	0.1	4.9	26.3	65.8	3.0	100.0	1,038
Ethnic Group							
Georgian	0.2	3.0	19.4	74.5	2.9	100.0	5,131
Azeri	0.0	1.5	3.0	89.2	6.3	100.0	115
Armenian	2.9	1.3	14.4	78.5	2.9	100.0	285
Other	0.0	4.1	21.3	72.3	2.4	100.0	136

Excludes 56 cases for whom there is no information.

Table 16.5.1 Percentage of Sexually Experienced Women Aged 15–44 Years Ever Tested for Selected STIs by Selected Characteristics Reproductive Health Survey: Georgia, 2005

Characteristic	Tested for at Least one STI %	STI Testing for: Yeast Infection %	Trichomoniasis %	Syphilis %	Chlamydia %	Gonorrhea %	Genital Herpes %	Genital Warts %	No. of Cases
Total	38.0	30.6	22.4	14.7	8.7	7.3	2.4	0.2	4,517
Residence									
Urban	47.8	38.4	28.5	19.3	12.5	9.3	3.1	0.4	2,188
Rural	27.1	21.9	15.7	9.6	4.4	5.0	1.7	0.1	2,329
Region									
Kakheti	25.4	18.7	12.2	9.8	5.8	0.7	2.2	0.0	405
Tbilisi	60.8	48.2	35.4	24.6	19.3	12.0	4.2	0.7	952
Shida Kartli	35.4	27.6	23.0	10.2	7.5	5.3	1.5	0.0	341
Kvemo Kartli	28.2	21.9	16.6	8.6	5.3	3.4	1.9	0.0	432
Samtskhe-Javakheti	35.5	25.3	29.4	21.7	1.8	17.4	1.3	0.8	328
Adjara	20.6	20.4	9.4	3.2	3.4	2.5	0.9	0.0	350
Guria	15.5	15.2	9.5	1.7	3.7	1.0	2.4	0.0	266
Samegrelo	17.6	17.6	10.6	3.1	3.6	4.4	2.6	0.0	336
Imereti	47.5	37.4	28.6	25.2	5.9	10.4	2.1	0.2	550
Mtskheta-Mtianeti	42.6	34.1	29.3	16.0	11.5	11.8	2.4	0.0	280
Racha-Svaneti	20.0	17.3	8.0	2.3	3.3	1.7	2.3	0.0	277
Age Group									
15–19	14.8	8.8	10.0	10.9	2.6	3.3	0.5	0.0	161
20–24	30.7	24.0	15.9	10.6	7.1	5.5	1.5	0.2	580
25–34	44.0	36.2	26.5	16.5	11.6	8.4	3.7	0.2	1,847
35–44	37.1	29.8	22.1	14.7	7.3	7.2	1.9	0.3	1,929
Education Level									
Secondary incomplete or less	15.9	12.9	5.3	4.5	1.8	2.5	0.0	0.0	461
Secondary complete	30.2	24.4	16.9	10.9	4.6	4.7	1.3	0.1	1,402
Technicum	39.9	32.6	25.0	16.9	7.3	8.3	2.2	0.2	1,208
University/postgraduate	50.8	40.5	31.0	19.8	15.8	10.3	4.5	0.5	1,446
Socioeconomic Status									
Low	24.5	19.7	13.2	9.0	2.9	3.7	1.2	0.0	1,649
Middle	40.3	33.0	24.4	14.9	8.8	7.6	2.2	0.2	2,102
High	57.3	44.8	34.8	24.8	19.2	13.2	5.3	0.7	766
Ethnic Group									
Georgian	40.7	32.9	23.9	15.5	9.3	7.7	2.6	0.2	3,857
Azeri	12.8	9.4	10.1	5.2	2.9	1.4	0.4	0.0	243
Armenian	23.8	20.1	14.4	9.7	4.0	4.5	2.3	0.4	284
Other	39.8	29.2	20.8	21.2	11.4	11.0	1.8	0.8	133
No. of Lifetime Sexual Partners									
1	37.7	30.3	22.2	14.7	8.5	7.1	2.4	0.2	4,393
2 or more	47.1	39.0	30.0	14.7	15.7	11.0	2.4	0.8	121
No response	*	*	*	*	*	*	*	*	3

* Less than 25 cases.

Table 16.5.2 Sexually Experienced Women Aged 15–44 Years Who Received the Results of Their Last STI Test, by Type of Infection Among Those Who Have Ever Been Tested for an STI Reproductive Health Survey: Georgia, 2005

	Syphilis		Gonorrhea		Chlamydia		Yeast Infection		Genital Herpes		Trichomomoniasis	
Characteristic	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases	%	No. of Cases
Total	69.9	652	70.3	353	93.8	382	92.9	1,336	92.9	117	90.6	1,004
Residence												
Tbilisi	76.4	231	82.5	120	96.4	183	97.6	458	91.7	44	95.5	340
Other urban	69.0	201	66.2	109	93.2	84	90.7	368	100.0	29	88.5	292
Rural	61.8	220	58.1	124	88.3	115	89.2	510	89.5	44	86.4	372
Age Group												
15–24	81.2	80	82.3	44	100.0	38	92.3	144	*	10	90.7	111
25–34	76.3	292	77.5	160	95.1	203	92.8	630	95.2	63	91.2	469
35–44	60.8	280	60.3	149	90.2	141	93.2	562	87.3	44	90.0	424
Education Level												
Secondary incomplete or less	64.4	25	*	16	*	10	88.3	49	*	0	83.7	28
Secondary complete	72.8	155	63.6	73	95.0	63	93.1	332	*	17	90.7	242
Technicum	62.0	194	66.7	112	92.2	89	91.5	380	81.1	32	87.2	298
University/postgraduate	74.0	278	76.0	152	94.2	220	94.2	575	95.5	68	93.0	436
Socioeconomic Status												
Low	69.3	144	64.5	71	91.0	55	90.9	313	100.0	26	88.9	217
Middle	68.7	315	67.6	172	95.2	181	92.4	676	87.5	50	89.6	515
High	71.9	193	77.1	110	92.9	146	95.5	347	95.6	41	93.4	272

Note: Excludes genital warts because of insufficient number of cases.

* Less than 25 cases.

Table 16.6.1 Percentage of Sexually Experienced Women Aged 15–44 Years Who Experienced STI Symptoms in the Past 12 Months by Selected Characteristics Reproductive Health Survey: Georgia, 2005

Characteristic	Symptoms					No. of Cases
	Vaginal Discharge with a Bad Smell %	Itching or Burning in the Genital Area %	Burning Pain on Urination %	Pain During Sexual Intercourse %	Sore, Ulcer or Warts in Genital Area %	
Total	18.4	12.8	10.0	7.3	3.6	4,517
Residence						
Urban	17.7	12.4	9.1	6.7	5.0	2,188
Rural	19.3	13.3	11.0	8.0	2.1	2,329
Region						
Kakheti	14.7	9.1	8.7	6.2	0.9	405
Tbilisi	18.1	13.9	9.8	9.0	6.2	952
Shida Kartli	25.2	18.2	13.6	9.2	4.4	341
Kvemo Kartli	10.5	7.3	6.9	5.0	1.1	432
Samtskhe-Javakheti	12.8	8.7	7.4	6.4	4.9	328
Adjara	25.9	15.1	7.8	7.3	2.5	350
Guria	14.5	9.5	8.1	7.8	3.4	266
Samegrelo	23.0	15.2	11.9	9.6	0.5	336
Imereti	17.2	13.8	12.8	5.5	4.3	550
Mtskheta-Mtianeti	23.3	13.3	14.2	5.7	5.4	280
Racha-Svaneti	19.7	11.0	8.3	4.7	4.0	277
Age Group						
15–19	9.6	5.0	7.0	4.0	0.8	161
20–24	14.5	10.6	8.8	6.3	4.3	580
25–34	20.3	12.9	8.9	8.6	3.4	1,847
35–44	18.8	14.1	11.5	6.9	3.8	1,929
Education Level						
Secondary incomplete or less	16.3	13.0	10.3	7.9	2.0	461
Secondary complete	19.7	13.0	10.9	6.8	3.2	1,402
Technicum	20.5	14.4	11.5	8.5	4.8	1,208
University/postgraduate	16.3	11.3	7.8	6.6	3.5	1,446
Socioeconomic Status						
Low	20.3	14.3	11.8	8.5	2.7	1,649
Middle	17.5	11.6	9.6	6.2	3.8	2,102
High	17.4	13.2	7.7	7.8	4.9	766
Ethnic Group						
Georgian	19.9	13.8	10.5	7.6	3.9	3,857
Azeri	8.5	5.2	5.6	4.2	0.0	243
Armenian	9.3	7.1	6.3	5.7	3.1	284
Other	15.7	10.5	11.3	7.3	2.8	133

Table 16.6.2 Percentage of Sexually Experienced Women Aged 15–44 Years Who Presented at Least One STI symptom in the Past 12 Months and Sought Treatment by Selected Characteristics (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

Characteristic	Sought Treatment	Did Not Seek Treatment	Not Sure	Total	No. of Cases
Total	46.0	53.9	0.1	100.0	1,097
Residence					
Urban	49.2	50.6	0.2	100.0	544
Rural	42.1	57.8	0.1	100.0	553
Age Group					
15–19	49.2	50.8	0.0	100.0	26
20–24	52.4	47.6	0.0	100.0	110
25–34	51.2	48.5	0.3	100.0	479
35–44	39.8	60.1	0.1	100.0	482
Education Level					
Secondary incomplete or less	33.9	66.1	0.0	100.0	105
Secondary complete	42.4	57.6	0.0	100.0	346
Technicum	47.3	52.2	0.5	100.0	324
University/postgraduate	52.2	47.8	0.0	100.0	322
Socioeconomic Status					
Low	36.4	63.5	0.1	100.0	414
Middle	49.4	50.3	0.3	100.0	488
High	56.2	43.8	0.0	100.0	195

Table 16.6.3 Type of STI Treatment Provider Used, by Selected Characteristics Among Sexually Experienced Women Aged 15–44 Years Who Sought Treatment for Recent STI Symptoms Reproductive Health Survey: Georgia, 2005

	STI Treatment Provider (Percentage Distribution)								
Characteristc	Ob/Gyn	Other Doctor	Nurse/ Midwife	Pharmacist	Friend/ Relative	Self Treatment	No Response	Total	No. of Cases
Total	82.5	1.9	1.1	1.2	1.7	11.5	0.2	100.0	498
Residence									
Tbilisi	87.1	2.3	0.6	0.0	0.0	9.9	0.0	100.0	143
Other urban	82.5	3.6	1.1	1.6	2.4	7.9	0.8	100.0	127
Rural	78.9	0.4	1.4	1.8	2.7	14.8	0.0	100.0	228
Age Group									
15–24	93.3	0.0	0.0	0.0	0.0	6.7	0.0	100.0	65
25–34	83.7	1.6	0.7	0.0	1.3	12.5	0.2	100.0	239
35–44	77.3	2.7	1.8	2.9	2.8	12.1	0.3	100.0	194
Education Level									
Secondary incomplete or less	64.6	8.0	0.0	3.3	5.8	18.3	0.0	100.0	39
Secondary complete	85.9	1.8	1.0	1.3	0.7	9.2	0.0	100.0	139
Technicum	79.4	0.0	2.3	1.9	3.7	12.3	0.4	100.0	151
University/postgraduate	85.9	2.2	0.2	0.0	0.0	11.4	0.3	100.0	169
Socioeconomic Status									
Low	74.0	1.3	2.5	2.6	4.5	15.1	0.0	100.0	155
Middle	87.0	0.7	0.7	0.9	0.9	9.6	0.2	100.0	232
High	84.0	4.7	0.0	0.0	0.0	10.8	0.4	100.0	111

Table 16.6.4 Primary Reason for Not Seeking Treatment by Selected Characteristics Among Sexually Experienced Women Aged 15–44 Years Who Experienced STI Symptoms in the Past 12 Months and Did Not Seek Treatment Reproductive Health Survey: Georgia, 2005

	Primary Reason for Not Seeking Treatment (Percentage Distribution)										
Characteristic	Cannot Afford Services or Treatment	Symptom(s) Disappeared	Didn't Think it was an STI	Afraid of Knowing the Results	It Is Embarrassing	Doesn't Know Where to Go for Services	Services Far Away/ Inaccessible	Other	Refused	Total	No. of Cases
Total	60.5	15.4	8.6	4.9	3.5	0.6	0.3	5.7	0.6	100.0	599
Residence											
Tbilisi	43.1	26.1	7.2	5.9	1.3	0.7	0.7	15.0	0.0	100.0	123
Other urban	61.0	9.6	14.0	6.6	3.9	0.6	0.1	3.5	0.8	100.0	151
Rural	68.9	13.0	6.4	3.6	4.4	0.5	0.2	2.2	0.8	100.0	325
Age Group											
15–24	38.4	20.6	9.2	9.2	8.7	3.5	0.2	7.1	3.1	100.0	71
25–34	53.2	21.6	7.9	4.8	3.9	0.0	0.5	7.6	0.6	100.0	240
35–44	70.4	9.9	8.9	4.1	2.1	0.3	0.1	4.1	0.1	100.0	288
Education Level											
Secondary incomplete or less	72.5	11.0	3.7	2.9	1.7	2.3	0.0	2.8	3.1	100.0	66
Secondary complete	64.0	9.9	9.9	6.1	6.4	0.4	0.1	3.1	0.0	100.0	207
Technicum	68.4	12.9	6.8	5.4	1.9	0.0	0.7	3.0	0.9	100.0	173
University/postgraduate	42.4	26.9	10.9	3.8	2.3	0.6	0.1	13.0	0.0	100.0	153
Socioeconomic Status											
Low	75.4	7.7	4.8	3.9	4.0	0.7	0.2	2.4	0.9	100.0	259
Middle	55.3	17.3	11.2	5.1	3.3	0.2	0.5	6.6	0.5	100.0	256
High	32.8	31.8	12.0	7.4	2.6	1.0	0.0	12.5	0.0	100.0	84

Table 16.7.1 Primary Source of Information about STIs, Including HIV/AIDS, by Selected Characteristics Among Women Aged 15–44 Years Who Were Aware of at Least One Type of STI
Reproductive Health Survey: Georgia, 2005

	Primary Source of Information (Percentage Distribution)													
Characteristic	TV	Friend/ Colleague	Print Media	Health Professional	Specialty Books	Other Relative	Teacher	Mother/ Father	Husband/ Partner	Radio	Other	Doesn't Know	Total	No. of Cases
Total	54.9	17.8	8.0	7.1	5.0	2.3	1.8	1.0	0.8	0.2	0.6	0.5	100.0	5,723
Residence														
Urban	55.7	15.6	8.6	7.1	6.4	1.3	2.2	1.6	0.7	0.2	0.5	0.3	100.0	3,054
Rural	53.7	20.9	7.1	7.2	3.2	3.7	1.2	0.2	1.1	0.2	0.9	0.8	100.0	2,669
Region														
Kakheti	43.9	27.1	7.4	8.8	4.5	4.3	1.0	0.0	1.2	0.0	0.6	1.2	100.0	425
Tbilisi	54.8	11.2	9.6	7.2	8.6	0.9	3.0	2.8	0.9	0.2	0.4	0.2	100.0	1,398
Shida Kartli	61.3	18.0	8.0	6.5	4.0	0.6	0.8	0.4	0.2	0.2	0.0	0.2	100.0	415
Kvemo Kartli	50.2	20.7	7.3	9.0	2.3	5.3	0.4	0.2	2.3	0.2	0.4	1.8	100.0	451
Samtskhe-Javakheti	75.4	15.3	4.4	0.7	1.3	0.0	0.2	0.2	1.5	0.0	0.0	1.1	100.0	356
Adjara	64.0	7.7	8.2	7.2	5.0	2.0	2.9	0.4	0.2	0.4	2.0	0.2	100.0	418
Guria	68.7	8.8	10.8	2.5	3.2	0.9	1.4	0.0	2.7	0.2	0.7	0.2	100.0	354
Samegrelo	52.8	17.9	5.7	9.1	5.5	4.3	1.9	0.2	0.8	0.2	1.5	0.2	100.0	445
Imereti	47.6	32.8	5.6	7.2	1.9	2.7	1.0	0.2	0.0	0.2	0.3	0.3	100.0	728
Mtskheta-Mtianeti	56.5	17.0	11.8	6.1	3.4	2.3	0.9	0.9	0.2	0.5	0.0	0.5	100.0	347
Racha-Svaneti	33.5	34.6	17.5	2.6	6.3	3.7	0.2	0.2	1.1	0.0	0.2	0.0	100.0	386
Age Group														
15–19	60.2	20.5	4.1	1.7	2.4	2.9	3.6	3.3	0.6	0.4	0.1	0.1	100.0	658
20–24	53.7	19.5	8.4	5.4	4.4	1.6	2.2	1.7	1.2	0.3	1.1	0.4	100.0	932
25–34	53.8	17.2	8.0	8.8	6.3	1.8	1.8	0.2	0.7	0.1	0.6	0.6	100.0	2,123
35–44	54.2	16.4	9.4	8.7	5.2	2.9	0.8	0.4	0.8	0.1	0.7	0.5	100.0	2,010
Education Level														
Secondary incomplete or less	60.9	19.0	3.3	5.5	0.9	5.0	1.0	1.5	1.0	0.1	0.1	1.7	100.0	574
Secondary complete	55.5	20.2	6.2	7.4	2.5	3.3	0.9	0.7	1.1	0.3	1.5	0.5	100.0	1,576
Technicum	56.1	18.4	7.4	7.2	4.3	2.1	2.2	0.4	0.8	0.2	0.6	0.5	100.0	1,405
University/postgraduate	51.9	15.4	11.0	7.4	8.5	0.8	2.4	1.4	0.6	0.2	0.2	0.1	100.0	2,168
Socioeconomic Status														
Low	54.9	20.3	5.9	7.5	2.6	3.8	0.9	0.2	1.1	0.4	1.4	1.0	100.0	1,888
Middle	55.4	17.9	8.9	6.2	5.3	1.9	2.0	1.0	0.8	0.1	0.3	0.3	100.0	2,796
High	53.6	13.7	8.8	8.6	8.2	0.9	2.6	2.3	0.6	0.1	0.4	0.1	100.0	1,039
Ethnic Group														
Georgian	54.3	18.5	8.1	7.2	5.4	2.2	1.9	0.8	0.6	0.2	0.6	0.2	100.0	5,159
Azeri	36.3	15.5	4.8	15.1	0.0	10.8	0.6	1.2	7.9	0.0	0.6	7.2	100.0	139
Armenian	74.4	6.9	7.8	1.3	1.3	0.0	0.6	2.2	2.3	0.0	1.1	2.1	100.0	287
Other	60.5	15.0	7.4	6.9	3.7	0.0	0.7	4.8	0.2	0.0	0.6	0.3	100.0	138
Sexual Experience														
No	57.2	21.2	6.9	1.5	4.9	1.9	3.5	2.1	0.0	0.4	0.3	0.1	100.0	1,527
Yes	53.8	16.3	8.5	9.7	5.1	2.5	1.0	0.5	1.2	0.1	0.8	0.6	100.0	4,196

Table 16.7.2 Public Announcements Seen or Heard in the Past 6 months on STIs Other Than HIV/AIDS, by Selected Characteristics and by Media Source Among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2005

	Media Source (Percentage Distribution)										
Characteristic	None	Radio/ Newspaper	TV/ Newspaper	Radio/TV/ Newspaper	Only Radio	Only TV	Radio/ TV	Only Newspaper	Doesn't Remember	Total	No. of Cases
Total	72.1	0.1	4.8	1.1	0.4	8.1	1.8	3.3	8.4	100.0	6,376
Residence											
Urban	63.6	0.1	7.0	1.9	0.5	9.9	2.6	4.7	9.7	100.0	3,196
Rural	82.5	0.0	2.0	0.0	0.1	5.9	0.9	1.6	6.9	100.0	3,180
Region											
Kakheti	89.7	0.0	0.6	0.0	0.2	3.6	1.1	0.9	3.9	100.0	538
Tbilisi	52.9	0.2	10.6	2.4	0.5	11.2	3.8	6.8	11.5	100.0	1,431
Shida Kartli	61.2	0.0	5.8	2.0	0.0	10.0	1.3	3.6	16.1	100.0	430
Kvemo Kartli	82.8	0.0	1.6	1.8	0.0	4.2	1.6	2.2	5.8	100.0	576
Samtskhe-Javakheti	77.4	0.0	1.2	0.3	0.0	2.2	0.5	1.6	16.7	100.0	434
Adjara	82.5	0.0	0.7	0.0	0.0	12.7	0.9	2.2	0.9	100.0	490
Guria	80.0	0.0	2.5	0.2	0.2	3.5	1.0	1.6	11.0	100.0	388
Samegrelo	80.9	0.0	2.3	0.0	1.5	9.7	1.8	0.7	3.1	100.0	506
Imereti	77.2	0.0	3.9	0.3	0.2	5.3	0.7	2.6	9.8	100.0	782
Mtskheta-Mtianeti	68.9	0.0	10.5	0.0	1.3	7.8	0.8	2.5	8.2	100.0	374
Racha-Svaneti	75.3	0.2	2.7	0.0	0.0	6.7	0.8	0.6	13.7	100.0	427
Age Group											
15–19	77.0	0.0	2.6	1.0	0.3	6.9	2.2	2.6	7.4	100.0	930
20–24	72.9	0.2	4.4	1.1	0.7	8.7	1.4	3.0	7.7	100.0	1,079
25–34	69.8	0.0	5.4	0.9	0.4	8.7	1.8	3.8	9.2	100.0	2,249
35–44	71.0	0.0	5.6	1.2	0.2	7.9	1.9	3.4	8.7	100.0	2,118
Education Level											
Secondary incomplete or less	83.9	0.0	1.6	0.4	0.3	5.2	1.7	1.0	6.0	100.0	907
Secondary complete	78.3	0.0	1.9	0.5	0.1	7.1	1.5	1.8	8.7	100.0	1,786
Technicum	71.1	0.1	5.2	1.1	0.2	8.8	1.8	2.1	9.7	100.0	1,466
University/postgraduate	62.3	0.1	8.2	1.8	0.7	9.8	2.2	6.3	8.6	100.0	2,217
Socioeconomic Status											
Low	85.1	0.0	1.3	0.0	0.3	5.6	0.7	0.9	6.1	100.0	2,277
Middle	68.9	0.1	5.1	1.1	0.3	8.9	1.8	3.9	10.0	100.0	3,028
High	56.2	0.2	10.3	2.8	0.6	10.7	4.0	6.3	8.8	100.0	1,071
Ethnic Group											
Georgian	70.5	0.1	5.0	1.1	0.4	8.8	2.0	3.5	8.7	100.0	5,545
Azeri	93.4	0.0	0.5	0.0	0.0	1.4	0.3	1.1	3.2	100.0	292
Armenian	78.5	0.0	3.6	0.0	0.0	4.0	1.4	1.7	10.9	100.0	382
Other	70.4	0.0	7.5	3.6	0.0	5.9	1.8	4.2	6.7	100.0	157
Sexual Experience											
No	71.6	0.1	4.6	1.4	0.4	8.4	2.2	3.4	7.8	100.0	1,859
Yes	72.4	0.0	4.9	0.9	0.3	7.9	1.6	3.2	8.8	100.0	4,517

Chapter 17

HIV/AIDS

17.1 HIV/AIDS in Georgia

The world's fastest growing HIV/AIDS epidemic is taking place in Eastern Europe and Central Asia (UNAIDS, 2004a). Until mid-1995, Eastern Europe and the former Soviet Union did not seem threatened by a substantial HIV epidemic. Of the 450 million people in the region, HIV infections were estimated at less than 30,000 cases. However, the number of people living with HIV in the region had reached 1.5 million at the end of 2005.

Between 2003 and 2005, the number of adults and children living with HIV in this region increased by more than a third (UNAIDS, 2006); an estimated 420,000 adult women were living with HIV in Eastern Europe and Central Asia in 2005. HIV rates are highest among young people; more than 80% of people who are HIV-positive in this region have not yet turned 30, in contrast to the situation in Western Europe, where 30% of the reported cases are among people who are aged 29 years or younger.

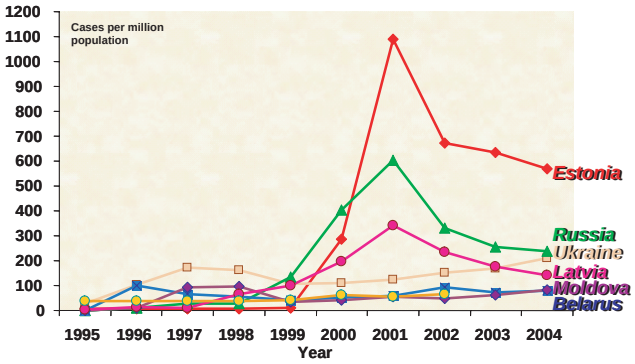
Most of these infections are occurring through the use of contaminated equipment when injecting drugs. Because most injecting drug users (IDUs) are young and sexually active, a second route of spreading the virus is through sexual transmission, when injecting drug users or their HIV-infected partners engage in unsafe sex (UNAIDS, 2006).

The most seriously affected countries are the Russian Federation, Ukraine, Estonia, Latvia, Belarus, and Moldova, which have also reported the highest rates of new infections (Figure 17.1.1) (EuroHIV, 2003 and 2005). Although HIV rates in Georgia remain relatively low, they have shown a two-fold increase from 2003; currently, an estimated 5,600 Georgians live with HIV/AIDS (UNAIDS, 2006). Notably, this UNAIDS estimate differs sharply from the official number of cases (1,028) reported in June 2006 by the Georgian government. (Georgian AIDS and Clinical Immunology Research Centre, 2006).

HIV rates in the Caucasus region appear to be growing less rapidly than elsewhere in the former Soviet Union. Georgia is a low-prevalence country—defined by UNAIDS as having less than 5% infections in all groups—but is currently facing the fastest growing number of HIV infections in the Caucasus region (Figure 17.1.2) (EuroHIV, 2003 and 2005). Most cases are concentrated among high risk groups; the overall prevalence is between 0.1% and 0.2%. The first HIV/AIDS case in Georgia was registered in 1989. Of the 1,028 HIV cases officially reported in Georgia, 419 had progressed to AIDS, including 216 people who died. Officially reported cases are identified through routine surveillance carried out under the Georgian AIDS Control Service, which consists of the AIDS and Clinical Immunology Research Center, established in 1989, and its 69 satellite diagnostic laboratories (Tkeshelashvili-Kessler et al., 2005). Additional cases are identified through recent behavioral and biomarker surveys, implemented within the framework of international partnership projects for HIV/AIDS prevention among high risk groups.

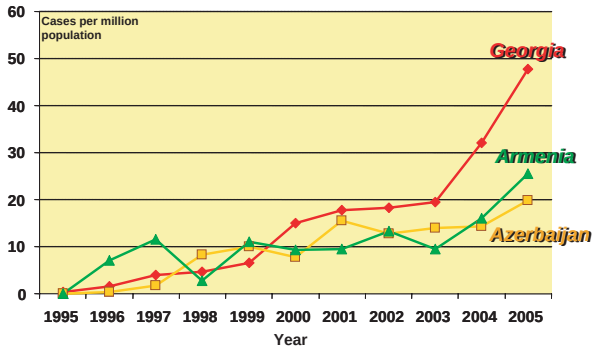
The main routes of transmission are: injecting drug use (IDU), which is attributable to 63% of HIV infections; heterosexual transmission (30%); homosexual transmission(3%);mother-to-childtransmission(1.4%), and blood transfusion (1%) (Figure 17.1.3)(Georgian AIDS and Clinical Immunology Research Center, 2006). Most HIV cases are confined to IDUs, female sex workers (FSWs), and men who have sex with men (MSM), though these populations are estimated to be

Figure 17.1.1 **Newly Diagnosed HIV Infections per Million Population Among the Most Affected Countries in Eastern Europe and Central Asia: 1995–2004**



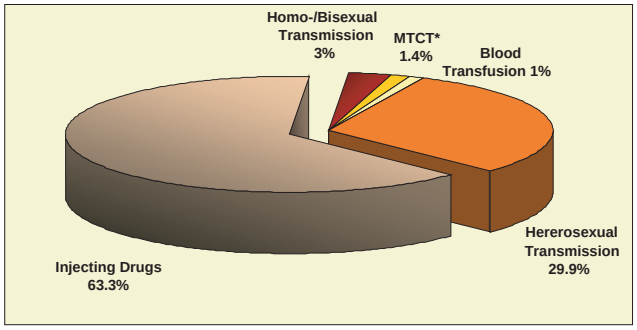
Source: EuroHIV, 2002 and 2006: HIV/AIDS Surveillance in Europe No. 68 and 72; Georgian AIDS Centre, 2006

Figure 17.1.2 **Newly Diagnosed HIV Infections per Million Population Among the Caucasus Countries: 1995–2005**



Source: EuroHIV, 2002 and 2006: HIV/AIDS Surveillance in Europe No. 68 and 72; Georgian AIDS Centre, 2006

Figure 17.1.3 **HIV/AIDS Transmission Routes Among Cases Reported to the Georgian HIV Surveillance System**



•MTCT = Mother-to-Child-Transmission
Source: Georgian AIDS and Clinical Immunology Research Centre, 2 006

very small (100,000 IDUs, 30,000 FSWs, and 10,000 MSM)(UNAIDS, 2004b). UNAIDS estimates suggest that prevalence among these vulnerable groups, though ten times higher than for the general population, is still low: 1% among IDUs, 1.3% among FSWs, and 3.2% among MSM (UNAIDS, 2006). Both the size of these populations and the prevalence of high risk behaviors among them are on the rise, which suggests high potential for further increases in HIV infection rates (UNGASS, 2006).

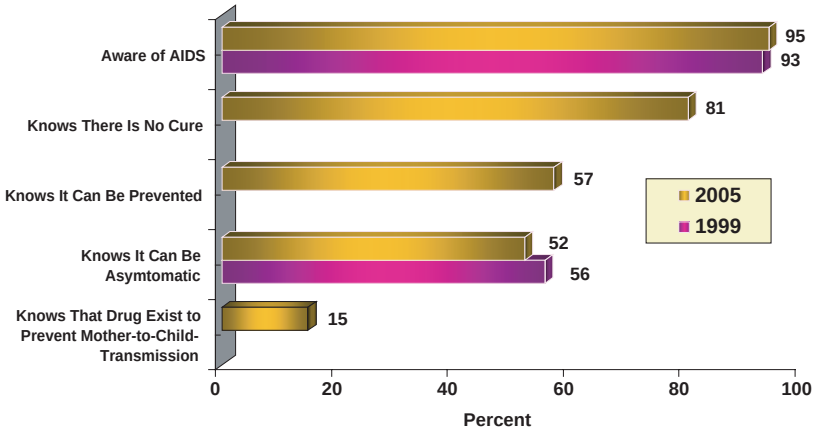
Most men and women affected by HIV in Georgia are 29–40 years of age. Almost 80% of HIV/AIDS cases are among men, but unsafe sex is likely to become a much more prominent factor in HIV transmission, leading to an increase in the proportion of women among infected individuals. Over a third of people living with HIV reside in the capital, Tbilisi (392 cases), and 31% in the Black Sea coastal regions of Georgia (167 in Samegrelo and 154 in Adjara) (Georgian AIDS and Clinical Immunology Research Center, 2006).

In addition to testing for HIV and surveillance activities, the Georgian AIDS and Clinical Immunology Research Center offers voluntary and confidential pre- and post-testing counseling; distributes and monitors HIV treatment (currently, 187 AIDS patients are receiving antiretroviral treatment); prepares and disseminates Information, Education, and Communication materials for HIV prevention; trains peer educators from high risk groups; and maintains an HIV hotline. In 2005, Georgia also began giving pregnant women universal access to voluntary HIV counseling and testing and providing prophylactic treatment to HIV-positive mothers to prevent mother-to-child transmission (MTCT).

17.2 Awareness and Correct Knowledge of HIV/AIDS

In Georgia, awareness of HIV/AIDS among women aged 15–44 years is almost universal (95%) (Table 17.2). This percentage is slightly higher than the 93% awareness found in the 1999 Reproductive Health Survey (Figure 17.2.1). Some subgroups in 2005 were less likely to have heard of HIV/AIDS, including rural women (89%), women with secondary incomplete or less education (79%), and especially Azeri women (46%).

Figure 17.2.1 **Awareness and Knowledge of HIV/AIDS Among Women Aged 15–44 Years**

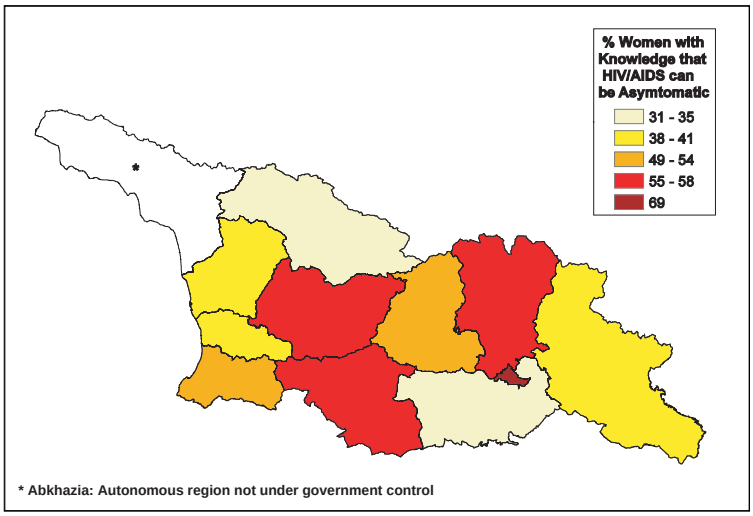


Overall, 81% of respondents knew that no cure exists for AIDS; knowledge of this fact was higher among women living in urban areas (85%) than rural women (75%). Knowledge that there is no cure for AIDS is directly related to respondent age, educational attainment, and SES, but differences by age group are not statistically significant.

The survey assessed respondent awareness of ways to prevent HIV transmission. First, respondents were asked if they were aware that there are ways to prevent transmission of HIV; 57% indicated that they were. Respondents were also asked to name specific preventive measures; awareness of at least one preventive measure was lowest among rural women (49%); residents of the Samtskhe-Javakheti region (31%); women aged 15–19 years (47%); women with low educational attainment (38%); those with low SES (47%); and Azeri women (16%). This topic will be discussed further in Section 17.5.

Slightly more than half (52%) of respondents were aware that a person can be infected with HIV and be asymptomatic or not show any clinical symptoms of the disease. This is 4% less than in 1999 (Figure 17.2.1). The proportion of respondents with this knowledge was greatest among women living in the urban areas of the country (64%), especially those in Tbilisi (69%). In general, knowledge that HIV/AIDS can be asymptomatic increases as respondent educational level and SES increase. Lower levels of knowledge were seen among women living in the regions of Kvemo Kartli (35%) and Racha-Svaneti (31%), and especially among Azeri women (9%) (Figure 17.2.2). Lack of knowledge about HIV being asymptomatic is an important public health issue because it can lead to exposure of uninfected persons to infection (based on the assumption that a healthy looking person cannot be infected). For this reason, the HIV Information, Education and Communication (IEC) in Georgia should intensify efforts to ensure correct knowledge about HIV transmission in the general population.

Figure 17.2.2 **Percentage of Women Who Know that HIV/AIDS Can be Asymptomatic, by Region**



Only 15% of the women had knowledge that drugs exist to reduce the likelihood of mother-to-child-transmission of HIV (MTCT). Urban women, women with a university education, and women of high socio-economic status were more likely to know about such drugs.

