Reproductive Health Survey Georgia, 1999

Final Report

WOMEN'S REPRODUCTIVE HEALTH SURVEY GEORGIA, 1999-2000

FINAL REPORT

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United Nations Population Fund (UNFPA)
United Nations Children's Fund (UNICEF)
United States Agency for International Development (USAID)
United Nations High Commissioner for Refugees (UNHCR)
American International Health Alliance, Inc. (AIHA)

October, 2001

PRINTED BY:
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, GA, 30333

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Preface

After the breakup of the former USSR, Georgia entered a long period of dramatic changes as it moved from a centralized, totalitarian regime, characteristic of the former Soviet Union, to an autonomous administrative, economical, political, and socio-cultural system whose priorities are state capacity building, transition to a democratic society, and development of a market economy. During these challenging years, Georgia faced divisive ethnic disputes, economic hardships, and profound societal transformation, including rapid deterioration of the health care sector. Poor health services contributed to a rapid deterioration of health indicators, such as lower life expectancy, decreasing natural population growth, and increasing levels of general mortality and morbidity, including high maternal and infant mortality rates. Abortions became the first method of fertility control and postabortion complications were a significant cause of maternal mortality and morbidity; their costly treatment severely burdened already scarce financial resources.

More information was needed to assess the reproductive health status of the Georgian population during a period of rapid changes that profoundly influence the health of women and children. In 1999, the Georgian Ministry of Health, with technical assistance provided by the Division of Reproductive Health of the Centers for Disease Control and Prevention (DRH/CDC), conducted the first national population-based survey of women's reproductive health in the country (99GERHS). The survey was designed to provide the Ministry of Health, international agencies, and nongovernmental organizations active in women's and children's health with essential information on fertility, women's reproductive practices, maternal care, maternal and child mortality, health behaviors, and attitudes toward selected reproductive health issues.

The 99GERHS provides data that will assist the government in improving services related to the health of women and children. The results describe reproductive health issues in Georgia and provide a better understanding of their causes and consequences. Survey data allow for better accountability, efficiency, and effectiveness of programs targeting the health of women, infants and children. For these programs to be successful, the needs of the targeted population must be accurately defined and appropriate interventions need to be designed, monitored and evaluated. The survey data will enhance the ability of the national reproductive health program to undertake data-based program planning, monitoring and evaluation.

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Acknowledgments

The 1999/2000 Georgian Reproductive Health Survey (99GERHS) was conducted by the Georgian Center for Disease Control (NCDC), in collaboration with the Georgian Ministry of Labor Health and Social Affairs (MOLHSA) and the Center for Medical Statistics and Information (CMSI). Technical assistance in survey design, sampling, questionnaire development, training, data processing, and report writing was provided by the Division of Reproductive Health (DRH) of the United States Centers for Disease Control and Prevention (CDC). Drs. Nick Nutsubidze and Paata Imnadze from the MOLHSA and NCDC, respectively, and Dr. Fiorina Serbanescu and Dr. Leo Morris from the DRH/CDC were principal investigators.

Most of the funding for the 99GERHS was provided by the United States Agency for International Development (USAID PASA DPE-3038-X-HC-1015-00), the United Nations Population Fund, and the United Nations Children's Fund (UNICEF).

We wish to thank the 7,798 women who made such a major contribution to our knowledge on women's reproductive health in Georgia by their participation in the 99GERHS. We thank our dedicated interviewers and supervisors for their commitment and discipline.

Many thanks are extended to the representatives of the MOHSA Marina Gudushauri, MD, PhD, Deputy Minister and Nata Kazakhashvili, MD, Head MCH Department for their continuous support of all the aspects of the survey. Special thanks are extended to the survey headquarters Nick Nutsubidze, Paata Imnadze, and Nelli Chakvetadze, Survey Directors, Merab Sikharulidze, Project Manager, Nana Papachashvili, Accountant, Galina Chubinidze, Secretary, Khatuna Zakhashvili and Marina Shakhnazarova, Field Coordinators, Irina Kocharova and Eugene Kornshtein, data entry supervisors.

Special thanks are also extended to the USAID staff in Georgia— Kent Larson, Humanitarian Officer, HR/ST Office Gegi Metaradze, Program Officer-Health, and Catherine Fisher, Regional Health Specialist—to the United Nations staff in Georgia—Marco Borsotti, UNDP Resident Representative, Tamar Khomasuridze, National Program Officer, UNFPA, Marina Tsintsadze, Administrative Assistant, UNFPA, Boris Tolstopiatov, UNICEF Area Representative, Caucasus, and Nino Partskhaladze, UNICEF Project Officer—and to the AIHA staff—Arsen Kubataev, Regional Director Caucasus Office and Nata Avaliani, Program Coordinator— for their assistance in design, planning and financial management. Many thanks to Mary Ann Micka, Mary Jo Lazear, and Willa Pressman, USAID/Washington, for their continued support of the survey. Special thanks are also extended to Shirley Appian-Obeah, Jay Friedman, and Abigail Schultz of the CDC, for their contribution to several chapters of the final report.

Executive Summary

In the early 1990s, Georgia entered a long period of dramatic changes as it moved from a centralized, totalitarian government, characteristic of the U.S.S.R, to an autonomous administrative, economical, political, and socio-cultural system whose priorities are state capacity building, transition to a democratic society, and development of a market economy. Since its independence from the Soviet Union in April 1991, Georgia has gone through a conflict with secessionist regions in Abkhazia and South Ossetia and a civil war. During these challenging years, Georgia faced divisive ethnic disputes, economic hardships, and profound societal transformation, including rapid deterioration of the health care sector. The status of women's health in Georgia has suffered greatly during the last decade. The 1999 Reproductive Health Survey (99GERHS), the first population based national survey of this type ever conducted in Georgia, documented poor reproductive health indicators compared with other Eastern European and former Soviet Union countries.

The 99GERHS, conducted by the National Center for Disease Control, Tbilisi, with technical assistance from the Division of Reproductive Health, Centers for Disease Control and Prevention, Atlanta (DRH/CDC), interviewed a sample of 7,798 women 15-44 years of age, including an oversample of 1,655 internally displaced women living in government facilities. The oversample was applied for a programmatic reason—to evaluate the reproductive health status of the internally displaced women at the end of the reproductive health program implemented by UNHCR since 1994—and a methodologic reason— to ensure that the survey sample represent all women in Georgia, living either in residential dwellings or internally displaced housed in non-residential government facilities. The overall response rate was 99%. The survey was designed to collect information from a representative sample of reproductive-age women throughout Georgia. The questionnaire covered a wide range of topics related to reproductive health for all women regardless of marital status and included additional questions on family-life education and sexual behavior for women aged 15-24 years.

Almost two of three women (61%) with completed interviews were married or in a consensual union. One of two women had more than a secondary education. The majority population was Georgian (83%) followed by Azeri (9%), Armenian (5%) and Russian (1%) ethnic groups. Georgian was the main language spoken in 83% of households, followed by Azeri (8%), Armenian (4%) and Russian (3%). Although 94% of households had a television set, only 46% of respondents stated that they watch television daily, presumably because of the electricity shortage (7 hours per day, on average); similarly, only 30% of respondents stated that they listen to the radio daily. The average viewing and listening time among those who watch TV or listen to the radio daily

was 4 and 3 hours, respectively. Only 16% and 6% of respondents reported seeing or hearing family planning messages on the television or radio, respectively.

Marriage and Fertility

The people of Georgia are proud of their long and rich cultural and social heritage. They believe that their national heritage survived through centuries of foreign domination largely because at the foundation of Georgian society lie the family unit and the existence of extended families. A stable family unit, including its strong kinship ties, contributes greatly to the spiritual growth of its members. Georgian children are treasured and they rarely live home until they marry. The 99GERHS showed that Georgian women marry early (median age at first marriage was 21.6 years), have low divorce rates, report having their first sexual experience at marriage (only 2% of sexually experienced women aged 15-24 reported premarital intercourse), have their first child soon after marriage (almost a half of married women aged 15-19 had already had their first child and 81% of women aged 20-24 had one or more children), and achieve the desired family size (two children) soon after. The highest fertility levels were among 20-24 year old women (accounting for one third of the total fertility rate), followed by women aged 25-29 and 15-19 years of age. The adolescent fertility rate in Georgia (65 per 1,000 women aged 15-19) was the second highest among former Soviet Union countries, after the fertility rate of adolescents in the Kyrgyz Republic of 75 per 1,000.

Pregnancy Intention Status

Sixty percent of women who have been pregnant in the past five years reported that their last pregnancy occurred sooner than they had wished (mistimed) or at a time when they had decided to have no more children (unwanted). Almost all of mistimed and unwanted pregnancies ended in induced abortion (91% and 97%). The 99GERHS found that the total induced abortion rate was 3.7 abortions per woman, more than twice the total fertility rate of 1.7 births per woman. Although abortions are legal in Georgia and most abortions reported in the survey were performed in clinical settings, a substantial proportion of these abortions was not reflected in official statistics. Approximately two-thirds of women in union reported having had at least one abortion, and, of those women reporting an abortion, 78% have had more than one abortion. Almost all abortions during the five years preceding the interview were performed in a hospital or governmental clinic (65% and 29%); only 2% were performed in a private clinic and 4% outside the health system. Forty percent of abortions were performed during the first 6 weeks of gestation by vacuum aspiration (mini-abortions). One in ten (10%) women reported early or late complications associated with their abortion. Of all fecund women in legal or consensual union, 64% did not want any more children:

78% of those with two living children and 91% of those with three or more children wanted to terminate childbearing.

Prenatal Care and Breastfeeding

Nine in ten (91%) women reported having had prenatal care but only 63% initiated prenatal care in the first trimester. Among women with any prenatal care, the average number of prenatal care visits was 6.6 visits. According to the adequacy of prenatal care index (Kotelchuck index), only about one fourth of women received adequate prenatal care. The principal source of prenatal care was the women's consultation clinic (73%), followed by a maternity hospital (14%), a primary health care center, and either a "medical circumscription" (5%) or a rural dispensary (6%). Only one percent of women sought prenatal care in a private clinic. Overall, most women who attended prenatal care clinics had received some counseling about nutrition during pregnancy (81%), breastfeeding (73%), and delivery (71%); about one in two women received information about the negative effects of smoking and alcohol (54% and 53%, respectively) and 48% of women were counseled about early signs of complications during pregnancy. About one third of women were told about postnatal care (37%) and only one in five women received information about family planning after birth. Almost all women with recent births (96%) had routine measurement of their blood pressure during pregnancy and 8% were identified as having high blood pressure. About one in eight women with recent births (13%) reported pregnancy complications that required medical attention, including 3% who had to be hospitalized for these complications. The majority of women gave birth in a maternity or a hospital obstetrical ward (92%) and only eight percent delivered at home. The overall prevalence of Caesarean deliveries among all deliveries that occurred between 1994 and 1999 was 6%. About one in six women (17%) experienced at least one postpartum complication. Postnatal care was substantially less utilized than prenatal care (11% vs. 91%). The mean duration of breastfeeding was 10.6 months but full breastfeeding averaged only 3.6 months, including exclusive breastfeeding that averaged 1.5 months. Although the official estimates of infant mortality were in the mid-20's per 1000 live births, estimated infant mortality rate from survey data was 40.7 per 1,000 between 1990-1999.

Contraception Awareness

Georgian women demonstrated a high level of family planning awareness, contrasting with their low prevalence of modern contraceptive use; almost all women heard about at least one contraceptive method; on average, they recognized at least 3 modern methods, generally IUD, condoms, and the pill (93%, 89%, and 68%, respectively). For the most widely known modern contraceptive methods, however, respondents had a serious gap between awareness of a method and

knowledge of how the method is used; the gap ranged from 27 percentage points for condom to 31 and 39 percentage points for the IUD and the pill, respectively. A gap of similar magnitude was obvious between awareness of contraception and knowledge of where the contraceptive procedure or product could be obtained—ranging from 22 percentage points for the pill and 23-25 percentage points for condom and IUD. Correct knowledge about the effectiveness of modern methods was also lacking. Excepting knowledge about IUD's and condom's contraceptive effectiveness, knowledge about the effectiveness of other modern methods was generally lacking; even for these two methods correct knowledge was reported by less than two thirds of women. The first source of information about contraception was a friend or acquaintance (51%), followed by a relative other than a parent (14%); both mass media (13%) and medical providers (11%) played a relatively minor role in the contraceptive educational efforts. A physician and mass media were more often mentioned by young adults then by women aged 25 or older, perhaps as a result of recent information campaigns launched by the Ministry of Health in collaboration with international donors (e.g., UNFPA, USAID) that primarily targeted youths.