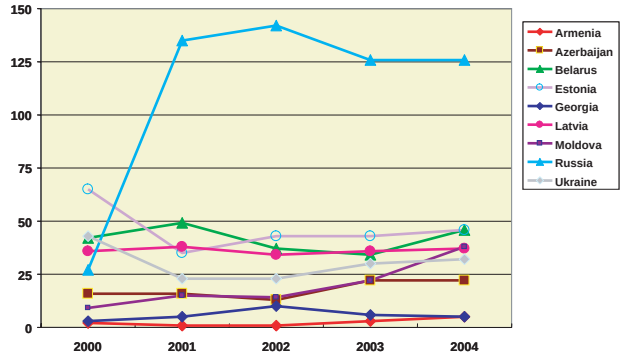
17.3 HIV-Testing

In Eastern Europe, HIV testing is performed primarily among high-risk groups and during screening for blood donations. Therefore, the rate of HIV testing in the general population is low (Figure 17.3.1). Furthermore, the number of HIV tests reported by Georgia's HIV surveillance system includes repeat tests performed on the same person. The official testing rate is therefore likely to overestimate the true rate of testing in the population. Population-based data can provide a more accurate estimate of rates of HIV testing in the general population.

Respondents aged 15–44 years were asked if they knew where HIV tests are provided; only 42% did, but this figure is 18% higher than in 1999 (Table 17.3.1 and Figure 17.3.2). Knowledge of where tests are provided was highest among women who live in the urban areas of the country (54%), especially those in Tbilisi (66%) (Figure 17.3.3). Knowledge of a testing source increases with educational attainment and SES, but was lower among rural women, women aged 15–19 years, women with lower educational attainment or SES, and Azeri women.

As shown in Table 17.3.1, 42% of respondents aged 15–44 years knew where HIV tests are provided. As mentioned above, this is almost a two-fold increase compared to 1999. The testing locales that respondents mentioned are shown in Table 17.3.2; 39% of respondents mentioned HIV centers, followed by women's clinics (16%), general government hospitals (11%), and government STI hospitals (10%). Less than 10% of respondents mentioned any of the remaining testing locales shown in the table.

Figure 17.3.1 **Number of HIV Tests per Thousand Population by Country and Year Among Selected Countries in Eastern Europe and Central Asia: 2000–2004**



Source: EuroHIV, 2000-2004: HIV/AIDS Surveillance in Europe End-of Year Reports

Figure 17.3.2 **Knowledge and Experience of HIV-Testing Among Women Aged 15-44 Years**

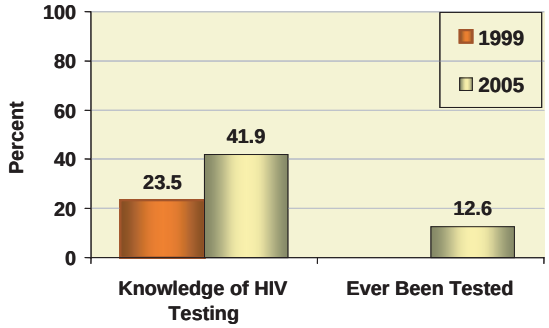
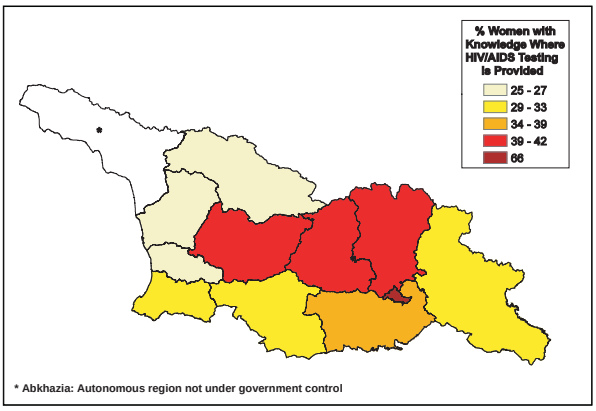


Figure 17.3.3 **Percentage of Women Who Know Where HIV Testing is Provided, by Region**



Relatively few respondents aged 15–44 years (12.6%) had ever been tested for HIV. The probability of having ever been tested was highest among urban women (17%), especially those who live in Tbilisi (22%) (Figure 17.3.4). Ever-tested rates increase with respondent educational attainment and SES. This finding may suggest that the self-perceived risk of contracting HIV/AIDS is higher among more educated and well-off women than among less educated women and those of lower SES. Another explanation may be that there are greater barriers to testing for less educated women and those of lower SES, including lack of access.

Of respondents who have ever been tested for HIV, 58% received their last test in a women's clinic, while 23% received their last test in a general government hospital, even though HIV centers and STI dispensaries and hospitals were the most frequently mentioned testing locales (Table 17.3.3 and Figure 17.3.5). Only 5% of respondents were last tested in a STI government hospital, 4%, in an HIV center, and 1%, in a STI dispensary, suggesting that there may be a stigma associated with being tested in these types of facilities.

As HIV rates increase in Georgia, one would expect testing rates to increase as well. However, only 29% of respondents who had ever been tested were last tested during the 23 months prior to being interviewed, whereas 38% were last tested four or more years prior to being interviewed (Table 17.3.4). The probability of having been tested recently was highest among women aged 15–24 years. A majority of respondents who had been tested (88.5%) also received the results of their last HIV test (data not shown).

UNAIDS uses an indicator of HIV-testing rates that is defined as the percentage of the general population aged 15–49 receiving HIV test results in the last 12 months. This indicator is designed to assess the reach of HIV testing services in the general population, as well as the percentage of people who know their HIV status. The numerator for this indicator is the number

Figure 17.3.4 **Percentage of Women Who Have Ever Been Tested for HIV, by Region**

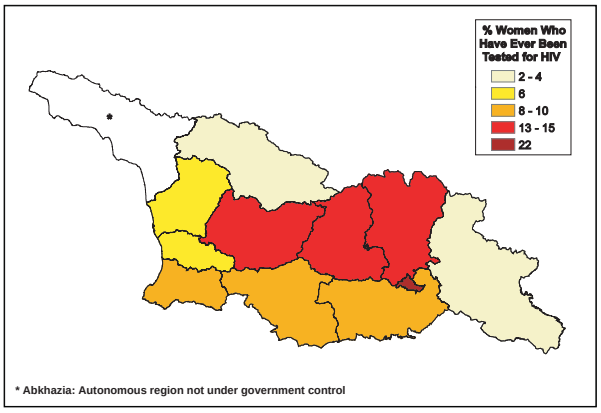
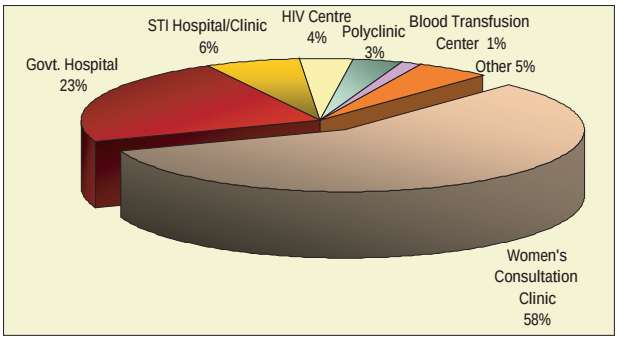


Figure 17.3.5 **Location of Last HIV Test for Women Aged 15–44 Years Who Reported Ever Being Tested for HIV**

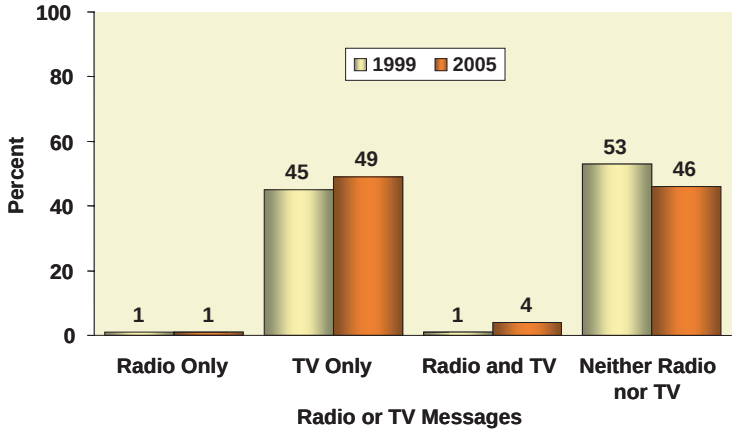


of respondents aged 15–49 who report receiving HIV test results in the last 12 months; the denominator is the total number of surveyed respondents aged 15–49. Because GERHS05 included women aged 15–44 only, this more restricted age group was used in the numerator and the denominator. The results of the calculation show that only 1.8% of the female population aged 15–44 received HIV test results in the last 12 months (13% of women ever tested; 88.5% of women who have ever received the results; 14.6% of women tested within the last 12 months).

17.4 Sources of Information on HIV/AIDS

All respondents aged 15–44 years were asked, "In the past 6 months, have you seen or heard any public announcements or advertisements on television or radio, or read anything in a newspaper or magazine, regarding HIV/AIDS?" As shown in Table 17.4, 38% had not heard, seen, or read any messages on HIV/AIDS via these media during the 6 months prior to interview. The probability of not being exposed to any message was highest in the rural areas of the country (51%), and in the regions of Kakheti (70%) and Kvemo Kartli (53%), and is inversely related to respondent educational attainment and SES. Notably, 79% of Azeri women did not see, hear, or read any messages on HIV/AIDS during the 6 months prior to interview. Overall, 30% of respondents saw an announcement or advertisement only on TV during the 6 month period, while 4% read a message only in a newspaper or magazine, and less than 1% heard an announcement only on the radio. Compared to 1999, the percentage of women who reported seeing or listening to public announcements or advertisements on television or radio increased from 47% to 54% (Figure 17.4). Most of the increase seems to be due to exposure to televised messages. Exposure to print media was not assessed in 1999.

Figure 17.4 **Recent Exposure to Radio or TV Messages on HIV/AIDS Among Women Aged 15–44 Years: 1999 and 2005**



17.5 Knowledge of HIV Transmission

Knowledge of MTCT-risk during pregnancy, delivery, and breast feeding is an essential component of IEC preventive efforts. IEC can build on this knowledge to encourage infected mothers to seek appropriate treatment when it is available and to exclusively bottle-feed their infants. Table 17.5.1 shows the percentage of respondents aged 15–44 who were aware that HIV can be transmitted from mother to child during pregnancy and delivery and through breastfeeding. Overall, 48% of respondents had knowledge of all three of the basic ways HIV can be transmitted from mother to child, including 52% of urban women, and 42% of rural women. Knowledge of these MTCT mechanisms was highest in the regions of Samtskhe-Javakheti (55%), Tbilisi (54%), and Shida Kartli (54%) and lowest in the regions of Kakheti (41%) and Samegrelo (41%) (Figure 17.5.1). Knowledge of all three transmission modes increases as age and educational attainment of respondents increases and is higher among women of middle or high SES. Azeri women were least likely to know about the three transmission modes (15%). Focusing on the individual modes of transmission, fewer women had correct knowledge that HIV can be transmitted from mother to child through breastfeeding (50%), compared to during pregnancy (74%) and during delivery (66%). Compared to 1999, overall knowledge of MTCT risk declined slightly in 2005; however, knowledge of the HIV-risk from breastfeeding declined substantially, from 69% to 50% (Figure 17.5.2).

Respondents aged 15–44 were asked to name the principle mechanisms of HIV transmission (Table 17.5.2). The most cited transmission route was unprotected heterosexual intercourse (92%), followed by unprotected male homosexual intercourse (89%). Nearly 86% of the respondents identified blood transfusions as a principle mechanism of HIV transmission, while 84% identified the use of non-sterile syringes or needles. Women aged 15–19, women with lower educational attainment and SES, and Azeri women were less likely to have knowledge of any of the four principle routes of HIV transmission. Overall,

Figure 17.5.1 **Percentage of Women Aged 15-44 Years Who Have Correct Knowledge of MTCT, by Region**

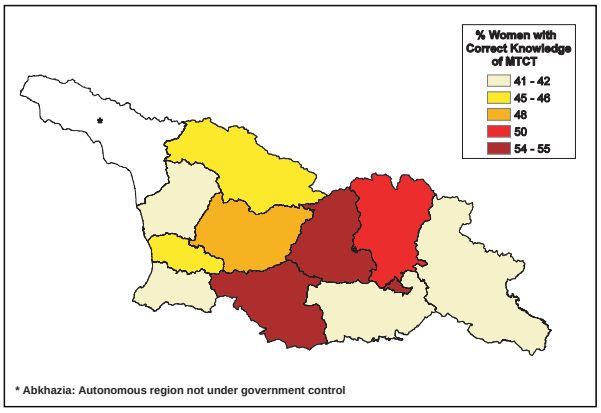
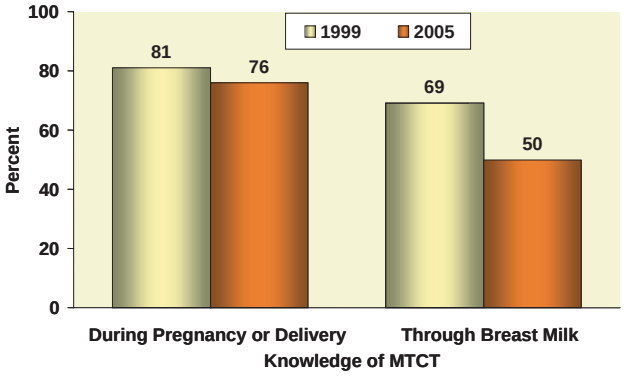


Figure 17.5.2 **Percentage of Women Aged 15-44 With Correct Knowledge About MTCT: 1999 and 2005**



levels of correct knowledge about the major modes of HIV transmission have not changed significantly since 1999 (Figure 17.5.3).

Respondents aged 15–44 were presented with a list of common misconceptions about HIV transmission and asked to identify which were incorrect (Table 17.5.3). None of the modes shown in this table have been identified scientifically as a source of HIV. Overall, 80% of respondents correctly rejected the concept that HIV is acquired through witchcraft or supernatural means, meaning that 20% of respondents either believed that witchcraft plays a role or indicated that they do not know if this is the case. Only 9% of respondents correctly rejected getting a manicure, pedicure, or haircut as a transmission route of HIV, meaning that fully 91% of respondents believed this misconception or did not know. In general, the probability of correctly rejecting a misconception increased with educational attainment and SES, while rural women, women aged 15–19 years, women with lower educational attainment and SES, and Azeri women were less likely to correctly reject misconceptions. Compared to 1999, the proportion of all respondents aged 15–44 who correctly rejected misconceptions increased for all but two misconceptions—that HIV can be contracted from having a manicure, pedicure, or a haircut or from having surgery or dental treatment. Unfortunately these are the two most commonly held misconceptions in Georgia (Figure 17.5.4), perhaps stemming from the correct knowledge that HIV can be transmitted via contaminated sharp objects, particularly needles. These misconceptions may signal a broad distrust of sterilization practices in health clinics and beauty parlors and it will likely take significant public health education efforts to overcome. Educational programs on the most likely routes of HIV transmission, particularly those relating to use of blood products, are urgently needed.

More than half (57%) of all respondents aged 15–44 years believed that a person can do something to reduce the risk of contracting HIV (Table 17.5.4); rates were highest among urban women (65%), older women (61%), and those with a university education (70%) and high SES (68%). However, 18% did not know if anything can be done to reduce the risk of

Figure 17.5.3 **Percentage of Women Aged 15-44 With Correct Knowledge about HIV Transmission: 1999 and 2005**

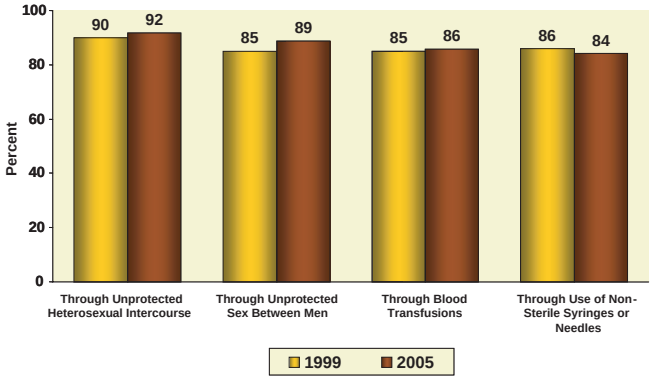
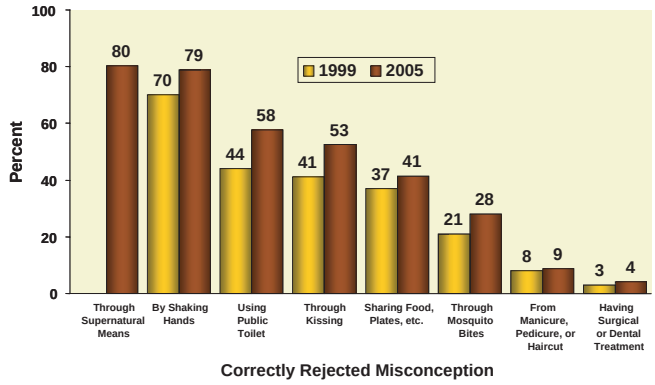


Figure 17.5.4 **Percentage of Women Aged 15-44 Who Correctly Reject Misconceptions about HIV Transmission: 1999 and 2005**



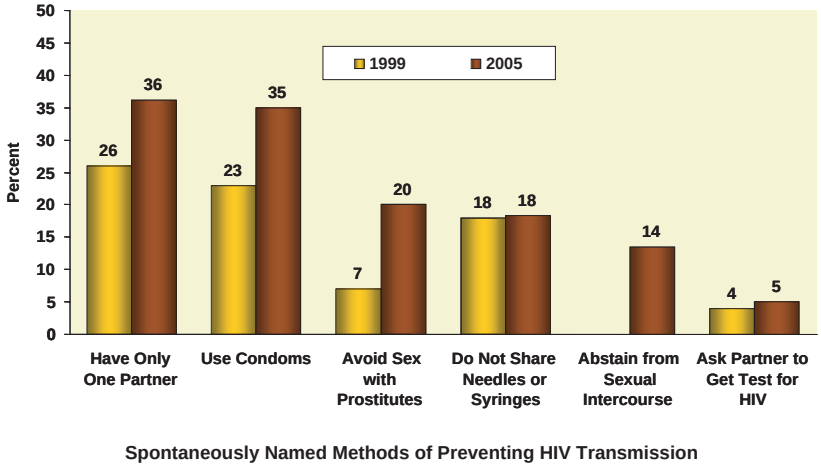
contracting HIV, including 26% among rural women, 37% among women with a secondary incomplete or less education, and 67% among Azeri women.

Respondents were asked to name the ways a person can reduce the risk of getting HIV/AIDS (Table 17.5.5). Nearly 43% were unable to spontaneously mention any means of preventing the transmission of HIV; rates were highest among rural women (51%), women who live in the Samtskhe-Javakheti region (69%), women aged 15–19 years (53%), women with lower educational attainment (62%) and SES (53%), and Azeri women (84%). Overall, 12% of respondents spontaneously mentioned three effective methods of reducing risk of getting HIV/AIDS, while 19% mentioned four ways and 26% mentioned five or more. Overall, the mean number of methods mentioned was 2.8; women living in urban areas of the country and those with higher educational attainment and SES mentioned on average more than 3 methods.

The two ways most frequently mentioned risk reduction strategies were "having only one partner" (36%) and "using condoms" (35%) (Table 17.5.6); more respondents cited these strategies than in 1999 (Figure 17.5.5). The percentage of respondents who mentioned being faithful to one partner or using condoms increases with age and as place of residence becomes more urban. The third most commonly mentioned strategy was "avoid sex with prostitutes" (20%), followed by "do not share razors, blades, needles or syringes" (18%), "abstain from sex" (14%), and "avoid injections" (12%). Each of the remaining six actions was mentioned by less than 10% of the respondents. The fact that only 18% of respondents mentioned "do not share razors, blades, needles, or syringes" is alarming, since injecting drugs appears to be the principle route of HIV transmission in Georgia.

GERHS05 data allow for the calculation of a composite prevention indicator to measure the extent to which national IEC programs and other efforts have succeeded in promoting the knowledge of valid HIV prevention methods. The indicator identifies women of reproductive age who know three basic means of protection against HIV infection: "using condoms," "having sex only with one faithful uninfected partner," and "abstaining from sexual intercourse." With prompting, 74% of all women aged 15–44 years correctly identified these three principal methods to prevent the sexual transmission of

Figure 17.5.5 **Percentage of Women Aged 15-44 Years Who Spontaneously Named Selected Methods of Preventing HIV Transmission: 1999 and 2005**



HIV (Table 17.5.7 and Figure 17.5.6). Knowledge of all three methods was highest in urban areas (81%), in the regions of Guria (87%) and Tbilisi (83%), and among women with higher educational attainment (85%) and SES (84%) (regional differences shown in Figure 17.5.7). In contrast, knowledge of all three ways was lowest in rural areas (66%) and the Kvermo Kartli region (58%) and among women aged 15–19 years (67%), those with lower educational attainment (48%) and SES (64%), and Azeri women (18%). Focusing on the individual components of the indicator, 87% of all respondents mentioned "be faithful to one partner," while 83% mentioned "abstain from sexual intercourse" and 79%, "always use condoms." Women least likely to mention condom use included those living in the region of Kvemo Kartli (71%), those with a secondary incomplete or less education (52%), and Azeri women (20%).

Figure 17.5.6 **Percentage of Women Aged 15-44 Years Who Knew 3 HIV Prevention Methods When Prompted**

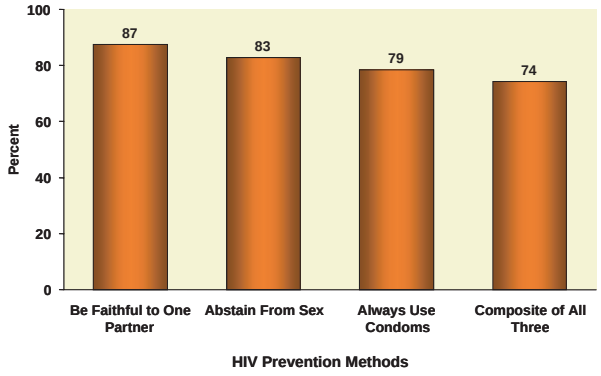
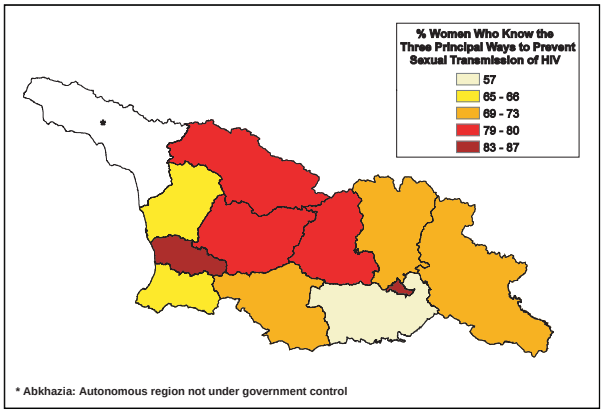


Figure 17.5.7 **Percentage of Women Aged 15-44 Years, Who Knew the 3 Principal Ways to Prevent Sexual Transmission of HIV, by Region**

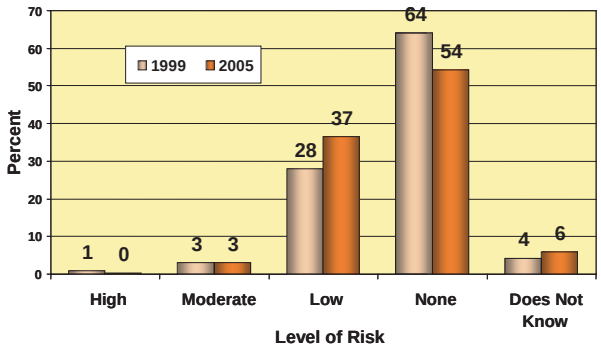


17.6 Self-perceived Risk of HIV/AIDS

Respondents aged 15–44 years who had ever heard of HIV/AIDS were asked to rate their own personal risk of getting HIV/AIDS. As shown in Table 17.6.1, less than 1% of these respondents believed that they were at great risk of contracting HIV, while 3% declared that their risk was moderate and 37%, that they were at little risk of getting HIV/AIDS. In summary, nearly four out of ten women believed that they were at some risk of contracting HIV, while 54% believed that they were at no risk of a HIV infection. An additional 6% stated that they did not know what their risk was.

Figure 17.6.1 compares self-perceived risk of contracting HIV in 1999 and 2005. During this period, the percentage of women stating that they were at no risk of a HIV infection decreased by 10%, while the percentage of women stating that they were at little risk of infection increased by 8%. These findings suggest that in 2005, women may have been more realistic in assessing their risk of getting HIV/AIDS than they were in 1999. However, a higher percentage

Figure 17.6.1 **Perceived Risk of Getting HIV/AIDS Among Women Aged 15-44 Years: 1999 and 2005**



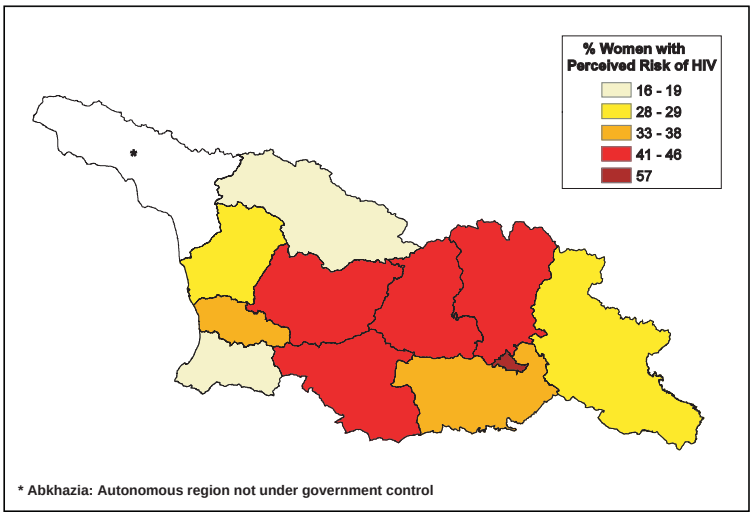
of women in 2005 compared to 1999 declared that they did not know what their risk was of contracting HIV (6% vs. 4%).

Returning to Table 17.6.1, the proportion of women who perceive that they have no risk of contracting HIV was higher among several subgroups, including rural women (64%), women living in the regions of Adjara (73%) and Racha-Svaneti (69%), women aged 15–19 years (63%), women with lower educational attainment (72%) and SES (67%), and Azeri women (71%). Women who perceived they were at some risk (either great risk, moderate risk, or low risk) were more likely to live in urban areas (48%), including Tbilisi (57%), and in its nearby regions of Shida Kartli (46%) and Mtskheta-Mtianeti (45%) (Figure 17.6.2). Self-perceived HIV risk increased with educational attainment and SES.

All respondents who believed that they had some level of risk of contracting HIV were asked why they considered themselves to be at risk. As shown in Table 17.6.2, 79% believed that they were at risk due to their utilization of medical or dental health services. An additional 15% believed that they were at risk because they get manicures, pedicures, or haircuts in a beauty parlor. Less than 1% declared that they have had several sexual partners, while an additional 3% said that their partner had been unfaithful. The percentage of women who believed they were at risk due to the utilization of health care services does not vary much according to the characteristics shown in the table. Interestingly, fear of contracting HIV by using beautician services was highest among women with higher educational attainment and SES.

Respondents who believed that they had no risk of contracting HIV were asked why. As shown in Table 17.6.3, 36% said it was because they were not sexually active. This was particularly the case among women aged 15–19 years (74%). Nearly 30% said that they had confidence in their partner, implying that he did not have additional sexual partners. One in four women said that they had only one partner, while 5% said they do not share syringes or needles. Older woman were more likely than those in other age groups to report monogamy and having a trustworthy partner as the reasons they were not at risk.

Figure 17.6.2 **Percentage of Women Who Believe They Have Some Risk of Contracting HIV, by Region**



17.7 Stigma and Discrimination

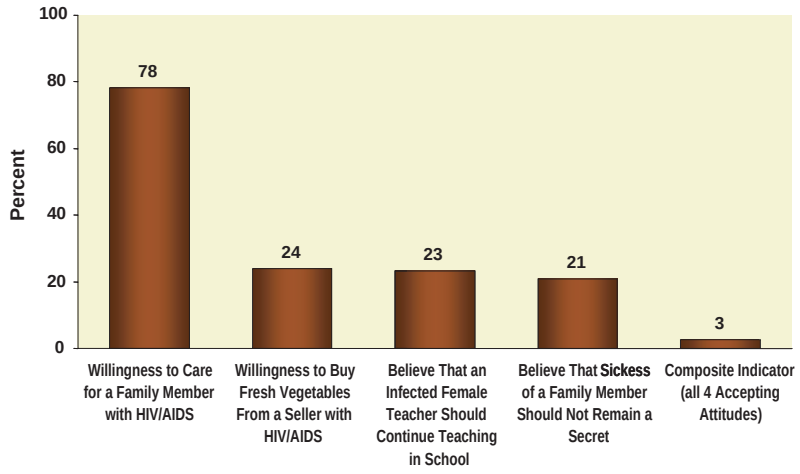
As HIV infections spread throughout the world, there was also a rising wave of stigma associated with being HIV positive or having AIDS, especially in the early days of the epidemic, when there was a great deal of misinformation. The social stigma surrounding HIV/AIDS was also due in part to the possible etiology of bisexuality or homosexuality, extramarital affairs, and drug use. However, in recent years, efforts have been made in many countries to decrease the stigma and discrimination against people living with HIV/AIDS.

The GERHS05 included a series of questions to assess the level of stigma and discrimination confronting people living with HIV/AIDS in Georgia. Respondents were asked 1) "If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?"; 2) "If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him or her?"; 3) "If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?"; and 4) "If a member of your family became infected with the AIDS virus, would you want it to remain a secret?"

As an indicator of acceptance towards people with HIV/AIDS, we determined the percentage of respondents who reported a tolerant or supportive attitude towards all four of the hypothetical situations. As shown in Table 17.7 and Figure 17.7, only 3% of all respondents aged 15–44 years reported a tolerant or supportive attitude towards all four situations. Acceptance was somewhat higher among women of high SES; however, only 4% of women with a university education were accepting of the four situations. Acceptance was only slightly higher in urban areas compared to rural areas.

Focusing on the individual components of the indicator, 78% of respondents said that they would care for a family member who became sick with the AIDS virus in their household. The percentage that would care for a family member increases with educational attainment and SES; however, only 21% of respondents said that if a family member became infected with the AIDS virus it should not be kept a secret. Only 23% said that they would

Figure 17.7 **Percentage of Women Aged 15-44 Years Expressing Accepting Attitudes toward Persons Living with HIV/AIDS**



buy fresh vegetables from a vendor who was infected with the AIDS virus, including 35% of women with a university education and 38% of those with high SES. Similarly, only 24% of respondents would want a female teacher infected with HIV to continue teaching in school, including a high of 42% among women with high SES.

While rural women, the youngest and oldest respondents, and women of lower educational attainment and SES are somewhat more likely to be discriminatory against or intolerant of people living with HIV/AIDS, levels of intolerance and discrimination against people living with HIV/AIDS are high among most reproductive aged females in the country.

In conclusion, the survey reveals that particular subgroups of women in Georgia—young adult women, rural residents, women from lower educational and socioeconomic levels, Azeri women, and sexually inexperienced women—are less informed about HIV transmission and possible means of preventing the spread of HIV infection. HIV prevention and education campaigns should target these groups of women in particular. Younger and sexually inexperienced women should be educated about the potential of HIV infection to help them avoid partaking in risky behavior in the future. Rural residents are less likely to gain knowledge through mass media campaigns and will likely require a health care provider to provide them with culturally sensitive HIV/AIDS-related materials and education. Women of lower SES may not have immediate access to health care providers and may require a targeted educational campaign that reaches them through an alternative venue.

Although the survey provides only data about women, education about HIV transmission and prevention for men is important as well, since men account for most HIV/AIDS cases in Georgia.

Georgian women must be made aware of their potential risk of HIV infection due to their own or their partner's behavior. In addition, educational efforts are needed to correct the common misconception that utilization of health care services will put a person at risk of HIV infection and to emphasize the important role health care services play in preventing and controlling infectious diseases. Finally, early prevention programs could limit the potential of an epidemic in Georgia and avert a possible major shift in HIV transmission from primarily high risk groups to the general population.

Table 17.2 Percentage of Women Aged 15-44 Years Who Are Aware of HIV/AIDS and Who Have Correct Knowledge of HIV/AIDS by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Awareness	Knowledge				
Characteristic	Have Heard of HIV/AIDS	That No Cure Exists for HIV/AIDS	That Transmission of HIV Can Be Prevented	That HIV Can Be Asymptomatic	That Drugs Exist to Reduce MTCT	No. of Cases
Total	94.5	80.6	57.4	52.3	14.9	6,376
Residence						
Urban	98.8	85.3	64.6	63.6	17.3	3,196
Rural	89.4	74.9	48.6	38.6	11.9	3,180
Region						
Kakheti	82.5	72.4	61.4	40.6	18.1	538
Tbilisi	99.9	88.4	71.6	69.4	17.5	1,431
Shida Kartli	98.7	82.2	60.1	51.8	9.8	430
Kvemo Kartli	82.8	65.7	55.1	34.7	10.3	576
Samtskhe-Javakheti	88.3	72.4	31.0	55.0	4.7	434
Adjara	98.8	83.5	47.8	49.0	13.5	490
Guria	98.0	85.3	69.5	38.4	5.9	388
Samegrelo	95.9	78.9	50.4	39.0	13.8	506
Imereti	95.4	81.4	48.4	54.8	21.2	782
Mtskheta-Mtianeti	96.6	85.5	46.2	57.8	10.1	374
Racha-Svaneti	96.7	81.8	57.9	30.5	19.8	427
Age Group						
15-19	91.4	76.2	47.1	45.4	14.5	930
20-24	93.5	79.7	55.4	52.5	14.8	1,079
25-34	96.0	82.8	60.4	54.8	14.5	2,249
35-44	95.5	81.6	61.5	53.9	15.4	2,118
Education Level						
Secondary incomplete or less	78.9	62.2	38.0	29.4	10.3	907
Secondary complete	94.8	78.8	52.0	43.4	12.7	1,786
Technicum	97.5	84.3	58.1	55.0	15.7	1,466
University/postgraduate	99.8	88.4	70.2	68.5	18.2	2,217
Socioeconomic Status						
Low	88.7	73.0	46.9	35.2	11.6	2,277
Middle	97.0	82.9	60.7	56.7	15.0	3,028
High	99.2	88.9	68.2	72.8	20.4	1,071
Ethnic Group						
Georgian	98.1	84.5	59.7	55.7	15.9	5,545
Azeri	45.8	30.3	16.4	8.6	3.8	292
Armenian	85.9	68.4	55.6	36.2	7.0	382
Other	91.3	76.7	63.9	60.6	20.0	157
Sexual Experience						
No	94.5	81.8	54.0	53.7	15.2	1,859
Yes	94.6	80.0	59.1	51.6	14.7	4,517

Table 17.3.1 Percentage of Women Aged 15-44 Who Know Where HIV-testing Is Provided and Who Have Ever Been Tested for HIV by Selected Characteristics Reproductive Health Survey: Georgia, 2005

Characteristic	Knows Where HIV/AIDS Tests are Provided	Has Been Tested for HIV/AIDS	No. of Cases
Total	41.9	15.2	6,376
Residence			
Urban	53.6	20.3	3,196
Rural	27.7	9.0	3,180
Region			
Kakheti	31.7	4.7	538
Tbilisi	65.5	24.6	1,431
Shida Kartli	40.2	15.4	430
Kvemo Kartli	34.3	11.1	576
Samtskhe-Javakheti	31.9	14.0	434
Adjara	29.4	12.6	490
Guria	26.2	7.0	388
Samegrelo	25.2	8.6	506
Imereti	38.7	15.7	782
Mtskheta-Mtianeti	41.8	18.1	374
Racha-Svaneti	26.8	3.3	427
Age Group			
15-19	24.0	2.6	930
20-24	41.2	17.7	1,079
25-34	50.0	22.0	2,249
35-44	45.0	14.6	2,118
Education Level			
Secondary incomplete or less	14.6	3.4	907
Secondary complete	31.1	12.5	1,786
Technicum	44.7	17.1	1,466
University/postgraduate	61.5	21.6	2,217
Socioeconomic Status			
Low	23.1	8.5	2,277
Middle	46.3	16.1	3,028
High	65.5	25.4	1,071
Ethnic Group			
Georgian	45.0	16.3	5,545
Azeri	6.4	3.5	292
Armenian	24.7	6.8	382
Other	44.9	18.6	157
Sexual Experience			
No	35.3	0.4	1,859
Yes	45.4	23.0	4,517

Table 17.3.2 Knowledge of a Place Where One Can Be Tested for HIV, by Selected Characteristics Among Women Aged 15-44 Years Who Reported Knowing Where an HIV Test Can Be Obtained Reproductive Health Survey: Georgia, 2005

	Place for HIV-Testing									
Characteristic	STI Dispensary	Polyclinic	Women's Consultation Clinic	Government Hospital (STI)	Government Hospital (Other)	HIV Center	Blood Transfusion Center	Other	Total	No. of Cases
Total	8.5	8.4	16.1	10.4	11.3	39.2	4.8	1.3	100.0	2,684
Residence										
Urban	8.6	8.5	14.8	9.2	8.7	44.0	4.9	1.5	100.0	1,743
Rural	8.2	8.1	19.1	13.3	17.7	28.0	4.5	1.0	100.0	941
Region										
Kakheti	14.8	11.4	15.2	9.5	12.9	27.6	7.6	1.0	100.0	182
Tbilisi	9.0	6.1	10.1	7.1	5.5	55.3	5.1	1.9	100.0	960
Shida Kartli	5.9	5.9	17.1	15.3	8.1	41.9	4.5	1.4	100.0	180
Kvemo Kartli	15.8	7.5	15.4	12.3	15.4	24.9	7.1	1.6	100.0	207
Samtskhe-Javakheti	1.6	6.5	40.5	4.9	8.1	33.5	3.8	1.1	100.0	146
Adjara	5.6	20.4	23.5	7.7	29.6	10.7	2.6	0.0	100.0	163
Guria	3.9	10.2	15.6	21.9	20.3	26.6	0.0	1.6	100.0	111
Samegrelo	4.6	26.8	20.3	6.5	18.3	19.6	2.0	2.0	100.0	133
Imereti	6.2	1.9	24.7	19.6	11.1	32.1	3.8	0.5	100.0	316
Mtskheta-Mtianeti	7.0	6.5	7.5	12.1	22.6	36.7	7.5	0.0	100.0	164
Racha-Svaneti	0.7	8.0	8.8	27.7	10.9	39.4	2.2	2.2	100.0	122
Age Group										
15-19	5.9	9.3	10.3	17.8	15.6	35.3	4.9	1.0	100.0	219
20-24	8.8	6.7	16.1	10.2	11.8	42.2	3.1	1.0	100.0	431
25-34	9.0	8.0	20.7	9.3	9.6	37.7	4.4	1.3	100.0	1,073
35-44	8.5	9.3	13.1	9.4	11.6	40.5	5.9	1.7	100.0	961
Education Level										
Secondary incomplete or less	5.9	16.3	17.0	13.5	17.5	25.0	4.3	0.5	100.0	141
Secondary complete	9.4	10.2	21.1	11.5	14.3	26.6	4.9	2.1	100.0	527
Technicum	9.7	9.2	17.4	10.3	14.0	33.3	4.7	1.5	100.0	653
University/postgraduate	7.8	6.4	13.5	9.7	8.3	48.5	4.8	1.1	100.0	1,363
Socioeconomic Status										
Low	7.0	11.9	19.1	12.3	19.8	26.0	3.3	0.6	100.0	562
Middle	8.8	8.2	16.4	11.3	11.1	37.8	5.3	1.2	100.0	1,407
High	8.9	6.4	13.7	7.6	6.4	50.2	4.8	2.0	100.0	715
Ethnic Group										
Georgian	8.6	8.2	16.3	10.1	11.1	39.3	4.9	1.4	100.0	2,508
Azeri	*	*	*	*	*	*	*	*	100.0	21
Armenian	3.3	9.7	13.7	22.5	10.7	38.0	2.2	0.0	100.0	84
Other	11.1	10.8	12.9	8.8	16.4	37.3	2.7	0.0	100.0	71
Sexual Experience										
No	9.2	9.9	4.7	13.0	10.3	47.4	4.7	0.7	100.0	671
Yes	8.2	7.7	20.8	9.3	11.7	35.8	4.8	1.6	100.0	2,013

* Less than 25 cases.

Table 17.3.3 Location of the Last HIV Test by Selected Characteristics Among Women Aged 15-44 Years Who Have Ever Been Tested Reproductive Health Survey: Georgia, 2005

	Location of the Last HIV Test (Percentage Distribution)										
Characteristic	STI Dispensary	Polyclinic	Women's Consultation Clinic	Government Hospital (STI)	Government Hospital (Other)	Mobile Clinic	HIV Center	Blood Transfusion Center	Other	Total	No. of Cases
Total	1.1	3.3	57.7	5.3	22.7	0.4	3.5	1.5	4.6	100.0	748
Residence											
Tbilisi	1.4	5.3	52.9	7.0	16.7	0.8	7.2	2.2	6.4	100.0	295
Other urban	0.5	0.9	67.6	2.4	25.4	0.0	0.0	1.5	1.7	100.0	220
Rural	1.1	2.3	54.8	5.8	30.6	0.0	0.8	0.0	4.6	100.0	233
Age Group											
15-24	0.0	1.2	58.8	5.0	24.9	0.0	4.5	0.6	5.2	100.0	159
25-34	1.8	3.4	64.2	3.8	20.9	0.0	2.7	0.3	2.9	100.0	368
35-44	0.8	4.7	47.6	7.8	23.6	1.2	4.0	3.8	6.6	100.0	221
Education Level											
Secondary incomplete or less	*	*	*	*	*	*	*	*	*	100.0	24
Secondary complete	1.3	1.4	61.0	5.6	23.0	0.0	1.7	1.2	4.7	100.0	170
Technicum	1.1	5.2	54.2	4.5	25.0	0.5	1.6	3.9	4.0	100.0	182
University/postgraduate	1.0	3.4	58.1	5.7	21.2	0.5	4.9	0.5	4.7	100.0	372
Socioeconomic Status											
Low	1.4	2.3	58.9	3.2	29.4	0.0	1.4	0.0	3.4	100.0	149
Middle	1.1	3.6	59.3	6.5	21.9	0.3	2.7	2.1	2.6	100.0	382
High	0.8	3.3	54.3	4.6	20.1	0.8	6.1	1.2	8.6	100.0	217

* Less than 25 cases.

Table 17.3.4 Time Since Last HIV Test by Selected Characteristics Among Women Aged 15-44 Years Who Have Ever Been Tested for HIV Reproductive Health Survey: Georgia, 2005

	Time Since Last HIV Test (Percentage Distribution)								
Characteristic	12 Months	13-23 Months	2 Years	3 Years	4 Years	5 or More Years	Does Not Remember	Total	No. of Cases
Total	14.6	15.4	19.1	12.7	9.7	28.2	0.3	100.0	748
Residence									
Tbilisi	14.5	14.5	22.3	10.9	7.8	29.8	0.3	100.0	295
Other urban	13.8	16.9	13.6	13.3	11.4	30.6	0.5	100.0	220
Rural	16.0	15.3	19.6	15.4	11.4	22.4	0.0	100.0	233
Age Group									
15-24	27.5	21.7	25.9	12.7	6.7	5.7	0.0	100.0	159
25-34	11.8	17.6	17.7	13.1	13.3	26.3	0.3	100.0	368
35-44	9.5	7.8	16.2	12.2	7.0	46.9	0.4	100.0	221
Education Level									
Secondary incomplete or less	12.9	17.8	30.1	18.7	13.9	6.5	0.0	100.0	24
Secondary complete	16.8	15.8	18.2	15.3	9.7	23.6	0.6	100.0	170
Technicum	15.8	12.7	21.2	9.9	7.8	32.6	0.0	100.0	182
University/postgraduate	13.3	16.3	17.9	12.6	10.4	29.3	0.3	100.0	372
Socioeconomic Status									
Low	13.1	15.0	18.2	19.3	8.8	25.6	0.0	100.0	149
Middle	15.5	15.2	17.8	9.9	11.1	30.4	0.3	100.0	382
High	14.1	15.9	21.7	13.6	8.1	26.1	0.4	100.0	217

Table 17.4 Media Source for Information on HIV/AIDS Received in the Past 6 Months, by Selected Characteristic All Women Aged 15-44 Years Reproductive Health Survey: Georgia, 2005

	Media Source										
Characteristic	None	Radio/ Newspaper	TV/ Newspaper	Radio/TV/ Newspaper	Only Radio	Only TV	Radio and TV	Only Newspaper	Doesn't Remember	Total	No. of Cases
Total	38.2	0.6	19.0	2.1	0.8	30.4	1.5	3.7	3.8	100.0	6,376
Residence											
Urban	27.4	0.8	26.5	3.4	0.9	30.2	2.3	4.6	3.9	100.0	3,196
Rural	51.3	0.2	9.8	0.4	0.6	30.6	0.6	2.7	3.8	100.0	3,180
Region											
Kakheti	70.3	0.2	2.7	0.2	0.2	20.5	1.1	3.8	1.2	100.0	538
Tbilisi	18.7	1.2	32.6	4.9	0.8	28.3	3.4	5.6	4.5	100.0	1,431
Shida Kartli	18.5	0.4	22.6	3.1	1.3	43.5	1.1	3.3	6.3	100.0	430
Kvemo Kartli	52.5	0.4	9.6	1.5	0.7	28.5	0.8	2.6	3.4	100.0	576
Samtskhe-Javakheti	34.7	0.5	21.0	1.0	0.9	28.8	1.0	1.2	10.9	100.0	434
Adjara	31.6	0.1	18.6	0.3	0.3	47.1	0.6	1.2	0.1	100.0	490
Guria	39.3	1.4	9.0	0.2	0.4	38.0	0.4	4.9	6.3	100.0	388
Samegrelo	50.6	0.2	11.5	1.0	2.0	30.6	1.8	1.2	1.2	100.0	506
Imereti	50.9	0.3	14.6	1.1	0.4	22.0	0.4	5.2	5.1	100.0	782
Mtskheta-Mtianeti	39.3	0.4	26.1	0.4	1.7	22.9	0.6	4.8	3.8	100.0	374
Racha-Svaneti	47.6	0.0	11.5	0.0	0.0	27.4	1.0	4.5	8.0	100.0	427
Age Group											
15-19	40.6	0.4	15.8	1.7	0.5	32.5	2.1	3.8	2.6	100.0	930
20-24	38.7	0.7	18.1	1.9	1.1	30.2	1.6	4.4	3.4	100.0	1,079
25-34	35.8	0.5	19.6	2.1	0.8	31.5	1.7	3.6	4.5	100.0	2,249
35-44	38.7	0.6	20.7	2.3	0.7	28.3	1.1	3.5	4.2	100.0	2,118
Education Level											
Secondary incomplete or less	54.2	0.1	8.9	0.9	0.7	28.4	1.4	2.3	3.2	100.0	907
Secondary complete	44.2	0.4	12.2	1.4	0.4	33.2	1.2	2.6	4.3	100.0	1,786
Technicum	36.9	0.4	19.6	1.6	1.0	30.6	1.1	3.9	4.9	100.0	1,466
University/postgraduate	26.7	1.0	28.7	3.4	0.8	29.0	2.2	5.1	3.1	100.0	2,217
Socioeconomic Status											
Low	53.9	0.2	8.4	0.4	0.7	29.7	0.6	2.5	3.5	100.0	2,277
Middle	34.2	0.6	21.1	2.3	0.8	31.1	1.3	4.2	4.4	100.0	3,028
High	19.3	1.0	33.1	4.6	0.6	29.9	3.9	4.7	3.0	100.0	1,071
Ethnic Group											
Georgian	35.2	0.6	20.4	2.2	0.8	31.4	1.6	4.0	3.8	100.0	5,545
Azeri	79.2	0.9	1.1	0.0	0.3	15.1	0.0	0.6	2.9	100.0	292
Armenian	43.3	0.0	12.0	0.5	0.9	33.7	1.5	1.6	6.5	100.0	382
Other	44.6	0.0	21.3	6.0	0.0	19.6	1.8	4.2	2.6	100.0	157
Sexual Experience											
No	34.7	0.4	20.1	2.4	0.8	31.1	2.4	5.0	3.0	100.0	1,859
Yes	40.0	0.6	18.4	1.9	0.7	30.0	1.1	3.0	4.3	100.0	4,517

Table 17.5.1 Percentage of Women Aged 15-44 Years Who Have Correct Knowledge of When Maternal-to-Child- Transmission (MTCT) Can Occur by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Correct Knowledge of When MTCT Can Occur				
Characteristic	During Pregnancy	During Delivery	During Breastfeeding	All Three	No. of Cases
Total	74.2	65.5	50.4	47.6	6,376
Residence					
Urban	81.9	73.0	55.6	51.9	3,196
Rural	64.9	56.3	44.1	42.3	3,180
Region					
Kakheti	62.4	57.8	42.8	40.6	538
Tbilisi	87.7	79.2	58.5	54.2	1,431
Shida Kartli	77.7	71.6	56.2	53.6	430
Kvemo Kartli	61.1	52.8	43.8	42.2	576
Samtskhe-Javakheti	65.5	63.4	55.2	55.0	434
Adjara	67.0	53.2	42.9	40.8	490
Guria	68.5	68.1	47.0	45.2	388
Samegrelo	76.3	59.3	42.8	41.4	506
Imereti	72.6	64.3	51.6	47.7	782
Mtskheta-Mtianeti	79.6	71.4	53.6	50.2	374
Racha-Svaneti	72.0	64.2	48.7	46.0	427
Age Group					
15-19	62.0	51.8	41.4	37.6	930
20-24	74.4	63.6	48.0	45.0	1,079
25-34	78.3	70.0	53.0	50.3	2,249
35-44	77.3	70.0	54.3	52.0	2,118
Education Level					
Secondary incomplete or less	48.1	39.1	30.0	28.0	907
Secondary complete	70.5	61.5	49.6	46.3	1,786
Technicum	79.1	70.6	54.5	52.1	1,466
University/postgraduate	86.4	77.8	57.9	54.9	2,217
Socioeconomic Status					
Low	61.9	52.5	40.9	38.8	2,277
Middle	78.2	69.1	53.1	50.3	3,028
High	86.9	80.0	60.8	56.9	1,071
Ethnic Group					
Georgian	78.0	68.6	52.7	49.7	5,545
Azeri	24.3	19.2	16.3	14.6	292
Armenian	62.2	59.9	44.7	44.7	382
Other	74.0	64.6	53.8	48.7	157
Sexual Experience					
No	71.3	60.9	45.6	42.4	1,859
Yes	75.8	67.8	52.9	50.3	4,517

Table 17.5.2 Percentage of Women Aged 15-44 Years Who Have Correct Knowledge of the Principal Mechanisms of HIV Transmission by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Main Mechanisms of HIV Transmsstion				
Characteristic	Through Unprotected Heterosexual Intercourse	Through Unprotected Sex Between Men	Through Blood Transfusions	Through Use of Non-Sterile Needles	No. of Cases
Total	91.8	88.8	85.7	84.2	6,376
Residence					
Urban	97.4	95.4	93.9	93.8	3,196
Rural	85.0	80.9	75.8	72.6	3,180
Region					
Kakheti	81.1	77.8	69.5	67.4	538
Tbilisi	98.7	96.9	96.8	97.6	1,431
Shida Kartli	97.3	94.6	91.8	93.1	430
Kvemo Kartli	78.3	75.2	69.6	68.8	576
Samtskhe-Javakheti	85.9	83.6	72.1	72.6	434
Adjara	94.9	89.4	84.7	78.0	490
Guria	94.1	88.8	85.3	86.3	388
Samegrelo	88.6	84.7	82.7	78.3	506
Imereti	93.4	91.8	90.6	87.8	782
Mtskheta-Mtianeti	94.7	91.2	90.8	92.0	374
Racha-Svaneti	93.5	86.3	86.9	86.9	427
Age Group					
15-19	88.9	84.6	80.1	77.0	930
20-24	90.3	87.4	84.8	84.0	1,079
25-34	92.9	90.1	88.3	86.9	2,249
35-44	93.3	90.8	87.0	86.0	2,118
Education Level					
Secondary incomplete or less	72.9	67.5	60.8	55.6	907
Secondary complete	90.6	87.0	82.3	81.1	1,786
Technicum	95.9	93.2	90.0	89.2	1,466
University/postgraduate	99.0	97.6	97.5	97.1	2,217
Socioeconomic Status					
Low	83.9	79.0	73.6	70.6	2,277
Middle	94.9	92.8	90.4	89.1	3,028
High	98.5	96.9	96.5	97.1	1,071
Ethnic Group					
Georgian	95.6	92.7	90.3	88.7	5,545
Azeri	38.9	34.3	28.8	26.7	292
Armenian	83.3	81.0	68.1	67.9	382
Other	86.7	84.2	83.3	82.0	157
Sexual Experience					
No	92.0	88.5	86.7	84.8	1,859
Yes	91.7	89.0	85.2	83.9	4,517

Table 17.5.3 Percentage of Women Aged 15-44 Years Who Correctly Reject Misconceptions About HIV Transmission by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Rejected Misconceptions About How HIV Transmission Can Occur								
Characteristic	Through Witchcraft/ Supernatural Means	Shaking Hands	Using Public Toilets	Through Kissing	Sharing Food, Plates, etc. With HIV+ Person	Through Mosquito Bites	Getting a Manicure, Pedicure or Haircut	Having Dental or Surgical Treatment	No. of Cases
Total	80.4	78.8	57.6	52.6	41.4	28.0	8.7	4.2	6,376
Residence									
Urban	87.6	88.5	67.5	62.9	51.5	34.0	8.9	4.1	3,196
Rural	71.7	67.1	45.6	39.9	29.1	20.8	8.5	4.3	3,180
Region									
Kakheti	69.5	69.2	48.9	48.4	31.8	24.6	11.2	6.0	538
Tbilisi	89.4	93.7	74.0	69.8	57.6	39.2	7.9	3.0	1,431
Shida Kartli	84.8	83.0	59.2	50.0	37.9	22.6	6.0	2.5	430
Kvemo Kartli	66.4	64.7	39.9	36.1	27.3	17.9	5.7	1.6	576
Samtskhe-Javakheti	73.3	70.7	48.3	40.5	19.0	23.3	5.9	4.8	434
Adjara	76.0	66.6	49.2	42.6	41.5	21.0	13.3	9.1	490
Guria	91.4	84.5	60.7	38.2	27.8	19.4	11.0	4.1	388
Samegrelo	76.8	71.0	54.2	47.3	41.0	20.8	9.7	3.1	506
Imereti	85.4	82.2	57.5	55.3	40.1	32.1	7.6	4.1	782
Mtskheta-Mtianeti	76.1	78.2	58.0	55.3	41.0	32.1	10.3	4.0	374
Racha-Svaneti	83.6	79.3	48.7	41.3	34.4	33.3	17.2	9.0	427
Age Group									
15-19	74.7	71.5	47.4	41.0	31.4	23.6	13.0	6.3	930
20-24	80.9	79.6	56.9	52.5	41.4	28.1	8.6	3.6	1,079
25-34	83.3	82.2	62.7	57.9	46.1	30.9	8.3	4.0	2,249
35-44	80.7	79.4	59.2	54.2	42.6	27.9	6.7	3.4	2,118
Education Level									
Secondary incomplete or less	60.2	54.4	34.6	25.2	22.9	16.9	10.0	5.1	907
Secondary complete	78.3	74.2	49.0	43.7	31.4	23.0	9.3	5.4	1,786
Technicum	82.9	82.7	61.0	56.0	40.4	27.1	6.7	3.4	1,466
University/postgraduate	90.0	91.5	73.1	70.2	58.5	37.8	8.8	3.3	2,217
Socioeconomic Status									
Low	70.4	64.5	42.7	37.1	26.7	19.0	9.9	4.9	2,277
Middle	84.9	84.1	62.2	56.2	44.9	29.6	8.3	4.3	3,028
High	87.6	92.0	73.7	71.9	59.6	40.6	7.5	2.5	1,071
Ethnic Group									
Georgian	84.4	82.6	61.2	56.0	44.8	29.7	9.1	4.4	5,545
Azeri	21.9	21.9	11.2	10.7	5.9	5.6	3.4	2.2	292
Armenian	76.0	71.9	44.6	36.6	21.3	20.5	8.1	4.2	382
Other	73.9	79.7	59.7	54.9	39.4	33.8	6.1	1.8	157
Sexual Experience									
No	80.1	78.6	56.2	51.2	41.0	28.7	10.3	5.0	1,859
Yes	80.6	78.9	58.4	53.3	41.6	27.7	7.9	3.7	4,517

Table 17.5.4 Percentage of Women Aged 15-44 Who Believe That a Person Can Take Measures to Reduce the Risk of Contracting HIV by Selected Characteristics (Percentage Distribution) Reproductive Health Survey: Georgia, 2005

Characteristic	Believes	Does Not Believe	Doesn't Know	Total	No. of Cases
Total	57.4	24.4	18.2	100.0	6,376
Residence					
Urban	64.6	23.7	11.8	100.0	3,196
Rural	48.6	25.3	26.1	100.0	3,180
Region					
Kakheti	61.4	13.9	24.7	100.0	538
Tbilisi	71.6	20.6	7.8	100.0	1,431
Shida Kartli	60.1	23.7	16.1	100.0	430
Kvemo Kartli	55.1	15.2	29.7	100.0	576
Samtskhe-Javakheti	31.0	29.8	39.1	100.0	434
Adjara	47.8	36.6	15.6	100.0	490
Guria	69.5	14.5	16.0	100.0	388
Samegrelo	50.4	33.3	16.3	100.0	506
Imereti	48.4	28.9	22.6	100.0	782
Mtskheta-Mtianeti	46.2	33.4	20.4	100.0	374
Racha-Svaneti	57.9	22.9	19.2	100.0	427
Age Group					
15-19	47.1	28.8	24.1	100.0	930
20-24	55.4	26.3	18.4	100.0	1,079
25-34	60.4	23.9	15.7	100.0	2,249
35-44	61.5	21.3	17.2	100.0	2,118
Education Level					
Secondary incomplete or less	38.0	24.6	37.5	100.0	907
Secondary complete	52.0	27.9	20.1	100.0	1,786
Technicum	58.1	24.9	17.0	100.0	1,466
University/postgraduate	70.2	21.2	8.6	100.0	2,217
Socioeconomic Status					
Low	46.9	26.4	26.7	100.0	2,277
Middle	60.7	23.4	15.9	100.0	3,028
High	68.2	23.2	8.6	100.0	1,071
Ethnic Group					
Georgian	59.7	25.6	14.6	100.0	5,545
Azeri	16.4	16.2	67.4	100.0	292
Armenian	55.6	15.2	29.2	100.0	382
Other	63.9	18.8	17.4	100.0	157
Sexual Experience					
No	54.0	26.4	19.5	100.0	1,859
Yes	59.1	23.3	17.6	100.0	4,517

Table 17.5.5 Number of Spontaneously Mentioned Methods to Reduce the Risk of Contracting HIV by Selected Characteristics Among Women Aged 15-44 Years
Reproductive Health Survey: Georgia, 2005

	Number of Methods (Percentage Distribution)							
Characteristic	Mean	0	1 or 2	3	4	5 or More	Total	No. of Cases
Total	2.8	42.6	0.6	11.9	19.0	25.9	100.0	6,376
Residence								
Urban	3.2	35.4	0.8	10.7	20.4	32.7	100.0	3,196
Rural	2.2	51.4	0.3	13.4	17.2	17.7	100.0	3,180
Region								
Kakheti	2.7	38.6	0.2	15.7	22.3	23.2	100.0	538
Tbilisi	3.6	28.4	1.2	10.1	22.9	37.4	100.0	1,431
Shida Kartli	3.0	39.9	0.2	16.5	18.1	25.4	100.0	430
Kvemo Kartli	2.3	44.9	0.9	13.7	21.2	19.3	100.0	576
Samtskhe-Javakheti	1.5	69.0	0.3	8.3	11.9	10.5	100.0	434
Adjara	2.3	52.2	0.1	13.6	15.1	18.9	100.0	490
Guria	3.0	30.5	0.6	16.0	22.5	30.5	100.0	388
Samegrelo	2.3	49.6	0.2	12.2	16.0	22.1	100.0	506
Imereti	2.5	51.6	0.2	7.7	15.9	24.6	100.0	782
Mtskheta-Mtianeti	2.7	53.8	0.2	9.9	12.6	23.5	100.0	374
Racha-Svaneti	2.4	42.1	1.0	20.0	17.6	19.4	100.0	427
Age Group								
15-19	2.2	52.9	0.5	10.5	17.7	18.4	100.0	930
20-24	2.6	44.6	0.7	11.0	19.9	23.8	100.0	1,079
25-34	3.0	39.6	0.4	11.5	18.9	29.6	100.0	2,249
35-44	3.0	38.5	0.7	13.5	19.3	28.0	100.0	2,118
Education Level								
Secondary incomplete or less	1.7	62.0	0.6	11.4	13.2	12.8	100.0	907
Secondary complete	2.3	48.0	0.8	14.3	19.1	17.8	100.0	1,786
Technicum	2.9	41.9	0.6	12.7	17.9	26.9	100.0	1,466
University/postgraduate	3.6	29.8	0.3	9.7	22.2	37.9	100.0	2,217
Socioeconomic Status								
Low	2.1	53.1	0.4	13.4	16.8	16.4	100.0	2,277
Middle	3.0	39.3	0.7	11.3	20.0	28.7	100.0	3,028
High	3.5	31.8	0.6	10.5	20.5	36.6	100.0	1,071
Ethnic Group								
Georgian	2.9	40.3	0.5	12.0	19.4	27.9	100.0	5,545
Azeri	0.7	83.6	.	7.4	6.0	3.0	100.0	292
Armenian	2.4	44.4	1.1	15.1	23.1	16.3	100.0	382
Other	3.2	36.1	2.4	10.2	24.1	27.2	100.0	157
Sexual Experience								
No	2.6	46.0	0.7	9.7	18.7	25.0	100.0	1,859
Yes	2.8	40.9	0.5	13.0	19.1	26.4	100.0	4,517

Table 17.5.6 Spontaneously Mentioned Methods to Reduce the Risk of Contracting HIV by Residence and Age: All Women Aged 15-44 Years Reproductive Health Survey: Georgia, 2005

		Residence			Age Group			
	Total	Tbilisi	Other Urban	Rural	15-19	20-24	25-34	35-44
Methods to Prevent Sexual Transmission of HIV								
Have only one partner	36.1	39.5	38.1	32.8	25.9	33.0	38.6	41.2
Use condoms	35.0	51.4	37.2	23.8	27.5	35.6	39.6	34.5
Abstain from sexual Intercourse	13.5	14.0	17.5	10.8	11.2	11.5	13.8	15.7
Limit number of sexual partners	9.5	11.5	10.9	7.5	7.0	7.7	10.0	11.5
Avoid sex with persons who have many partners	5.3	8.1	6.1	3.0	4.7	4.9	5.5	5.6
Ask partner to get test for HIV	5.1	8.1	5.5	3.0	3.9	4.9	5.2	5.7
Methods to Prevent Blood Transmission of HIV								
Do not share razors, blades, needles or syringes	18.4	28.8	17.5	12.7	12.7	18.1	19.9	20.4
Avoid injections	11.7	18.5	12.6	6.9	8.2	10.2	13.6	12.7
Avoid blood transfusions	8.0	15.4	7.1	4.0	5.8	6.5	8.5	9.5
Methods to Prevent the Transmission of HIV from High Risk Groups								
Avoid sex with prostitutes	20.0	25.2	21.1	16.2	18.0	18.0	21.5	20.9
Avoid sex with persons who inject drugs intravenously	5.0	9.8	4.7	2.2	3.6	4.7	4.8	6.0
Avoid sex with bisexuals	3.8	6.4	4.4	1.8	2.5	3.6	3.9	4.4
No. of Cases	6,376	1,431	1,765	3,180	930	1,079	2,249	2,118

Table 17.5.7 Percentage of Women Aged 15-44 Years Who Could Name the Three Principal Ways to Prevent the Sexual Transmission of HIV in Response to Prompted Questions, by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Principal Ways to Prevent Sexual Transmission of HIV				
Characteristic	Be Faithful to One Partner	Abstain From Sexual Intercourse	Always Use Condoms	All Three	No. of Cases
Total	87.4	82.9	78.5	74.3	6,376
Residence					
Urban	93.0	88.6	86.4	81.3	3,196
Rural	80.6	75.9	68.9	65.7	3,180
Region					
Kakheti	80.1	77.5	75.0	73.3	538
Tbilisi	93.4	90.4	89.5	83.4	1,431
Shida Kartli	90.8	87.7	81.0	80.1	430
Kvemo Kartli	71.6	72.6	60.7	57.3	576
Samtskhe-Javakheti	80.9	75.2	71.6	69.0	434
Adjara	90.3	77.5	72.4	65.7	490
Guria	95.1	89.0	91.0	86.5	388
Samegrelo	85.0	76.4	71.0	65.4	506
Imereti	91.7	86.8	82.8	80.1	782
Mtskheta-Mtianeti	84.0	82.8	72.7	70.0	374
Racha-Svaneti	84.1	84.7	83.6	78.5	427
Age Group					
15-19	82.9	78.1	70.3	66.9	930
20-24	85.2	80.2	80.3	74.0	1,079
25-34	89.4	84.8	81.4	77.3	2,249
35-44	89.3	85.2	79.6	75.8	2,118
Education Level					
Secondary incomplete or less	68.0	59.5	51.9	48.0	907
Secondary complete	86.0	83.2	76.8	73.2	1,786
Technicum	91.0	86.7	82.3	78.6	1,466
University/postgraduate	95.4	91.1	90.1	84.7	2,217
Socioeconomic Status					
Low	80.1	74.0	67.6	64.1	2,277
Middle	90.0	85.9	82.1	77.7	3,028
High	94.4	91.4	89.8	84.4	1,071
Ethnic Group					
Georgian	91.4	86.2	82.8	78.1	5,545
Azeri	32.5	32.6	19.7	18.3	292
Armenian	78.5	77.1	67.1	66.1	382
Other	82.3	82.3	78.7	75.7	157
Sexual Experience					
No	85.7	80.9	76.2	71.1	1,859
Yes	88.3	83.9	79.8	75.9	4,517

Table 17.6.1 Self-Perceived Risk of Contracting HIV by Selected Characteristics Among Women Aged 15-44 Years with Knowledge of HIV/AIDS Reproductive Health Survey: Georgia, 2005

	Perceived Risk Level (Percentage Distribution)						
Characteristic	High Risk	Moderate Risk	Low Risk	No Risk at All	Doesn't Know	Total	No. of Cases
Total	0.3	3.1	36.5	54.3	5.9	100.0	6,042
Residence							
Urban	0.3	4.5	43.2	47.1	4.9	100.0	3,157
Rural	0.1	1.3	27.4	63.9	7.2	100.0	2,885
Region							
Kakheti	0.0	0.5	28.0	67.5	4.0	100.0	444
Tbilisi	0.5	7.0	49.9	40.6	2.1	100.0	1,429
Shida Kartli	0.2	3.3	42.6	49.0	5.0	100.0	424
Kvemo Kartli	0.5	3.6	29.3	61.3	5.2	100.0	480
Samtskhe-Javakheti	0.4	2.3	37.9	49.6	9.8	100.0	391
Adjara	0.0	0.5	15.2	73.3	11.1	100.0	483
Guria	0.2	2.7	35.1	58.7	3.3	100.0	380
Samegrelo	0.0	1.0	27.0	64.6	7.4	100.0	485
Imereti	0.1	1.0	40.4	50.2	8.3	100.0	751
Mtskheta-Mtianeti	0.2	1.5	43.0	47.2	8.0	100.0	362
Racha-Svaneti	0.0	0.6	18.6	69.2	11.5	100.0	413
Age Group							
15-19	0.1	1.0	27.1	62.7	9.1	100.0	843
20-24	0.4	2.6	32.8	57.2	6.9	100.0	1,011
25-34	0.2	4.1	42.2	47.9	5.6	100.0	2,159
35-44	0.3	3.7	38.1	54.1	3.8	100.0	2,029
Education Level							
Secondary incomplete or less	0.4	0.3	17.4	71.5	10.4	100.0	704
Secondary complete	0.4	1.9	29.0	61.7	7.0	100.0	1,695
Technicum	0.2	3.1	39.1	51.9	5.7	100.0	1,430
University/postgraduate	0.1	5.2	47.5	43.8	3.4	100.0	2,213
Socioeconomic Status							
Low	0.3	1.4	23.4	67.4	7.4	100.0	2,042
Middle	0.2	3.2	40.4	50.6	5.6	100.0	2,938
High	0.2	5.9	48.4	41.6	3.9	100.0	1,062
Ethnic Group							
Georgian	0.1	3.3	37.2	53.8	5.6	100.0	5,436
Azeri	0..0	1.9	11.4	71.4	15.3	100.0	135
Armenian	1.6	1.4	32.1	59.1	5.8	100.0	329
Other	2.2	2.0	44.5	45.3	6.0	100.0	142

Table 17.6.2 Reasons Why Women Believe They Are at Risk of Contracting HIV by Selected Characteristics Among Women Aged 15-44 Years Who Believe They Are at Some Risk of Contracting HIV/AIDS
Reproductive Health Survey: Georgia, 2005