About one in two women stated that they want more information about contraception (including 63% of young adults). Of these women, 46% said that a physician would be the most reliable source of information and 36%, mostly those living in Tbilisi and older women, said that mass media would be the most reliable source of information.

Contraception Use

Contraceptive prevalence among Georgian women in union was the lowest among any of the former Soviet republics with survey data. Only 40% of women in union reported using any method of contraception during the month preceding the interview and only half of them used a modern method, principally the IUD (10%) and condoms (6%). Although more than 90% of women with three or more children do not want any more children, only 3% had a surgical contraception procedure. Seventy-two percent of modern method users obtained their method in the public medical sector (hospitals, women's consultation clinics, polyclinics, and rural dispensaries) and 36% in pharmacies.

Most women using traditional methods (withdrawal 11% and the rhythm method 10%) stated that fear of side effects, lack of knowledge about modern methods, cost of modern methods, and partner preference were the major factors that influenced their decision to not use a modern method. The majority of traditional method users (78%) perceived that their method was more effective or equally effective as modern methods such as the IUD and the pill. Conversely, the one-year failure rates for withdrawal and the rhythm method users were 17% and 19%, respectively, compared with

9% for condom users, 5% for pill users and 2% for IUD users. Except for the IUD users (10%), discontinuation rates were very high at one year: 37%-40% for traditional methods, 54% for condom, and 73% for pill users. Overall, 44% of women in union were estimated to have an unmet need of modern contraceptive methods to effectively prevent unintended pregnancies; the majority of these women (78%) were in need of methods that could effectively help them limit fertility.

Of women using a modern method in the past five years, 58% were advised to use modern contraception by a physician but only a third of them received counseling about other contraceptive methods or about the method's effectiveness. For women who have had an abortion in the last five years, only 15% received counseling about contraception following the abortion procedure and only 3% and 1%, respectively, were given a method or a prescription for a contraceptive method. Similarly, only 20% of women who gave birth in the past five years received any family planning counseling during pre- or postnatal care.

Women's Health

Of sexually experienced women, 28% reported never having had a routine gynecologic exam and another 19% had their last exam more than 3 years ago. Only 4% have ever had a pap smear and a third of women never heard of cervical cancer screening. Only half of women were aware of breast self-exams; of those, less than one in four have ever performed such an exam. One in five women (19%) reported that they have been diagnosed with pelvic inflammatory disease; additionally, one fourth (24%) experienced abnormal vaginal discharge and 5% reported genital ulcers or sores during the previous year.

Family Life Education

The majority of women aged 15-44 (85%) thought that age appropriate family life education should be taught in school and that school-based courses on reproductive biology ("how pregnancies occur"), contraception, and sexually transmitted diseases should start by age 16 (85%, 78%, and 75%, respectively); only one in five women, however, favored lectures on reproductive biology before age 14 and only 14% favored lectures on contraception and STDs before this age. Less than two thirds of young adults reported that they had parental discussions on sex education topics and less than 5% had discussions about contraception or STDs, including HIV/AIDS. Similarly, only half of young adults had family life education topics in school, and very few had courses related to HIV/AIDS or other STDs (5% and 2%) or contraception (1%). Results indicated that the quality of teaching of family life education should be improved, as only 25% of young adults knew the time

during the menstrual cycle when conception is most likely to occur, 40% knew that breastfeeding could decrease the risk of getting pregnant, and 76% knew it was possible to get pregnant following the first sexual intercourse. The majority of young adults did not know or had misinformation about the effectiveness of most contraceptive methods.

HIV/AIDS and Other STDs

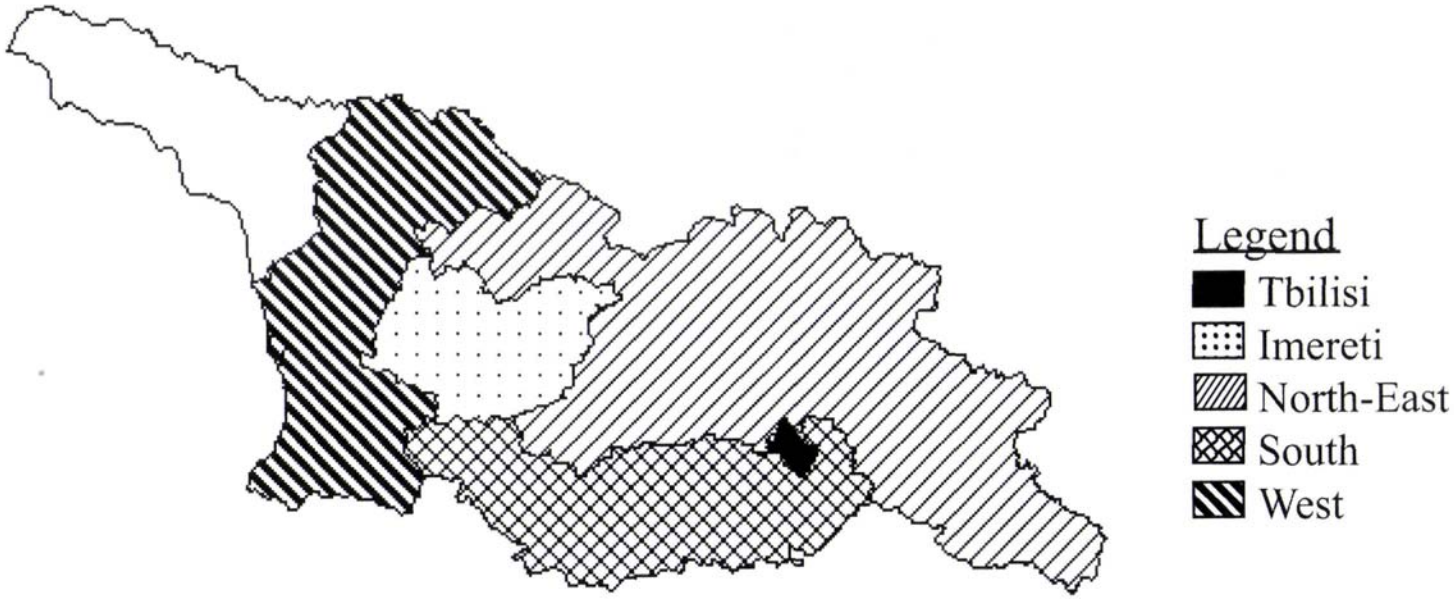
Awareness of HIV/AIDS was generally high in Georgia but only 56% knew that an HIV/AIDS infection could be asymptomatic. The majority of women heard of syphilis (82%) and yeast infection (80%), but fewer were aware of other common STDs: gonorrhea (60%), trichomonas (57%) chlamydia (16%), genital warts (15%), and genital herpes (11%). Mass media was almost unanimously considered the most important source of information about STDs but most media messages reportedly contained information (and possible misinformation) about HIV/AIDS whereas the other STDs were seldom mentioned. There is compelling evidence in the literature that behavioral changes can be positively influenced by well designed media-campaigns. The governmental STD-prevention program should actively involve mass-media in implementing behavioral interventions aimed at decreasing exposure to and transmission of STDs. However, public health efforts to educate the public have to first offset the negative image projected by media about the risk of HIV from health care utilization.

Conclusion

In conclusion, the 99GERHS showed that Georgian women have inadequate knowledge and access to diverse contraceptive methods. Doctors and nurses need pre-service and in-service education and training in contraceptive technology and development of contraceptive counseling skills. The public need appropriate education—through social marketing and family life education in schools. Researchers at the Johns Hopkins University School of Public Health have developed an informed choice strategy for people to make contraceptive decisions based on well-informed choices about family planning and protection against HIV/AIDS and other sexually transmitted diseases. They urge sustained efforts in five areas: government policies, communication programs, access to contraception, family planning program management and leadership, and counseling (Upadhyat U et al., 2001). "Informed choice" means that individuals and couples can make their own free decisions on spacing and limiting children based on accurate information and access to services and supplies to carry out their decisions. This principle has long been fundamental to family planning programs around the world but, unfortunately, its implementation has been uneven.

Georgian culture supports delaying sexual intercourse until a woman's marriage and monogamy to an extent rarely found in other countries. The 99GERHS documented these behaviors that have clear public health benefits and should be encouraged. However, given the difficulties in obtaining valid data from young people about their sexual behaviors, particularly if sexuality is a taboo topic, which seems to be the case, survey results on this topic should be interpreted with caution. Since the fall of the Soviet Union, political, economical and social changes have precipitated changes in cultural norms that relate to reproductive health, sexual behaviors, and family values. These effects may not yet have occurred in Georgia, but it is unrealistic to expect they will never happen. Family life education courses promoting delayed initiation of first intercourse, knowledge of human sexuality, contraception, and disease prevention have been shown to promote increased use of contraceptives to protect against unintended pregnancy and STDs when sexual initiation occurs. Accurate information campaigns in the mass media and in the community can inform people of their right to make their own decisions, explain their options, and direct them to appropriate health care providers. Improving access should include the availability of a range of contraceptive methods and a network of women's health clinics. Program management that improves quality of care enhances client's choices and improves contraception efficacy and continuation rates. Counseling can be crucial to helping couples think through their decisions. In Georgia, fertility control has been predominantly achieved through the practice of induced abortion. Abortion complications and their treatment burden an already struggling health system. Post-abortion care activities, including emergency obstetrical care, family planning counseling and services, and appropriate referral for other health care needs would seem a particularly useful way to prevent recurrent abortions and redirect funds toward preventive activities.

Georgia
Regional Boundaries,
Georgia Reproductive Health Survey, 1999



CHAPTER I

INTRODUCTION

Georgia is located on the southern side of the Caucasus Mountains between the Black and Caspian seas in the Trans-Caucasian region. Most of the 70,000 sq km area of the country is mountainous. Georgia is bordered on the north and northeast by Russia, on the southeast by Azerbaijan, on the south by Armenia and Turkey, and on the west by the Black Sea. In earlier times, Georgia was an important part of "the Great Silk Road" and in many ways continues to be a bridge between East and West. The people of Georgia have a long and rich cultural history. Georgia was among the first countries to convert to Christianity (in 330 A.D.). The Georgian language, with its unique alphabet (one of fourteen different alphabets in the world), is one of the oldest living languages. The majority of the population is constituted of ethnic Georgians, but, as a reflection of the country's geopolitical location, 94 ethnic groups contribute to various proportions of the total population. According to data from the last census in 1989, the population of Georgia was 5.4 million including 70% Georgians, 8% Armenians, 6% Russians, 6% Azeri, 3% Ossetians, 2% Greeks, 2% Abkhazians, 1% Ukrainians, 1% Kurds, and 1% others *(The Population of Georgia,* All-Georgian World Congress, Tbilisi, 1993). The 1999 population estimate for Georgia was recently reported to be 4.6 million inhabitants (not including Abkhazia and Tskhinvali region, also known as South Ossetia), after a recent reassessment of migration and resettlements (SDS unpublished data, April 2000). Slightly more than a half of the population resides in urban areas.

At the national level, the health system is directed by the Ministry of Health (recently fused with the Ministry of Social Affairs into an unique Ministry of Health and Social Affairs), which sets the budget for health care programs, coordinates services and is responsible for health policy. Local health care is administered by local authorities and the Ministry of Health through regional public health centers. They monitor all local health services, report communicable diseases, supervise immunization and other preventive activities, and regulate environmental hazards. Health services are provided through three types of health care facilities: a) a primary health care network, represented by various ambulatories —feldsher ambulatory posts (FAPs) and doctor ambulatory centers (DACs) in rural areas and public polyclinics and women's consultation clinics in urban areas;
b) a secondary health care network, consisting of rural, central district, and municipal hospitals; and
c) a tertiary health care system delivered by specialized municipal and republican level hospitals, polyclinics, and research institutes.

A series of decrees, resolutions and laws issued since August 1994 are aimed at the decentralization of health care and the development of a health insurance system. The newly created insurance system has a compulsory component, implemented through the MOH State Medical Insurance Company (SMIC), and a voluntary component, implemented through voluntary health insurance programs registered through the MOH and supported exclusively by employees and employers. The compulsory medical insurance covers all citizens of Georgia and is based on mandatory payroll taxes (3% from employer and 1% from employee), specific earmarked taxes (e.g., taxes on tobacco and alcohol) and funds (e.g., for military personnel and veterans), governmental and municipal subsidies (UNICEF, 1997). The SMIC is responsible for implementing several state health care programs, including pre-, intra-, and post-natal care and the care for children under one year of age (Gzirishvili D. and Mataradze G., 2000). Within the context of the transition to a market economy, the medical institutions are gradually switching over to self-financing (Presidential Decree 269, July 1995).

So far, the health care reforms have had mixed results and the health sector has not received adequate resources to provide basic standards of care. Between 1995-1998, less than 2% of the GDP was allocated for health expenditures and actually less than this amount was disbursed. In 1999, the health expenditures from the Central Budget (including a recent World Bank loan for the rehabilitation of the health system) increased to 3.7% of the GDP (UNDP, 1999). A recent study of health care financing in Georgia suggested that the real national spending on health is approximately ten times higher than the amount allocated from the central budget; thus, almost 90% of health care expenditures are supported as out-of-pocket expenses (Actuarial Research Group, 1998).

The status of women's health in Georgia has suffered greatly during the last decade. Georgia declared its independence from the Soviet Union in April 1991. After the break-up from the Soviet Union, Georgia entered a time of major socio-economic crisis associated with the transition from the framework inherited from the previous regime to a new political and legislative system. Two of the autonomous regions of the former Soviet Republic of Georgia— South Ossetia and Abkhazia—in disagreement with legislative and political reforms in the newly independent Georgia, declared their sovereignty (in 1991 and 1992, respectively). The conflict escalated quickly into war and ethnic cleansing with a cease-fire status monitored by the UN reached soon after (in 1991 in South Ossetia and in 1993 in Abkhazia). Secessionist conflicts in Abkhazia and South Ossetia have been dormant since spring 1994, although political settlements remain uncertain. Presently, the status of both South Ossetia and Abkhazia remains the subject of negotiations and they do not recognize the Georgian central government. It is estimated that 264,000 Georgians fled the conflict affected area and reside currently in other parts of Georgia. In the aftermath of these politically and ethnically-based conflicts, forced migration, prolonged displacement, disruption of the infrastructure,

environmental degradation and the deterioration of foreign trade have had catastrophic economic consequences and a major negative impact on the entire health care system, particularly on maternal and infant health services, and have altered many aspects of life, including the patterns and consequences of childbearing.

In Caucasian societies, women mostly marry and start their childbearing at young ages. A child is considered to be a symbol of family wealth. Young wives and mothers in these settings generally have the economic and social support of their families. Premarital intercourse is culturally unacceptable. Although, in Georgia, women have a higher level of education than men, most women do not have jobs appropriate to the education they have received. After marriage many women stop working or they do not have time to improve their qualifications. Working women have little free time, most of it taken up with household duties. Subsequently, women are much less active than men in the political sphere, partly because of cultural and economic constraints but also because of negative stereotypes associated with the public image of female supporters of the government in the first years after independence. Even today, when there is more exposure to mass media and western life style, changes in the status of women are lagging far behind other countries in the region. Sex education in school is largely nonexistent. Regardless of their education, most women hold no jobs or have poverty-level incomes. Poor women are less informed about lifestyle options, have less control over their lives, less understanding of their bodies, and less knowledge about and access to family planning.

Recently, the rate of childbearing has fallen below the replacement level of slightly more than two births per woman. The main method of fertility regulation is legal abortion. Despite a substantial supply of contraceptives delivered to the country (condoms, IUDs, pills and barrier devices), the contraceptive prevalence rate for modern methods remains low. Sexually transmitted diseases (STDs) and AIDS/HIV rates are reportedly increasing. Pregnancy related morbidity and mortality are higher than in most countries in Europe. For example, in 1997, 5,945 cases of complications during pregnancy, delivery and postpartum were reported to the MOH (112 per 1000 live births). In the same year, maternal mortality was also very high (70.8 deaths per 100,000 live births) but declined in 1999 to 51.3 deaths per 100,000 live births. The official infant mortality rate has decreased slightly, from 24.9/1000 in 1997 to 23.4/1000 in 1999, but is still higher than in most countries in the region. As part of its health care reform, the government plans to generalize family planning services throughout the country, to reverse the increasing levels of STDs and to improve reproductive health care services. In November 1999 the Minister of Health of Georgia ratified its new national program entitled "Development of Reproductive Services in Georgia". The new program has several components: a) family planning; b) STD-AIDS/HIV; c) antenatal and perinatal surveillance; d) sexual education; and e) training for health professionals.

A National Heath Policy Document was adopted by the Parliament in May 2000. Priorities of health in Georgia are formulated in the document. The main priorities for maintaining and improving the health of the population of Georgia until 2010 are as follows: improvement of maternal and child health; reduction of morbidity and mortality caused by cardiovascular diseases; improvement of prevention, detection and treatment of oncological diseases; reduction of traumatism; reduction of communicable and socially dangerous diseases; mental health; establishment of healthy lifestyle; provision of an environment safe for human health.

The acute demographic situation which exists in the country, a low birth rate, relatively high rates of maternal and child mortality, and increased external migration, creates the danger of depopulation. Improvement of maternal and child health and reduction of maternal and child mortality are of the great importance in the given situation. Besides, in order to improve the general state of health of the population, it is important to have a healthy start, i.e. special care and monitoring of the development of children from pre- and postnatal periods. "The priority of maternal and child health improvements is conditioned by the necessity of the formation of healthy, harmoniously developed, socially active new generation."(National Health Policy, Tbilisi, 2000)

One of the targets of the Policy is a reduction in the maternal mortality rate. To achieve this target, a comprehensive family planning system and improved pre-natal care services must be developed. Reduction of infant mortality and still birth rates, and prevention of STDs are also targets of the Health Policy. The real situation must be assessed to plan activities for the achievement of targets mentioned above. The national reproductive health survey of women 15-44 years of age conducted in Georgia at the end of 1999 and early 2000 (99GERHS) is the first nationwide survey aimed at providing a wide array of information about the current status of health of women in Georgia, including the internally displaced population. Principal objectives of the 99GERHS include the examination of different aspects of women's reproductive health and investigation of their needs in this field. Collected information will be used for service delivery improvement, for changes in health program strategies and for development of new proposals for health care improvement. The health care structure and budget in the Soviet period were standard for the entire Soviet Union and specific country information were limited; for the first time, population-based data are available at national level and needs at the regional level are also documented. Because no nationwide reproductive health survey was conducted in Georgia before, these data are valuable in describing in detail the women's reproductive health (RH) status in Georgia. The survey provides a baseline for a wide array of RH indicators, whose monitoring over time could help evaluate and tailor newly implemented interventions. The very high response rate (98%) adds confidence in the data and argues for using this methodology in the future for collecting population based health information.

At the start of the health system reform, priorities were determined by the financial abilities

of the country. As a result of the reorientation, institutional arrangements of the system have been changed and a considerable part of medical care is now based on insurance principles. Thus, the determination of priorities for the national health services has become one of the most important tasks of the national health policy program. Financial, material and human resources must be directed to selected priority areas, and the participation and responsibility of different sectors in solving problems related to the health of the population must be considered. Principles for monitoring the progress to achieve MOH priorities are the use of scientific data, evaluation, and accountability.

The primary goal of the new Health Policy is to bring about a reduction of maternal morbidity and mortality through the reduction of abortion rates. This is to be achieved principally through increased availability and improved use of modern contraception. Important topics examined in the survey were the level and trends in contraception prevalence, contraceptive method-mix, patterns of contraceptive use, and access to contraceptive services. In addition, the survey investigates women's opinions and attitudes about specific pregnancy prevention methods, their knowledge of selected reproductive health issues, and their intention to use contraception in the future, to determine how well informed the population is and to assist in the development of information, education, and communication messages.

The abrupt drop in the total population reported by the official sources (from 5,135,000 in 1998 to 4,600,000 in 1999) is due to: 1) a delayed official recognition of the massive external migration of a segment of population in search of better living conditions; and 2) the lack of population statistics from the separatist territories. Although the new total population projection is consistent with various independent population projections (e.g., US Bureau of Census, Georgia National Center for Population Study), gender and age differentials are not available and all health indicators calculated for various subgroups are clearly under-reported when the larger population figures are used as the denominator. Thus, in the absence of reliable population statistics, survey data are essential in documenting current reproductive health status and recent trends, although comparisons between survey data and official figures are likely to be greatly hampered by the lack of reliable demographic statistics.

In conclusion, Georgia has undergone major socio-economic and political changes: civil war, forced migration and population displacement, economic hardships, deterioration of social services, which have affected practically all aspects of life for it's people. About 279,000 Internally Displaced Persons (IDPs) are distributed throughout the country. About a half of this population continue to live in government facilities. More information is needed to assess the reproductive health status of the population during this transition period, a period of profound changes in health needs and access to health services. The 99GERHS was specifically designed to meet the following objectives:

-to assess fertility, abortion, contraception and various other reproductive health issues in Georgia;

-to enable policy makers, program managers, and researchers to evaluate existing reproductive health programs and develop new strategies;

-to study factors that affect fertility, contraceptive use, and maternal and infant health, such as geographic and socio-demographic factors, breast-feeding patterns, use of induced abortion, and availability of family planning services;

-to identify characteristics of women at risk of unintended pregnancy;

-to obtain data about knowledge, attitudes, and behavior of young adults 15-24 years of age;

-to provide data on the level of STDs symptoms and knowledge about transmission and prevention of AIDS;

-to identify high-risk groups and focus additional reproductive health studies toward them.

-to provide data on women living in prolonged displacement.

The survey could not be organized successfully without participation, support and cooperation of many organizations working on the American and Georgian sides. USAID, UNICEF and UNFPA were the main sources of financing the project and the main driving force behind its execution. The National Center for Disease Control (NCDC), Tbilisi, Georgia in collaboration with the MOH were responsible for implementing the survey and dissemination the results.

Leo Morris and Fiorina Serbanescu coordinated the participation of the Division of Reproductive Health (DRH), Centers for Disease Control and Prevention (CDC), Atlanta, and were responsible for technical assistance on the organization and planning of the survey, questionnaire development, data analysis, and preparation of the final report.

Special thanks to many people working in the American and Georgian government and non-government organizations, who put their time and efforts in the development and implementation of the survey.

CHAPTER II

METHODOLOGY

2.1 Sampling Design

Results of the 99GERHS are based on in-person, face-to-face interviews with 7,798 women at their homes. The survey was designed to collect information from a representative sample of women of reproductive age throughout Georgia. Of the total, 6,143 respondents were selected from the universe of all females between the ages of 15 and 44, regardless of marital status, who were living in households in Georgia (excluding South Ossetia and Abkhazia) when the survey was carried out. In addition to the household sample, a separate sample of 1,655 internally displaced (IDP) women, who formerly resided in Abkhazia and South Ossetia and currently are living in state facilities, was performed in parallel with the household survey. This strata was added to provide a complete picture of reproductive health and women's needs in Georgia. Although about half of the IDPs in Georgia live in private dwellings (either alone or with relatives), an important segment continues to live in improvised households in communal centers (located in hotels, schools, kindergartens, farms, factories and other official buildings). Currently, it is estimated that over 100,000 IDPs are living in collective centers (UNHCR, 1999). The IDP sample of the 99GERHS was selected from the universe of IDP families living in government facilities (collective centers); these women would have otherwise been omitted from the survey, which used households in residential dwellings as the sample frame. The 1,655 women selected in the IDP sample were representative of all IDP women living in state facilities in Georgia and detailed information about their reproductive health status was published separately in the 99GERHS preliminary report (Serbanescu et al., 2000). In this final report, the IDP sample, with proper statistical weighting due to the fact that they were over-sampled, was combined with the household sample to allow the survey results to represent all women of reproductive age residing in Georgia, regardless of their housing arrangements.