	Reasons Why Women Believe They Are at Risk of Contracting HIV/AIDS (Percentage Distribution)								
Characteristic	Receives Medical/ Dental Treatment	Receives Manicures, Pedicures, Haircuts	Partner Unfaithful	Has Received Blood Transfusions	Has Had Many Sexual Partners	Other	Doesn't Know	Total	No. of Cases
Total	78.9	15.0	2.8	1.0	0.3	0.8	1.1	100.0	2,423
Residence									
Urban	77.9	17.4	2.0	0.7	0.4	1.1	0.4	100.0	1,533
Rural	81.2	9.7	4.5	1.7	0.0	0.3	2.6	100.0	890
Region									
Kakheti	85.3	8.3	4.5	0.6	0.0	0.0	1.3	100.0	135
Tbilisi	74.9	21.4	1.0	0.7	0.5	1.2	0.3	100.0	832
Shida Kartli	90.4	5.2	1.6	0.8	0.0	0.0	2.0	100.0	199
Kvemo Kartli	68.6	19.6	5.4	2.0	1.5	2.5	0.5	100.0	167
Samtskhe-Javakheti	80.8	10.6	8.7	0.0	0.0	0.0	0.0	100.0	165
Adjara	88.3	5.8	2.9	1.0	0.0	0.0	1.9	100.0	84
Guria	91.8	5.5	1.6	0.0	0.0	0.5	0.5	100.0	142
Samegrelo	81.0	4.9	4.3	3.1	0.0	1.2	5.5	100.0	135
Imereti	79.3	13.6	4.3	1.1	0.0	0.3	1.6	100.0	318
Mtskheta-Mtianeti	81.6	14.6	1.0	1.9	0.0	0.5	0.5	100.0	164
Racha-Svaneti	82.1	10.5	3.2	3.2	0.0	1.1	0.0	100.0	82
Age Group									
15-19	76.8	17.6	0.6	1.0	1.5	0.8	1.8	100.0	225
20-24	80.0	16.6	1.4	0.6	0.5	0.7	0.2	100.0	349
25-34	77.3	16.5	3.1	0.8	0.0	0.8	1.5	100.0	978
35-44	80.9	11.9	3.8	1.5	0.1	1.0	0.8	100.0	871
Education Level									
Secondary incomplete or less	76.9	10.9	3.4	2.6	1.9	0.3	4.0	100.0	132
Secondary complete	78.6	14.3	3.5	1.2	0.0	0.7	1.8	100.0	526
Technicum	81.2	11.7	3.6	1.4	0.2	1.0	1.0	100.0	607
University/postgraduate	78.3	17.5	2.0	0.6	0.3	0.9	0.5	100.0	1,158
Socioeconomic Status									
Low	78.2	11.9	5.6	1.3	0.0	0.3	2.7	100.0	560
Middle	79.4	15.0	2.4	1.1	0.4	0.8	0.8	100.0	1,275
High	78.6	17.4	1.3	0.8	0.3	1.3	0.4	100.0	588

Table 17.6.3 Reasons Why Women Believe They Are Not at Risk of Contracting HIV by Selected Characteristics Among Women Aged 15-44 Years Who Believe They Do Not Have Any Risk of Contracting HIV Reproductive Health Survey: Georgia, 2005

	Reasons Why Women Believe They Are Not at Risk of Contracting HIV (Percentage Distribution)									
Characteristic	No Sexual Relations	Has Confidence in Partner	Has Only One Partner	Does Not Share Needles	Does Not Get/ Need Transfusions	Uses Condoms	Other	Doesn't Know	Total	No. of Cases
Total	35.7	29.8	25.0	4.5	1.7	0.6	0.1	2.6	100.0	3,258
Residence										
Urban	39.5	27.5	23.3	5.1	2.1	0.7	0.2	1.6	100.0	1,471
Rural	31.8	32.1	26.7	3.8	1.4	0.5	0.1	3.5	100.0	1,787
Region										
Kakheti	35.2	32.8	27.9	2.4	0.3	0.0	0.0	1.4	100.0	295
Tbilisi	41.0	20.6	25.4	6.7	2.8	1.6	0.4	1.6	100.0	567
Shida Kartli	30.0	24.3	36.0	4.5	1.9	0.0	0.0	3.4	100.0	203
Kvemo Kartli	34.2	28.3	26.5	6.4	2.1	0.0	0.3	2.1	100.0	285
Samtskhe-Javakheti	25.6	22.0	35.4	4.3	7.1	0.0	0.0	5.5	100.0	185
Adjara	35.0	42.4	17.8	1.0	0.4	0.6	0.0	2.7	100.0	350
Guria	38.1	13.9	38.4	5.7	1.8	0.0	0.0	2.1	100.0	225
Samegrelo	38.0	31.1	22.3	4.5	1.1	1.1	0.0	1.9	100.0	312
Imereti	32.7	35.2	21.1	4.4	1.5	0.4	0.0	4.6	100.0	376
Mtskheta-Mtianeti	34.1	39.2	17.5	5.1	0.5	0.9	0.0	2.8	100.0	170
Racha-Svaneti	38.9	17.3	33.0	6.4	0.9	0.3	0.0	3.2	100.0	290
Age Group										
15-19	73.6	6.9	5.7	6.2	4.3	0.0	0.0	3.3	100.0	546
20-24	44.4	26.1	19.9	4.5	2.3	0.1	0.2	2.4	100.0	583
25-34	24.8	37.8	29.8	3.4	0.9	1.2	0.3	1.8	100.0	1,062
35-44	15.8	39.7	36.2	4.2	0.5	0.8	0.0	2.9	100.0	1,067
Education Level										
Secondary incomplete or less	54.6	16.3	17.5	3.9	3.5	0.0	0.0	4.1	100.0	506
Secondary complete	27.1	38.4	25.9	3.6	1.1	0.6	0.1	3.2	100.0	1,038
Technicum	23.2	35.4	34.7	4.3	0.9	0.5	0.0	1.0	100.0	742
University/postgraduate	42.1	24.9	21.8	5.8	1.8	1.1	0.3	2.1	100.0	972
Socioeconomic Status										
Low	35.7	32.0	23.9	3.4	1.3	0.3	0.1	3.3	100.0	1,344
Middle	35.1	28.5	26.7	4.8	1.9	0.8	0.0	2.3	100.0	1,483
High	37.1	28.0	23.3	6.5	2.2	1.0	0.6	1.4	100.0	431

Chapter 18

DOMESTIC VIOLENCE

Millions of women around the world are subjected to physical, sexual, and emotional abuse every day. Violence against women includes a wide range of behaviors and acts perpetrated against women by their partners or other assailants. Domestic violence—also known as intimate partner violence (IPV), "battering," or spousal abuse—is the most common form of violence against women. It occurs in all cultures and affects women of all ages and all socioeconomic and educational backgrounds. Several studies have shown that domestic violence is an important public health problem around the world. However, most data on the impact of IPV on women's health are compiled from studies targeting small population subgroups (e.g., women attending prenatal care clinics and women in shelters); population-based, representative data on this subject are scarce. Particularly in Eastern Europe, little documentation beyond anecdotal evidence exists to estimate the magnitude of violence against women. To address this need, CDC, together with its international partners (USAID, UNFPA, UNICEF, and WHO), has assisted a number of reproductive health surveys that included violence modules. Although not focusing primarily on violence, reproductive health surveys provide a unique opportunity to study characteristics of battered women and linkages with reproductive health indicators. Moreover, because the violence indicators collected in CDC-assisted reproductive health surveys are similar, they allow for a regional examination of IPV risk factors and prevalence.

In addition to documenting IPV in the context of maternal and child health, survey findings can be used to raise awareness at the individual and community level, to educate law enforcement and social service agencies, to influence current public health policies, to develop laws to protect and benefit battered women and, ultimately, to predict future needs for support services and interventions for abused women. In Georgia, only a limited number of nongovernmental organizations currently provide assistance to victims of family violence, including the Women's Advice Center "Sakhli", which offers free psychological consultations and legal advice; the association "Article 42 of the Constitution," which offers free legal services; the Crisis Center "Ndoba"; and the International Center for Culture and Education of Georgian and German Women (IHF, 2000).

The GERHS05 included a series of questions to assess the burden of domestic violence in Georgia and its impact on reproductive health, and to determine how to effectively respond to one of the most critical violations of human rights today. The questions, which focus principally on IPV, explore acts of violence perpetrated by current and former husbands and male partners with whom the respondent had lived together as a couple at some point. IPV, which can take a variety of forms including physical abuse, psychological abuse, and coercive sex, was documented using a modified version of the eight-item Conflict Tactic Scale (Straus, 1979). IPV in GERHS05 was defined as psychological, physical, and sexual abuse towards ever-married (whether legally or consensually) women. Psychological abuse includes insults, curses, psychological threats, and gestures with intent of physical harm. Physical violence, further classified into moderate and severe violence (O'Campo et al., 1994), includes pushing, shoving, and slapping (moderate violence), as well as kicking, hitting with the fist or an object, being beaten up, and being threatened with a knife or other weapon (severe violence). Women who experienced recent physical abuse were further asked about the severity of physical injuries and whether they sought help from law enforcement agencies, family, friends, or health care providers. Sexual abuse is defined as any episode when the intimate partner "physically forced [the woman] to have sex against her will." In addition, all respondents were asked about their history of witnessing physical abuse between parents or experience of abuse as a child or adolescent.

18.1 Comparative Findings on Intimate Partner Violence in Eastern Europe

After 1989, the countries of Eastern Europe and the Caucasus experienced profound social, economic, and political upheaval associated with the collapse of the Soviet Union and the subsequent post-communist transition. This transition—characterized by decentralization of administrative, economic, and political systems, democratically elected governments, and development of market economies—has presented formidable challenges for women and their status in society. In many countries of the region, the transition years contributed to deteriorating economic conditions that affected women's health and quality of life, including increased levels of poverty, greater economic dependency on men, and deteriorating health care conditions.

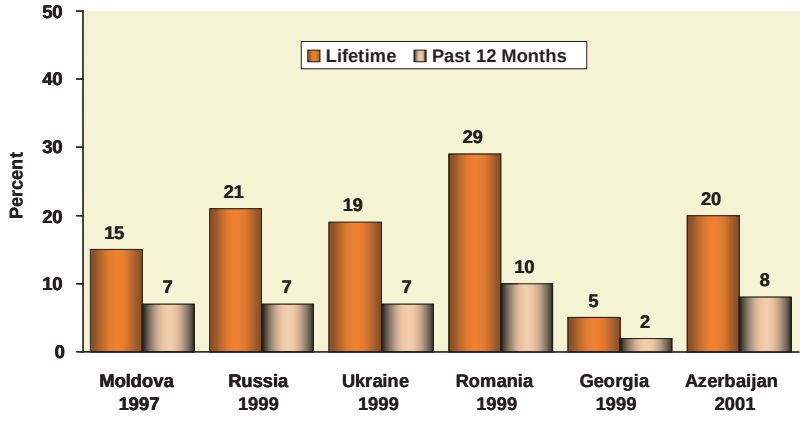
Although the countries of Eastern Europe and the former Soviet Union are quite diverse, their shared history since World War II resulted in commonalities in legal traditions, status of women, and characteristics related to women's reproductive health. Despite the establishment of legal structures giving women substantial rights and protection, investigations by the International Helsinki Federation for Human Rights indicated clearly that such laws were largely unenforced by governments in the region (IHF, 2000). Moreover, women's status in society, despite the illusion of gender equity, remains defined by their traditional dual role as workers and mothers, and women are often additionally burdened by having sole responsibility for household chores. Inequity in women's status in countries of the region is perhaps nowhere more clearly manifested than in

women's limited access to reproductive health services, including family planning, and corresponding high rates of unintended pregnancy, induced abortions, and post-abortion complications due to unsafe health care service practices. Under these conditions, it is not surprising that the problem of violence against women has not figured prominently as a pressing social, legal, or health problem in the region until recently. Only two countries, Romania and Georgia, have recently promulgated laws against domestic violence (Government of Romania, 2003; Government of Georgia 2006).

To address the need for more information about the characteristics of battered women and linkages with reproductive health, the CDC-assisted Reproductive Health Surveys conducted in Eastern Europe and former Soviet Union have been collecting data on domestic violence since the mid 1990s. Since the violence indicators collected in these surveys are similar, they allow for a regional examination of risk factors and prevalence of domestic violence. In all but one country (Russia, where the survey was limited to three primarily urban regions), the survey data provided the first population-based national estimates on violence against women. Reported lifetime experience with spousal physical abuse varied between 5% in Georgia in 1999 and 29% in Romania, while physical abuse during the 12 months preceding the survey ranged from 2% in Georgia to 10% in Romania (Figure 18.1 and Table 18.1) (CDC and ORC/Macro, 2003). Sexual abuse by a current or former partner was measured only in Azerbaijan (10%), Romania (7%), and Georgia (3%). Both the prevalence of domestic violence and the profile of battered women in Eastern Europe are comparable with data documented in the United States. Despite these similarities, the consequences of domestic violence in Eastern Europe are likely to be more severe and to result in worse health outcomes because of limited resources and poor social and legal infrastructure.

Dissemination of survey findings on domestic violence and reproductive health can facilitate changes in the legal and support-service environments of developing countries. Encouragingly, some of these changes have already occurred. For example, forced intercourse within a marriage was not considered a crime anywhere in the region until recently: In 2000, in Romania, when survey-based evidence documenting that most forced sexual intercourse is perpetrated

Figure 18.1 **Prevalence of Lifetime and Recent (Past 12 Months) Physical Abuse Among Ever-Married Women Aged 15–44 Years: Selected Countries in Eastern Europe***



* Source: CDC and ORC/Macro, 2003. Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report

by a husband or intimate partner was first made available to the public health community, the Penal Code was revised to allow prosecution of marital rape (Romanian Constitutional Court, Decision 211, November 2000). Romania's first comprehensive law against domestic violence was developed and enacted in 2003 (Government of Romania, 2003). In Georgia, where domestic violence is seldom reported, the "Law on Prevention of Domestic Violence, Protection and Support of Domestic Violence Victims," enacted in June 2006, is anticipated to increase the formal reporting of violence acts to the authorities.

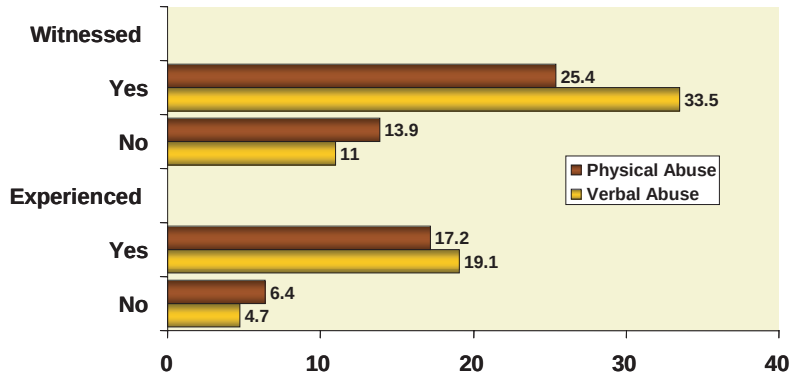
18.2 History of Witnessing or Experiencing Parental Physical Abuse

Research on violence against women has identified experiencing and witnessing parental abuse as a child as strong independent predictors of being in an abusive relationship as an adult. Several studies have linked childhood exposure to family violence with emotional and behavioral problems during childhood (Edleson, 1999; Kolbo and Blakely, 1996), child and adolescent violent behaviors (Song et al., 1998), and physical abuse during adulthood (Hotaling and Sugarman, 1986).

As shown in Table 18.2, 7% of all respondents reported having heard or seen abuse between their parents, while 14% reported that they had experienced parental physical abuse. The highest prevalence of witnessing or experiencing parental abuse was reported by women residing in Tbilisi (10% and 18%, respectively) and by women belonging to "other" (minority) ethnic groups (17% and 25%, respectively).

Among women who reported having witnessed abuse in the home as a child, prevalence of having been psychologically and physically abused in the 12 months prior to the survey was 3 to 4 times as high as among those who had not witnessed abuse in their childhood home (Figure 18.2). Similarly, those who had experienced parental abuse had prevalence of recent psychological abuse three times as high and prevalence of physical abuse twice as high as those who had not experienced parental abuse.

Figure 18.2 **Recent Physical and Verbal Abuse by Having Witnessed or Experienced Parental Physical Abuse as a Child Among Ever-Married Women Aged 15-44 Years**



18.3 Prevalence of Intimate Partner Violence

The two basic measures of the prevalence of domestic violence are lifetime abuse in adulthood by a formal or consensual partner, and current abuse (in the last 12 months). Less than 20% of Georgian women in both the 1999 and the 2005 surveys reported lifetime psychological abuse, and only 5% in 1999 and 2% in 2005 reported lifetime physical or sexual violence from current or previous partners. The levels of current violence were much lower in both surveys (Figure 18.3.1). Not surprisingly, considerable overlap was found between the three types of abuse: Virtually all women (99.5%) who had been subjected to physical violence said that the physical abuse was accompanied by psychological abuse. Similarly, sexual abuse was frequently associated with other acts of physical harm: 78% of women who had been sexually abused also reported other acts of physical violence (data not shown).

Women residing in Tbilisi were slightly more likely to be subjected to lifetime domestic violence than women residing in other urban or rural areas (Table 18.3 and Figure 18.3.2). Compared with reports from currently married women, previously married women experienced twice as much psychological abuse, 12 times as much physical abuse, and 9 times as much sexual abuse, suggesting that domestic abuse is a common factor leading to separation (Table 18.3 and Figure 18.3.3).

Current abuse was reported by far fewer women: prevalence of psychological abuse ranged from 3% to 15%, and prevalence of physical and sexual abuse did not exceed 6% and 1%, respectively. Women who experienced higher levels of recent abuse shared many characteristics with those reported lifetime abuse.

Figure 18.3.1 **Reported Lifetime and Recent Abuse (Past 12 Months), by Type of Abuse Among Ever-Married Women Aged 15–44 Years: 1999 and 2005**

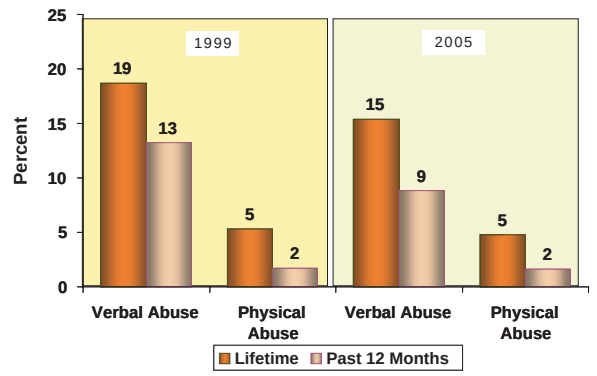


Figure 18.3.2 **Reported Lifetime Abuse by Type of Abuse and Residence Among Ever-Married Women Aged 15–44 Years**

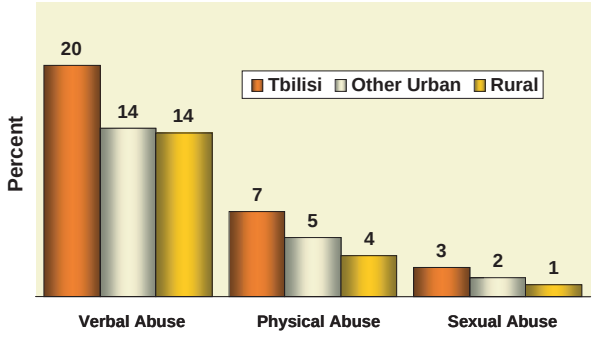
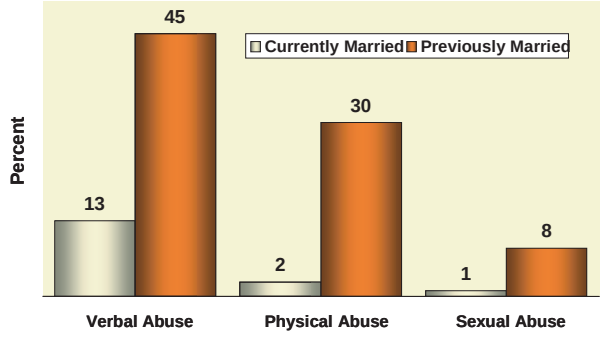


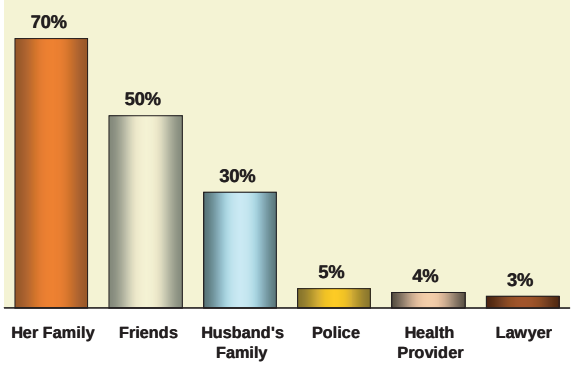
Figure 18.3.3 **Reported Lifetime Abuse by Current Marital Status Among Ever-Married Women Aged 15–44 Years**



18.4 Levels of Help-Seeking Among Victims of Domestic Abuse

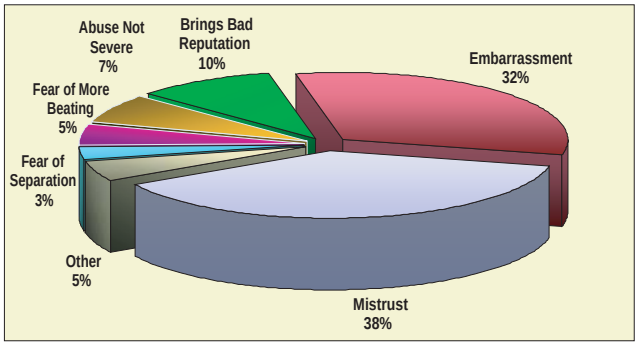
About one in five Georgian women who were subjected to domestic physical abuse had not disclosed their experience to anyone (Table 18.4). The majority of women exposed to physical abuse who did disclose their experience were most likely to talk about the abuse with a family member or a friend, rather than to seek legal or medical help. Between 50% and 70% of women who were physically abused had talked to a family member or a friend about it, but only 5% reported the abuse to the police, 4% sought medical help, and 3% sought legal counsel (Figure 18.4.1). There were few differences in discussing recent abuse by respondent's characteristics, although rural women, women aged 35 years or older, those with less than complete secondary education, and of low SES were the least likely to seek legal or medical help.

Figure 18.4.1 **Levels of Help-Seeking by Source of Help Among Ever-Married Women Aged 15–44 Years Who Reported Lifetime Physical Abuse**



The most common reasons cited by a battered woman for not seeking formal help were mistrust that law enforcement agencies or health providers could be helpful (38%) and embarrassment associated with disclosing the abuse (32%) (Figure 18.4.2). Other reasons mentioned were concerns that reporting violence would bring the family a bad reputation (10%), belief that the physical abuse was not very severe (7%), and a fear of more beating (5%) or that the marriage would end as a result (3%).

Figure 18.4.2 **Most Commonly Cited Reasons for Not Seeking Formal Help Among Ever-Married Women Aged 15–44 Years Who Reported Lifetime Physical Abuse**



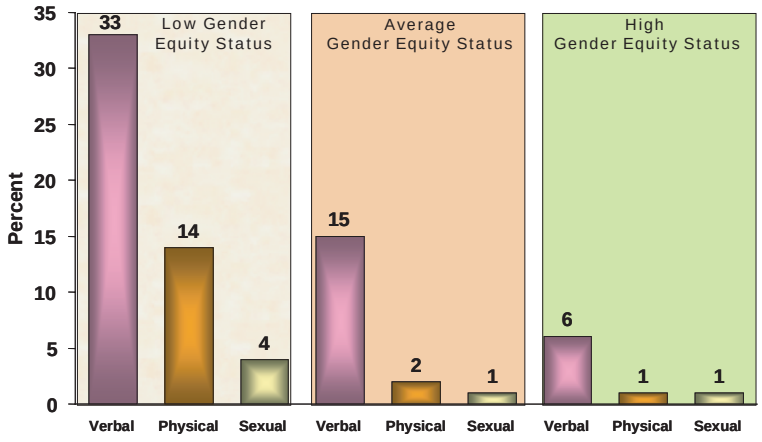
In order to increase rates of seeking formal help among abused woman, barriers to doing so such as those cited by respondents must be addressed. Law enforcement agencies and the health care community in Georgia should be made aware of the prevalence of domestic violence and the reluctance of victims to seek help. Inquiries about domestic violence experience during police incident reports and routine health visits could contribute to early detection and interventions for victims of domestic abuse.

18.5 Domestic Violence and Gender Norms

IPV is borne out of prevailing gender inequalities, which lead to the acceptance by families and society of fixed gender roles that emphasize subordination of women to men. As such, domestic violence is often triggered by a perceived transgression of gender norms in a family. In contrast, gender norms that are conducive to gender equity guarantee that men and women are in an equal position to use basic social services and make social, economic, and health-related decisions. The GERHS05 sought to characterize the perceived roles and responsibilities of husbands and wives in Georgia and their correlates with domestic abuse, information that can guide design of effective prevention programs to challenge societal norms that justify violence, promote non-violent conflict resolution, and promote quality family life and healthy relationships.

Ever-married respondents were asked about several characteristics of their husband, including expression of affection, tolerance of wife's contact with her family and friends, sharing of household chores, and whether or not the husband insists on making all decisions (i.e., demands the "final say"). Most respondents reported that their husbands were usually affectionate (74%), never tried to limit their wives in contacting their family and friends (69%), and usually shared household responsibilities (64%). However, only 8% of women reported that their husband did not insist on having the final say (Table 18.5.1). Behaviors of husbands that promote gender equity (e.g., sharing household chores, never insisting on having the final word in household decisions, being affectionate with one's wife, and never limiting her contacts with family and friends) were summed to create a score to classify the "gender norms status" of a family. Equal values were assigned for reports of each "positive" norm; possible scores ranged from 0 (no norm associated with gender equity in the household) to 4 (all 4 positive norms existed in the family). Respondents who reported 0 or 1 positive norm were classified as having relationships with low gender equity, those with 2 positive norms were classified as having average gender equity, and those with 3 or 4 positive norms were considered as having high gender equity in their spousal relationships. Women living in households with low gender equity were much more likely to be subjected to any type of violence than those who had high gender equity in their households (Figure 18.5.1).

Figure 18.5.1 **Prevalence of Lifetime Physical or Sexual Abuse by Gender Equity Status of the Household Among Ever-Married Women Aged 15–44 Years**



Another set of questions explored women's acceptance of gender norms that grant husbands power over their wives and may be misconstrued as justification for wife-beating (Table 18.5.2). Agreement with wife-beating under any circumstance reflects acceptance of gender inequity and lack of understanding that domestic abuse is a serious violation of a woman's human rights. Overall, only a small proportion of ever-married women agreed with specific reasons for justifying wife-beating. Women were most likely to affirm that beating is acceptable under the circumstance that "the wife had been unfaithful" (28%) or that "she neglected the children" (13%). Support for the other reasons listed on the table was affirmed by 3%–6% of ever-married women. Agreement with every specific reason for wife-beating was higher among women who reported lifetime physical or sexual abuse than those who had never been abused (Figure 18.5.2). These findings suggest that women who accept gender inequity are less empowered than women who reject it; lack of empowerment may leave them more vulnerable to domestic abuse.

Figure 18.5.2 **Agreement with Selected Justifications for Wife-Beating by Experience of Physical Abuse Among Ever-Married Women Aged 15–44 Years**

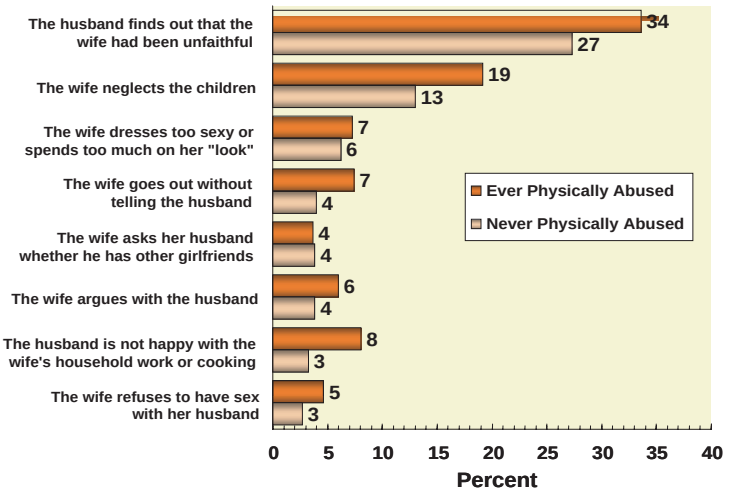


Table 18.1 Prevalence of Lifetime and Current (Within the Past 12 Months) Physical Abuse Among Ever-Married Women Aged 15–44 Years: Selected Countries in Eastern Europe and the Caucasus Region, 1997-2001

Characteristic	Eastern Europe								Caucasus			
	Moldova, 1997		Romania, 1999		Russia, 1999*		Ukraine, 1999		Azerbaijan, 2001		Georgia, 1999	
	Lifetime %	Current %	Lifetime %	Current %	Lifetime %	Current %	Lifetime %	Current %	Lifetime %	Current %	Lifetime %	Current %
Total	15	8	29	10	21	7	19	7	20	8	5	2
Residence												
Urban	13	6	27	9	*	*	19	7	19	7	7	2
Rural	18	10	32	12	*	*	20	9	21	8	4	2
Age												
15–24	10	6	26	14	13	6	14	8	21	13	4	2
25–34	15	8	27	10	23	9	18	8	22	9	6	2
35–44	18	9	33	9	22	5	22	6	19	5	5	1
Marital Status												
Currently Married	13	8	25	10	17	7	16	7	18	8	4	2
Previously Married	34	6	64	6	35	5	40	7	43	6	23	2
No.of Living Children												
0	10	3	21	8	17	7	16	7	21	7	5	2
1	14	6	26	8	20	6	18	7	21	9	8	2
2	14	8	28	10	21	7	20	7	20	8	5	2
3+	23	13	48	18	29	7	26	8	20	7	4	1
Education Level												
Secondary Incomplete	22	13	38	14	35	15	26	10	27	11	7	2
Secondary Complete	18	9	21	6	23	8	21	8	20	7	5	2
Technicum	11	5	†	†	22	6	19	7	16	5	6	2
Postsecondary	7	3	14	2	13	3	15	6	17	6	5	1

* Data for Russia pertain to three primarily urban areas.

† Technicum, specific to former Soviet Union countries, does not exist in Romania.

Reference: CDC and ORC Macro, 2003

Table 18.2 Percentage of Women Aged 15–44 Years Who Have Witnessed or Experienced Parental Physical Abuse as a Child by Selected Characteristics Reproductive Health Survey: Georgia, 2005

	Witnessed Abuse	Experienced Abuse	No. of Cases*
Total	6.9	14.4	6,331
Residence			
Tbilisi	9.6	17.7	1,425
Other Urban	5.4	15.0	1,747
Rural	6.2	12.2	3,159
Age Group			
15-24	5.9	13.4	1,987
25-34	7.5	16.1	2,239
35-44	7.3	14.1	2,105
Education			
Secondary incomplete or less	6.1	13.3	898
Secondary complete	8.5	15.7	1,772
Technicum	5.6	13.7	1,458
University/postgraduate	6.7	14.4	2,203
Socioeconomic Status			
Low	8.0	14.8	2,264
Middle	6.0	14.3	3,004
High	7.0	14.1	1,063
Ethnicity			
Georgian	6.7	14.8	5,507
Azeri	6.2	10.4	291
Armenian	5.5	7.3	376
Other	17.3	24.5	157

* Excludes 45 women who reported that they did not grow up with their parents.

Table 18.3 Percentage of Ever-Married Women Aged 15–44 Years Who Reported Intimate Partner Violence (IPV) in Their Lifetime and Percentage Who Reported IPV in the Last Year, by Type of Abuse and by Selected Characteristics Reproductive Health Survey: Georgia 2005

	Lifetime IPV			IPV During the Last Year			
	Verbal Abuse	Physical Abuse	Sexual Abuse	Verbal Abuse	Physical Abuse	Sexual Abuse	No. of Cases
Total	15.4	4.8	1.5	8.8	1.6	0.3	4,505
Residence							
Tbilisi	19.6	7.2	2.5	10.1	1.8	0.3	944
Other urban	14.3	5.0	1.6	7.6	1.7	0.3	1,234
Rural	13.9	3.5	1.0	8.8	1.5	0.3	2,327
Age Group							
15–19	3.8	0.0	0.0	3.2	0.0	0.0	160
20–24	10.8	4.8	1.8	6.9	1.8	0.5	578
25–29	12.6	4.4	1.4	7.8	1.9	0.3	881
30–34	16.1	5.0	2.1	9.1	1.7	0.4	961
35–39	17.9	5.1	0.3	11.0	1.7	0.2	937
40–44	18.9	5.5	2.2	9.1	1.3	0.3	988
Marital Status							
Currently married	12.6	2.4	0.9	9.0	1.2	0.3	4,119
Not currently married	44.5	29.5	8.1	6.5	5.9	0.5	386
Number of Living Children							
0	8.0	3.5	1.2	4.6	1.8	0.4	431
1	17.6	7.7	1.6	8.7	1.9	0.2	1,128
2	15.5	4.2	1.7	9.0	1.5	0.3	2,168
3	15.1	3.0	0.9	10.2	1.5	0.3	654
4 or more	19.8	4.1	2.6	11.6	0.4	0.2	124
Education							
Secondary incomplete or less	15.2	6.7	3.0	7.1	2.0	0.6	461
Secondary complete	14.8	4.8	1.3	9.8	1.9	0.4	1,399
Technicum/university	15.7	4.5	1.4	8.5	1.4	0.2	2,645
Socioeconomic Status							
Low	18.5	5.8	1.4	11.3	2.3	0.5	1,647
Middle	13.4	4.4	1.3	7.7	1.6	0.2	2,095
High	14.5	4.0	2.3	6.7	0.3	0.0	763
Ethnicity							
Georgian	15.7	4.6	1.6	8.9	1.5	0.3	3,846
Azeri	6.9	2.2	0.7	5.1	1.1	0.0	243
Armenian	14.7	7.4	0.2	6.8	1.9	0.0	283
Other	25.3	12.3	2.1	15.3	4.6	0.3	133

Table 18.4 Percentage of Ever-Married Women Aged 15–44 Years Who Were Physically Abused by an Intimate Partner and Sought Help, by Selected Characteristics Reproductive Health Survey: Georgia, 2005

		Source of Help						
Characteristic	Ever Sought Help	Respondent's Family	Friend	Husband's Family	Police	Health Provider	Legal Counsel	No. of Cases
Total	79.5	70.1	50.3	29.9	4.7	3.6	3.3	214
Residence								
Tbilisi	82.0	68.5	55.1	20.2	9.0	5.6	6.7	70
Other urban	72.1	60.8	50.5	35.9	1.8	3.1	2.4	60
Rural	82.9	79.4	45.0	35.2	2.5	2.0	0.4	84
Age Group								
15–24	*	*	*	*	*	*	*	24
25–34	80.8	76.3	49.9	42.9	4.8	3.9	4.8	87
35–44	78.7	66.1	54.0	22.9	4.2	1.9	3.1	103
Marital Status								
Married	69.9	60.3	45.7	23.5	2.8	2.2	0.6	109
Previously married	88.1	78.9	54.4	35.6	6.5	4.9	5.8	105
Number of Living Children								
0	*	*	*	*	*	*	*	14
1	94.2	84.0	57.1	33.9	7.7	7.0	6.6	72
2	74.6	66.1	47.2	23.8	1.3	1.1	1.7	98
3+	58.4	43.6	35.8	28.4	6.6	4.2	1.2	30
Education								
Secondary incomplete or less	78.8	72.7	34.8	23.4	2.7	0.0	0.0	30
Secondary complete	80.5	71.4	50.4	39.1	3.2	5.9	0.5	69
Technicum/university	79.1	68.7	54.3	26.7	6.1	3.4	5.7	115
Socioeconomic Status								
Low	81.5	76.6	45.7	31.6	4.1	2.6	0.4	95
Middle	78.1	65.6	53.4	28.7	5.2	4.3	5.4	119
Ethnicity								
Georgian	80.1	69.1	55.6	31.5	4.6	3.9	3.4	171
Other	76.5	74.3	26.1	22.3	5.1	2.4	3.2	43

* Fewer than 25 cases in this category.

Table 18.5.1 Percentage of Ever-Married Women Aged 15–44 Years Who Reported Specific Gender Norms That Promote Gender Equity in the Household, by Selected Characteristics Reproductive Health Survey: Georgia, 2005

Characteristic	Husband is Usually Affectionate	Husband Never Tries to Limit Wife's Contacts With Family and Friends	Husband Usually Shares Household Chores	Husband Never Wants to Have the Final Say	No. of Cases
Total	74.3	68.9	63.9	7.6	4,505
Residence					
Urban	77.7	69.7	65.9	8.1	2,178
Rural	70.7	68.1	61.7	7.1	2,327
Region					
Kakheti	75.7	72.2	62.6	6.7	405
Tbilisi	82.1	67.1	64.7	8.4	944
Shida Kartli	67.7	72.1	67.2	8.0	340
Kvemo Kartli	66.8	67.7	55.2	5.0	432
Samtskhe-Javakheti	83.4	66.0	65.2	6.6	328
Adjara	69.7	61.4	56.3	2.5	349
Guria	74.3	77.0	56.8	4.4	266
Samegrelo	69.8	75.2	62.5	7.0	336
Imereti	74.8	70.6	73.7	10.3	550
Mtskheta-Mtianeti	70.3	71.5	68.5	9.4	279
Racha-Svaneti	67.9	75.6	70.9	15.7	276
Age Group					
20–24	84.5	70.4	64.7	9.7	738
25–34	76.6	68.7	63.2	8.1	1,842
35–44	68.6	68.6	64.1	6.5	1,925
Marital Status					
Married	76.4	70.9	65.7	7.5	4,119
Previously married	52.4	48.9	44.4	8.8	386
Education					
Secondary incomplete or less	66.9	57.4	54.1	2.7	461
Secondary complete	70.0	69.3	58.8	7.4	1,399
Technicum	73.0	69.1	67.7	7.3	1,204
University/postgraduate	81.7	72.1	68.6	9.6	1,441
Socioeconomic Status					
Low	64.2	64.8	53.7	4.9	1,647
Middle	77.8	70.6	68.4	9.1	2,095
High	84.5	72.6	71.5	9.1	763
Ethnicity					
Georgian	75.1	69.8	65.6	8.6	3,846
Azeri	63.7	59.9	47.8	1.8	243
Armenian	78.4	71.9	57.6	1.1	283
Other	65.4	57.8	56.3	4.6	133

Table 18.5.2 Percentage of Ever-Married Women Aged 15–44 Years, by Whether They Had Ever Experienced Physical or Sexual Intimate Partner Violence in Their Lifetime and Their Agreement with Different Reasons That May Justify Wife-Beating Reproductive Health Survey: Georgia 2005

		Physical Abuse		Sexual Abuse	
Agreement With a Specific Reason	Total %	Never Abused %	Ever Abused %	Never Abused %	Ever Abused %
The husband finds out that the wife had been unfaithful	27.6	27.3	33.6	27.2	53.2
The wife neglects the children	13.3	13.0	19.2	12.9	40.5
The wife dresses too sexy or spends too much money on her "look"	6.3	6.2	7.3	6.2	7.4
The wife goes out without telling the husband	4.2	4.0	7.4	3.9	19.2
The wife asks her husband whether he has other girlfriends	3.9	3.8	3.7	3.7	9.4
The wife argues with the husband	3.8	3.8	6.0	3.7	13.5
The husband is not happy with the wife's household work or cooking	3.5	3.3	8.1	3.4	13.3
The wife refuses to have sex with her husband	2.8	2.7	4.6	2.7	5.6
Agreement with any reason	29.7	29.4	35.6	29.3	54.6
No. of Cases	4,505	4,306	199	4,445	60

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Annex A: Sampling Error Estimates

The estimates for a sample survey are affected by two types of errors: non-sampling error and 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 GERHS05 to minimize this type of error, non-sampling errors are impossible to avoid altogether 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, which 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 that could have been selected from the female population aged 15–44 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 women 15–44 years of age in Azerbaijan 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 x SE) for selected proportions and sample sizes are shown in Table A.1. The estimates in Table A.1 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 GERHS05 did not employ a simple random sample but included clusters of elements in the second stage of the sample selection.

The selection of clusters is generally characterized by some homogeneity that tends to increase the variance of the sample. Thus, the variance in the sample for the GERHS05 is greater than a simple random sample would be 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). For more details regarding design effects for specific reproductive health variables, the reader is referred to the Le and Verma report, which studied demographic and health surveys in 48 countries (Le TN and Verma JK, 1997). The pattern of variation of design effects is shown to be consistent across countries and variables. Variation among surveys is high but less so among variables. Urban -rural and regional differentials in design effects are small, which can be attributed to the fact that similar sample designs and cluster sizes were used across domains within each country. At the country level, the overall design effect, averaged over all variables and countries, is about 1.5 (we used 1.6 in Table A.1 to be slightly more conservative).

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 percentage points; for a sample size of 300 (midway between 200 and 400) and an estimate of 20%, the 95% CI would be plus or minus 6.0 percentage points.

Table A.1 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

	Estimated Proportions (Pi)					
Sample Size	**0.05/0.95**	**0.10/0.90**	**0.20/0.80**	**0.30/0.70**	**0.40/0.60**	**0.50/0.50**
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
3000	0.011	0.014	0.020	0.021	0.022	0.023
4000	0.008	0.012	0.016	0.018	0.019	0.020
5000	0.008	0.011	0.014	0.016	0.017	0.018

For an example using data from the 2005 Georgia survey results, we can look at the percentage of married women using modern contraception (see Chapter 8). This percentage is 26.6% with a denominator of 4,119 married women. Utilizing the sample size of 4000 in Table A.1, we can interpolate between 20.0% (0.016) and 30.0% (0.018), 6.6% divided by 10.0%, yielding a result of 0.0173, or 1.73%. The actual computed confidence interval is 1.71%. Both results round off to 1.7% and we can report, with 95% confidence, that the proportion of married women using modern contraception ranges from 24.9% to 28.1% with a point estimate of 26.6%.

Differences between estimates discussed in this report were found to be statistically significant at the five percent level using a two-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 proportion in the population.

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.1). 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.

Annex B: Institutional Participation

National Center for Disease Control and Medical Statistics (NCDC)
Paata Imnadze, Director
Manana Tsintsadze, Deputy Director
Neli Chakvetadze, Scientific Director
Marina Shakhnazarova, Head of Data Analysis and Presentation Department
Khatuna Zakhashvili, Head of Surveillance and Prevention Department

Georgia Ministry of Labor, Health, and Social Affairs (MoLHSA)
Levan Jugeli, Deputy Minister
Varlam Mosidze, Deputy Minister
Zaza Bokhua, Director, Health Policy Department
Nikoloz Nutsubidze, Deputy Head, Human Resources Department
Levan Baramidze, Director, Public Health Department

Ministry of Economic Development, Department for Statistics
Joseph Archvadze, Deputy Chair

Georgian AIDS & Clinical Immunology Research Center
Tengiz Tsertsvadze, Director

Zhordania Institute of Human Reproduction
Giorgi Tsagareishvili, Director, Department of In Vitro Fertilization
Giorgi Tsertsvadze, Director, Department of Family Planning

Georgian Association of Obstetricians and Gynecologists
Tengiz Asatiani, Vice President

Institute of Social Research and Statistics
Giorgi Tsuladze, Deputy Director

Curatio International Foundation
Ketevan Chkhatarashvuli, President

USAID/Tbilisi
Tamara Sirbiladze, Project Officer for GERHS05
Denni Robertson, Mission Director
Khalid Khan, Chief, Office of Health and Social Development
Gegi Metaradze, Program Officer-Health
Nana Chkonia, Administrative Assistant

UNFPA/Tbilisi
Tamar Khomasuridze, Assistant Representative
Lela Bakradze, National Program Officer
Marina Tsintsadze, Administrative Assistant

Centers for Disease Control and Prevention, Division of Reproductive Health (CDC/DRH), Atlanta
Florina Serbanescu, Survey Principal Investigator
Mary Goodwin, Epidemiologist
Paul Stupp, Sampling Statistician (Demographer)
Danielle Jackson, Public Health Analyst (ORISE)
Richard Monteith, Survey Consultant (SAIC)
Alicia Ruiz, System Programmer (SAIC)
Fernando Carlosama, System Programmer (SAIC)
Leo Morris, Survey Consultant (SAIC)
Howard Goldberg, Global Health Deputy Director
Maureen Clyde, Information Use/Communications Advisor (COMFORCE)

Annex C: Field and Data Entry Personnel

Field Coordinators:

Khatuna Zakhashvili
Marina Shakhnazarova

Team Supervisors:

Eka Narchemashvili (Team I)
Nato Tsereteli (Team II)
Khatuna Aladashvili (Team III)
Rusudan Etsdashvili (Team IV)
Dali Trapaidze (Team V)
Olga Tarkhan-Mouravi (Team VI)
Ketevan Kokiauri (Team VII)

Team Interviewers and Drivers:

Team I
Julietta Gulua
Marina Lashkarashvili
Ia Kochiashvili
Natia Nutzubidze

Team II
Tamar Dudauri
Manana Maridashvili
Tamar Jashiasvili
Eka Jorjoliani

Team III
Lela Sturua
Tamar Tsetsvadze
Lela Urushadze
Irma Burjenadze

Team IV
Marika Khatashvili
Ketevan Sanadze
Ia Benidze
Eka Tsertsvadze

Team V
Rusiko Chlikadze
Marina Baidauri
Sopho Datukishvili
Marina Chubinidze

Team VI
Nana Mebonia
Rusudan Chumburidze
Tamar Chachava
Sopho Chumburidze

Team VII
Nino Shubladze
Tamar Sulhanishvili
Irina Kalandadze
Maia Kasrashvili

Field Coordinators:

Irina Kocharova
Konstantin Kazanjian

Field Coordinators

Eka Narchemashvili (Team I)
Nato Tsereteli (Team II)
Khatuna Aladashvili (Team III)
Rusudan Etsdashvili (Team IV)
Dali Trapaidze (Team V)
Olga Tarkhan-Mouravi (Team VI)
Ketevan Kokiauri (Team VII)

Annex D: MoLHSA Board of Experts

The authors would like to thank the MoLHSA Board of Experts for their critical review of the survey questionnaire and the Summary Report manuscript. The Board consisted of the following Georgian reproductive health experts, brought together by the Minister of Labor, Health and Social Affairs, **Dr. Lado Chipashvili**:

Dr. Tengiz Asatiani
President
Georgian Obstetrics and Gynecology Association

Dr. Zaza Bokhua
Director, Health Policy Department
Georgia Ministry of Labor, Health and Social Affairs

Dr. Levan Jugeli
Deputy Minister
Georgia Ministry of Labor, Health and Social Affairs

Dr. Vaarlam Mosidze
Deputy Minister
Georgia Ministry of Labor, Health and Social Affairs

Dr. Giorgi Tsertsvadze
Director, Department of Family Planning
Zhordania Institute of Human Reproduction

Dr. Manana Tsintsadze
Director, Center for Medical Statistics and Information
National Centre for Disease Control and Medical Statistics

Dr. Levan Baramidze
Director, Public Health Department
Georgia Ministry of Labor, Health and Social Affairs

Dr. Ketevan Chkhatarashvili
President
Curatio International Foundation

Dr. Tamar Manjavidze
Adviser for the Minister of Health
Georgia Ministry of Labor, Health and Social Affairs

Dr. Giorgi Tsagareishvili
Director, Department of In Vitro Fertilization
Zhordania Institute of Human Reproduction

Dr. Tengiz Tsertsvadze
Director
Georgian AIDS & Clinical Immunology Research Center

Dr. Giorgi Tsuladze
Deputy Director, Institute of Social Research and Statistics
Academy of Sciences of Georgia

2005 GEORGIA REPRODUCTIVE HEALTH SURVEY
HOUSEHOLD QUESTIONNAIRE

STRATUM ___ ___ **ID NUMBER** ___ ___ ___ ___ ___

REGION_____

PSU ___ ___ ___

RESIDENCE (URBAN=1; RURAL=2) ___

RAION _____ ___ ___ ___ ___

STATISTICS CODE ___ ___ ___ ___ ___ ___ ___

SECTOR ___ **INSTRUCTOR AREA**___ **CENSUS AREA** ___

LOCALITY _____

STREET ADDRESS _____

BUILDING/HOUSE NUMBER ___ ___ ___ ___

APARTMENT 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. **COMPLETED INTERVIEW**
2. **NO ELIGIBLE WOMAN (AGE 15-44) LIVES IN THE HOUSEHOLD**
3. **NOBODY HOME**
4. **SELECTED RESPONDENT NOT HOME**
5. **HOUSEHOLD REFUSAL**
6. **SELECTED RESPONDENT REFUSAL**
7. **UNOCCUPIED HOUSE**
8. **RESPONDENT INCOMPETENT**
9. **OTHER** _____
10. **INCOMPLETE INTERVIEW**

Q1

1. How many families live in this household? ____ families

NOTE: A HOUSEHOLD CONSISTS OF ONE PERSON OR MORE; IF THERE ARE TWO OR MORE PERSONS—WITH OR WITHOUT FAMILY RELATIONS—WHO SHARE THE DWELLING AND THE HOUSEHOLD EXPENSES, HEY CONSTITUTE ONE HOUSEHOLD WITH ONE OR MORE FAMILIES;

IF THE PERSONS DO NOT SHARE THE DWELLING AND HOUSEHOLD EXPENSES, REGARDLESS OF BEING RELATED, THEY CONSTITUTE TWO OR MORE HOUSEHOLDS

2. How many people normally live in this flat/house? ___ ___ people

2A. Are any of the persons living in this household either internally displaced or refugees?

1. YES
2. NO------>**GO TO Q3**

2B. How many persons living in this dwelling are internally displaced or refugees? ___ ___ person(s)

3. How many females between the ages of 15 and 44 live in this flat/house? ____ women aged 15–44

IF NO ELIGIBLE WOMAN (AGE 15-44) LIVES IN THE HOUSEHOLD FINISH THE INTERVIEW (CODE=2)
IF THE HOUSEHOLD CONTAINS AT LEAST ONE ELIGIBLE WOMAN, CONTINUE

4. For each of these women could you give me the following information **(STARTING WITH THE OLDEST WOMAN TO THE YOUNGEST) :**

No.	First Name	Age	Marital Status	Education Level	IDP/Refugee Status*	
					Yes	No
1	_____	__ __	__	__ __	1	2
2	_____	__ __	__	__ __	1	2
3	_____	__ __	__	__ __	1	2
4	_____	__ __	__	__ __	1	2
5	_____	__ __	__	__ __	1	2
6	_____	__ __	__	__ __	1	2

Marital Status

1. MARRIED
2. UNREGISTERED MARRIAGE
3. SEPARATED
4. DIVORCED
5. WIDOWED
6. NEVER MARRIED
8. DO NOT KNOW
9. REFUSED

Education:

0. NO FORMAL EDUCATION
1. PRIMARY EDUCATION (1-4 YRS)
2. BASIC SECONDARY (5–9 YRS.)
3. INCOMPLETE SECONDARY (10 YRS OF EDUCATION COMPLETED)
4. COMPLETE SECONDARY (11 YRS OF EDUCATION COMPLETED)
5. BASIC SECONDARY + VOCATIONAL EDUCATION
6. COMPLETE SECONDARY + TECHNICAL EDUCATION
7. INCOMPLETE POSTSECONDARY
8. COMPLETE POSTSECONDARY (DIPLOMA)
9. POSTGRADUATE EDUCATION
88. UNKNOWN

IDP/Refugee Status*
DO NOT ASK IF Q2A=2

GO TO THE RANDOMIZATION TABLE

Q2

SELECTION OF INDIVIDUAL RESPONDENT USING RANDOMIZATION TABLE:

NUMBER OF ELIGIBLE WOMEN LIVING IN THE HOUSEHOLD (SEE # IN Q 3)	LAST DIGIT OF QUESTIONNAIRE NUMBER									
	0	1	2	3	4	5	6	7	8	9
1	1	1	1	1	1	1	1	1	1	1
2	1	2	1	2	1	2	1	2	1	2
3	3	1	2	3	1	2	3	1	2	3
4	3	4	1	2	3	4	1	2	3	4
5	1	2	3	4	5	1	2	3	4	5
6	6	1	2	3	4	5	6	1	2	3

IF ONLY ONE WOMAN AGED 15-44 LIVES IN THIS HOUSEHOLD, WRITE "1" IN Q5

5. RANK ORDER OF THE SELECTED RESPONDENT: _____

IF YOU DO NOT SPEAK WITH THE SELECTED RESPONDENT OR IF SHE IS NOT AVAILABLE FOR AN INTERVIEW AT THAT TIME, WRITE DOWN HER FIRST NAME AND SCHEDULE ANOTHER VISIT (DATE AND TIME)

FIRST NAME _____

DATE OF THE NEXT VISIT:_____ TIME:_____

Q3

2005 GEORGIA REPRODUCTIVE HEALTH SURVEY
FEMALE QUESTIONNAIRE

Hello. I'm_____ from the Georgian Center for Disease Control. We are doing a national survey about the health of women in Georgia. The purpose of the survey is to collect information that will help us to plan reproductive health services in Georgia.

I would like to ask you about your health and where you obtain health services. All of the information you give us will be confidential. The interview is completely voluntary and if we should come to any question that you don't want to answer, just let me know and we'll go on to the next question. The interview will take about 35-40 minutes. I would like to start now, is that OK?

SIGNATURE OF THE INTERVIEWER_____ DAY ___ ___ MONTH ___ ___

MARK IF THE WOMAN AGREES TO BE INTERVIEWED
1. YES----> CONTINUE
2. NO------>END OF INTERVIEW

TIME STARTED: __ __ : __ __ **ID NUMBER ___ ___ ___ ___ ___ - ___**

I. BACKGROUND CHARACTERISTICS

100. In what month and year were you born?

MONTH ___ ___ YEAR ___ ___ ___ ___ 98 DON'T KNOW

101. How old are you (at last birthday)? ___ ___ YEARS OLD 98 DON'T KNOW

MAKE SURE THAT AGE AND DATE OF BIRTH CORRESPOND

102. What is the highest level of education you completed, not counting the current grade you are in?

0. NO FORMAL EDUCATION
1. PRIMARY EDUCATION (1-4 YRS.)
2. BASIC SECONDARY (5-9 YRS.)
3. INCOMPLETE SECONDARY (10 YRS OF EDUCATION COMPLETED)
4. COMPLETE SECONDARY (11 YRS OF EDUCATION COMPLETED)
5. BASIC SECONDARY + VOCATIONAL EDUCATION
6. COMPLETE SECONDARY + TECHNICAL EDUCATION
7. INCOMPLETE POSTSECONDARY
8. COMPLETE POSTSECONDARY (DIPLOMA)
9. POSTGRADUATE EDUCATION
88. DO NOT REMEMBER

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

1. YES→ **GO TO Q105**
2. YES, BUT ON MATERNITY/PREGNANCY LEAVE→ **GO TO Q105**
3. NO

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

1. ATTENDING SCHOOL
2. I NTERNAL DISPLACEMENT
3. LOOKING FOR WORK
4. LAID OFF
5. DOES NOT NEED/WANT/LIKE TO WORK
6. MEDICAL LEAVE
7. MATERNITY LEAVE
8. INABILITY TO FIND/AFFORD CHILD CARE
9. HOMEMAKER
10. PERMANENT DISABILITY
11. HUSBAND DOES NOT ALLOW HER TO WORK
12. PARENTS DO NOT ALLOW HER TO WORK
13. ODD JOBS (<20 HOURS PER WEEK)
14. TEMPORARY BACK FROM WORK ABROAD
20. OTHER (SPECIFY)_____

105. I would like to ask you some questions about where you have lived. For most of the time until you were 12 years old, did you live in a town, or in a village?

1. TOWN
2. VILLAGE

106. In what month and year did you start to live continuously in _____ (NAME THE PLACE OF RESIDENCE)?

MONTH___ ___ YEAR __ __ __ __

00. ALWAYS, SINCE BIRTH----> **GO TO Q108**
88. DON'T REMEMBER

107. Just before you moved here (CURRENT PLACE OF RESIDENCE), did you live in a town, a village, or outside Georgia ?

1. A town (URBAN AREA),
2. A village (RURAL AREA), or
3. Outside Georgia?

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

1. MARRIED ----------> **GO TO Q111**
2. NOT MARRIED BUT LIVING WITH A PARTNER --> **GO TO Q111**
3. SEPARATED ----------**GO TO Q111**
4. DIVORCED ----------**GO TO Q111**
5. WIDOWED ----------**GO TO Q111**
6. NEVER MARRIED

109. Have you ever lived with a boyfriend or partner? **(LIVING TOGETHER MEANS HAVING A SEXUAL RELATIONSHIP WHILE SHARING THE SAME USUAL ADDRESS)**

1. YES----**GO TO Q111**
2. NO

110. If you could choose exactly the number of children to have in your whole life, how many would that be?

____ ____ CHILDREN

22. AS MANY AS GOD GIVES
33. AS MANY AS HUSBAND WOULD WANT
88. NOT SURE/DON'T REMEMBER

GO TO Q124

111. How many **times** have you been married or lived with a man as husband and wife?

___ TIMES 9. REFUSAL---------->**GO TO Q118**

TIMES	**112.** In what month and year did you begin living with your... (first, second, third, or fourth) husband/partner?	**113.** How old was your I, II, III, IV husband/ partner when you started to live together?	**114**. What was the highest grade in school that your I,II,III,IV husband/ partner completed when you got married/started to live together ?	**115.** What is your current union relationship with your I, II, III, IV, husband/ partner, are you still in the relationship or how did the relationship end?	**116.** In what month and year did your union with your I,II,III,IV, .husband/partner end?	**117. IF:**
I	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88. DK	0. NEVER ATTENDED 1. PRIMARY (1-8) 2. SECONDARY (9-11) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1. Married---->**Q117** 2. Living with partner->**Q117** 3. Separated 4. Divorced 5. Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**Q111=1 GO TO Q118; ELSE CONTINUE**
II	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88. DK	0.NEVER ATTENDED 1. PRIMARY (1-8) 2. SECONDARY (9-11) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1. Married---->**Q117** 2. Living with partner->**Q117** 3. Separated 4. Divorced 5. Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**Q111=2 GO TO Q118; ELSE CONTINUE**
III	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88. DK	0.NEVER ATTENDED 1. PRIMARY (1-8) 2. SECONDARY (9-11) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1. Married---->**Q117** 2. Living with partner->**Q117** 3. Separated 4. Divorced 5. Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**Q111=3 GO TO Q118 ELSE CONTINUE**
IV	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88. DK	0.NEVER ATTENDED 1. PRIMARY (1-8) 2. SECONDARY (9-11) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1. Married---->**Q117** 2. Living with partner->**Q117** 3. Separated 4. Divorced 5. Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**GO TO Q118**

118. When you first got married/living together as husband and wife did you wish to have any children?

1. YES
2. NO---------->**GO TO Q120**
8. NOT SURE----->**GO TO Q120**

119. How many children did you wish to have when you first got married?

___ __ CHILDREN

22. AS MANY AS GOD GIVES
33. AS MANY AS HUSBAND WANTS
88. NOT SURE/DON'T REMEMBER

120. How many children did your husband wish to have when you first got married?

___ ___ CHILDREN

00. HUSBAND DID NOT WANT ANY
22. AS MANY AS GOD GIVES
33. AS MANY AS RESPONDENT WANTS
77. NEVER DISSCUSSED
88. NOT SURE/DON'T REMEMBER

120F. REVIEW Q115 (LAST UNION) CURRENTLY SEPARATED, DIVORCED OR WIDOWED?
(Q115_LAST = 3,4,5)
1. YES----------→ GO TO Q124
2. NO

121. Is your husband currently employed (either in Georgia or abroad)?

1. YES
2. NO
8. DK/REF

122. Is he away for work in another country?

1. YES
2. NO---------->**GO TO Q124**
8. DK/REF---->**GO TO Q124**

123. Since when has he been working abroad?

___ ___ MONTH ___ ___ ___ ___ YEAR

22. SEASONAL WORKER
88. DK/DR

124. More or less how many hours a day do you listen to the radio?

___ ___ HOURS A DAY

00. NEVER
55. DOES NOT HAVE ACCESS TO RADIO
77. NOT EVERY DAY
88. DON'T KNOW

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

___ ___ HOURS A DAY

00. NEVER
55. DOES NOT HAVE ACCESS TO TV
66. WHEN THE HOUSEHOLD HAS ELECTRICITY
77. NOT EVERY DAY
88. DON'T KNOW

126. How often do you read a newspaper?

1. DAILY/NEARLY EVERY DAY
2. ABOUT 3-4 TIMES PER WEEK
3. ONCE OR TWICE PER WEEK
4. LESS THAN ONCE PER WEEK
5. NEVER/ALMOST NEVER

II. SEX EDUCATION

The next set of questions is about sex education.

201. Do you think schools should teach courses about human reproduction, methods of pregnancy prevention, and prevention of sexually transmitted diseases (venereal diseases)?

1. YES
2. NO --> **GO TO Q203**
8. DK
9. NR --> **GO TO Q203**

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

A. Human Reproduction? ___ ___
B. Contraception? ___ ___
C. STI's (vevereal diseases) ___ ___

77. SHOULD NOT BE TAUGHT IN SCHOOL.
88. DK
99. NR

GO TO 203F

203. 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-D)**

	AGREE	DISAGREE	DK	NR
A. Sex education will give adolescents the idea to begin sex earlier	1	2	8	9
B. Sex education should be taught only in the house	1	2	8	9
C. Sex education goes against my religious beliefs	1	2	8	9
D. Teachers do not have enough training to teach such courses	1	2	8	9

203F. CHECK CURRENT AGE OF RESPONDENT (Q101):
1. 15 TO 24
2. 25 TO 44 ----------→ GO TO Q300

204. Before you were 18 years old, did a parent ever talked to you about....**(READ A-F)**

	YES	NO	DK/DR	REF
A. Menstrual Cycle?	1	2	8	9
B. How Pregnancy Occurs?	1	2	8	9
C. Not Having Sexual Intercourse Before Marriage?	1	2	8	9
D. Methods of Contraception?	1	2	8	9
E. HIV/AIDS?	1	2	8	9
F. Other Sexually Transmitted Infections?	1	2	8	9

READ QUESTION 205-206 FROM THE TABLE FOR EACH TOPIC OF SEX EDUCATION:

TOPIC	**205.** Before you were 18 years old, have you ever been taught at school about.? (**READ A-G**)	**206.** How old were you when you first were taught at school about...?
A. Menstrual Cycle	1 YES -->**GO TO Q206** 2 NO --> **GO TO Q205_B** 8 DK --> **GO TO Q205_B** 9 NR --> **GO TO Q205_B**	___ ___
B. Female Reproductive System	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205_C** 8 DR --> **GO TO Q205_C** 9 NR --> **GO TO Q205_C**	___ ___
C. Male Reproductive System	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205_D** 8 DR --> **GO TO Q205_D** 9 NR --> **GO TO Q205_D**	___ ___
D. How Pregnancy Occurs	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205_E** 8 DR --> **GO TO Q205_E** 9 NR --> **GO TO Q205_E**	___ ___
E. Contraceptive Methods	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205_F** 8 DR --> **GO TO Q205_F** 9 NR --> **GO TO Q205_F**	___ ___
F. HIV/AIDS	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205_G** 8 DR --> **GO TO Q205_G** 9 NR --> **GO TO Q205_G**	___ ___
G. Other Sexually Transmitted Diseases	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q207** 8 DR --> **GO TO Q207** 9 NR --> **GO TO Q207**	___ ___

207. In your opinion, who or what was the most important source of information you have had about topics related to sexual matters?

1. MOTHER
2. FATHER
3. RELATIVE
4. BOYFRIEND
5. FRIENDS
6. CO-WORKER
7. COLLEAGUES, PEER
8. PARTNER/HUSBAND
9. DOCTOR
10. NURSE, MIDWIFE
11. TEACHER
12. PHARMACIST
13. BOOKS
14. NEWSPAPERS, MAGAZINES, BROCHURES, FLYERS
15. RADIO
16. TV
20. OTHER (SPECIFY): _____
88. DON'T REMEMBER

208. In your opinion, who is the most appropriate person to teach young people about sexual matters in school **(READ 1-7)**?

1. Biology teacher
2. Teacher with special training in sexuality education
3. Class master
4. School doctor or nurse
5. Other doctor or nurse
7. Other (please specify)_____
8. DO NOT KNOW

III. FERTILITY/PREGNANCY

300. Are you currently pregnant?

1. YES
2. NO--->**GO TO Q305**
3. NOT SURE--->**GO TO Q305**

301. How many months pregnant are you now? ____ MONTHS

302. Just before you get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?

1. WANTED TO GET PREGNANT THEN
2. WANTED TO GET PREGNANT LATER
3. DID NOT WANT THE PREGNANCY THEN OR ANY TIME IN THE FUTURE
8. NOT SURE

303. Is this your first pregnancy?

1. YES
2. NO---------->**GO TO Q307**
8. NOT SURE

304. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

1. YES **---->GO TO PREGNANCY HISTORY, PAGE 8**
2. NO------>**GO TO MODULE IV, PAGE 20**

305. Have you ever been pregnant?

1. YES---------->**GO TO Q307**
2. NO
3. NOT SURE
4. NEVER HAD SEX -->**GO TO MODULE IV, PAGE 20**

306. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

1. YES----->**GO TO PREGNANCY HISTORY, PAGE 8**
2. NO------>**GO TO MODULE IV, PAGE 20**

307. How many children have you given birth to who live with you now?

_____ _____ CHILDREN

308. How many children have you given birth to who do not live with you?

_____ _____ CHILDREN

309. Have you ever had a child born alive who later died, including those who may have died in the first hours or days after birth?

1. YES
2. NO → **GO TO Q311**

310. How many children died? ___ ___ CHILDREN

311. So altogether you had a total of **___ ___ (Q307+Q308+Q310)** live births?

1. YES
2. NO-----**>CHECK Q307, Q308, Q309 AND Q310 AND MAKE CHANGES IF NECESSARY**

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:

#	312	313	314	315	316	317	318
							IF Q313_YR < 2000--->GO TO NEXT PREGNANCY
	How did that pregnancy end?	When did that pregnancy end? (month & year)	How many weeks or months had you been pregnant when that pregnancy ended?	Was the baby a boy or a girl?	Is the child still alive?	How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YRS.)	Just before you get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 99. NR	1. ___ ___ WKS OR 2. ___ ___ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 99. NR	1. ___ ___ WKS OR 2. ___ ___ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 99. NR	1. ___ ___ WKS OR 2. ___ ___ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 99. NR	1. ___ ___ WKS OR 2. ___ ___ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

#	312	313	314	315	316	317	318
							IF Q313B < 2000 --->GO TO NEXT PREGNANCY
	How did that pregnancy end?/	When did that pregnancy end? (month & year)	How many weeks or months had you been pregnant when that pregnancy ended?	Was the baby a boy or a girl?	Is the child still alive?	How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YRS.)	Just before you get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
9	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

#	312	313	314	315	316	317	318 IF Q313_YR <2000 --->GO TO NEXT PREGNANCY
10	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
11	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
12	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
13	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
14	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL **IF Q312=2** 2nd Twin: 1. BOY 2. GIRL	1. YES->**Q318** 2. NO 2nd Twin: 1.YES 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF 2nd Twin age at death: ___ . ___ ___	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

#	312	313	314	315	316	317
	How did that pregnancy end?	When did that pregnancy end? (month & year)	How many weeks or months had you been pregnant when that pregnancy ended?	Was the baby a boy or a girl?	Is the child still alive?	How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS)
15	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
16	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
17	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
18	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
19	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___

#	312	313	314	315	316	317
20	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
21	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
22	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO NEXT PREG**	1. BOY 2. GIRL	1. YES->**NEXT PREG** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___
23	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. MINIABORTION 9. ECTOPIC PREGNANCY	__ __ MTH __ __ __ __YR 98. DK/NR	1. __ __ WEEKS OR 2. __ __ MTHS 8. 8 8 DK 9. 9 9 NR/REF **IF Q312>3** **GO TO BOX 3-1**	1. BOY 2. GIRL	1. YES->**BOX 3-I** 2. NO	1. ___ ___ DAYS 2. ___ ___ MTHS 3. ___ ___ YEARS 8. 8 8 DK 9. 9 9 NR/REF
				IF Q312=2 2nd Twin: 1. BOY 2. GIRL	2nd Twin: 1.YES 2. NO	2nd Twin age at death: ___ . ___ ___

BOX 3-1

THE FOLLOWING QUESTIONS ARE ONLY FOR PREGNANCIES ENDED BETWEEN 2000-2005:

- **IF RESPONDENT HAD AT LEAST ONE LIVE BIRTH, STILLBIRTH, OR AN INDUCED ABORTION (Q312=1-5, 7, 8) THAT ENDED BETWEEN 2000-2005 THEN <u>CONTINUE WITH Q319 ON THE NEXT PAGE;</u>**
- **IF RESPONDENT HAD ONLY MISCARRIAGE(S) OR MOLAR PREGNANCY OR ECTOPIC PREGNANCY(IES) (312=6, 9), <u>GO TO MODULE IV, PAGE 20 AFTER WRITING "0" IN Q319 AND Q338</u>**
- **IF RESPONDENT DID NOT HAVE ANY PREGNANCY ENDED IN 2000-2005 (CHECK Q313_YR), <u>GO TO MODULE IV, PAGE 20 AFTER WRITING "0" IN Q319 AND Q338</u>**

319. HOW MANY INDUCED ABORTIONS (Q312=7,8) DID THE RESPONDENT HAVE BETWEEN JANUARY 2000 AND THE DATE OF THE INTERVIEW (SEE PAGE 8–12)

1. INDUCED ABORTIONS __ __
2. MINIABORTIONS __ __ (IF NO INDUCED ABORTION OR MINIABORTION, GO TO Q338)

319A. COPY LINE #. FROM PREG. PAGE 8–12	**LAST ABORTION __ __**	**NEXT TO LAST AB. __ __**	**SECOND TO LAST AB. __ __**	**THIRD TO LAST AB. __ __**
319B. ABORTION TYPE (SEE Q312)	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**
320. What was the principal reason that you decided to have this abortion?	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER_____	. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER_____	. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER_____	. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER_____
320A. What was the attitude of the child's father toward you having that abortion?	1. FAVORED 2. OPPOSED 3. NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER	1. FAVORED 2. OPPOSED 3. NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER	1. FAVORED 2. OPPOSED 3. NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER	1. FAVORED 2. OPPOSED 3. NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER
321. When you got pregnant with this baby, were you using any method of contraception?	1. YES 2. NO ---------->GO TO Q323 8. DK/NR---------->GO TOQ323	1. YES 2. NO ---------->GO TO Q323 8. DK/NR---------->GO TOQ323	1. YES 2. NO ---------->GO TO Q323 8. DK/NR---------->GO TOQ323	1. YES 2. NO ---------->GO TO Q323 8. DK/NR---------->GO TOQ323
322. What method of contraception was that?	1. PILL 9. INJECTABLE 2. "SPIRALI" 11. CALENDAR 3. CONDOM 12. WITHDRAW. 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRD 20. OTHER_____ 6. SPERMICIDES 88. DR	1. PILL 9. INJECTABLE 2. "SPIRALI" 11. CALENDAR 3. CONDOM 12. WITHDRAW. 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRD 20. OTHER_____ 6. SPERMICIDES 88. DR	1. PILL 9. INJECTABLE 2. "SPIRALI" 11. CALENDAR 3. CONDOM 12. WITHDRAW. 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRD 20. OTHER_____ 6. SPERMICIDES 88. DR	1. PILL 9. INJECTABLE 2. "SPIRALI" 11. CALENDAR 3. CONDOM 12. WITHDRAW. 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRD 20. OTHER_____ 6. SPERMICIDES 88. DR
323. Before this abortion, did you have an ultrasound exam of the pregnancy?	1. YES 2. NO -------**>GO TO Q 325** 8. DK/ DR--------**>GO TO Q325**	1. YES 2. NO -------**>GO TO Q 325** 8. DK/ DR--------**>GO TO Q325**	1. YES 2. NO -------**>GO TO Q 325** 8. DK/ DR--------**>GO TO Q325**	1. YES 2. NO -------**>GO TO Q 325** 8. DK/ DR--------**>GO TO Q325**
324. Did you find out the gender of the baby after the ultrasound?	1. YES 2. NO 8. DON'T KNOW/ DR	1. YES 2. NO 8. DON'T KNOW/ DR	1. YES 2. NO 8. DON'T KNOW/ DR	1. YES 2. NO 8. DON'T KNOW/ DR
325. Where was that abortion performed? (VERIFY IF PRIVATE OR PUBLIC)	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER_____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER_____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER_____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER_____
326. Who performed that abortion?	1. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5. SELF-INDUCED 8. DON'T KNOW/ DR	1. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5. SELF-INDUCED 8. DON'T KNOW/ DR	1. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5. SELF-INDUCED 8. DON'T KNOW/ DR	1. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5. SELF-INDUCED 8. DON'T KNOW/ DR
327. What method was used?	1. D&C 2. VACUUM ASPIRATION 3. OXITOCIN 4. CATHETER 5. MEDICAL ABORTION (RU486) 7. OTHER_____ 8. DON'T KNOW/ DR	1 D&C 2. VACUUM ASPIRATION 3. OXITOCIN 4. CATHETER 5. MEDICAL ABORTION (RU486) 7. OTHER_____ 8. DON'T KNOW/ DR	1 D&C 2. VACUUM ASPIRATION 3. OXITOCIN 4. CATHETER 5. MEDICAL ABORTION (RU486) 7. OTHER_____ 8. DON'T KNOW/ DR	1 D&C 2. VACUUM ASPIRATION 3. OXITOCIN 4. CATHETER 5. MEDICAL ABORTION (RU486) 7. OTHER_____ 8. DON'T KNOW/ DR