Field work was conducted between November 7, 1999 and March 31, 2000. The desired sample was about 6,000 respondents for the household sample, including an oversample of women in the Imereti region, and 1,500 respondents for the IDP sample. Because the response rates were higher than expected, the actual sample size exceeds the projected sample size.

The questionnaire included information on each woman's education, employment, living arrangements, and other background characteristics as well as a marital history, sexual experience, pregnancy history and contraceptive use. Additional questions investigated maternal and child health indicators, health risk behaviors which may affect reproductive health (including smoking and drinking habits), women's health screening practices, and intimate partner violence (IPV). The complete survey instrument is included as Appendix Q of this report.

The household survey utilized a multistage sampling design using an updated sampling frame prepared by the State Department of Statistics (SDS) for the Multiple Indicator Cluster Survey conducted by UNICEF in collaboration with NCDC in July 1999. The MICS survey was designed to collect nationwide data (excluding Abkhazia and South Ossetia due to political instability) with subnational estimates. Twelve regions of the country were combined into seven survey regions and separate sampling was performed in each survey region. Grouping of regions was done taking into account the geographic location and similarity of socio-economic characteristics of the population. (UNICEF, 2000). The SDS sampling frame contains all Georgian regions, districts, sectors, census enumeration units, census areas, and household addresses. The size of the smallest unit, the census area, contains 20-60 households; the following unit by size is the census enumeration unit incorporating 4—5 census areas with a size from 67 to 900 households; the sector is the combination of 3-5 census enumeration areas. All sectors are grouped in 53 *raions* (districts) that make up 12 regions (regrouped in seven regions for the MICS sampling frame). Some of the seven regions grouped for the UNICEF survey are small in size and do not always allow for independent estimates (e.g., Kakheti, Adjara). Thus, in this report the Kakheti region is part of the North-East region and Adjara is part of the West region. A detailed description of the grouped regions is footnoted in Table 2.1.

The first stage of the three-stage sample design was a selection of census sectors with probability proportional to the number of households. This was accomplished by using a systematic sample with a random start in each strata; this first stage selection included 300 sectors as follows: Tbilisi (73), Imereti-Urban (28), Other-Urban (59), Imereti-Rural (27) and Other-Rural (113). In the second stage of sampling, clusters of households were randomly selected in each census sector chosen in the first stage. Cluster size determination was based on the number of households required to obtain an average of 20 completed interviews per cluster (38 households, on average). The total number of households in each cluster took into account estimates of unoccupied households, average number of women aged 15-44 per household, the interview of only one respondent per household, and an estimated response rate of 90% in urban areas and 92% in rural areas. Finally, in each of the households selected, one woman between the ages of 15 and 44 was selected at random for interview (if there was more than one woman in the household).

The 99GERHS sample includes two oversamples: a) a regional oversampling and b) an oversampling among the internally displaced population living in government facilities. Imereti region was oversampled for programmatic reasons. As in several other recent reproductive health surveys in eastern Europe conducted with CDC technical assistance (the 1996 and 1999 three-oblast surveys in Russia, the 1999 national survey in Romania and the 1999 national survey in Ukraine), the oversampling in Imereti region illustrates how surveys may be designed and integrated in the development, monitoring, and evaluation of new reproductive health programs. The oversampling of Imereti region was specifically designed to measure the impact of a region wide Women's Reproductive Health Project, a multi-faceted effort involving national and international cooperating agencies (USAID and American International Health Alliance). The project aims at reducing the reliance on induced abortion by increasing access and availability to effective contraceptive methods and promoting healthy behaviors among women, such as routine gynecologic exams, cervical and breast cancer screening. The project encompasses various interventions, such as the establishment of modern women's health clinics, training of health professionals, development of EEC messages, social marketing, and provision of high-quality contraceptive supplies and services.

The IDP oversample was also applied for programmatic reasons—to evaluate the reproductive health status of the IDP women at the end of the reproductive health program implemented by UNHCR since 1994. In addition, it was dictated by the fact that the SDS household sample did not include internally displaced households living in non-residential government facilities (collective centers). This sample also used a three-stage design. The first stage constituted of a selection of 74 collective centers throughout Georgia, proportional to the number of IDPs living in all collective centers. Most centers were located in Samegrelo, Zemo Svaneti, and Guria regions (23), Tbilisi (20), and Imereti region (19). Because information on unoccupied IDP households and the average number of women aged 15-44 per IDP household were not available, cluster size was inferred from the household sample in urban areas, since most IDP collective centers were in urban areas. Similar to the household sample, in each of the DP households selected, only one woman between the ages of 15 and 44 was selected at random for interview. The IDP sample was labeled as the sixth strata of the 99GERHS. In the preliminary report, data for the IDP women were presented separately for programmatic reasons. In this final report, however, data for all reproductive-age women in Georgia are presented as a whole and the IDP status is identified in most stratified analyses.

The weights used for the final report include a component to adjust for oversampling of households in the Imereti region (urban and rural) and the oversampling of women in the IDP strata; another component of the final weight compensates for the fact that some households included more than one eligible respondent. Except for Table 2.1, all tables in this report present weighted results. However, the unweighted number of cases, used for variance estimation, are also shown in each table (see also Annex A). The survey can be used to make national estimates because of the elaborate and

careful process used to "weight" the data—that is, to determine how many women in the population were represented by each woman in the sample.

2.2 Data Collection

The interviews were performed by 30 female interviewers, mostly physicians, specially trained in interview techniques, questionnaire content, and survey procedures prior to the beginning of field work. Fieldwork was managed by staff of the NCDC and MOH. Interviewer training was managed by the NCDC and MOH, with the involvement of Dr. Nick Nutsubidze, survey director, Paata Imnadze, assistant survey director, Nelly Chakvetadze, project manager, and the CDC team (Dr. Anna Shakarishvili, medical epidemiologist, Dr. Fiorina Serbanescu, medical epidemiologist and Dr. Natalia Melnikova). Interviewer training took place at the NCDC headquarters just before data collection began and consisted of one week of classroom training in fieldwork procedures and proper administration of the questionnaire and one week of practical training in the field with close monitoring by the trainers. At the end of the training period, six female teams were selected, each consisting of four interviewers and one supervisor. The overall fieldwork implementation was supervised by two fieldwork coordinators (Marina Shaknazarova and Hatuna Zakhashvili). Fieldwork lasted from November 1999 through March 2000. Each team was assigned to visit a number of primary sampling units in all regions of the country. Interviews were conducted at the homes of respondents and lasted, on average, about 40 minutes (excludes 95 interviews with missing information on duration of the interview). Although most interviews were conducted in Georgian, a Russian language questionnaire was also available . All interviewers were bi-lingual. Azeri speakers assisted teams in some PSUs. Completed questionnaires were first reviewed in the field by team supervisors and then were taken by the fieldwork coordinators to the MOH National Center for Medical Statistics and Information (CMSI) headquarters for data processing.

2.3 Response Rates

As shown in Table 2.3.1, of the 14,495 households selected in the sample, 55% included at least one eligible woman (aged 15 to 44 years). Households selected in the sample in urban areas were slightly more likely to refuse an interview than in rural areas, but the refusal rates were less than one percent. In the 7,896 households with at least one eligible woman, 7,798 women were successfully interviewed (only one respondent was randomly selected per household), yielding a response rate of 98.8%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed and were very cooperative. Response rates were not significantly different by region, ranging from 98.3% in Tbilisi to 99.1% in Imereti and the North-Eastern regions (including Kakheti, Shida Kartli, Mtskheta-Mtianeti and Racha Lechkhumi).

The geographic distribution of the sample by region is very close to the official figures of the latest regional population estimates projected by the SDS (Table 2.3.2, top panel). Compared to the

cohort projections from the 1989 Census, the regional distribution of women in the sample (once adjusted for interviewing only one respondent per household and the over-sampling of the IDP women and Imereti region) closely resembles the official estimate of the population distribution. Only Guria and Samegrelo appear to be slightly over-represented, presumably because they received a more active influx of IDPs from the neighboring region of Abkhazia. Since sample size does not permit individual regional estimates (with the exception of Tbilisi, where 26% of the Georgian population resides, and Imereti, which is oversampled to allow independent estimates), all other regions are grouped geographically. The geographical grouping allows for broad regional analyses but do not imply any cultural grouping. Thus, throughout the report, the North-East region includes Kakheti, Shida Kartli, Mtskheta-Mtianeti and Racha Lechkhumi, the South region includes Kvemo

TABLE 2.3.1
Results of Household Visits and Interview Status of Eligible Women By Region
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

		Residence		Region*				
Households	**Total**	**Urban**	**Rural**	**Tbilisi**	**Imereti**	**North East†**	**South‡**	**West§**
Identified Eligible Women¶	54.5	55.4	53.1	57.0	52.0	49.7	55.7	57.0
No eligible women	35.9	34.2	38.4	33.5	38.7	39.7	31.6	35.3
Unoccupied Household	8.6	9.2	7.7	8.3	8.8	9.7	12.2	5.9
Resident(s) Not At Home	0.7	0.6	0.7	0.2	0.3	0.8	0.2	1.6
Household Refusal	0.4	0.7	0.1	1.1	0.3	0.1	0.3	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Households	**14,495**	**8,697**	**5,798**	**3,624**	**3,087**	**2,558**	**1,850**	**3,376**
Eligible Women								
Completed Interviews	98.8	98.7	98.8	98.3	99.1	99.1	98.7	98.9
Selected Respondent Absent	0.3	0.3	0.3	0.4	0.1	0.0	0.3	0.4
Selected Respondent Refusal	0.4	0.5	0.2	0.7	0.3	0.4	0.3	0.2
Other¥	0.6	0.5	0.7	0.6	0.5	0.6	0.7	0.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Eligible Women	**7,896**	**4,820**	**3,076**	**2,065**	**1,605**	**1,271**	**1,030**	**1,925**
Eligible Women Interviewed	**7,798**	**4,759**	**3,039**	**2,029**	**1,590**	**1,259**	**1,017**	**1,903**

* Except for Imereti region, which was oversampled, and Tbilisi, sample size does not permit individual regional estimates. Other regions have been grouped geographically and do not imply any cultural grouping.
† Includes Kakheti, Shida Kartli, Mtskheta-Mtianeti and Racha Lechkhumi.
‡ Includes Kvemo Kartli and Samtskhe-Javakheti.
§ Includes Adjara, Guria, Samegrelo and Zemo Svaneti.
¶ Includes women aged 15-44 with completed interviews, incomplete interviews, absentee women, women with a handicap preventing an interview, and women who refused to be interviewed.
¥ Women with a handicap and women with incomplete interviews

TABLE 2.3.2
Percent Distribution of Women with Complete Interviews* Compared with Official Estimates by Region and Age Group
Reproductive Health Survey: Georgia, 1999/2000

	Sample	±CI†	Official Estimates (1998)‡
Region¶			
Kakheti	7.4	(0.7)	8.7
Shida Kartli; Mtskheta-Mtianeti	9.9	(0.8)	10.0
Kvemo Kartli; Samtskhe-Javakheti	15.9	(1.0)	16.5
Adjara	7.3	(0.7)	7.9
Guria; Samegrelo; Zemo Svaneti	15.7	(1.0)	13.8
Racha-Lechkhumi	1.4	(0.5)	1.1
Tbilisi	26.1	(1.2)	25.7
Imereti	16.2	(1.0)	16.2
Total	100.0		100.0
	Sample	**±CI†**	**Official Estimates (2000)‡**
Age Group			
15-19	20.0	(1.1)	16.9
20-24	16.8	(1.0)	16.4
25-29	15.6	(1.0)	14.9
30-34	15.9	(1.0)	16.7
35-39	17.5	(1.0)	18.8
40-44	14.3	(0.9)	16.4
Total	100.0		100.0

* Adjusted for oversampling in the IDP sample and in the Imereti region (sample design) and for interviewing only one eligible woman per household.
† Plus or minus 95% Confidence Interval (CI)
¶ Regions are for identification purposes only to be consistent with sampling frame codes at the State Department of Statistics.
‡ Official estimates provided by Center for Medical Statistics and Information (CMSI), MOH.