CONTINUE ON NEXT PAGE

	LAST ABORTION	NEXT TO LAST AB.	SECOND TO LAST AB.	THIRD TO LAST AB.
328. How much did you pay for that abortion, including gifts or money given to the doctor? **(IF GIFTS CONVERT IN LARI)**	___ ___ ___ LARI 0 0 0 NO CHARGE 8 8 8 DON'T REMEMBER	___ ___ ___ LARI 0 0 0 NO CHARGE 8 8 8 DON'T REMEMBER	___ ___ ___ LARI 0 0 0 NO CHARGE 8 8 8 DON'T REMEMBER	___ ___ ___ LARI 0 0 0 NO CHARGE 8 8 8 DON'T REMEMBER
329. Did you have any local or intravenous anesthesia for that abortion? By local anesthesia we mean an injection in the uterus opening.	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR
330. Did you take any antibiotics after that abortion?	1. YES 2. NO →**GO TO Q331** 8. DK/DR→**GO TO Q331**	1. YES 2. NO →**GO TO Q331** 8. DK/DR→**GO TO Q331**	1. YES 2. NO →**GO TO Q331** 8. DK/DR→**GO TO Q331**	1. YES 2. NO →**GO TO Q331** 8. DK/DR→**GO TO Q331**
330A Who prescribed the antibiotics?	1. OB/GYN 2. GENERAL PRACTITIONER 3. PHARMACIST 4. SELF-MEDICATED 7. OTHER_____	1. OB/GYN 2. GENERAL PRACTITIONER 3. PHARMACIST 4. SELF-MEDICATED 7. OTHER_____	1. OB/GYN 2. GENERAL PRACTITIONER 3. PHARMACIST 4. SELF-MEDICATED 7. OTHER_____	1. OB/GYN 2. GENERAL PRACTITIONER 3. PHARMACIST 4. SELF-MEDICATED 7. OTHER_____
331. Within 30 days after that abortion did you have any health problems as a result of that abortion?	1. YES 2. NO------> **GO TO Q333**	1. YES 2. NO------> **GO TO Q333**	1. YES 2. NO------> **GO TO Q333**	1. YES 2. NO------> **GO TO Q333**
332. Did you have one of the following problems: **(READ A-F)**	YES NO A. Perforation 1 2 B. Severe Bleeding 1 2 C. Fever >38 °C 1 2 D. Purulent Discharge 1 2 E. Belly Pain 1 2 F. Other_____ 1 2	YES NO A. Perforation 1 2 B. Severe Bleeding 1 2 C. Fever >38 °C 1 2 D. Purulent Discharge 1 2 E. Belly Pain 1 2 F. Other_____ 1 2	YES NO A. Perforation 1 2 B. Severe Bleeding 1 2 C. Fever >38 °C 1 2 D. Purulent Discharge 1 2 E. Belly Pain 1 2 F. Other_____ 1 2	YES NO A. Perforation 1 2 B. Severe Bleeding 1 2 C. Fever >38 °C 1 2 D. Purulent Discharge 1 2 E. Belly Pain 1 2 F. Other_____ 1 2
333. How many nights did you spend in the hospital after that abortion (+re-admissions during the first month)?	__ __ NIGHTS 88 DK	__ __ NIGHTS 88 DK	__ __ NIGHTS 88 DK	__ __ NIGHTS 88 DK
334. Did you have any related health problems more than 6 months later as a result of that abortion?	1. YES 2. NO------> **Q336** 3. NOT YET 6 MTH.--->**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------> **Q336** 3. NOT YET 6 MTH.--->**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------> **Q336** 3. NOT YET 6 MTH.--->**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------> **Q336** 3. NOT YET 6 MTH.--->**Q336** 8. DON'T REMEMBER->**Q336**
335. What was the most important health problem?	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____
336. Either before or after the most recent abortion, did a doctor talk to you about contraception?	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO ----->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO ----->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO ----->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO ----->**GO TO Q337A** 8. DON'T REMEMBER
337. After that abortion, did you receive a method of contraception or prescription for a method?	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR PRESCR. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR PRESCR. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR PRESCR. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR PRESCR. 8. DON'T REMEMBER
337A. After that abortion, did a doctor or nurse refer you to a Family Planning clinic?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER

338. HOW MANY PREGNANCIES ENDING IN A STILLBIRTH OR LIVE BIRTH (Q312 = 1, 2, 3, 4 OR 5) DID THE RESPONDENT HAVE BETWEEN JANUARY 2000 AND PRESENT (SEE PAGES 8–12)

1. LIVE BIRTHS (Q312=1, 2 OR 3) ___ ___ __ __
2. STILLBIRTHS (Q312=3, 4 OR 5) ___ ___ (IF NO LIVE BIRTH OR STILLBIRTH GO TO MODULE IV PAGE 20)

339. COPY LINE #. AND HOW ENDED (Q312) FROM PREGNANCY TABLE (PAGES 8–12)	**LAST BIRTH** **Line # ___ ___** **How ended(Q312) ___**	**NEXT TO LAST BIRTH** **Line # ___ ___** **How ended(Q312) ___**	**SECOND TO LAST BIRTH** **Line # ___ ___** **How ended(Q312) ___**
340. During the 6 mths before you found out you were pregnant, how many cigarettes did you smoke a day, on average?	0. NONE ----**>GO TO Q342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER---**>GO TOQ342**	0. NONE ----**>GO TOQ342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER---**>GO TOQ342**	0. NONE ----**>GO TOQ342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER---**>GO TOQ342**
341. On the average, how many cigarettes did you smoke per day after you found out that you were pregnant?	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER
342. How many times per week did you drink alcoholic beverages during that pregnancy?	1. 4 TIMES OR MORE /ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER	1. 4 TIMES OR MORE /ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER	1. 4 TIMES OR MORE/ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER
343. When you got pregnant with this baby, were you using any method of contraception?	1. YES 2. NO ----------->GO TO Q345 8. DON'T REMEMBER-->GO TO Q345	1. YES 2. NO ----------->GO TO Q345 8. DON'T REMEMBER -->GO TO Q345	1. YES 2. NO ----------->GO TO Q345 8. DON'T REMEMBER -->GO TO Q345
344. What method of contraception was that?	1. PILL 9. INJECTABLES 2. "SPIRALI"(IUD) 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR	1. PILL 9. INJECTABLES 2. "SPIRALI"(IUD) 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5.CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR	1. Pill 9. INJECTABLES 2. "SPIRALI" 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR
345. How many weeks or months pregnant were you when you learned that you were pregnant that time?	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR
346. During that pregnancy, did you have any prenatal care visits?	1. YES 2 NO---**>GO TO Q355** 8. DON'T REMEMBER-**>GO TO Q355**	1. YES 2 NO---**>GO TO Q355** 8. DON'T REMEMBER-**>GO TO Q355**	1. YES 2 NO---**>GO TO Q355** 8. DON'T REMEMBER-**>GO TO Q355**
347. How many weeks or months pregnant were you at the time of your first prenatal care visit?	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 8 88 DK/DR
348 How many prenatal visits did you have during the pregnancy?	___ ___ VISITS 88. DK 99. REF	___ ___ VISITS 88. DK 99. REF	___ ___ VISITS 88. DK 99. REF
349. Where did you receive most of the prenatal care visits?	1. RURAL AMBULATORY 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER_____	1. RURAL AMBULATORY 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER_____	1. RURAL AMBULATORY 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER_____
350. Who provided most of the prenatal care?	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER 7. OTHER_____	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER 7. OTHER_____	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER 7. OTHER_____
351. During those visits, did you receive any information about: **(READ A-H):**	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
352. During this pregnancy, were any of the following done at least once: A. Were you weighed? B. Was your height measured? C. Did you give a urine sample? D. Did you give a blood sample? E Were you tested for HIV?	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2 E. HIV TESTED 1 2	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2 E. HIV TESTED 1 2	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2 E. HIV TESTED 1 2
353. During those visits, did you have your blood pressure measured?	1. YES 2. NO------>**GO Q355** 8. DON'T REMEMBER-->**GO TO Q355**	1. YES 2. NO------>**GO Q355** 8. DON'T REMEMBER-->**GO TO Q355**	1. YES 2. NO------>**GO Q355** 8. DON'T REMEMBER-->**GO TO Q355**
354. During those visits, were you ever told that you have high blood pressure?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER
355. Did you have an ultrasound (US) exam during that pregnancy?	1. YES 2. NO------>**GO TO Q357** 8. DON'T REMEMBER->**GO TOQ357**	1. YES 2. NO------>**GO TOQ357** 8. DON'T REMEMBER->**GO TOQ357**	1. YES 2. NO------>**GO TOQ357** 8. DON'T REMEMBER->**GO TOQ357**
356. How many weeks or months pregnant were you at the time of your first US?	1. ___ ___ WEEKS OR 2. ___ ___ MONTHS 888 DK/DR	1. ___ ___ WEEKS OR 2. ___ ___ MONTHS 888 DK/DR	1. ___ ___ WEEKS OR 2. ___ ___ MONTHS 888 DK/DR
357. Did you find out the gender of the baby after the US?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER
357A. During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus (convulsions after birth)?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER
358. During this pregnancy, have you taken any iron supplements (iron tablets, injection or iron syrup) ?	1. YES 2. NO ---------->**GO TO Q360** 8. DON'T REMEMBER -->**GO TO Q360**	1. YES 2. NO ---------->**GO TO Q360** 8. DON'T REMEMBER ->**GO TO Q360**	1. YES 2. NO ---------->**GO TO Q360** 8. DON'T REMEMBER ->**GO TO Q360**
358A. In what week or month of pregnancy did you start taking iron supplements?	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR	1. ____ ____ WEEKS OR 2. ____ ____ MONTHS 888 DK/DR
359. How often did you take iron supplements?	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR
360. During that pregnancy, did you have **a**ny complications that required medical attention?	1. YES 2. NO------>**GO TO Q364** 8. DON'T REMEMBER-->**GO TO Q364**	1. YES 2. NO------>**GO TO Q364** 8. DON'T REMEMBER--->**GO TO Q364**	1. YES 2. NO------>**GO TO Q364** 8. DON'T REMEMBER--->**GO TO Q364**
361. What complications did you have? Did you have: **(READ EACH CONDITION FROM A-K)**	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mth 1 2 C. Bleeding at 6 Mths or More 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 I. Risk of Preterm Delivery 1 2 J. Rh Isoimmunization 1 2 K. Other_____ 1 2	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mth 1 2 C. Bleeding at 6 Mths or More 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 I. Risk of Preterm Delivery 1 2 J. Rh Isoimmunization 1 2 K. Other_____ 1 2	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mth 1 2 C. Bleeding at 6 Mths or More 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 I. Risk of Preterm Delivery 1 2 J. Rh Isoimmunization 1 2 K. Other_____ 1 2
362. Not including the delivery, how many times were you hospitalized for pregnancy complications?	____ ____ TIMES 00. NEVER HOSP. 88. DK/DR **IF "00" GO TO Q364**	____ ____ TIMES 00. NEVER HOSP. 88. DK/DR **IF "00" GO TO Q364**	____ ____ TIMES 00. NEVER HOSP. 88. DK/DR **IF "00" GO TO Q364**
363. Altogether, how many nights were you in the hospital for these complications?	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR
364. Where did you give birth to this baby?	1. GOVT. HOSPITAL, MATERNITY 2. TBILISI MATERNITY HOSP. 3. OTHER MEDICAL FACILITY 4. AT HOME-----> **Q370** 5. ON THE WAY TO HOSP.----> **Q366**	1. GOVT. HOSPITAL, MATERNITY 2. TBILISI MATERNITY HOSP. 3. OTHER MEDICAL FACILITY 4. 4. AT HOME-----> **Q370** 5. ON THE WAY TO HOSP.----> **Q366**	1. GOVT. HOSPITAL, MATERNITY 2. TBILISI MATERNITY HOSP. 3. OTHER MEDICAL FACILITY 4. 4. AT HOME-----> **Q370** 5. ON THE WAY TO HOSP.----> **Q366**
365. How much did you pay for that delivery, including gifts or money given to the doctor? **(IF GIFTS CONVERT IN LARI)**	___ ___ ___ ___ LARI 0 0 0 0 NO CHARGE 8 8 8 8 N)'T REMEMBER	___ ___ ___ ___ LARI 0 0 0 0 NO CHARGE 8 8 8 8 N)'T REMEMBER	___ ___ ___ ___ LARI 0 0 0 0 NO CHARGE 8 8 8 8 N)'T REMEMBER

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
366. How many nights were you in that place after delivery?	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88. DK/DR
367. Where was your husband or partner at the time of delivery, was he: **(READ 1–5)**	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home or with friends 4. At Work 5. Traveling 8. DK/DR	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home or with friends 4. At Work 5. Traveling 8. DK/DR	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home or with friends 4. At Work 5. Traveling 8. DK/DR
368. Was that baby born by vaginal delivery, forceps, or C-section?	1. VAGINAL DELIVERY->**GO TO Q370** 2. FORCEPS ->**GO TO Q370** 3. VACUUM EXTRACTION--->**Q370** 4. CESAREAN SECTION	1.VAGINAL DELIVERY-->**GO TO Q370** 2. FORCEPS ->**GO TO Q370** 3. VACUUM EXTRACTION--->**Q370** 4. CESAREAN SECTION	1. VAGINAL DELIVERY->**GO TO Q370** 2. FORCEPS ->**GO TOQ370** 3. VACUUM EXTRACTION---->**Q370** 4. CESAREAN SECTION
369. Do you know what was the most important reason that you had to deliver by cesarean section ?	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C- SECTION 7. ON REQUEST 20. OTHER_____ 88. DON'T KNOW	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C- SECTION 7. ON REQUEST 20. OTHER_____ 88. DON'T KNOW	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C- SECTION 7. ON REQUEST 20. OTHER_____ 88. DON'T KNOW
370. How long had you been in labor with that pregnancy (regular contractions 5' apart)	___ ___ HOURS 77. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 77. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 77. C-SECTION BEFORE LABOR 88. DK/DR
371. Who attended the delivery of that child?	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER_____ 5. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER_____ 5. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER_____ 5. UNATTENDED
372. How much did the baby weigh at birth?	___ ___ ___ ___ GRAMS-->**GO TO Q374** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS--->**GO TO Q374** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS-->**GO TO Q374** 8888 DON'T KNOW
373. Do you know if the baby weighed less than 2500 g or was considered too small?	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR
374. During the first 6 weeks after birth, did you have any of the following complications: **(READ A-I)**	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 G. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 G. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 G. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2
375. After leaving the hospital (DO NOT READ IF HOME DELIVERY) did you have any post-delivery check-ups?	1. YES 2. NO ----->**GO TO Q378** 8. DO NOT REMEMBER-->**GO TO Q378**	1. YES 2. NO ----->**GO TO Q378** 8. DON'T REMEMBER -->**GO TO Q378**	1. YES 2. NO ----->**GO TO Q378** 8. DO NOT REMEMBER ->**GO TO Q378**
376. How many days or weeks after the delivery did the first check take place?	1. ___ ___ DAYS 000. SAME DAY OR 888. DON'T REMEMBER 2. ___ ___ WEEKS	1. ___ ___ DAYS 000. SAME DAY OR 888. DON'T REMEMBER 2. ___ ___ WEEKS	1. ___ ___ DAYS 000. SAME DAY OR 888. DON'T REMEMBER 2. ___ ___ WEEKS
377. During those visit(s) did you receive information about: **(READ A-F)**	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2
378. For how many months after birth did you not have a period?	___ ___ MONTHS 88. DK/DR 77. NOT YET	___ ___ MONTHS 88. DK/DR	___ ___ MONTHS 88. DK/DR
379. How many months after birth did you resume sexual relations?	___ ___ MONTHS 88. DK/DR 77. NOT YET	___ ___ MONTHS 88. DK/DR	___ ___ MONTHS 88. DK/DR

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
380. COPY FROM Q339 HOW THE PREGNANCY ENDED	1. SINGLE LIVE BIRTH 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. SINGLE STILLBIRTH -→ **NEXT BRTH** 5. MULTIPLE STILLBIRTH>**NEXTBRTH**	1. SINGLE LIVE BIRTH 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. SINGLE STILLBIRTH -→ **NEXT BRTH** 5. MULTIPLE STILLBIRTH>**NEXTBRTH**	1. SINGLE LIVE BIRTH 2. MULTIPLE LIVE BIRTH 3. MULTIPLE (LB WITH SB) 4. SINGLE STILLBIRTH→ **MODULE IV** 5. MULTIPLE STLLBIRTH→ **MODULE IV**
INTERVIEWER: IF THE PREGNANCY RESULTED IN A MULTIPLE LIVE BIRTH (Q380=2) THEN THE FOLLOWING QUESTIONS REFER TO THE FIRST TWIN. IF THE PREGNANCY ENDED IN A MULTIPLE (LB WITH SB) (Q380=3) THEN THE QUESTIONS REFER TO THE LIVE BIRTH			
381. After leaving the hospital (DO NOT READ IF HOME DELIVERY) did a health professional check on the baby's health?	1. YES 2. NO ----->**GO TO Q384** 3. NO, BABY DIED----->**GO TO Q384** 8. DO NOT REMEMBER-->**GO TO Q384**	1. YES 2. NO ----->**GO TO Q384** 3. NO, BABY DIED----->**GO TO Q384** 8. DO NOT REMEMBER-->**GO TO Q384**	1. YES 2. NO ----->**GO TO Q384** 3. NO, BABY DIED----->**GO TO Q384** 8. DO NOT REMEMBER ->**GO TO Q384**
382. How many days or weeks after delivery did the first health check take place?	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER
383. Was the health check because the baby was sick or was it a routine health exam?	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER
383A. Who provided most of the baby's health checks?	1. GENERAL PRACTITIONER 2. PEDIATRICIAN 3. NURSE/MIDWIFE 7. OTHER_____	1. GENERAL PRACTITIONER 2. PEDIATRICIAN 3. NURSE/MIDWIFE 7. OTHER_____	1. GENERAL PRACTITIONER 2. PEDIATRICIAN 3. NURSE/MIDWIFE 7. OTHER_____
384. How many days or weeks after the delivery did you register the baby at the city/village council?	1. ___ ___ DAYS 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	**1**. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED NOT REGISTERED 888. DO NOT REMEMBER
385. Did you breastfeed this child?	1. YES 2. NO-------->**GO TO Q387**	1. YES 2. NO ----->**GO TO Q387**	1. YES 2. NO---------->**GO TO Q387**
386. How long after birth did you start breastfeeding?	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.
387. CHECK PREGNANCY HISTORY (Q316 AND Q385) IS THIS CHILD STILL ALIVE?	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED → **GO TO Q393** 3 DIED → **GO TO Q392**	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED → **GO TO Q393** 3 DIED → **GO TO Q392**	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED → **GO TO Q393** 3 DIED → **GO TO Q392**
388. Are you still breastfeeding?	1. YES ----->**GO TO Q390** 2. NO	1. YES ----->**GO TO Q390** 2. NO	1. YES ----->**GO TO Q390** 2. NO
389. How old was the baby when you stopped breastfeeding?	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
	GO TO Q393	**GO TO Q393**	**GO TO Q393**
390. In the period of time from 6am yesterday to 6am today how many times did you breastfeed this child?	__ __ NUMBER FEEDINGS	__ __ NUMBER FEEDINGS	__ __ NUMBER FEEDINGS
391. In the period of time from 6am yesterday to 6am today did you give this child any of the following:?	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2
	GO TO Q393	**GO TO Q393**	**GO TO Q393**
392. Did you register the death of this child with the civil registry?	1. YES 2. NO 8. DO NOT REMEMBER	1. YES 2. NO 8. DO NOT REMEMBER	1. YES 2. NO 8. DO NOT REMEMBER
393. COPY FROM Q380 HOW THE PREG ENDED	1. SINGLE LIVE BIRTH->**NEXT BIRTH** 2. MULTIPLE LIVE BIRTH 3. MULTIPLE(LB & SB)>**NEXT BIRTH**	1. SINGLE LIVE BIRTH->**NEXT BIRTH** 2. MULTIPLE LIVE BIRTH 3. MULTIPLE(LB & SB)>**NEXT BIRTH**	1. SINGLE LIVE BIRTH→ **400** 2. MULTIPLE LIVE BIRTH 3. MULTIPLE(LB & SB)→**400**

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
	ASK THE FOLLOWING FOR THE SECOND TWIN	**ASK THE FOLLOWING FOR THE SECOND TWIN**	**ASK THE FOLLOWING FOR THE SECOND TWIN**
T381. After leaving the hospital (DO NOT READ IF HOME DELIVERY) did a health professional check on the baby's health?	1. YES 2. NO -----**>GO TO T384** 3. NO, BABY DIED-----**>GO TO T384** 8. DO NOT REMEMBER **-->GO TO T384**	1. YES 2. NO -----**>GO TO T384** 3. NO, BABY DIED-----**>GO TO T384** 8. DO NOT REMEMBER-->**GO TO T384**	1. YES 2. NO -----**>GO TO T384** 3. NO, BABY DIED-----**>GO TO T384** 8. DO NOT REMEMBER **->GO TO T384**
T382. How many days or weeks after delivery did the first health check take place?	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. SAME DAY 888. DO NOT REMEMBER
T383. Was the health check because the baby was sick or was it a routine health exam?	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER	1. HEALTH CHECK FOR SICKNESS 2. ROUTINE HEALTH CHECK 8. DO NOT REMEMBER
T384. How many days or weeks after the delivery did you register the baby at the city/village council?	1. ___ ___ DAYS 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000. NOT REGISTERED YET 777. BABY DIED NOT REGISTERED 888. DO NOT REMEMBER
T385. Did you breastfeed this child?	1. YES 2. NO-------**>GO TO T387**	1. YES 2. NO -----**>GO TO T387**	1. YES 2. NO----------**>GO TO T387**
T386. How long after birth did you start breastfeeding?	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.	1. __ __ HOURS 777. LESS THAN 1HR OR 2. __ __ DAYS 888. DON'T REMEMB.
T387. CHECK PREGNANCY HISTORY (Q316 AND Q385) IS THIS CHILD STILL ALIVE?	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED **→ GO TO T393** 3 DIED **→ GO TO T392**	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED **→ GO TO T393** 3 DIED **→ GO TO T392**	1. STILL ALIVE, EVER BREASTFED 2. STILL ALIVE, NEVER BREASTFED **→ GO TO T393** 3 DIED **→ GO TO T392**
T388. Are you still breastfeeding?	1. YES -----**>GO TO T390** 2. NO	1. YES -----**>GO TO T390** 2. NO	1. YES -----**>GO TO T390** 2. NO
T389. How old was the baby when you stopped breastfeeding?	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
	GO TO NEXT BIRTH – Q339	**GO TO NEXT BIRTH – Q339**	**GO TO Q400**
T390. In the period of time from 6am yesterday to 6am today how many times did you breastfeed this child?	__ __ NUMBER FEEDINGS	__ __ NUMBER FEEDINGS	__ __ NUMBER FEEDINGS
T391. In the period of time from 6am yesterday to 6am today did you give this child any of the following:?	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2	YES NO A. Water 1 2 B. Milk other than Breastmilk 1 2 C. Formula 1 2 D. Juice, Tea or other liquids 1 2 E. Semisolid foods 1 2 F. Solid foods 1 2
	GO TO NEXT BIRTH – Q339	**GO TO NEXT BIRTH – Q339**	**GO TO Q400**
T392. Did you register the death of this child with the civil registry?	1. YES 2. NO 8. DO NOT REMEMBER	1. YES 2. NO 8. DO NOT REMEMBER	1. YES 2. NO 8. DO NOT REMEMBER
	GO TO NEXT BIRTH – Q339	**GO TO NEXT BIRTH – Q339**	**GO TO Q400**

MODULE 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.** What was the most important source of information about this method **(SEE CODES BELOW)**
A. The Pill (Oral Contraceptives)	1 YES→Q401 2 NO-→B	1 YES→Q402 2 NO→Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
B. IUD (*Spirali*)	1 YES→Q401 2 NO-→C	1 YES→Q402 2 NO→Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
C. Condoms (*Prezervativ)*	1 YES-->Q401 2 NO--->D	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
D. Foam/Jelly/ Cream/Foamy Tablets or other Local Spermicides (e.g. Pharmatex)	1 YES-->Q401 2 NO--->E	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
E. Tubal Ligation (Femle Sterilization)	1 YES-->Q401 2 NO--->F	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
F. Vasectomy (Male Sterilization)	1 YES-->Q401 2 NO--->G	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
G. Injectables (e.g. Depo-Provera, Norplant)	1 YES-->Q401 2 NO--->H	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
H. Emergency Hormonal Contraception (“Morning After Pill”; Postinor)	1 YES-->Q401 2 NO--->I	1 YES-->Q402 2 NO-->Q402	1 YES→Q403 2 NO→ Q403	1 YES→Q404 2 NO→ Q404	__ __
I. Rhythm/Calendar Method	1 YES-->Q401 2 NO--->J	1 YES-->Q402 2 NO-->Q402	1 YES→Q404 2 NO→ Q404		__ __
J. Withdrawal (Coitus Interruptus)	1 YES-->Q401 2 NO--->K	1 YES-->Q402 2 NO--->Q402	1 YES→Q404 2 NO→ Q404		__ __
K. Other contraceptive methods (SPECIFY): _____	1 YES-->Q401 2 NO--->Q405	1 YES-->Q402 2 NO--->Q402	1 YES→Q404 2 NO→ Q404		__ __

CODES FOR Q404 (DO NOT READ)

1. MOTHER
2. FATHER
3. RELATIVE
4. BOYFRIEND
5. FRIENDS
6. CO-WORKER
7. COLLEAGUES, PEER
8. PARTNER/HUSBAND
9. DOCTOR
10. NURSE, MIDWIFE, FELDCHER
11. COMMUNITY HEALTH WORKER
12. TEACHER
13. PHARMACIST .....
14. BOOKS
15 NEWSPAPERS, MAGAZINES, BROCHURE, FLYERS
16. RADIO
17. TV
20. OTHER (SPECIFY): _____
88. DON'T REMEMBER

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

1. The Pill
2 IUD ("SPIRALI")
3. Condom
4. Norplant
6. Foams/jelly/creams/Foamy Tablets
7. Tubal Ligation (Female Sterilization)
8. Emergency Hormonal Contraception ("Morning After Pill")
9. Injectables (Depo-Provera)
10. Vasectomy (Male Sterilization)
11. Rhythm Method
12. Withdrawal
77. NONE OF THEM
88. DON'T KNOW/NOT SURE

406. How would you rate each of the following methods with regard to effectiveness at preventing pregnancy? Would you say that _____ is very effective, effective, somewhat effective, not very effective or not at all effective? (INTERVIEWER: ASK THE QUESTION FOR EACH OF THE METHODS LISTED BELOW, UNLESS RESPONDENT HAS SAID IN Q400 THAT SHE NEVER HEARD OF THAT SPECIFIC METHOD; MARK "9" FOR THOSE CASES WITHOUT ASKING)

	Very Effective	**Effective**	**Somewhat Effective**	**Not Effect.**	**DO NOT KNOW**	**NEVER HEARD**
1. The Pill	1	2	3	4	8	9
2. IUD ("SPIRALI")	1	2	3	4	8	9
3. Condom	1	2	3	4	8	9
7. Tubal Ligation	1	2	3	4	8	9
9. Injectables	1	2	3	4	8	9
11. Calendar	1	2	3	4	8	9
12. Withdrawal	1	2	3	4	8	9

407F. CHECK CURRENT AGE OF RESPONDENT (Q101):
1. 15 TO 24
2. 25 TO 44 ----------→ GO TO Q420

408. How old were you when you had your first menstruation __ __ AGE.

00. NOT YET
88. DON'T REMEMBER
99. REFUSE TO ANSWER

409. Did you know what menstruation was at that time?

1. YES
2. NO
8. NOT SURE

410. 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?)**

___ ___ MONTH ___ ___ ___ ___ YEAR

00. NEVER HAD INTERCOURSE→**GO TO Q601, PG 36**
88. DON'T REMEMBER
99. REFUSE TO ANSWER

411. How old were you at that time? ___ ___ YEARS 88. DON'T REMEMBER

411A How would you describe the first time that you had sex? Would you say that you wanted to have sex, you did not want to have sex but it happened anyway, or were you forced to have sex?

1. WANTED TO HAVE SEX
2. NOT WANT BUT HAD SEX
3. FORCED TO HAVE SEX
8. DON'T KNOW/DON'T REMEMBER
9. REFUSED

412. At the time you first had sexual intercourse, what was your relationship to that man?

1. HUSBAND, CONSENSUAL PARTNER
2. FIANCEE
3. BOYFRIEND
4. FRIEND
5. LOVER
6. ACQUAINTANCE
7. JUST MET------>**GO TO Q414**
8. RELATIVE
9. RAPE---------->**GO TO Q421**
10.. INCEST---------->**GO TO Q421**
20. OTHER(SPECIFY) _____
88. DO NOT REMEMBER/REF

413. 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_____

414. How old was your first partner? ___ ___ YEARS
88. DON'T REMEMBER
99. REFUSED

415. Before you had sex for the first time, did you and your partner ever talk about using contraception?

1. YES
2. NO
8. DON'T REMEMBER

416. At the time you had first sexual intercourse, did you or your partner use any contraceptive method?

1. YES
2. NO --->**GO TO Q419**
8. DK/DO NOT REMEMBER --->**GO TO Q421**
9. REF --->**GO TO Q421**

417. Which contraceptive method did you or your partner use at the first intercourse?

1 THE PILL
2 "SPIRALI" (IUD)
3 CONDOM
6 FOAM/JELLY/CREAM/VAGINAL FILMS
8 EMERGENCY HORMONAL CONTRACEPTION
9 INJECTABLES
10 OTHER MODERN METHODS_____
11 CALENDAR METHOD
12 WITHDRAWAL
19 DOUCHE
20 OTHER: _____
88 DON'T KNOW/DON'T REMEMBER

418. Who made the 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 Q421

419. What was the main reason for not using a contraceptive method at that time?

1. SEX WAS NOT EXPECTED
2. THOUGHT IT WAS A SAFE TIME OF THE MONTH
3. DID NOT KNOW WHERE TO GET A METHOD//DIFFICULT TO GET/NOT AVAILABLE
4. RESPONDENT WAS AGAINST IT
5. PARTNER WAS AGAINST IT
6. DID NOT KNOW ABOUT CONTRACEPTION
7. WANTED TO GET PREGNANT
8. THOUGHT THAT CONTRACEPTIVE METHODS ARE HARMFUL
9. DID NOT THINK ABOUT USING A METHOD/NEGLIGENCE
10. RESPONDENT AFRAID OF PARTNER'S REACTION
11. TOO DRUNK (PARTNER OR RESPONDENT)
12. RESPONDENT WAS TOO EMBARRASSED TO USE A METHOD
20. OTHER (SPECIFY) _____
88. DON'T REMEMBER/DON'T KNOW

GO TO Q421

420. How old were you at the time of your first sexual intercourse?

___ ___ YEARS

00. NEVER HAD INTERCOURSE----**>GO TO Q601 PAGE 36**
88. DK/DR

421. During the past 30 days (past month) have you had sexual intercourse?

1. YES
2. NO --->**GO TO Q423**
9. REF --->**GO TO Q423**

422. How often have you had sexual intercourse during the past 30 days (**READ 1-5**)?

1. Every day
2. 3-5 times per week,
3. 1-2 times per week,
4. 2-3 times per month, or
5. Only once
9. REF

GO TO Q424

423. During the past 3 months, have you had sexual intercourse?

1. YES
2. NO **--->GO TO Q425**
9. REF **--->GO TO Q425**

424. During the past 3 months, with how many different men have you had intercourse? Please count every sexual partner, even those you had sex with only once.

___ ___ PARTNERS
88. DK
99. NR

425. When was the last time you had sexual intercourse?

___ ___ MONTH ___ ___ ___ ___ YEAR
88. DK/DR
99. REFUSE TO ANSWER

426. At the time of your last intercourse, what was your relationship with that man?

1. HUSBAND, CONSENSUAL PARTNER
2. FIANCEE
3. BOYFRIEND
4. FRIEND
5. LOVER
6. ACQUAINTANCE
7. JUST MET
8. RELATIVE
9. RAPE----------**>GO TO Q431**
10.. INCEST----------**>GO TO Q431**
20. OTHER(SPECIFY) _____
88. DO NOT REMEMBER/REF

427. At the time you had your last sexual intercourse, did you or your partner use any contraceptive method?

1. YES
2. NO ---------**>GO TO Q431**
9. DK/REF --->**GO TO Q431**

428. Which contraceptive method did you or your partner use at the last intercourse?

1. THE PILL
2. "SPIRALI" (IUD)
3. CONDOM
4. CONDOM +SPERMICIDE
5. CONDOM +WITHDRAWAL/CALENDAR
6. FOAM/JELLY/CREAMS/C-FILMS
7. TUBAL LIGATION (FEMALE STERILIZATION)
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES(DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS_____
88. NOT SURE

429. Was a condom used the last time you had sexual intercourse (DO NOT ASK IF ALREADY MENTIONED)?
1. YES
2. NO----------→ **GO TO Q431**
3. DON'T REMEMBER-----→ **GO TO Q431**

430. The last time you had sexual intercourse did you use the condom to:

1. To prevent pregnancy,
2. To prevent sexually transmitted diseases,
3. For both reasons,
4. Or for some other reason?

431. Counting all the men you had sexual intercourse with, even only once, how many partners have you had sexual intercourse with in your life?

___ ___ PARTNERS
85. 85+ PARTNERS
88. DK
99. NR

V. CURRENT AND PAST CONTRACEPTIVE USE

501. RECORD WHETHER RESPONDENT REPORTED HAVING USED ANY METHOD (ANY Q402=1 AT PG.20)

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

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

1. NEVER USED--->**GO TO Q515, PAGE 27**
2. EVER USED--->**CORRECT Q402 THEN CONTINUE**

503. Are you (or your partner) **currently** using (in the last 30 days) any method or doing anything to prevent pregnancy?

1. YES
2. NO--->**GO TO Q515 PAGE 27**

504. What method are you currently using?

1. THE PILL
2. "SPIRALI" (IUD)
3. CONDOM---------->**GO TO Q506**
4. CONDOM +SPERMICIDE--->**GO TO Q506**
5. CONDOM +WITHDRAWAL/CALENDAR->**GO TO Q506**
6. FOAM/JELLY/CREAMS/C-FILMS
7. TUBAL LIGATION (FEMALE STERILIZATION)
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES(DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS_____
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

505F. CHECK QUESTION 504 (IF CURRENT METHOD IS COITAL-SPECIFIC):
1. Q504=3,4,5,6,8,12,13,20
2. Q504=1,2,7,9,10,11----------→GO TO Q507

506. In the last 30 days how often did you/your partner use this method (METHOD MENTIONED IN Q504) (**READ 1-4**)?

1. Always, at each sexual intercourse,
2. Almost always,
3. Sometimes,
4. Only once
9. REFUSE TO ANSWER

507. What was the most important reason for choosing this method?

1. A DOCTOR RECOMMENDED
2. AFFORDABLE COST
3. VERY EFFECTIVE
4. VERY SAFE (FEW OR NO SIDE EFFECTS)
5. SAW ADS (TV, RADIO, PRESS, BROCHURES)
6. EASY TO USE
7. PARTNER PREFERS IT
8. KNOWS SOMEBODY WHO USES IT
9. CURIOSITY/WANTED TO TRY IT
10. ALLOWS SPONTANEITY DURING INTERCOURSE
11. RELIGIOUS BELIEVES
20. OTHER_____
88. DO NOT KNOW/ DO NOT REMEMBER

507F. CHECK QUESTION 504 (IF CURRENT METHOD IS TRADITIONAL):
1. Q504=11,12,13,20
2. Q504= 1-10 OR 88 ----------→GO TO Q510

508. Please tell me whether each of the following reasons was very important, somewhat important, or not important at all in your decision to use _____ (**CODE FROM Q504 FOR TRADITIONAL METHOD**) instead of a modern method:

	Very Important	Somewhat Important	Not Important	Not Sure
A. Difficult to get a modern method	1	2	3	8
B. Cost of these modern methods	1	2	3	8
C. Little knowledge of modern methods	1	2	3	8
D. Fear of or experience with side effects	1	2	3	8
E. Husband/Partner choice	1	2	3	8
F. Religious beliefs	1	2	3	8
G. Doctor's recommendation	1	2	3	8
H. Another person's advice	1	2	3	8

509. How effective at preventing pregnancy do you think _____ (**CODE FROM Q504 FOR TRADITIONAL METHOD**) is compared to modern methods, like the pill or "Spirali" ? **(READ 1–3)**

1. Current method more effective
2. About equally effective
3. Current method less effective
8. DON'T KNOW/NOT SURE

510. Do you have any problems or concerns with using your current method?

1. YES
2. NO--->**GO TO Q512**

511. What is the most important problem?

1. EXPERIENCED SIDE EFFECTS
2. HEALTH CONCERNS
3. SOMETIMES NOT AVAILABLE
4. COST
5. SOMETIMES FORGET TO USE
6. SOMETIMES DIFFICULT/INCONVENIENT TO USE
7. HUSBAND/PARTNER DISAPPROVES
8. LESS EFFECTIVE METHOD/GOT PREGNANT WHILE USING IT
9. DEEPLY UNSATISFIED WITH THE METHOD
10. SOURCE FOR THE METHOD IS TOO FAR
20. OTHER_____

512. Would you prefer to use a different method of family planning from the one you are currently using?

1. YES
2. NO--->**GO TO Q521**

513. What method would you prefer to use (**OTHER THAN THE METHOD SPECIFIED IN Q504**)?

1. THE PILL
2. "SPIRALI" (IUD)
3. CONDOM
4. CONDOM +SPERMICIDE
5. CONDOM +WITHDRAWAL/CALENDAR-
6. FOAM/JELLY/CREAMS/C-FILMS
7. TUBAL LIGATION (FEMALE STERILIZATION)
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES (DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS_____
88. DO NOT KNOW/NOT SURE

514. 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 TO OBTAIN
4. TOO FAR AWAY
5. DO NOT KNOW HOW/WHERE 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
10. DIFFICULT TO USE
11. FEAR OF SURGICAL PROCEDURE (IUD, TUBAL LIGATION, NORPLANT)
20. OTHER_____
88. DON'T KNOW

GO TO Q 521 PAGE 28

515. What is the main reason that you or your partner are not currently using a contraceptive method?

1. DOES NOT CURRENTLY HAVE A PARTNER/ NOT SEXUALLY ACTIVE IN THE LAST MONTH
2. TRYING TO GET PREGNANT
3. POSTPARTUM/ BREASTFEEDING
4. CURRENTLY PREGNANT
5. HYSTERECTOMY/MENOPAUSE----------->**GO TO Q523**
6. DOCTOR SAID SHE OR HER PARTNER CANNOT HAVE CHILDREN----------> **GO TOQ523**
7. SHE/COUPLE TRIED TO GET PREGNANT FOR AT LEAST 2 YEARS AND DIDN'T SUCCEED --->**Q523**
8. FEAR OF SIDE EFFECTS
9. LOVEMAKING WOULD BE INTERRUPTED
10. RESPONDENT DID NOT THINK ABOUT USING CONTRACEPTION
11. COST, CANNOT AFFORD BIRTH CONTROL
12. CONTRACEPTION IS THE PARTNER'S RESPONSIBILITY
13. CONTRACEPTION IS NOT (VERY) EFFECTIVE
14. RESPONDENT DOES NOT WANT TO USE A METHOD/DOES NOT LIKE TO USE A METHOD
15. PARTNER OBJECTS TO USING METHOD
16. OBJECTS DUE TO RELIGIOUS REASONS
17. DOES NOT KNOW WHERE TO GET METHOD
18. RESPONDENT DOES NOT KNOW HOW TO USE BIRTH CONTROL METHODS
19. RESPONDENT DOES NOT THINK THAT SHE CAN GET PREGNANT
20. RESPONDENT USES DOUCHING
77. OTHER (SPECIFY) _____
88. DK/REF

516. Do you think that you will use a contraceptive method during the next 12 months (ADD:OTHER THAN BREASTFEEDING OR DOUCHING IF Q515=2 OR Q515=20)?

1. YES --------> **GO TO Q518**
2. NO
8. NOT SURE

517. Do you think that you will use a contraceptive method any time in the future?

1. YES
2. NO ----------> **GO TO Q521**
8. NOT SURE --------> **GO TO Q521**

518. What method would you want to use most?

1. THE PILL
2. "SPIRALI" (IUD)
3. CONDOM
4. CONDOM +SPERMICIDE
5. CONDOM +WITHDRAWAL/CALENDAR-
6. FOAM/JELLY/CREAMS/C-FILMS
7. FEMALE STERILIZATION
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES(DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR----------**>GO TO Q521**
12. WITHDRAWAL----------**>GO TO Q521**
13. WITHDRAWAL + CALENDAR----------**>GO TO Q521**
20. OTHER TRADITIONAL METHODS_____----------**>GO TO Q521**
88. NOT SURE----------**>GO TO Q521**

519. On average, how much are you willing to pay for contraception, per month?

____ ____ LARI

85. 85+ LARI
98. NOT SURE/DON'T KNOW

520. Where would you want to get your contraceptive method?

1. RURAL AMBULATORY (FAP, DAC)
2. VILLAGE HOSPITAL
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. GOV HOSPITAL-GYN WARD
6. GOV HOSPITAL-MATERNITY WARD
7. PRIVATE CLINIC OR OFFICE
8. NGO
9. PHARMACY
10. OPEN MARKET, BAZAAR
11. STORE/ KIOSK
12. PARTNER/HUSBAND
13. FRIEND
14. RELATIVE
20. OTHER (SPECIFY): _____
88. DON'T KNOW

521. During the last year, how often did you talk about contraception with your husband/ partner?

1. NEVER----------->**GO TO Q523**
2. ONE OR TWO TIMES
3. THREE TIMES OR MORE
4. RESPONDENT HAD NO PARTNER DURING THE LAST YEAR ---------->**GO TO Q523**

522. Generally, does your husband/ partner agree or disagree with the use of contraceptive methods?

1. AGREES
2. DISAGREES
3. NEITHER AGREES NOR DISAGREES
8. NOT SURE/DON'T KNOW

523. 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 for: **(READ 1-4)**

1. Birth Control Only----------**>GO TO 524F**
2. Disease Prevention Only----------**>GO TO 524F**
3. Both, or----------**>GO TO 524F**
4. You Never Used a Condom?
5. USED CONDOM OUT OF CURIOSITY
8. NOT SURE/ DO NOT REMEMBER

524. 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 EXTRAMARITAL RELATIONS
6. CONDOMS DIMINISH PLEASURE/SPONTANEITY
7. CONDOMS ARE LESS EFFECTIVE IN PREVENTING PREGNANCY
8. CONDOMS ARE TOO DIFFICULT TO USE
9. LOVEMAKING WOULD BE INTERRUPTED
10. CONDOM USE IS TOO MESSY
11. COST
12. SHE HAS NEVER THOUGHT ABOUT IT
13. IT IS EMBARRASSING TO BUY CONDOMS
14. PREFERS OTHER CONTRACEPTIVE METHODS
20. OTHER_____
88. DON'T KNOW

524F.

FIRST COMPLETE COLUMNS 1 AND 4 (SEE PREGNANCY HISTORY PAGES 9-13 AND MARITAL HISTORY PAGE 3**).**

CIRCLE ONE OF FOLLOWING AND FOLLOW THE INSTRUCTION AFTER IT:

1. **RESPONDENT HAS USED ANY CONTRACEPTIVE METHOD SINCE JANUARY 2000:** FILL COLUMNS 2 & 3
2. **NO METHOD USED SINCE JANUARY 2000:** FILL "0" AT BEGINNING AND END OF COLUMN 2 AND LEAVE COL.3 BLANK

525. CONTRACEPTIVE METHODS USED/PREGNANCY OUTCOMES/AND MARITAL STATUS CALENDAR

COLUMN 1

PREGNANCY OUTCOME

1. PREGNANT THAT MONTH
2. LIVE BIRTH
4. STILLBIRTH
6. MISCARRIAGE
7. INDUCED ABORTION
8. MINIABORTION
9. ECTOPIC PREGNANCY

COLUMN 2

METHOD USED

0. NO METHOD
1. PILL
2. "SPIRALI" (IUD)
3. CONDOM
4. CONDOM+SPERMICIDES
5. CONDOM+CAL./WITHDRAWAL
6. SPERMICIDES
7. TUBAL LIGATION
8. EMERGENCY HORM.
9. INJECTABLES (E.G. DEPO-PROVERA)
10. OTHER MODERN
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL +CALENDAR
20. OTHER TRADITIONAL MET.
88. DO NOT REMEMBER

COLUMN 3

REASON STOPPED USING A METHOD

1. GOT PREGNANT WHILE USING
2. WANTED TO GET PREGNANT
3. HUSBAND OBJECTED
4. SIDE EFFECTS
5. HEALTH CONCERNS
6. STOPPED TO "REST THE BODY"
7. PHYSICIAN DECISION
8. SUPPLY/AVAILABILITY
9. DIFFICULT/INCONVENIENT TO USE
10. MARRIAGE/RELATIONSHIP ENDED
11. WANTED TO TRY OTHER METHOD
12. SPORADIC SEXUAL ACTIVITY
13. HUSBAND NOT IN GEORGIA
14. SHE NEGLECTED TO USE
15. METHOD NOT EFFECTIVE
20. OTHER_____

COLUMN 4 (MARITAL STATUS)

0. NOT MARRIED/NOT IN UNION
1. MARRIED/IN UNION

DATE	1	2	3	4	DATE	1	2	3	4
2000					**2003**				
1 Jan					1 Jan				
2 Feb					2 Feb				
3 Mar					3 Mar				
4 Apr					4 Apr				
5 May					5 May				
6 Jun					6 Jun				
7 Jul					7 Jul				
8 Aug					8 Aug				
9 Sep					9 Sep				
10 Oct					10 Oct				
11 Nov					11 Nov				
12 Dec					12 Dec				
2001					**2004**				
1 Jan					1 Jan				
2 Feb					2 Feb				
3 Mar					3 Mar				
4 Apr					4 Apr				
5 May					5 May				
6 Jun					6 Jun				
7 Jul					7 Jul				
8 Aug					8 Aug				
9 Sep					9 Sep				
10 Oct					10 Oct				
11 Nov					11 Nov				
12 Dec					12 Dec				
2002					**2005**				
1 Jan					1 Jan				
2 Feb					2 Feb				
3 Mar					3 Mar				
4 Apr					4 Apr				
5 May					5 May				
6 Jun					6 Jun				
7 Jul					7 Jul				
8 Aug					8 Aug				
9 Sep					9 Sep				
10 Oct					10 Oct				
11 Nov					11 Nov				
12 Dec					12 Dec				

525F. DETERMINE FROM THE CALENDAR:

1. **CONTRACEPTION USED IN JANUARY 2000→ CONTINUE**
2. **NO METHOD USED IN JAN. 2000, BUT ONE USED AFTER→ GO Q527**
3. **NO METHOD USED SINCE JAN. 2000 (COL 2 ONLY "0")→ GO Q551, PG 33**

526. You said that in January of 2000 you were using ___ ___ (**WRITE METHOD USED IN COLUMN 2_JAN 2000**). When did you start using that method?

___ ___ MONTH ___ ___ ___ ___ YEAR 88. DON'T KNOW/DON'T REMEMBER

527. LAST CONTRACEPTIVE METHOD USED (COPY THE METHOD FROM THE CONTRACEPTIVE CALENDAR):

1. THE PILL
2. "SPIRALI" (IUD)
3. CONDOM
4. CONDOM +SPERMICIDES
5. CONDOM +WITHDRAWAL/CALENDAR
6. FOAM/JELLY/CREAMS
7. FEMALE STERILIZATION
8. EMERGENCY HORMONAL CONTRACEPTION
9. DEPO-PROVERA
10. OTHER MODERN METHOD_____
11. CALENDAR----------->GO TO Q536
12. WITHDRAWAL ---------->GO TO Q536
13. WITHDRAWAL+CALENDAR------->GO TO Q536
20. OTHER TRADITIONAL MET.------->GO TO Q536
88. DO NOT REMEMBER ---------->GO TO Q536

528. The next following questions concern **the last contraceptive method** you have used. Where did you get that method?

1. RURAL AMBULATORY
2. VILLAGE HOSPITAL
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. GOV HOSPITAL-GYN WARD
6. GOV HOSPITAL-MATERNITY WARD
7. PRIVATE CLINIC OR OFFICE
8. NGO
9. PHARMACY
10. OPEN MARKET, BAZAAR
11. STORE/ KIOSK
12. PARTNER/HUSBAND
13. FRIEND
14. RELATIVE
20. OTHER (SPECIFY): _____
88. DON'T KNOW

529 Did you pay for this method?

1. YES
2. NO---------->**GO TO Q531**
3. PARTNER GETS THE METHOD----->**GO TO Q531**

530. Did you pay for **(READ 1–3):**

1. The method itself,
2. The medical consultation,
3. Or both?

530A. Altogether, on average, how much did(do) you pay for contraception, per month?

___ ___ LARI

85. 85+ LARI
98. NOT SURE/DON'T KNOW

531. At the time you started using the last contraceptive method, who advised you about how to use that method?

1. OB/GYN
2. GENERAL PRACTITIONER
3. NURSE/MIDWIFE/FELDCHER
4. PHARMACIST------>**GO TO Q536**
5. MOTHER---------->**GO TO Q536**
6. OTHER RELATIVE---------->**GO TO Q536**
7. FRIEND---------->**GO TO Q536**
8. PARTNER---------->**GO TO Q536**
9. NOBODY---------->**GO TO Q536**
20. OTHER_____----->**GO TO Q536**

532. When you received the information concerning use of the method, did the health provider tell you about other contraceptive methods?

1. YES
2. NO---------->**GO TO Q534**

533. Did the health provider explain how effective your method is compared to other contraceptive methods?

1. YES
2. NO

534. Did the health provider explain the possible side effects of your method?

1. YES
2. NO

534A. Were you told what to do if you experienced side effects while using the method?

3. YES
4. NO

535. Overall, would you say you have been very satisfied, satisfied, somewhat satisfied, or not satisfied with the family planning services you have received?

1. VERY SATISFIED
2. SATISFIED
3. SOMEWHAT SATISFIED
4. NOT SATISFIED
8. DO NOT KNOW

535F. REVIEW CALENDAR (Q525 – COLUMN 2):
HAS RESPONDENT USED EITHER PILL OR IUD SINCE JANUARY 2000 (CODE =1 OR 2 ON COLUMN 2)?

1. YES
2. NO-→ GO TO Q550F

536F. REVIEW CALENDAR (Q525 – COLUMN 2)

1. HAS USED PILL (CODE 1) SINCE JANUARY 2000
2. HAS NOT USED PILL SINCE JANUARY 2000→ GO TO Q540

537. **OBSERVE THE CALENDAR AND VERIFY IN WHAT MONTH AND YEAR RESPONDENT STARTED TO TAKE PILLS MOST RECENTLY (PAST OR CURRENT USERS).** You said you most recent started taking pills in:

___ ___ MONTH ___ ___ ___ ___ YEAR 88. DO NOT REMEMBER

538. What brand of pills did you use most recently? **(SHOW CARD B; ASK TO SEE PACKAGE, IF SHE IS CURRENTLY USING PILLS)**

1. BISECURIN
2. CILEST
3. CYCLO-PROGYNOVA
4. DIANE-35
5. FEMODEN
6. FERTILAN
7. GYNOFEN 35
8. MARVELON
9. MERCILON
10. MICROGYNON
11. MICROLUT
12. NONOVION
13. OVIDON
14 **POSTINOR**
15. RIGEVIDON
16. SIGORAL
17. TRIREGOL
18. JANIN
20. OTHER_____
88. DO NOT KNOW

539F. REVIEW CALENDAR (Q525 – COLUMN 2)

1. HAS USED IUD ("SPIRALI") (CODE 2) SINCE JANUARY 2000
2. HAS NOT USED IUD ("SPIRALI") SINCE JANUARY 2000→ GO TO Q550F

540. OBSERVE THE CALENDAR AND VERIFY IN WHAT MONTH AND YEAR RESPONDENT STARTED TO USE THE LAST (OR CURRENT) IUD. You said you had an IUD inserted in.....

___ ___ MONTH __ __ __ __ YEAR 88. DO NOT REMEMBER

541. Now, I want you to think back at the time when you had inserted your (last) "Spirali" (IUD). Where did you have the "spirali" (IUD) inserted?

1. VILLAGE HOSPITAL
2. POLICLINIC
3. WOMEN'S CONSULTATION CLINIC
4. GOV HOSPITAL-GYN WARD
5. GOV HOSPITAL-MATERNITY WARD
6. PRIVATE CLINIC OR OFFICE
7. OTHER_____

542. Was that "Spirali" (IUD) inserted immediately after an abortion?

1. YES
2. NO

543. After the "Spirali" (IUD) was inserted, when did the physician tell you to come back for a routine check-up?

___ ___ WEEKS

00 DID NOT SAY TO COME BACK FOR CHECK-UP
33 AFTER THE FIRST PERIOD
44 SAID TO COME BACK ANYTIME SHE WANTS
55 SAID TO COME BACK ONLY WHEN SHE HAS SPECIFIC PROBLEMS
77 OTHER (SPECIFY)_____
88 DON'T REMEMBER

544. When the "Spirali" (IUD) was inserted, did the physician tell you how to check that it is in place?

1. YES
2. NO
8. DON'T REMEMBER

545. Did the physician tell you how long the "Spirali" (IUD) could be left in place?

1. YES
2. NO
8. DON'T REMEMBER

546. Did you have any health problems or side effects that you think were related to your "Spirali" (IUD)?

1. YES
2. NO--->**GO TO Q550F**

547. What kind of problem or side effect did you have? **(CIRCLE ALL MENTIONED, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
A. ABDOMINAL CRAMPING	1	2
B. PROLONGED OR HEAVY LEEDING DURING MENSTRUAL PERIODS	1	2
C. SPOTTING/BLEEDING BETWEEN PERIODS	1	2
D. INFECTION/DISCHARGE/PID	1	2
E. PARTNER'S COMPLAINS ABOUT THE STRINGS	1	2
F. EXPULSION	1	2
G. OTHER (SPECIFY)_____	1	2

548. Did you see a doctor for this(ese) problem(s)?

1. YES
2. NO

550F. REVIEW CALENDAR (Q525 – COLUMN 2):
WAS RESPONDENT USING ANY CONTRACEPTIVE METHOD IN THE LAST MONTH (CODE > "0" IN COLUMN 2)?

1. YES ---→ GO TO Q553
2. NO

551. Do you think you are physically able to get pregnant at the present time?

1. YES--->**GO TO Q553**
2. NO
3. NOT SURE
4. CURRENTLY PREGNANT--->**GO TO Q553**

552. What is the main reason why you think you cannot get pregnant?

1. RESPONDENT DOES NOT HAVE A PARTNER/ IS NOT SEXUALLY ACTIVE
2. CURRENTLY BREAST-FEEDING /POSTPARTUM
3. PELVIC IINFLAMMATORY DISEASE (PID)
4. ENDOCRINE DYSFUNCTION
5. HYSTERECTOMY (SURGICAL REMOVAL OF UTERUS)----------->**GO TO Q558 PG. 34**
6. PREMENOPAUSE/ MENOPAUSE----------->**GO TO Q558 PG. 34**
7. OVARIAN CYSTS/ OVARIAN DYSFUNCTION----------->**GO TO Q557 PG. 34**
8. RESPONDENT HAD BOTH TUBES REMOVED OR OBSTRUCTED----------->**GO TO Q557 PG. 34**
9. HAS TRIED TO GET PREGNANT IN THE PAST 2 YEARS AND DID NOT SUCCEED->**GO TO Q557 PG. 34**
10. PARTNER HAD A MEDICAL OPERATION AND CANNOT HAVE CHILDREN---------->**GO TO Q557 PG. 34**
11. PARTNER IS INFERTILE----------->**GO TO Q557 PG. 34**
12. CURRENTLY USES A METHOD **(GO BACK TO Q504 AND CORRECT IT)**
20. OTHER (SPECIFY) _____
88. DO NOT KNOW
99. REFUSE TO ANSWER

553. Looking to the future, do you yourself intend to have (a/another) baby at some time (**IF CURRENTLY PREGNANT ADD** "…after this pregnancy"?)

1. WANTS A BABY
2. DOES NOT WANT A BABY --->**GO TO Q555**
3. RESPONDENT WANTS A BABY BUT PARTNER DISAGREES
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS **---> GO TO Q555**
8. DK **---->GO TO Q555**

554. When do you, yourself, actually want to get pregnant (again)...**(READ 1-4)**

1. Right away, (**DO NOT READ IF THE WOMAN IS ALREADY PREGNANT**)
2. Within the next 12 months,
3. Within 1-2 years,
4. or after 2 years?
6. AFTER SHE MARRIES
7. WHEN GOD WANTS
8. DK

555. **IF Q553 =1,3, OR 8 BEGIN WITH**: "After having all the children you want,...")
Do you think you would be interested in having an operation to prevent you from having any more children?

1. YES----------->**GO TO Q558**
2. NO
3. ALREADY STERILIZED----------->**GO TO Q558**
8. NOT SURE

556. What is the most important reason you wouldn't be interested in such a procedure?

1. HEALTH RISKS/FEAR OF SIDE EFFECTS
2. FEAR OF OPERATION
3. DOESN'T KNOW ENOUGH ABOUT /NEVER HEARD OF STERILIZATION
4. MIGHT WANT ANOTHER CHILD
5. COST
6. DOES NOT HAVE A PARTNER/NOT SEXUALLY ACTIVE
7. AGE TOO YOUNG OR TOO OLD (APPROACHING MENOPAUSE)
8. HAVEN'T THOUGHT ABOUT IT
9. NOT CULTURALLY ACCEPTABLE
10. RELIGIOUS REASONS
11. PREFERS (OR USES) OTHER CONTRACEPTIVE METHODS
12. CANNOT GET PREGNANT (INFERTILITY, MEDICAL REASONS)
20. OTHER_____
88. DON'T KNOW

GO TO Q558

557. Looking to the future, do you yourself intend to seek any medical help to have a(nother) baby ?

1. YES
2. NO
3. RESPONDENT WANTS A BABY BUT PARTNER DISAGREES
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS
8. DK

558 Do you know a place where you can seek diagnostic or treatment for helping you to become pregnant?

1. YES
2. NO----------**>GO TO Q560**
8. DK/NR----------**>GO TO Q560**

559. How far is that place from where you live (IF MORE THAN ONE PLACE RECORD DISTANCE TO THE NEAREST)?

___ ___ HOURS 00 LESS THAN ONE HOUR
88 DO NOT KNOW/NOT SURE

560. The next questions are about any infertility services you may have ever received. This includes any medical help to become pregnant that you or your husband(s)/partner(s) may have received. Have you or your husband(s)/partner(s) <u>ever been</u> to a doctor or other medical care provider to talk about ways to help you become pregnant?

1. YES
2. NO----------**>GO TO Q567**
8. DK/NR----------**>GO TO Q567**

561. Thinking back to your or your partner's first visit when you sought medical help for becoming pregnant, in what month and year was that visit (IF PARTNER 1ST VISIT PRECEEDED HERS, RECORD THAT DATE)

____ ____ MONTH ____ ____ ____ ____ YEAR 88. DK/NOT REMEMBER

562. When you first went for medical help in (MONTH/YEAR), how many <u>months or years</u> had you (and your husband/partner) been trying to become pregnant?

1. ___ ___ MONTHS OR 2. ___ ___ YEARS 888. DK/DR

563. When you and your husband or partner went for medical help to become pregnant were you ever told that you or he had any of the following infertility problems: (**READ A–E AND CODE ALL THAT APPLY**.)

	YES	NO
A. Problems with ovulation (includes hormonal dysfunction)?	1	2
B. Blocked tubes?	1	2
C. Endometriosis (a disease in which tissue from the inside of uterus fixes to other places)?	1	2
D Semen or sperm problems (low count, poor motility, varicocele) ?	1	2
E. Any other infertility problems? (**SPECIFY**)_____	1	2

564. During the past 12 months, were you (and your (husband/partner)) pursuing medical help to become pregnant?

1. YES
2. NO---------->**GO TO Q566**

565. During the past 12 months, how many visits have you or your husband/partner made to a doctor to help you to get pregnant?

___ ___ VISITS 88. DK/DR

566. In what month and year was your (most recent/last) visit for help to become pregnant?

____ ____ MONTH ___ ___ ___ ___ YEAR 88. DK/NOT REMEMBER

567. Have you ever been treated for an infection in your fallopian tubes, womb, or ovaries, also called a pelvic infection, pelvic inflammatory disease, or P.I.D.? (IF DON'T KNOW, PROBE: This is a female infection that sometimes causes abdominal pain or lower stomach cramps.) **NOTE**: INFECTIONS OF THE VAGINA ALONE, ENDOMETRIOSIS, PELVIC TUMORS, AND CYSTS **DO NOT COUNT** AS PELVIC INFECTIONS

1. YES
2. NO----------->**GO TO MODULE VI**
8. DK/NR----->**GO TO MODULE VI**

568. Were you having any symptoms, such as pain, discharge, or bleeding, that caused you to go for treatment?

1. YES
2. NO

569. Please try to remember when you first received treatment for a pelvic infection or P.I.D. In what month and year was that?

____ ____ MONTH ___ ___ ___ ___ YEAR 88. DK/NOT REMEMBER

570. In what month and year did you last receive treatment for a pelvic infection or P.I.D.?

____ ____ MONTH ___ ___ ___ ___ YEAR 88. DK/NOT REMEMBER

571. Altogether, how many different times have you been hospitalized one night or longer for a pelvic infection?

1. NEVER----------->**GO TO MODULE VI**
2. ONCE
3. 2-3 TIMES
4. 4 TIMES OR MORE
8. DO NOT REMEMBER

572. Overall, how many nights did you spend in the hospital for a pelvic infection or P.I.D.?

____ ____ NIGHTS 88. DK/DR

VI. WOMEN'S HEALTH

Now I would like to ask you some questions about your general health.

601. In the past 12 months, have you visited any health facility for care for yourself, including obtaining preventive services, such as family planning counseling or health check-ups?

1. YES
2. NO----------**GO TO Q604**
8. DK/DO NOT REMEMBER------**GO TO Q604**

601A How far is that place from where you live (IF MORE THAN ONE PLACE RECORD DISTANCE TO THE NEAREST)?

___ ___ HOURS

00 LESS THAN ONE HOUR
88 DO NOT KNOW/NOT SURE

602. Where did you receive these services (**CIRCLE ALL MENTIONED AND PROBE "Any Other Place"**)?

	MENTIONED	NOT MENTIONED
A. GOVT. HEALTH CLINIC OR HOSPITAL	1	2
B. PRIVATE HEALTH CLINIC OR HOSPITAL	1	2
C. INTERNATIONAL RELIEF ORGANIZATION	1	2
D LOCAL NGO	1	2
E MOBILE HEALTH UNIT	1	2
F. OTHER_____	1	2

603. During any of your health visits in the past 12 months, did a doctor or health care provider talk to you about family planning methods?

1. YES
2. NO
8. DON'T KNOW/DON'T REMEMBER

604. In the past 12 months, have you had an injection for any reason?

1. YES
2. NO----→**GO TO Q606**

605. How many injections did you have in the past 12 months? ___ ___ INJECTIONS

85. 85+
98. DK/DR

606. Many different factors can prevent women from getting medical advice or treatment for themselves. When you want to get medical advice or treatment, is each of the following a big problem or not (**READ A–G**)?

	BIG PROBLEM	NOT A BIG PROBLEM
A. Knowing where to go.	1	2
B. Getting permission to go	1	2
C. Getting money needed for treatment	1	2
D. The distance to the health facility	1	2
E. Having to take transport	1	2
F. Not wanting to go alone	1	2
G. Concern that there may not be a female health provider	1	2

607. In general, would you describe your overall health as excellent, good, fair, poor or very poor?

1. EXCELLENT
2. GOOD
3. FAIR
4. POOR
5. VERY POOR
8. DON'T KNOW/DON'T REMEMBER
9. REFUSED/NO ANSWER

608. Have you ever had a routine gynecologic exam (**PHYSICAL EXAMINATION OF EXTERNAL AND INTERNAL GENITAL AREA FOR DIAGNOSTIC OTHER THAN PREGNANCY**)?

1. YES ----**GO TO Q610**
2. NO
8. NR

609. What is the most important reason that you have never 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. DOES NOT KNOW WHERE TO GO FOR SUCH AN EXAM
14. CANNOT AFFORD THE COST
15. NEVER HAD SEXUAL INTERCOURSE (VIRGIN)
20. OTHER _____
88. DK/NOT RESPONSE

GO TO Q611

610. When was your last routine gynecologic exam (not pregnancy related)? **(READ 1-4)**

1. During the past 12 months
2. 1-2 years ago (12-23 MTH)
3. 2-3 years ago (24-35 MTH)
4. 3 or more years ago
8. DK/DR

611. Have you ever had a cervical smear (a test that takes a sample of cells from the cervix, or opening to the uterus to detect cancer) , also called Papanicolau test?

1. YES ----**>GO TO Q613**
2. NO
8. DK
9. REF

612. What is the main reason you have never had a Pap smear?

1. NEVER HEARD OF IT
2. DOCTOR HAS NOT RECOMMENDED IT
3. SHE IS HEALTHY AND HAS NO GYNECOLOGIC PROBLEMS
4. SHE DOES NOT FEEL TEST IS NECESSARY
5. DOES NOT HAVE TIME TO GO FOR A TEST/ SHE FORGETS ABOUT IT
6. NEVER THOUGHT OF IT
7. SHE IS AFRAID OF THE RESULTS
8. SHE IS AFRAID IT COULD BE PAINFUL
9. TOO EMBARRASSED TO GET THE TEST OR A PELVIC EXAM.
10. COST
11. SHE HAD NO PARTNER/ NOT SEXUALLY ACTIVE
12. NEVER HAD SEXUAL INTERCOURSE
20. OTHER (SPECIFY):_____
88. DON'T KNOW
99. REFUSE TO ANSWER

GO TO O614

613. 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. DON'T KNOW

614. Have you heard about breast self-examinations?

1. YES
2. NO----------**>GO TO Q617**

615. Do you ever do breast self-examinations?

1. YES
2. NO----------**>GO TO Q617**

616. How often do you do it, on average?

1. ONCE A MONTH/AFTER EACH MENSTRUATION
2. EVERY 2-5 MONTHS
3. EVERY 6-11 MONTHS
4. ONCE PER YEAR OR LESS

617. Have you ever tried cigarette smoking, even one or two puffs?

1. YES
2. NO---> **GO TO Q624**

618. How old were you when you smoked a cigarette for the first time?

__ __ YEARS 88. DO NOT REMEMBER
99. REFUSE TO ANSWER

619. Have you smoked at least 100 cigarettes in your entire life? (**PROBE**: 100 cigarettes is about 5 packs)

1. YES
2. NO---> **GO TO 624**
8. DK---> **GO TO 624**
9. REF---**>GO TO 624**

620. How old were you when you first started smoking fairly regularly?

___ ___ YEARS 00. NEVER SMOKED REGULARLY
88. DO NOT REMEMBER
99. REFUSE TO ANSWER

621. During the last 30 days, did you smoke cigarettes: **(READ 1-4)**

1. Every Day
2. Almost Every Day
3. Some Days
4. Not at All in the last 30 days**-->GO TO Q623**
9. REF----------**>GO TO Q623**

622. During the last 30 days, on the days you smoked, how many cigarettes did you smoke per day?

1. 1 CIGARETTE PER DAY
2. 2-5 CIGARETTES PER DAY
3. 6-10 CIGARETTES PER DAY
4. 11-19 CIGARETTES PER DAY
5. 20 OR MORE CIGARETTES PER DAY

GO TO Q624

623. In what month and year did you last smoke cigarettes at all? **(PROBE FOR SEASON IF MONTH IS UNKNOWN)**

___ ___ MONTH ___ ___ ___ ___ YEAR 88. DO NOT REMEMBER
99. REF

624. Now, I will ask you about some medical conditions that you may have had. Has a doctor or other health care provider ever told you that you had Diabetes or “high sugar”?