Kartli and Samtskhe-Javakheti, and the West region includes Adjara, Guria, Samegrelo and Zemo Svaneti.

The percent distribution of women in the sample by five-year age groups is slightly different than the official estimates for the year 2000: the survey sample has slightly over-represented adolescent women (15-19 year-olds) and under-represented women aged 40-44 by two and one percentage point, respectively, once confidence intervals are taken into account (bottom panel of Table 2.3.2). At least two factors may have contributed to the differences observed: 1) official estimates are projections of the age composition recorded by the 1989 census and thus dependent on assumptions used in projecting the aging of a cohort; and 2) official estimates cannot rigorously account for the ethnic displacement and migration triggered by the 1991-1993 armed conflicts.

CHAPTER III

CHARACTERISTICS OF THE SAMPLE

3.1 Household Characteristics

Similar to the definition used by the Georgian State Department of Statistics, a household was defined as a person or group of persons who share the dwelling and the household expenses. Visitors were not counted in the household composition and were not included in the number of eligible respondents. After listing all eligible respondents in the household, only one woman aged 15-44 years was randomly selected for the individual interview.

TABLE 3.1.1
Size of Households with at Least One Eligible Woman by Residence and Region
Reproductive Health Survey: Georgia, 1999/2000

		Residence		Region				
Size of Household	Total	Urban	Rural	Tbilisi	Imereti	North East	South	West
No. of Persons per Household								
One	1.3	2.2	0.3	2.5	0.8	0.5	1.2	1.2
Two	6.2	8.0	3.9	9.8	5.1	5.3	5.0	4.3
Three	13.8	17.0	9.8	18.2	12.2	12.9	12.7	11.4
Four	28.8	32.9	23.6	34.1	29.2	27.4	25.9	25.7
Five	23.7	21.2	26.9	19.8	24.2	24.0	26.3	25.9
Six	15.0	11.9	19.1	9.5	18.4	18.5	14.4	16.6
Seven	6.6	4.2	9.6	3.5	6.5	6.4	9.1	8.5
Eight or More	4.5	2.8	6.8	2.6	3.7	5.0	5.4	6.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average Number	4.7	4.3	5.1	4.2	4.7	4.8	4.8	4.9
Unweighted No. of Cases*	7,895	4,819	3,076	2,065	1,604	1,271	1,030	1,925

* Excludes three households whose number of inhabitants was unknown

TABLE 3.1.2
Size of Households with at Least One Eligible Woman by the Internally Displaced Status (IDP) of the Household Reproductive Health Survey: Georgia, 1999/2000

Size of Household	Total	IDP Household	Non-IDP Household
No. of Persons per Household			
One	1.3	3.6	1.3
Two	6.2	8.0	6.1
Three	13.8	16.9	13.7
Four	28.8	35.6	28.5
Five	23.7	17.6	24.0
Six	15.0	10.8	15.2
Seven	6.6	4.3	6.6
Eight or More	4.5	3.1	4.6
Total	100.0	100.0	100.0
Average Number	4.7	4.2	4.7
Unweighted No. of Cases*	7,895	1,782	6,113

* Excludes three households whose number of inhabitants was unknown

Table 3.1.1 presents the percent distribution and average number of persons per household for households which contain at least one eligible respondent. More than half of the households with eligible respondents (52%) have four or five persons. About one in four households contains six persons or more and this proportion increases to about one in three households in rural areas.

One- or two-person households (presumably childless couples) were very uncommon in Georgia, where single women usually live with their extended families and young couples have children soon after marriage. Overall, one-person households represented only one percent of all households and were virtually non-existent in rural areas; these types of households were more frequent in urban areas (2%), including Tbilisi (3%). Two-person households were twice as common in urban areas than in rural areas (8% vs. 4%); they were most prevalent in Tbilisi (10%) whereas their prevalence in other regions was equally low (4%-5%).

A typical household containing an eligible respondent was composed of almost five persons. Households in urban areas contained fewer persons (4.3 per household) than did rural households (5.1 per household). The larger household size in rural areas can be partially explained by higher fertility levels among rural residents (see Chapter IV). The mean household size was lowest in Tbilisi, where a higher proportion of women of reproductive age live in single households and fertility is the lowest in the country (TFR=1.6 child per woman).

The average number of persons per IDP household was about 10% higher than the average number per non-IDP household (4.2 vs. 4.7 persons per household) (Table 3.1.2). The prevalence of single women in the IDP households, although small, was three times higher than in the non-IDP households (3.6% vs. 1.3%), presumably because marital dissolution and widowhood are more prevalent among these women, as shown in the preliminary report (9% of IDP women have been previously married compared to 6% among non-IDP women) (Serbanescu et al., 2000).

Socio-economic well-being of respondents is an important determinant of their reproductive health status. To assess respondents's socio-economic conditions, the 99GERHS collected information on household amenities (electricity, central heat, flush toilet, and telephone) and ownership of various goods or properties (television, refrigerator, VCR, private car, mobile phone,

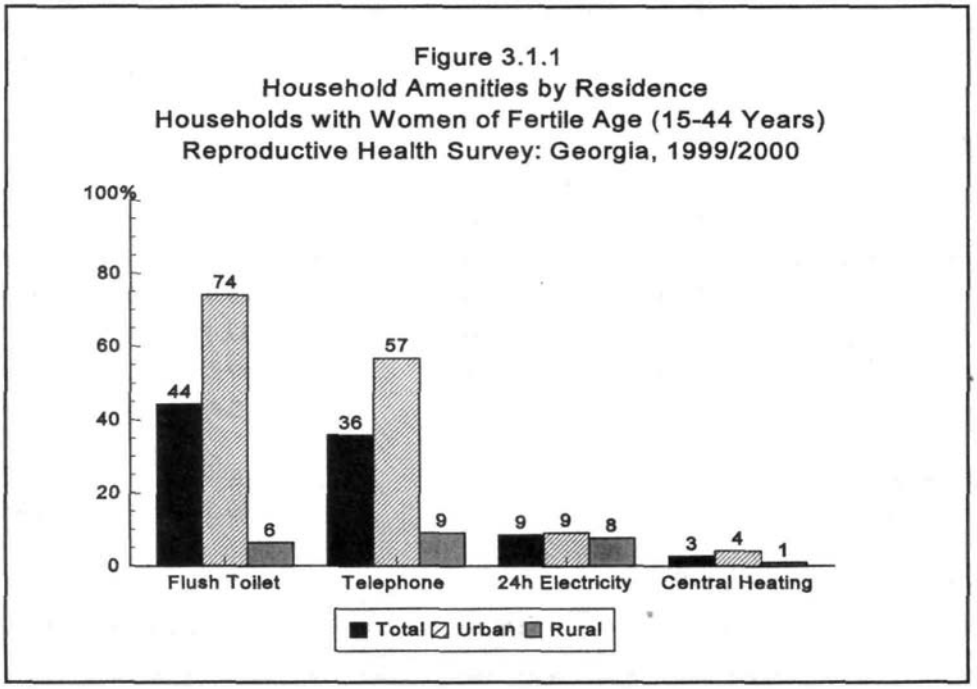
TABLE 3.1.3
Households with Women Aged 15–44 That Had Basic Household Amenities and Goods by Residence and Region
Reproductive Health Survey: Georgia, 1999/2000

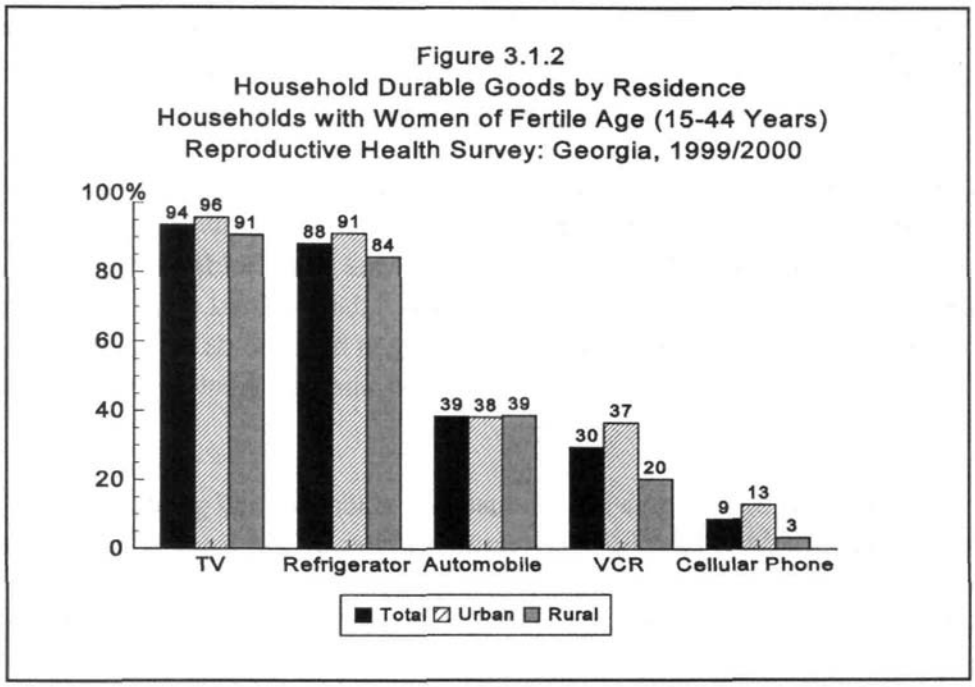
		Residence		Region				
	Total	Urban	Rural	Tbilisi	Imereti	North-East	South	West
Household Amenities								
Flush Toilet	44.3	74.1	6.4	88.1	37.8	20.3	24.8	32.3
Telephone	35.8	56.8	9.1	72.0	28.8	20.4	16.8	25.4
Electricity (24 hours)	8.5	9.1	7.7	11.6	4.4	5.9	3.9	13.0
Central Heat	2.7	4.1	1.0	5.2	1.8	1.3	2.4	1.9
Household Goods								
Television	93.6	95.8	90.8	97.2	92.3	91.5	92.6	92.9
Refrigerator	88.2	91.2	84.4	93.9	87.2	85.2	89.1	84.2
Vegetable Garden/Orchid/Vineyard	79.3	67.3	94.6	60.8	83.5	91.0	84.4	84.3
Recreational Home (Villa)	55.6	58.9	51.3	66.9	48.4	55.7	50.8	51.0
Automobile	38.5	38.3	38.8	42.8	33.0	38.6	40.5	36.0
Video recorder	29.6	36.8	20.4	48.8	17.2	22.3	27.5	23.9
Cellular phone	8.8	13.0	3.4	19.9	3.4	5.0	4.6	5.8
Crowded Conditions* **(Percentage of Households)**	56.3	66.2	43.5	78.6	40.5	50.9	64.5	40.7
Unweighted No. of Cases	7,798	4,759	3,039	2,029	1,590	1,259	1,017	1,903

* The total number of persons living in the household divided by the total number of rooms in the house (not including kitchen and bathroom) was higher than one.

vacation home, and vegetable garden or orchid or vineyard). Response options to each of these items were 'yes' and 'no'. In addition, information on the average number of hours of electricity per day and on household crowding were obtained for each respondent. Crowding was determined by dividing the total number of persons living in the household by the total number of rooms in the house (not including kitchen and bathroom); respondents were classified as living in crowded conditions (more than one person per room) or not living in crowded conditions (one or fewer person per room).