1. YES
2. NO -----**>GO TO Q626**
8. NOT SURE -----**>GO TO Q626**
9. REFUSAL-------**>GO TO Q626**

625. Were you ever told you had diabetes when you were not pregnant?

1. YES
2. NO
3. NEVER BEEN PREGNANT
8. DO NOT REMEMBER

626. Has a doctor or other health care provider ever told you that you had anemia, or "thin blood"?

1. YES
2. NO **----->GO TO Q628**
8. NOT SURE **----->GO TO Q628**
9. REFUSAL**------->GO TO Q628**

627. Were you ever told you had anemia or "thin blood" when you were not pregnant?

1. YES
2. NO
3. NEVER BEEN PREGNANT
8. DO NOT REMEMBER

628. Has a doctor or other health care provider ever told you that you had Hypertension or High Blood Pressure?

1. YES
2. NO **---------->GO TO Q630**
8. NOT SURE **----->GO TO Q630**
9. REFUSAL**------->GO TO Q630**

629. Were you ever told you had Hypertension or High Blood Pressure when you were not pregnant?

1. YES
2. NO
3. NEVER BEEN PREGNANT
8. DO NOT REMEMBER

630. Since the age of 15, has a doctor or other health care provider ever told you that you had Rubella?

3. YES
4. NO **---------->GO TO Q632**
8. NOT SURE **----->GO TO Q632**
9. REFUSAL**------->GO TO Q632**

631. Were you ever told you had Rubella when you were pregnant?

1. YES
2. NO
3. NEVER BEEN PREGNANT
8. DO NOT REMEMBER

632. In the past 12 months have you had any of the following symptoms?

	YES	NO	NOT SURE
A. Vaginal discharge with a bad smell	1	2	8
B. Itching or burning in the genital area	1	2	8
C. Burning pain on urination	1	2	8
D. Pain during sexual intercourse	1	2	8
E. Sore, ulcer or warts in genital area	1	2	8

633F. ARE ANY OF 632_A THRU 632_E = 1? (ANY SYMPTOMS)?
1. YES
2. NO ------→ GO TO Q637

634. Did you have any treatment for this(ese) condition(s)?

1. YES
2. NO----> **GO TO Q636**
8. NOT SURE ---> **GO TO Q636**

635. Who treated you?

1. OB/GYN
2. FAMILY DOCTOR/GP
3. DERMATOLOG
4. INFECTIOUS DISEASES DOCTOR
5. UROLOG
6. NURSE/MIDWIFE
7. PHARMACIST
8. PARTNER
9. FRIEND/RELATIVE
10. SELF-TREATMENT
20. OTHER:_____
99. REFUSED

GO TO Q637

636. What was the main reason you did not seek treatment?

1. SERVICES TOO FAR AWAY / INACCESSIBLE
2. DON'T KNOW WHERE TO GO FOR SERVICES
3. CANNOT AFFORD SERVICES OR TREATMENT
4. AFRAID OF KNOWING THE RESULTS
5. IT IS EMBARRASSING
6. DID NOT THINK WAS AN STI
7. SYMPTOM(S) DISAPPEARED
8. OTHER (SPECIFY)_____
9. REFUSED

637. 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 a shot of vodka, liquor or whiskey. In the past 3 months, have you had a drink containing alcohol?

1. YES
2. NO----> **GO TO MODULE VII**
8. NOT SURE/DO NOT REMEMBER ---> **GO TO MODULE VII**
9. REFUSE ---> **GO TO MODULE VII**

638. In the past 3 months, on the days that you drank alcohol, how many drinks did you usually have?

_____ _____ # OF DRINKS

00. NO DRINKS/ONLY FEW SIPS---> **GO TO MODULE VII**
88. NOT SURE/DO NOT REMEMBER ---> **GO TO MODULE VII**
99. REFUSED --> **GO TO MODULE VII**

639. In the past 3 months, how often did you drink that amount (PROBE: per day, week, or month)?

1. EVERYDAY
2. ALMOST EVERY DAY
3. 1-2 TIMES A WEEK
4. 2-3 TIMES A MONTH
5. ONCE A MONTH
6. 1-2 TIMES IN THREE MONTHS

640. In the past 3 months, have there been days when you had more than usual (# FROM Q632) drinks?

1. YES
2. NO ---> GO TO MODULE VII
8. NOT SURE/DO NOT REMEMBER ---> GO TO MODULE VII
9. REFUSE --> GO TO MODULE VII

641. In the past 3 months, how many times did you drink 5 or more drinks within a couple of hours?

_____ _____ # OF TIMES

88. NOT SURE/DO NOT REMEMBER

VII. REPRODUCTIVE HEALTH KNOWLEDGE/ATTITUDES

700. In your opinion, how many children in general should young family have in Georgia?

___ ___ # of children

66. AS MANY AS GOD GIVES
77. AS MANY AS POSSIBLE
88. NOT SURE, DON'T KNOW

701. During a woman's menstrual cycle, are there certain days when she is more likely to become pregnant if she has sexual relations?

1. YES
2. NO----------->**GO TO Q702**
8. DO NOT KNOW-->**GO TO Q702**

701A. When is it most likely for a woman to become pregnant, just before her period begins, during her period, right after her period has ended, or halfway between two periods?

1 Just before her period starts
2 During her period
3 Right after period ends
4 Halfway between her periods
8 DON'T KNOW

702. Do you think that breastfeeding increases, decreases or has no effect on a woman's chance to get pregnant?

1. INCREASES THE CHANCE
2. DECREASES THE CHANCE
3. HAS NO EFFECT
8. DO NOT KNOW

703. Do you think that a woman always has the right to decide about her pregnancy, including whether or not to have an abortion?

1. YES--->**GO TO Q705**
2. NO

704. Under which of the following conditions is it all right for a woman to have an abortion **(READ A-F)**?

	YES	NO	DEPENDS	DK
A. Her life is endangered by the 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 the pregnancy	1	2	3	8
E. She is unmarried	1	2	3	8
F. The couple cannot afford to have a(nother) child	1	2	3	8
G. Couple desire no(more) children	1	2	3	8

705. If a woman had an 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

706. I would like to know if you are in agreement with the following statements **(READ A-L)**:

	AGREE	DISAGREE	DK
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
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 woman can refuse sex with her husband if he has an STI	1	2	8
L. A woman can ask her husband to use a condom when they have sex if he has a disease that can be transmitted through sexual contact	1	2	8

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. How would you rank each of the following birth control methods **(SHOW CARD C)** with regard to their risk of developing health problems; please tell me if the risk is low, medium, or high:

	Low Risk	Medium Risk	High Risk	DK
A. Pill	1	2	3	8
B. "SPIRALI" (IUD)	1	2	3	8
C. Condom	1	2	3	8
D. Tubal Ligation	1	2	3	8
E. Injectables	1	2	3	8
F. Abortion on Request	1	2	3	8

709F. EVER HEARD OF THE PILL (PAGE 20: Q400_A = "1")? **1. YES**
2. NO ----→ GO TO Q710F

709. Please tell me if you agree or disagree with the following statements about birth control pills **(READ A-K)**:

	AGREE	DISAGREE	DK
A. Pills are easy to use	1	2	8
B. Pills are easy to get	1	2	8
C. Pills are too expensive	1	2	8
D. It is stressful to remember to take the pill every day	1	2	8
G. Pills may make you gain weight	1	2	8
H. Pills make women's periods more regular	1	2	8
I. Pills decrease blood loss during menstruation	1	2	8
K. Pills are bad for blood circulation	1	2	8

710F. EVER HEARD OF IUD (PAGE 20: Q400_B = "1")? **1. YES**
2. NO ----→ GO TO Q712

711. Please tell me if you agree or disagree with the following statements about "SPIRALI" **(READ A-F)**

	AGREE	DISAGREE	DK
A. "Spirali" is easy to use	1	2	8
C. "Spirali" increases the risk of pelvic inflammatory disease	1	2	8
D. "Spirali" is a relatively inexpensive contraceptive method	1	2	8
F "Spirali" may increase the blood loss during menses	1	2	8

712. Do you want to have more information about contraceptive methods?

1. YES
2. NO ----------> **GO TO Q714**
8. DON'T KNOW ---> **GO TO Q714**

713. Who do you think would be the best source of information about contraceptive methods?

1. MOTHER
2. OTHER RELATIVE
3. BOYFRIEND
4. HUSBAND, PARTNER
5. SOMEBODY WHO USES CONTRACEPTION
6. CO-WORKER
7. FRIEND, COLLEAGUE, PEER
8. GYNECOLOGIST
9. GENERAL PRACTITIONER
10. NURSE, MIDWIFE
11. TEACHER
12. PHARMACIST
13. BOOKS
14 NEWSPAPERS, MAGAZINES, BROCHURES
15. RADIO----------**GO TO Q715**
16. TV----------**GO TO Q715**
20. OTHER (SPECIFY): _____
88. DON'T KNOW

714. Do you think that information about contraception should be broadcast on radio or television?

1. YES
2. NO
8. DO NOT KNOW

715. Some people use condoms to keep from getting sexual transmitted diseases. How effective do you think a properly used condom is for this purpose? **(READ 1-3)**

1. Very Effective
2. Somewhat effective
3. Not effective
8. DON'T KNOW

716F. CHECK CURRENT AGE OF RESPONDENT (Q101):
1. 15 TO 24
2. 25 TO 44 ----------→ GO TO Q800

717. Have you ever talked to a partner about him using a condom?

1. YES
2. NO
3. NEVER HAD A SEXUAL PARTNER---> **GO TO Q721**
8. DON'T REMEMBER
9. REFUSE

718. Have you ever asked a partner to use a condom?

1. YES
2. NO --> **GO TO Q721**
8. DON'T REMEMBER -------→ **GO TO Q721**
9. REFUSE-------→ **GO TO Q721**

719. Has any of the following **ever** happened because you asked a partner to wear a condom……..**(READ A-F)**
(ANY OF THESE INCIDENTS COULD HAVE HAPPENED MORE THAN ONCE, WITH THE SAME PARTNER OR DIFFERENT PARTNERS)

	YES	NO	DK	REF
A. Did a partner refuse to wear a condom?	1	2	8	9
B. Did a partner refuse to have sexual intercourse with you?	1	2	8	9
C. Did a partner threaten to break up with you?	1	2	8	9
D. Did a partner yell at you or threaten to hurt you?	1	2	8	9
E. Did a partner make you have sex anyway without a condom?	1	2	8	9
F. Did a partner physically hurt you?	1	2	8	9

720. In the last 12 months have you tried to obtain condoms?

1. YES
2. NO
3. DON'T KNOW WHERE TO GET THEM
8. DON'T REMEMBER

721. If your partner/husband would want to use a condom when having sex with you, would you feel:
(READ A-E)

	AGREE	DISAGREE	DK	REF
A. Insulted or angry?	1	2	8	9
B. Safe from getting pregnant?	1	2	8	9
C. Like you had done something wrong?	1	2	8	9
D. Safe from getting STI or HIV/AIDS?	1	2	8	9
E. Suspicious that he may sleep around?	1	2	8	9

722. Please indicate whether you agree or disagree with the following statements about condoms (**READ A-H**):

	AGREE	DISAGREE	DK	REF
A. Using condoms with a new partner is a smart idea	1	2	8	9
B. Using condoms is not necessary if you know your partner	1	2	8	9
C. Women should ask their partners to use condoms	1	2	8	9
D. It is easy to discuss using a condom with a prospective partner	1	2	8	9
E. Condoms diminish sexual enjoyment	1	2	8	9
F. Same condoms can be used more than once	1	2	8	9
G. People who use condoms sleep around a lot	1	2	8	9
H. It is embarrassing to ask for condoms in FP clinics or pharmacies	1	2	8	9

VIII. SOCIOECONOMIC CHARACTERISTICS

800. Please tell me whether this household or any member of it has the following items: **(READ A–H):**

		YES	NO
A.	Refrigerator	1	2
B.	TV	1	2
C.	Working Automobile	1	2
D.	VCR	1	2
E.	Household phone	1	2
F.	Cellular phone	1	2
G.	Vacation home (villa)	1	2
H.	Air Conditioner	1	2

801. What kind of toilet facility does this household use?

1. FLUSH TOILET
2. PIT LATIRNE
3. BUCKET
4. NO FACILITY/BUSH/FIELD
7. OTHER_____

802. What type of fuel does this household mainly use for cooking?

1. ELECTRICITY
2. NATURAL GAS
3. COAL
4. WOOD
5. KEROSENE
6. PETROL
7. OTHER_____

803. What type of heating system does this household mainly use?

1. CENTRAL HEATING
2. OWN BOILER
3. INDIVIDUAL ROOM HEATING
4. STOVE HEATING
5. NO HEATING
7. OTHER_____

804. What is the main source of drinking water for members of your household?

1. PIPED WATER (PIPED INTO RESIDENCE OR YARD)----→**GO TO Q806**
2. PIPED WATER (PUBLIC TAP)
3. WELL WATER (RESIDENCE OR YARD) ----→**GO TO Q806**
4. PUBLIC WELL
5. SURFACE WATER (SPRING, RIVER, POND, LAKE)
6. RAIN WATER----→**GO TO Q806**
7. BOTTLED WATER----→**GO TO Q806**

805. How long does it take to go to the water source, get water and come back, in minutes?

____ ____ ____MINUTES 88. DON'T KNOW

806. Which of the following describes your living arrangements? Do you live: (**READ 1-5**)

1. In your privately owned flat or house
2. In rented space (room, flat or house)
3. With your immediate family (NO RENT)
4. With other relatives (NO RENT)
5. With friends (NO RENT)
7. OTHER (SPECIFY): _____

807. How many rooms are occupied by you and your family (not including bathrooms and kitchen):

___ ___ ROOMS

808. How many hours per day do you have electricity?

___ ___ HOURS 88. DON'T KNOW

809. What is your ethnic background?

1. GEORGIAN
2. RUSSIAN
3. AZERI
4. ARMENIAN
5. OSSETIAN
6. MIXED ETHNICITY (SPECIFY)_____
7. OTHER (SPECIFY):_____
9. REFUSED/NOT STATED

810. What is your religion?

1. GEORGIAN ORTHODOX
2. RUSSIAN ORTHODOX
3. GREEK ORTHODOX
4. ARMENIAN GREGORIAN
5. MUSLIM
6. CATHOLIC
7. PROTESTANT (BAPTIST, LUTHERAN, PENTECOSTAL, ETC)
8. ADVENTIST
9. JEWISH
10. JEHOVAH'S WITNESSES
20. OTHER_____
77. NO RELIGION ------>**GO TO Q812**
99. UNDECLARED----->**GO TO Q812**

811. 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, or
5. Never

812. WHAT ARE THE MAIN MATERIALS USED IN THE ROOF? RECORD OBSERVATION

1. ROOF FROM NATURAL MATERIALS
2. RUDIMENTARY ROOF (PLASTIC/CARTON)
3. TILED OR CONCRETE ROOF
4. CORRUGATED IRON
7. OTHER: _____

813. How do you assess the material status of your family (**READ 1-3**)?

1. we can easily satisfy our needs
2. we can somehow satisfy our needs
3. we can hardly make two ends meet
8. DON"T KNOW

IX. VIOLENCE

900. Thinking back to your childhood and adolescence, did you ever see or hear your parents or step-parents physically abuse each other?

1. YES
2. NO
3. DID NOT LIVE WITH 2 PARENTS-------**>GO TO Q901**
8. DR/REF

900A. As a child, have you ever being beaten or physically mistreated in any way by anyone in your family?
1. YES
2. NO
8. DR/REF

901. THE INTERVIEWER SHOULD GO BACK TO PAGE 3 AND RECORD HOW MANY TIMES THE RESPONDENT LIVED WITH A MAN AS HUSBAND AND WIFE (SEE Q111):

___ TIMES

IF Q901=0 GO TO Q920; IF Q903>0 CONTINUE

Now I would like to ask you questions about some other important aspects of a woman's life. I know that some of these questions are very personal. However, your answers are crucial for helping to understand the condition of women in Georgia. Let me assure you that your answers are completely confidential and will not be told to anyone.

902 When two people marry or live together, they share both good and bad moments. In your relationship with your (last) husband/partner do (did) the following happen frequently, only sometimes, or never?

	FREQUENTLY	SOMETIMES	NEVER
A. He usually shares/shared with you household responsibilityes?	1	2	3
B He (does/did) like to have the final say on household decisions?	1	2	3
C. He usually (is/was) affectionate with you?	1	2	3
D. He (tries/tried) to limit your contact with your friends and family.....	1	2	3

903. Does (did) your husband/partner drink (alcohol)? [1]

1. YES
2. NO----→GO TO Q904 (READ INTRODUCTION) BELOW

903A How often does (did) he get drunk: very often, only sometimes, or never?

1. VERY OFTEN
2. SOMETIMES
3. NEVER
9. REFUSE TO ANSWER

The next set of questions is about violence and physical abuse that may have happened between you and a partner or ex-partner. When we say a partner we mean a husband, ex-husband, as well as any other man you have been living with as husband and wife.

904. Please tell me if any of your partners or ex-partners ever **(READ A–H):**		**905.** When was the **last time** when **(A–H)** happened to you?	**906.** During the last year, **how many times** did **(A–H)** happen to you?
A. Insulted you, or swore at you?	1. YES---> **905** 2. NO----> **904_B** 8. DON'T REMEMB->**904_B** 9. REF---> **904_B**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_B** 3. 4-5 YEARS AGO--------> **904_B** 4. 5 YEARS AGO OR MORE-->**904_B**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
B. Threatened to hurt you or someone you care about?	1. YES---> **905** 2. NO----> **904_C** 8. DON'T REMEMB→**904_C** 9. REF---> **904_C**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_C** 3. 4-5 YEARS AGO--------> **904_C** 4. 5 YEARS AGO OR MORE-->**904_C**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
C. Pushed you, shook you, shove you, or threw something at you?	1. YES---> **905** 2. NO----> **904_D** 8. DON'T REMEMB->**904_D** 9. REF---> **904_D**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_D** 3. 4-5 YEARS AGO--------> **904_D** 4. 5 YEARS AGO OR MORE-->**904_D**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
D. Slapped you or twisted your arm?	1. YES---> **905** 2. NO----> **904_E** 8. DON'T REMEMB->9**04_E** 9. REF---> **904_E**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_E** 3. 4-5 YEARS AGO--------> **904_E** 4. 5 YEARS AGO OR MORE-->**904_E**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
E. Hit you with his fist or with something else?	1. YES---> **905** 2. NO----> **904_F** 8. DON'T REMEMB.->**904_F** 9. REF---> **904_F**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_F** 3. 4-5 YEARS AGO--------> **904_F** 4. 5 YEARS AGO OR MORE-->**904_F**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
F. Threatened you with a knife or other weapon?	1. YES---> **905** 2. NO----> **904_G** 8. DON'T REMEMB.->**904_G** 9. REF---> **904_G**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_G** 3. 4-5 YEARS AGO--------> **904_G** 4. 5 YEARS AGO OR MORE-->**904_G**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
G. Kicked you, choke you or beat you up?	1. YES---> **905** 2. NO----> **904_H** 8. DON'T REMEMB.->**904_H** 9. REF---> **904_H**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO--------> **904_H** 3. 4-5 YEARS AGO--------> **904_H** 4. 5 YEARS AGO OR MORE-->**904_H**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
H. Physically forced you to have sexual relations even though you did not want to?	1. YES---> **905** 2. NO----->**907F** 8. DON'T REMEMB.->**907F** 9. REF--->**907F**	1. WITHIN THE LAST YEAR-->**906** 2. 1-3 YEARS AGO-------->**907F** 3. 4-5 YEARS AGO-------->**907F** 4. 5 YEARS AGO OR MORE->**907F**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES

907F. RESPONDENT EVER ABUSED? (ANY OF Q904 A thru H = "1")?
1. YES
2. NO -→ GO TO Q919

908. You told me before that you lived with a man as husband and wife _____ times **(RECORD THE NUMBER OF TIMES FROM Q903)**. During which of these periods has a partner physically abused you as you have just mentioned? **MARK THE INTERVAL(S) NUMBER FROM THE UNION TABLE AT PAGE 3 (ALLOW FOR MULTIPLE RESPONSES):**

I. ___
II. ___
III. ___
IV ___

909. How long after you first got married to/started living with your (last abusive) husband/partner did (this/any of these things) first happen?

____ ____ NUMBER OF YEARS

85. BEFORE MARRIAGE/BEFORE LIVING TOGETHER
86. AFTER SEPARATION/DIVORCE
88. DON'T REMEMBER

910F. REVIEW VIOLENCE TABLE (Q904 – Q906) FOR <u>PHYSICAL</u> ABUSE<u>: ROWS C-H ONLY</u>:

1. NEVER PHYSICAL ABUSE (ALL Q904C-H > "1")----------→ GO TO Q919
2. PHYSICAL ABUSE > 1 YEAR AGO (ALL Q905C-H > "1")-------→ GO TO Q914
3. PHYSICAL ABUSE IN THE LAST YEAR (ANY OF Q905C-H = "1")

911. In the past 12 months, did you have any swelling, bruises, cuts, or other physical injuries as a result of this/these incident(s)?

1. YES
2. NO----------**GO TO Q914**
8. DON'T REMEMBER -----**GO TO Q914**

912. In the past 12 months, did you see a doctor, or other medical care provider for medical treatment of these injuries?

1. YES
2. NO----------**GO TO Q914**
8. DO NOT REMEMBER -----**GO TO Q914**

913. Did this(these) injury(ies) require hospitalization?

1. YES
2. NO
8. DO NOT REMEMBER

914. Did you talk to anyone about this(these) incidents of violence?

1. YES
2. NO--------**GO TO Q916**

915. Who did you talk with**? (MARK ALL MENTIONED AND PROBE FOR ANYONE ELSE)?**

	MENTIONED	NOT MENTIONED
A. YOUR MOTHER	1	2
B. OTHER RELATIVE	1	2
C. HUSBAND'S (PARTNER'S) FAMILY	1	2
D. CHILDREN	1	2
E. FRIEND	1	2
F. NEIGHBOR	1	2
G. DOCTOR/HEALTH PROVIDER/SOCIAL WORKER	1	2
H. POLICE	1	2
I. LEGAL ADVISER	1	2

916F. SOUGHT MEDICAL OR LEGAL HELP (Q915_G=1 OR Q915_H=1 OR Q915_I=1)?

1. YES -----→ GO TO Q918
2. NO

917. What is the main reason you have never sought any medical or legal help?

1. DID NOT KNOW WHERE TO SEEK HELP
2. NO USE/WOULD NOT DO ANY GOOD
3. EMBARRASSED
4. AFRAID OF MORE BEATINGS/BEING PUNISHED
5. AFRAID OF DIVORCE/END OF RELATIONSHIP
6. AFRAID OF LOOSING THE CHILDREN
7. THOUGHT WOULD NOT BE TAKEN SERIOUSLY/NOT BELIEVED/LAUGHED AT
8. VIOLENCE IS NORMAL/NO NEED TO COMPLAIN
9. THOUGHT SHE WOULD BE BLAMED
10. BRING BAD NAME TO FAMILY
11. INJURY NOT VERY SEVERE
20. OTHER _____
88. DK/REF

918. Could you tell me a little more about what usually happens when your partner is/was violent. Are there any particular situations that make him violent? **(CIRCLE ALL THAT APPLY PROBING "ANY OTHER…")**

NOTE: IF SHE REPORTED MORE THAN ONE PARTNER THIS QUESTION REFERS TO THE LAST PARTNER WHO USED PHYSICAL VIOLENCE

	MENTIONED	NOT MENTIONED
A. WHEN DRUNK	1	2
B. WHEN SHE DOES NOT LOOK AFTER CHILDREN	1	2
C. WHEN THE FAMILY HAS MONEY TROUBLES	1	2
D. WHEN HE HAS DIFFICULTIES AT WORK	1	2
E. WHEN HE IS UNEMPLOYED	1	2
F. FAMILY PROBLEMS/MOTHER-IN-LAW PROBLEMS	1	2
G. WHEN HE OR SHE IS JEALOUS	1	2
H. WHEN SHE IS PREGNANT	1	2
I. WHEN HE CANNOT GET ALCOHOL/DRUGS	1	2
J. WHEN THEY DO NOT HAVE FOOD AT HOME	1	2
K. WHEN SHE REFUSES TO HAVE SEX WITH HIM	1	2
L. OTHER_____	1	2

919. Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations **(READ A—H):**

	YES	NO	DK
A. If she goes out without telling him?	1	2	8
B. If she neglects the children?	1	2	8
C. If she argues with him?	1	2	8
D. If she refuses to have sex with him?	1	2	8
E. If he is not happy with her household work or food provisions?	1	2	8
F. If she asks him whether he has other girlfriends?	1	2	8
G. If he finds out that she has been unfaithful?	1	2	8
H. If she dresses too sexy or spends too much on her "look"?	1	2	8

920. At any time in your life, have you ever been forced by a man to have sexual intercourse against your will? (For this question, sexual intercourse includes vaginal, anal or oral penetration)

1. YES
2. NO----------->**GO TO MODULE X**
8. DON'T REMEMBER--->**GO TO MODULE X**

921. How old were you the first time you were forced by a man to have sexual intercourse against your will?

___ ___ AGE 88. DON'T REMEMBER

922. At that time, what was your relationship with the person(s) who forced you to have sexual intercourse?

1. STRANGER
2. ACQUAINTANCE
3. FRIEND
4. DATE
5. BOYFRIEND
6. HUSBAND OR PARTNER
7. EX-HUSBAND OR EX-PARTNER
8. FATHER OR STEP-FATHER
9. OTHER RELATIVE (SPECIFY_____)
77. OTHER (SPECIFY_____)
88. DON'T REMEMBER
99. REF

X. AIDS/STIs

The next set of questions are about sexually transmitted infections, including HIV/AIDS. For each of the following conditions please tell me if:

CONDITION	**1000.** Have you ever heard of it?	**1001.** Have you ever been tested for...?	**1002.** I don't want to know the results, but did you get the results of the (last) test?	**1003.** How long ago was your last test?	**1004.** Where was the (last) test done? **(SEE CODES BELOW)**
A. Syphilis	1. YES 2. NO--->**B**	1. YES 2. NO--->**B** 8. DK--->**B**	1. YES 2. NO--->**B** 8. DK/DR-->**B**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
B. Gonorrhea	1. YES 2. NO--->**C**	1. YES 2. NO--->**C** 8. DK--->**C**	1. YES 2. NO--->**C** 8. DK/DR-->**C**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
C. Chlamydia	1. YES 2. NO--->**D**	1. YES 2. NO--->**D** 8. DK--->**D**	1. YES 2. NO--->**D** 8. DK/DR-->**D**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
D. Yeast Infection	1. YES 2. NO--->**E**	1. YES 2. NO--->**E** 8. DK--->**E**	1. YES 2. NO--->**E** 8. DK/DR-->**E**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
E. Genital Herpes	1. YES 2. NO--->**F**	1. YES 2. NO--->**F** 8. DK--->**F**	1. YES 2. NO--->**F** 8. DK/DR-->**F**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
F. Genital Warts	1. YES 2. NO--->**G**	1. YES 2. NO--->**G** 8. DK--->**G**	1. YES 2. NO--->**G** 8. DK/DR-->**G**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
G. Trichomoniasis	1. YES 2. NO--->**H**	1. YES 2. NO--->**H** 8. DK--->**H**	1. YES 2. NO--->**H** 8. DK/DR-->**H**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____
H. HIV/AIDS	1. YES 2. NO->**Q905**	1. YES 2. NO->**Q1005** 8. DK->**Q1005**	1. YES 2. NO--->**Q1005** 8. DK/DR-->**Q1005**	1. __ __ DAYS 2. __ __ MTHS 3. __ __ YRS 888 NOT REMEMBER	_____

CODES FOR Q1004:

1. STI DISPENSARY
2. POLICLINIC
3. WOMEN'S CONSULT CLINIC
4. GOVT. HOSPITAL STI
5. GOVT. HOSPITAL OTHER
6. FAMILY PLANNING CLINIC
7. MOBILE CLINIC
8. PRIVATE CLINIC
9. HIV CENTER
10. BLOOD TRANSFUSION CENTER
20. OTHER:_____
99. REFUSE TO ANSWER

1005. If a woman has a sexually transmitted disease, what symptoms might she have?
(RECORD ALL MENTIONED, DO NOT READ LIST)

	MENTIONED	**NOT MENTIONED**
A. ABDOMINAL PAIN	1	2
B. VAGINAL DISCHARGE	1	2
C. FOUL SMELLING DISCHARGE	1	2
D. BURNING PAIN ON URINATION	1	2
E. REDNESS/INFLAMMATION IN GENITAL AREA	1	2
F. SWELLING IN GENITAL AREA	1	2
G. GENITAL SORES/ULCERS OR WARTS	1	2
H. GENITAL ITCHING	1	2
I. WEIGHT LOSS	1	2
J. HARD TO GET PREGNANT/HAVE A CHILD	1	2

1006. Do you know a place where you could get an HIV/AIDS test?

1. YES
2. NO-----→**GO TO Q1007**

1006A Where is this place?

1. STI DISPENSARY
2. POLICLINIC
3. WOMEN'S CONSULT CLINIC
4. GOVT. HOSPITAL STI
5. GOVT. HOSPITAL OTHER
6. FAMILY PLANNING CLINIC
7. MOBILE CLINIC
8. PRIVATE CLINIC
9. HIV CENTER
10. BLOOD TRANSFUSION CENTER
20. OTHER:_____
99. REFUSE TO ANSWER

1007. In general, what has been your most important source of information about STIs including AIDS? (Where or from whom have you learned the most about STIs?)

1. MOTHER
2. FATHER
3. OTHER RELATIVE
4. BOYFRIEND
5. HUSBAND, PARTNER
6. SOMEBODY WHO HAD STIs
7. FRIENDS COLLEAGUES, PEERS
8. OB/GYN DOCTOR
9. DERMATOLOGIST
10. INFECTIOUS DISEASES DOCTOR
11. FAMILY DOCTOR, GP
12. NURSE, MIDWIFE, FELDCHER
13. TEACHER
14. PHARMACIST
15. SPECIALITY BOOKS
16. NEWSPAPERS, MAGAZINES, BROCHURES, FLYERS
17. RADIO
18. TV
20. OTHER (SPECIFY):_____
77. NEVER HEARD OF ANY STIs **(Q1000_A--Q1000_H=2)**
99. DR/REF.

1008. In the past 6 months, have you seen or heard any public announcements or ads on television or radio about: **(READ A–D, PROBE FOR BOTH)**

	YES, RADIO	YES, TV	YES, BOTH	NO	DO NOT REMEMBER
A. HIV/AIDS	1	2	3	4	8
B. Other STIs	1	2	3	4	8
C. Condoms	1	2	3	4	8
D. Modern Contraceptive Methods	1	2	3	4	8

1008A. In the past 6 months, have you read in any newspapers or magazines about: **(READ A–D)**

	YES	NO	DO NOT REMEMBER
A. HIV/AIDS	1	2	8
B. Other STIs	1	2	8
C. Condoms	1	2	8
D. Modern Contraceptive Methods	1	2	8

1008F. EVER HEARD OF AIDS? (Q1000_H = "1")?	**1. YES** **2. NO ----→ GO TO Q1026, PG 55**

1009. Do you think that a person can be infected with the HIV virus but have no symptoms of disease?

1. YES
2. NO
8. DK

1010. Please tell me whether you think that the AIDS virus can be transmitted in the following ways? **(READ A–L)**

	YES	NO	DK
A. Through blood transfusion	1	2	8
B. Using public toilets	1	2	8
C. Through kissing	1	2	8
D. Through unprotected sexual intercourse between a man and a woman	1	2	8
E. Through unprotected sexual intercourse between men	1	2	8
F. By shaking hands	1	2	8
G. Using non-sterile syringes or needles	1	2	8
H. Through mosquito bites	1	2	8
I. Sharing food, plates, forks, or glasses with someone who has HIV/AIDS	1	2	8
J. Getting a manicure, pedicure or haircut	1	2	8
K. Having dental or surgical treatment	1	2	8
L. Through witchcraft or other supernatural means	1	2	8

1011. Can the virus that causes AIDS be transmitted from a mother to her baby during:

	YES	NO	DK
A. Pregnancy	1	2	8
B. Delivery	1	2	8
C. Breastfeeding	1	2	8

1011A. Are there any drugs that a woman infected with the AIDS virus can take to reduce the risk of transmission to the baby during pregnancy?

1. YES
2. NO
8. DR/REF

1012 Is there anything a person can do to reduce the risk of getting AIDS?

1. YES
2. NO----------→**GO TO Q1014**
8. DR/REF-------→**GO TO Q1014**

1013. What can a person do to reduce the risk of getting AIDS (RECORD ALL MENTIONED)?

	MENTIONED	NOT MENTIONED
A. USE CONDOMS	1	2
B. ABSTAIN FROM SEX	1	2
C. HAVE ONLY ONE PARTNER/STAY FAITHFUL TO ONE PARTNER	1	2
D. LIMIT NUMBER OF SEXUAL PARTNERS	1	2
E. AVOID SEX WITH PROSTITUTES	1	2
F. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS	1	2
G. AVOID SEX WITH BISEXUALS	1	2
H. AVOID BLOOD TRANSFUSIONS	1	2
I. ASK PARTNER TO GET BLOOD TESTED FOR AIDS	1	2
J. AVOID INJECTIONS	1	2
K. DO NOT SHARE RAZORS/BLADES, NEEDLES OR SYRINGES	1	2
L AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY	1	2
M. OTHER (SPECIFY)_____	1	2

1014 Can people reduce their chances of getting the AIDS virus by having just one sex partner who is not infected and who has no other partners?

1. YES
2. NO
8. DR/REF

1015. Can people reduce their chances of getting the AIDS virus by using a condom every time they have sex?

1. YES
2. NO
8. DR/REF

1016. Can people reduce their chance of getting the AIDS virus by abstaining from sexual intercourse?

1. YES
2. NO
8. DR/REF

1017. How much of a risk do you think you personally have of getting HIV/AIDS? Would you say you are at **READ 1–4):**

1. Great risk,
2. Moderate Risk,
3. Little risk, or
4. No risk at all ----------**>GO TO Q1019**
8. DON'T KNOW----------**>GO TO Q1020**

1018. Why do you think you have any risk of getting the AIDS virus?

1. RECEIVED BLOOD TRANSFUSIONS/BLOOD PRODUCTS
2. HAD MANY SEXUAL PARTNERS/ TRADED SEX FOR MONEY
3. HAD UNPROTECTED INTERCOURSE WITH CASUAL PARTNER(S)
4. USED IV DRUGS/SHARED NEEDLES
5. PARTNER HAD/HAS SEX WITH OTHER WOMEN
6. SHE MAY GET INFECTED WHILE RECEIVING MEDICAL OR DENTAL TREATMENT
7. SHE MAY GET INFECTED GETTING A MANICURE, PEDICURE, OR HAIRCUT
8. OTHER (SPECIFY)_____
9. DK/REF

GO TO Q1020

1019 Why do you think you have no risk of getting the AIDS virus?

1. ONLY ONE PARTNER
2. NO SEXUAL RELATIONS
3. USES CONDOMS
4. CONFIDENCE IN PARTNER
5. DOES NOT GET/NEED TRANSFUSIONS
6. DOES NOT SHARE NEEDLES
7. OTHER (SPECIFY)_____
9. DK/REF

1020 How much of a risk do you think you personally have of getting other STI? Would you say you are at: **(READ 1–4)**

1. Great risk,
2. Moderate Risk,
3. Little risk, or
4. No risk at all
8. DON'T KNOW

1021. As far as you know, is there any cure for AIDS?

1. YES
2. NO
3. NO, BUT THERE IS TREATMENT TO PROLONG REMISSION
8. DR/REF

1022. If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household?

1. YES
2. NO
8. DR/REF

1023. If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him or her?

1. YES
2. NO
8. DR/REF

1024. If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school?

1. YES
2. NO
8. DR/REF

1025. If a member of your family became infected with the AIDS virus, would you want it to remain a secret?

1. YES
2. NO
8. DR/REF

1026. THANK THE WOMAN FOR GIVING HER TIME AND RECORD THE TIME THE INTERVIEW ENDED :

TIME INTERVIEW ENDED _____ ____ : _____ _____

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