Table 3.1.3 and Figure 3.1.1 show the percentage of respondents living in households with basic amenities by residence. On average, less than half of respondents live in households with flush toilets and about one in three has a telephone line at home. The proportion of households with such amenities varies significantly by residence. For example, urban women are 12 times more likely than rural residents to have flush toilets, and six times more likely to have a telephone. Tbilisi has by far the highest prevalence of households with these amenities; the majority of households have flush toilets (90%) and almost three fourths have a telephone. Conversely, in other regions, fewer than one-third of households has a flush toilet and fewer than one-fourth has telephone coverage. Virtually all households in Georgia are affected by the electricity shortage that has plagued the country since it declared independence from the former Soviet Union. Less than one in ten women live in households with 24-hour-per-day electricity (during the winter months). Power shortage is the highest in the West regions of Adjara and Samegrelo, where less than 2% of households have uninterrupted power supply. On average, a Georgian household has only seven hours of electrical





power per day and 50% of households have electricity only six hours per day (data not shown). The power supply is most limited in rural areas, where 50% of households have only four hours of electricity per day (compared to urban areas where 50% of households have seven hours daily coverage).

Most Georgian households lack central heating. Heating practices changed after Georgia left the former Soviet Union principally because of the economic turmoil suffered during the past decade and the country's dependence on natural gas supplied by Russia. Georgia lacks internal resources and has not been able to afford to pay for gas or oil imports. Recently, most households have used wood for heating individual rooms.

As shown in Table 3.1.3 and Figure 3.1.2, among durable consumer goods, television is available in almost every household with women of reproductive age (94%), with slightly higher coverage in urban areas (96%) than in rural areas (91%). Almost all households have refrigerators (84-94%), especially in Tbilisi (94%) and other urban areas (91%). As expected, almost all women of reproductive age in rural areas live in households which have vegetable gardens, orchards, or vineyards (95%), whereas only one half of urban households have such gardens. Almost 40% of women live in households with automobiles and this proportion does not vary significantly by their place of residence. About one in two families own a vacation home or a secondary residence (56%). Respondents in urban areas, especially in Tbilisi, were more likely than rural residents to own an additional residence. Video recorders are not very widespread in Georgia. Only one in three households in urban areas and 20% in rural areas own a video recorder. The use of mobile phones

is still low (only 9% of women reported that they have one) and concentrated in urban areas. Interestingly, they are mostly owned by households which also have telephone lines whereas only 6% of households without phones have mobile phones (data not shown).

The level of household crowding is another important indicator of housing conditions. Overall, more than half (56%) of reproductive-age women live in crowded conditions. Crowding is significantly higher in urban households (66%) than in rural households (44%), though the average number of persons per household is lower in urban areas than in rural areas. The most crowded households are in Tbilisi—79% of women reported living in households with more than one person per room. The least crowded households are in Imereti and the Western regions of Adjara and Samegrelo (41%).

As shown in Table 3.1.4, some basic household amenities and goods are more likely to be missing in the IDP households. Telephone coverage is lower in IDP households compared to non-IDP households (24% vs. 36%). Similarly, many durable goods (e.g. television set, VCR, refrigerator, car) are more likely to be missing in IDP households than in non-IDP households.

TABLE 3.1.4
Households with Women Aged 15–44 That Had Basic Household Amenities and Goods by the IDP Status of the Household
Reproductive Health Survey: Georgia, 1999/2000

	Total	IDP Status	
		IDP Household	Non-IDP Household
Household Amenities			
Flush Toilet	44.3	62.7	43.4
Telephone	35.8	23.8	36.4
Electricity (24 hours)	8.5	15.3	8.1
Central Heat	2.7	1.7	2.8
Household Goods			
Television	93.6	87.0	93.9
Refrigerator	88.2	56.0	89.9
Vegetable Garden/Orchard/Vineyard	79.3	42.4	81.2
Recreational Home (Villa)	55.6	25.8	57.1
Automobile	38.5	21.6	39.4
Video recorder	29.6	20.2	30.1
Cellular phone	8.8	7.5	8.8
Crowded Conditions* (Percentage of Households)	56.3	77.7	55.1
Unweighted No. of Cases	7,798	1,828	5,970

* The total number of persons living in the household divided by the total number of rooms in the house (not including kitchen and bathroom) was higher than one.

Since most IDP families live in urban areas, they are far less likely to own an orchard or a vegetable garden than the non-IDP families (42% vs. 81%). Moreover, since most of their possessions were left behind in the secessionist regions of Abkhazia and South Ossetia, they are less likely to have a secondary residence or vacation house than non-IDP households (26% vs. 57%).

Although the average family size did not significantly vary among IDP and non-IDP households, the level of crowding, greatly influenced by living conditions, is much higher in IDP households. Over three-fourths of the IDP families live in crowded living spaces compared to only 55% of the non-IDP families.

All of these household amenities and goods, including living in uncrowded conditions and having electricity 24 hours per day, were summed to create a score to classify the socio-economic status (SES) of the household. Equal values were assigned for possession of each amenity or good. For each household this inventory yielded a score whose reliability was assessed using the Cronbach coefficient alpha. Based on this initial evaluation only ten items were selected for use in the socio-economic score (alpha coefficient=.61) Possession of a vegetable garden, orchard or vineyard and having electricity 24 hours a day were not included in the final score. These items were excluded since the score is based exclusively on possession of items that are associated with higher socio-economic status. Possession of a garden is inversely correlated with socio-economic status and the electricity shortage in Georgia households is practically universal.

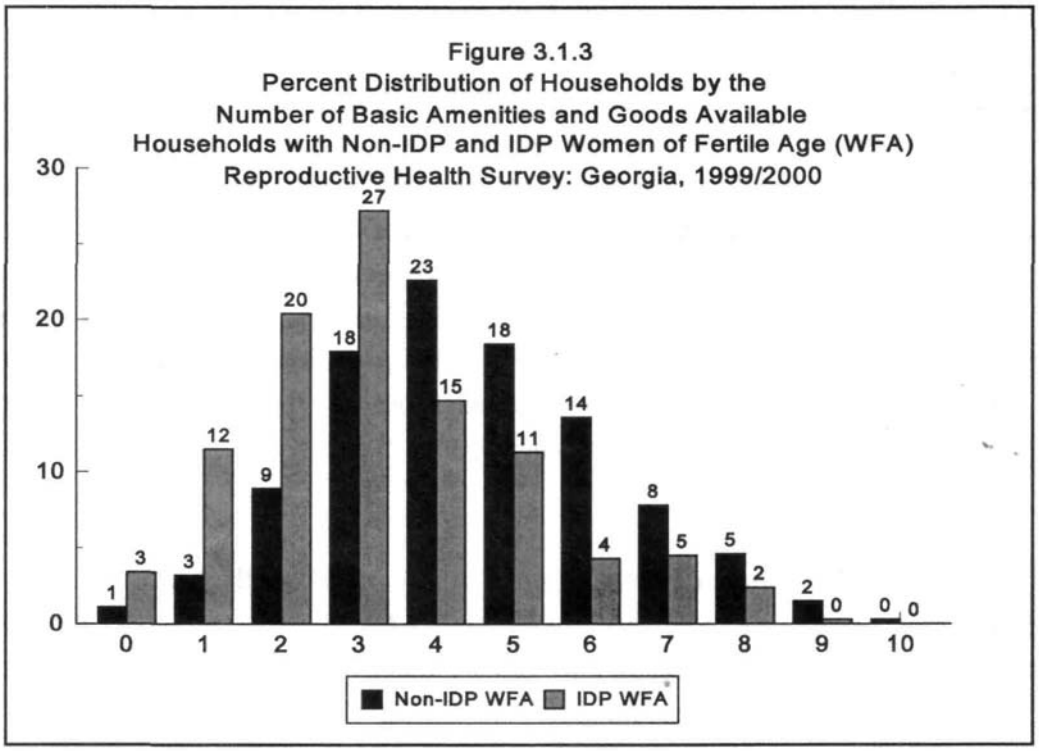


Figure 3.1.3 shows the percent distribution of households by their SES score; the score ranged from 0 to 10, where 0 represented the lower end (no amenities and goods included in the score) and 10 represented the higher end (all 10 items included in the score). The score was further divided into terciles to create three levels for the socio-economic status variable (SES). 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. The same methodology to assess the socio-economic distribution of the population was applied in other reproductive health surveys in Eastern Europe and former Soviet Union countries.

According to this computation, one third of reproductive age women in Georgia live in households with a low socio-economic status, about one half have a middle socioeconomic status, and only 14% are classified as high socioeconomic status. As shown in Figure 3.1.2, the IDP women consistently report living in households with fewer amenities and goods than the non-IDP women. Likewise, among these women, the percentage having low SES is twice as high as among non-IDP women (63% vs. 31%) whereas the percentage with high SES is only 7% vs 14% among non-IDPs (data not shown).

3.2 Characteristics of Eligible Women

General characteristics of respondents with completed interviews, by residence, are shown in Table 3.2.1. Overall, 37% of the respondents were young adults from 15 to 24 years of age. The age distribution did not vary significantly by the place of residence. However, a substantially higher proportion of Azeri women were between the ages of 15 and 24 than in any other ethnic group (data not shown). A slight majority of women were legally married (60%) and less than one percent were in consensual (unregistered) marriages or living with a partner but not married. These two categories constitute the universe of currently married or in union respondents. Women residing in rural areas were somewhat more likely to be in a legal or consensual marriage (65%) than women living in Tbilisi (56%) or other urban areas (59%). Divorce and separation appeared to be uncommon in Georgia, reflected by the fact that only 6% of women reported that they were previously married (slightly higher in Tbilisi). One of three women (33%) had never been married or lived with a partner.

Consistent with the pattern of a rapid decline in birth rates which characterizes all countries of the region, Georgia is also a low-fertility country, with a total fertility rate under the replacement level of two children per woman. Overall, 40% of women in the sample were childless, 15% had only one child, 31% had two children and only 14% had three or more children.

TABLE 3.2.1
Characteristics of Women with Completed Interviews by Residence
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

Characteristic	Total	Residence		
		Tbilisi	Other Urban	Rural
Age Group				
15-19	20.0	17.3	19.5	21.9
20-24	16.8	18.0	18.0	15.2
25-29	15.6	16.6	13.9	16.1
30-34	15.9	16.6	16.3	15.2
35-39	17.5	18.1	17.0	17.6
40-44	14.3	13.4	15.4	14.0
Marital Status				
Married	60.0	54.1	58.3	64.7
Consensual Union	0.8	1.4	0.6	0.5
Previously Married	6.0	8.4	5.9	4.5
Never Married	33.3	36.1	35.2	30.3
No. of Living Children				
None	39.6	42.5	40.3	37.3
One	14.8	19.2	15.9	11.4
Two	31.3	30.9	32.5	30.8
Three	11.5	6.5	9.0	16.2
Four+	2.8	0.9	2.3	4.2
Education				
Secondary Incomplete	16.7	9.3	13.3	23.4
Secondary Complete	33.4	26.9	30.5	39.2
Technical College	23.8	20.8	28.2	22.6
University	26.1	43.0	28.0	14.8
Socioeconomic Index				
Low	32.8	12.5	28.5	47.7
Middle	53.4	57.7	57.6	48.0
High	13.9	29.9	14.0	4.3
Church Affiliation				
Georgian Orthodox	78.9	87.3	87.7	67.9
Armenian Apostolic	3.1	5.1	0.5	3.7
Other Orthodox	1.3	2.5	1.3	0.6
Muslim	13.2	0.9	7.3	24.6
Other	2.1	3.2	1.7	1.8
None	1.3	1.0	1.6	1.3
Employment				
Working	22.5	30.4	25.4	15.7
Not Working	77.5	69.6	74.6	84.3
IDP Status				
IDP	4.9	5.4	8.5	2.2
Non-IDP	95.1	94.6	91.5	97.8
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,798	2,029	2,730	3,039

Fertility was higher in rural areas, where only 37% of women were childless (compared with 43% in Tbilisi and 40% in other urban areas) and 20% reported three or more children, three times as many as in Tbilisi (7%) and twice as many as in other urban areas (11%).

Georgians are well educated, as evidenced by the fact that only 17% of women did not complete secondary education. Most of the respondents who did not complete secondary education were older respondents or very young respondents, who were still in secondary school (data not shown). Respondents residing in Tbilisi and other urban areas were more likely to be better educated than those in rural areas. The urban-rural difference was most pronounced at the postsecondary level, where women of reproductive age living in Tbilisi or other urban areas were approximately three and two times more likely, respectively, to have completed university training than their rural counterparts (43% and 28%, respectively, vs. 15%).

One-third of respondents lived in households classified as low socio-economic status (SES); more than half lived in middle socio-economic households and only one of seven lives in an upper socio-economic household. The percentage of respondents living in lower SES households was four times and almost two times higher, respectively, among rural residents than among Tbilisi or other urban residents. At the same time, only 4% of rural women were classified as living in upper SES households, compared with 31% and 15%, respectively, of those living in Tbilisi or other urban areas.

The dominant religion among survey respondents was Georgian Orthodox; 79% of respondents overall (only 68% in rural areas) stated they belong to this religious denomination. Other Orthodox denominations were far less prevalent: Armenian Apostolic (3%) and Russian or Greek Orthodox (1%). The majority of respondents who were not Orthodox said they were either Muslims (13%) or had other church affiliation (2%) whereas only 1% of women declared they had no religious affiliation. The majority of Muslims lived in rural areas where they constituted a fourth of the population (25%); in Tbilisi and other urban areas they represented only 1% and 8%, respectively, of the total population.

Most women (77%) reported that they did not work outside the house (even part time). Because of lower job availability, rural women were less likely to work outside the house (16% vs. 30% in Tbilisi and 25% in other urban areas), which contributes further to the urban-rural differences in SES.

Approximately 5% of all women of reproductive age in Georgia were internally displaced (IDP) by the secessionist war in Abkhazia and South Ossetia. Most of the internally displaced families in Georgia resided in urban areas (80%) in temporary housing conditions in government

facilities (hotels, schools, factories, and other state institutions). Almost half of them (41%) had fled Abkhazia to seek residence into the neighboring Samegrelo region where they constituted 13% of women of reproductive age. In some urban areas of Samegrelo region (e.g., Zugdidi) the IDP women represented up to 21% of women of fertile age (data not shown). About a fourth of the IDP women resided in Tbilisi (representing 5% of women aged 15-44) and 18% in the Imereti region (6% of women aged 15-44).

For most of the background characteristics, there were no significant differences between the IDP and non-IDP women. The lower SES (62% vs. 31%), slightly higher un-employment rate (82% vs. 77%) and overwhelmingly Georgian ethnic background (98% vs. 82%) among the IDP group represented the only notable exceptions (data not shown).

Variation in ethnic background and main language spoken in the household by residence and region are shown in Table 3.2.2 and Figure 3.2. About four of five women reported themselves to be Georgian (83%), 9% Azeri, 5% Armenian, 1% Russian, and 3% of other ethnic backgrounds. Georgian was the principal language spoken in the household for the majority of respondents (83%), followed by Azeri (8%) and, to a lesser extent, by Armenian (4%) and Russian (3%). Women of Azeri background were more likely to live in rural areas (17%) than in Tbilisi (1%) or other urban areas (5%). They constituted almost half of the population of the southern part of the country. The Armenian population was concentrated either in Tbilisi, where they represent 7% of the population, or in the Southern region, in rural settlements close to the Georgian-Armenian border (13%).

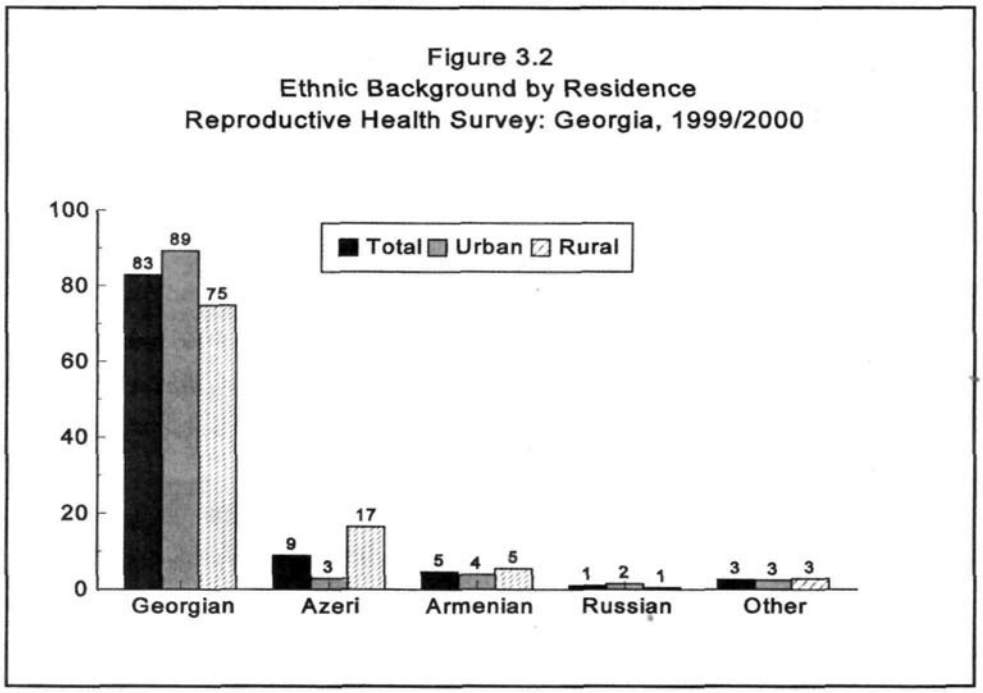


TABLE 3.2.2

Ethnicity and Main Language Spoken in the Household by Residence and by Region

Women Aged 15–44 Years

Reproductive Health Survey: Georgia, 1999/2000

(Percent Distribution)

Characteristic	Total	Residence	
		Urban	Rural
Ethnicity			
Georgian	82.9	89.3	74.8
Azeri	8.9	2.9	16.5
Armenian	4.6	3.9	5.4
Russian	1.0	1.5	0.5
Ossetian	0.5	0.4	0.6
Other*	2.1	2.1	2.2
Language			
Georgian	83.2	90.0	74.4
Azeri	8.3	2.6	15.6
Armenian	3.5	2.0	5.3
Russian	2.9	4.5	0.7
Mengrelian (Georgian dialect)	1.1	0.4	2.0
Other	1.1	0.5	1.9
Total	100.0	100.0	100.0
Number of Cases	7,798	4,759	3,039

	Total	Region				
		Tbilisi	Imereti	North East	South	West
Ethnicity						
Georgian	82.9	86.0	98.9	83.1	39.5	97.9
Azeri	8.9	0.8	0.1	7.3	45.6	0.1
Armenian	4.6	7.1	0.3	2.8	12.9	0.4
Russian	1.0	2.0	0.3	0.6	0.4	1.2
Ossetian	0.5	0.5	0.0	1.6	0.2	0.0
Other*	2.1	3.6	0.5	4.6	1.3	0.4
Language						
Georgian	83.2	88.1	98.7	86.7	40.7	93.2
Azeri	8.3	0.3	0.1	6.0	44.5	0.0
Armenian	3.5	3.4	0.0	2.6	12.8	0.2
Russian	2.9	7.2	0.9	0.6	1.5	2.0
Mengrelian (Georgian dialect)	1.1	0.0	0.1	0.0	0.0	4.6
Other	1.1	0.8	0.2	4.1	0.4	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,798	2,029	1,590	1,259	1,017	1,903

* Includes Kurds (Iezidi), Kistians, Avarkans, Chechnians, Greeks, Ukrainians and other ethnic groups.

TABLE 3.2.3
Marital Status by Age Group for Women Aged 15–44 Years with Completed Interviews by Residence
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status				
Residence	Age Group	Currently Married	Previously Married	Never Married	Total	No. of Cases
Total	**15–44**	**60.8**	**6.0**	**33.3**	**100.0**	**7,798**
Total	15–19	15.6	0.2	84.2	100.0	1,142
	20–24	48.8	3.7	47.5	100.0	1,246
	25–29	70.7	6.2	23.1	100.0	1,312
	30–34	79.1	7.2	13.7	100.0	1,419
	35–39	82.4	8.7	8.9	100.0	1,523
	40–44	80.3	11.7	8.0	100.0	1,156
Urban	15–19	12.5	0.0	87.5	100.0	666
	20–24	39.2	4.0	56.8	100.0	778
	25–29	66.9	7.1	25.9	100.0	765
	30–34	76.4	8.7	14.9	100.0	882
	35–39	80.1	10.9	9.0	100.0	946
	40–44	77.4	13.5	9.0	100.0	722
Rural	15–19	18.8	0.5	80.7	100.0	476
	20–24	63.1	3.4	33.5	100.0	468
	25–29	75.2	5.1	19.7	100.0	547
	30–34	82.9	5.1	12.0	100.0	537
	35–39	85.3	5.9	8.8	100.0	577
	40–44	84.1	9.3	6.7	100.0	434

As shown in Table 3.2.3, some important differences in marital experience exist between urban and rural residents. Overall, almost one of two women 20-24 years of age (49%) was legally married or in a consensual union and an additional 4% were previously married. The proportion of ever married women among rural residents was about 50% higher than among urban women (67% vs. 43%). By age 30, however, the difference in marital experience between urban and rural residents tended to disappear; the proportion of women currently or ever married increased to 85% and 88%. Women in urban areas were much more likely to postpone marriage, probably because they delayed marriage until after they completed their desired educational level; once they advanced beyond postsecondary education they resembled the same marital patterns as their rural counterparts. The effect of school attendance on marital behaviors was particularly visible among young adults; 19% of rural women aged 15-19 and 67% of rural women aged 20-24 had ever been married but only 13% and 43%, respectively, had done so in urban areas. Marriage dissolution among the oldest respondents was 50% higher in urban than in rural areas (14% vs. 9%).

TABLE 3.2.4
Educational Attainment by Age Group for Women with Completed Interviews by Residence
Reproductive Health Survey: Georgia, 1999/2000

		Education Level					
Residence	Age Group	Primary or Less	Secondary Incomplete	Secondary Complete	College & University	Total	Unweighted No. of Cases
Total	**15–44**	**16.7**	**33.4**	**23.8**	**26.1**	**100.0**	**7,798**
Total	15–19	53.0	38.5	4.9	3.6	100.0	1,142
	20–24	10.5	42.1	18.0	29.5	100.0	1,246
	25–29	6.6	29.0	26.4	38.1	100.0	1,312
	30–34	5.4	28.8	33.6	32.2	100.0	1,419
	35–39	6.5	30.0	33.3	30.3	100.0	1,523
	40–44	9.3	30.0	31.7	29.0	100.0	1,156
Urban	15–19	46.9	40.2	7.5	5.4	100.0	666
	20–24	5.7	39.7	18.2	36.3	100.0	778
	25–29	3.2	21.2	25.9	49.8	100.0	765
	30–34	2.0	21.4	33.7	42.9	100.0	882
	35–39	3.0	23.9	33.1	40.0	100.0	946
	40–44	3.0	23.1	33.2	40.7	100.0	722
Rural	15–19	59.6	36.7	2.1	1.6	100.0	476
	20–24	17.6	45.7	17.6	19.1	100.0	468
	25–29	10.6	38.2	27.1	24.1	100.0	547
	30–34	10.2	39.0	33.4	17.4	100.0	537
	35–39	11.0	37.6	33.5	17.8	100.0	577
	40–44	17.7	39.1	29.6	13.6	100.0	434

Table 3.2.4 presents the percent distribution of respondents by the highest level of education attained, according to age and residence. Overall, women aged 25-29 years (age by which the university training is usually completed) were more likely than older women to have a postsecondary education. As expected, women in urban areas were much better educated (high school completed or higher education level) in each age group; for example, among urban women aged 20-24, 75% had completed secondary school compared with only 37% in rural areas. Also, the proportion of women with a university education was two times higher in urban areas (36%) than in rural areas (19%). Similarly, the urban-rural disparity in education was also notable among older residents. Urban residents, regardless of their age, were almost twice as likely as rural residents to have completed high school or a higher level of education.

CHAPTER IV

FERTILITY AND PREGNANCY EXPERIENCE

One objective of the 99GERHS was to assess the current levels and trends of reproductive behaviors and to identify factors that might change such behaviors. Policy makers and program managers may use the findings presented here to design programs that respond to the reproductive behavior of the population and tailor them to meet the needs of key subgroups. To obtain information about reproductive patterns, the questionnaire included a series of questions about marriage, divorce, sexual activity, contraceptive use, childbearing and the use of induced abortion, infertility, desired family size, planning status of all pregnancies in the last five years, and information about prenatal care for all births during the past five years. Information about pregnancies (births, abortions, and fetal losses) was collected through a complete pregnancy history for each woman 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 examination of fertility and abortion differentials by background characteristics and behaviors. In addition, the survey explores in depth the circumstances surrounding each abortion or birth within the past five years, documenting utilization of abortion services and prenatal care and the prevalence of pregnancy-related morbidity.

4.1 Fertility Levels and Trends

During the past decade, scientifically designed nationwide population-based surveys of reproductive health have been conducted in many countries of eastern Europe and the former Soviet Union with support from USAID and UN agencies and technical assistance from the Centers for Disease Control (Reproductive Health Surveys) or Macro Incorporated (Demographic Health Surveys). All these surveys used similar methodology and questionnaires, allowing for good comparability across countries.

Such surveys have been implemented in countries that share a common history in recent decades, including the social, political and economic changes since the fall of communism, that profoundly influenced their health policies and practices; countries that inherited state subsidized health care systems modeled after the Russian centralized system (Semashko model), well-known

Table 4.1.1
Three-Year* Age-Specific Fertility Rates and Total Fertility Rates per 1000 Women Aged 15–44
Reproductive and Demographic Health Surveys in Selected Eastern European and Former Soviet Union Countries, 1993–2000

Country	Age Specific Fertility Rate (per 1000)†						Total Fertility Rate‡
	15–19	20–24	25–29	30–34	35–39	40–44	
Eastern-European Region							
Czech Republic, 1993	49	176	92	41	11	4	**1.9**
Romania, 1993	49	129	83	33	12	5	**1.6**
Romania, 1999	36	100	83	29	13	2	**1.3**
Russia (three oblasts§), 1996	36/36/60	98/108/140	62/56/55	31/31/30	4/11/5	3/3/0	**1.2/1.2/1.5**
Russia (three oblasts§), 1999	46/39/41	83/109/128	68/72/80	30/25/21	8/16/10	8/3/3	**1.2/1.3/1.4**
Moldova, 1997	57	158	88	40	17	6	**1.8**
Ukraine, 1999	49	114	66	36	14	4	**1.4**
Caucasus Region							
Georgia, 1999-2000	65	113	92	48	22	7	**1.7**
Armenia, 2000	50	149	88	35	16	3	**1.7**
Central Asian Region							
Kazakhstan, 1995	64	190	136	67	35	7	**2.5**
Kazakhstan, 1999	40	167	106	64	24	9	**2.1**
Uzbekistan, 1996	61	266	176	114	39	9	**3.3**
Kyrgyz Republic, 1997	75	246	179	113	47	13	**3.4**
Turkmenistan, 2000	30	184	195	105	48	14	**2.9**

* Three years prior to the interview.
† Age at Pregnancy Outcome.
‡ Number of Births per Woman.
§ Yekaterinburg, Perm, and Ivanovo, respectively.
Source: Goldberg et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu et al. 1994, 1998, 2001.

for their lack of funds, relative inefficacy in terms of structure, management and resource allocation, and unresponsiveness to the patients' needs. Demographically, most of these countries have much in common in the areas of fertility and fertility regulation practices. As shown in Table 4.1.1, except for Uzbekistan and Kyrgyz Republic, most countries have relatively low fertility rates that have decreased even more recently, with high levels of childbearing among women in their 20's, followed by sharp declines at age 30 or over.

TABLE 4.1.2
Three-Year* Age-specific Fertility Rates and Age-specific Marital Fertility Rates
Per 1,000 Women Aged 15-44
Reproductive Health Survey: Georgia, 1999/2000

Age-Specific Fertility Rate (per 1,000)	All Women	Ever Married Women†
15-19	65	377
20-24	113	200
25-29	92	118
30-34	48	55
35-39	21	24
40-44	(7)	(8)
Total Fertility Rate (per woman)	**1.7**	**3.9**

* Live births occurring between December 1996-November 1999
† Excludes births occurring before the date of first union.
( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis

As in the other survey projects conducted in eastern Europe and the former Soviet Union countries, current levels of fertility in Georgia were estimated using age-specific fertility rates calculated from information collected through the respondents' lifetime pregnancy histories. The total fertility rate (TFR) was computed by accumulating the age-specific fertility rates and multiplying the sum by five. The TFR is thus defined as the average number of live births a woman would have during her reproductive lifetime (15-44) if she experienced the currently observed age-specific fertility rates. Numerators for the age-specific fertility rates were calculated by selecting live births that occurred during the 36-month period preceding the survey and grouping them (in five-year age groups) by the age of the mother at the time of pregnancy outcome (calculated from the mothers' reported date of birth). The denominators for the rates represent the number of woman-years lived in each specified five-year age group by those mothers during the three-year period preceding the survey. The total fertility rate for the three years preceding the survey (December 1996-November 1999) was 1.7 births per woman (see Tables 4.1.1 and 4.1.2), slightly under replacement level.

Similar to other countries of the region, Georgian women initiate and complete childbearing at an early age (Table 4.1.1). The highest fertility levels are among 20-24-year-old women, accounting for a third of the TFR, and among 25-29-year-olds, accounting for 27% of the TFR (Tables 4.1.1 and 4.1.2). Notably, fertility among adolescent women (65 births per 1,000 women aged 15-19) is the third highest, contributing to 19% of the TFR in Georgia; it is also the second

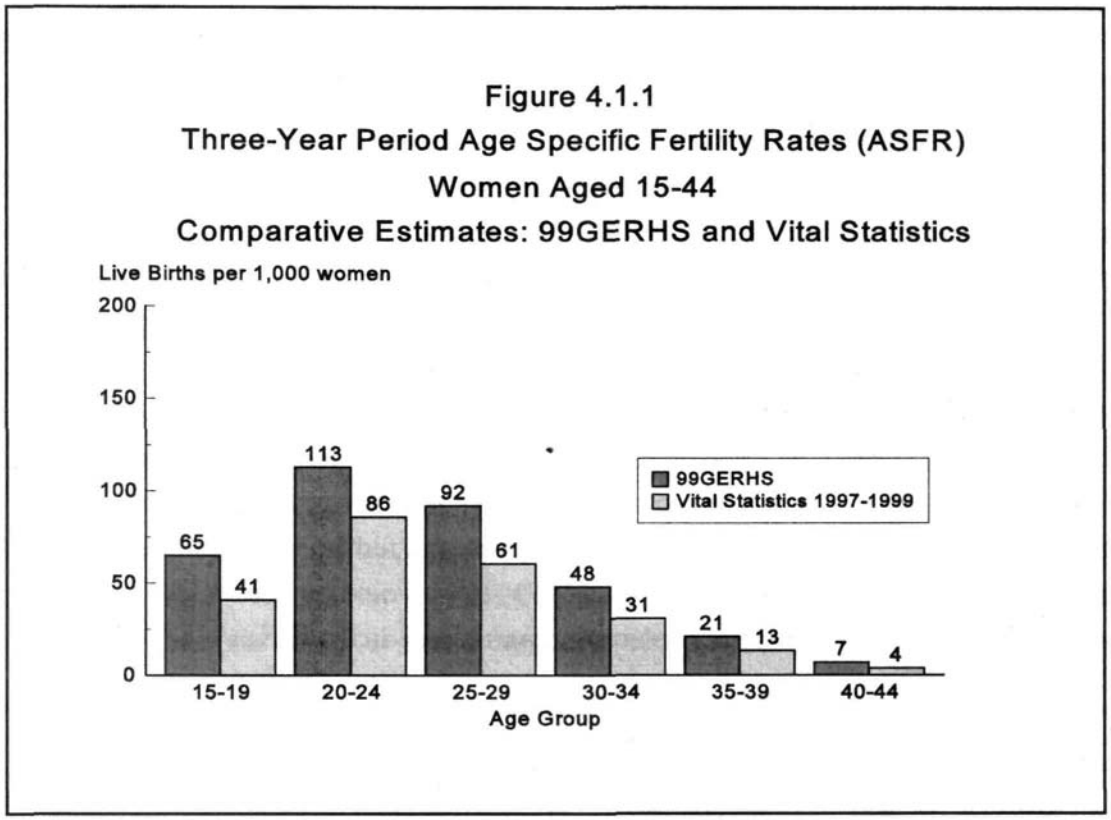
highest adolescent fertility rate in Eastern European and former Soviet Union countries with population-based data available . Thus, 51% of the TFR in Georgia is contributed by women aged 15-24 years old. Women aged 35-39 and 40-44 make minimal contributions to total fertility; their age-specific fertility rates account for only 6% and 2%, respectively, of overall fertility.

The age pattern of marriage in Georgia is comparable with other countries of the region but younger than in the western Europe (data not shown). Survey results show that the median age at first marriage among women aged 15-44 (15-49 in Central Asian republics and Armenia) is between 20-22 years of age in all countries mentioned in Table 4.1.1. Since the probability of having the first birth is much higher among married women and there is a strong desire to initiate childbearing soon after marriage (median age at first birth is typically 1-2 years after marriage), a high marital fertility rate among the youngest women is also typical in the region. In addition, out-of-wedlock births are very rare in Georgia and unmarried women contribute very little to overall fertility.

As shown in Table 4.1.2, young married women (15-24) have much higher age-specific fertility rates than all young adult women (377 vs. 65 births per 1,000 women aged 15-19 and 199 vs. 113 births per 1,000 women aged 20-24); likewise, total fertility among married women was more than twice as high as for all women 3.9 vs. 1.7), which implies that extramarital fertility plays a minor role in overall fertility. After age 30 there is no significant difference between marital fertility and fertility of all women, since almost all women have marital experience by that age. Other fertility determinants (education attainment, ethnic background) are also likely to play a role in increased marital fertility rate among young adult women (see also Table 4.4.2).

Figure 4.1.1 compares age specific fertility rates calculated from information recorded in each woman's pregnancy history with the rates published by the official vital statistics. Overall, the three-year period TFR estimated from the 99GERHS is about 40% higher than the most recent vital statistics estimates (the TFR reported by the State Department for Statistics for the same period of time is 1.2 births per woman aged 15-49). Similarly, the general fertility rate (GFR), defined as the number of births per 1,000 women of reproductive age (15-44), was 66 births per 1,000 women aged 15-44 when calculated from the survey data but only 38/1000 according to the vital records. Several factors may have contributed to these discrepancies. The official fertility rates were calculated using denominators that included 1989 census projections of the population living in the separatist territories of Abkhazia and Tskhinvali (South Ossetia) regions. According to the SDS Statistical Yearbook (State Department for Statistics, 1999), almost 600,000 persons (11% of the 1993 population) were living in these territories in 1993, the last year for which data were available (516,600 in Abkhazia and 49,200 in the Tskhinvali region). By calculating age specific fertility rates using the overestimated population projections, the SDS fertility rates are likely to be smaller than

the actual rates. Independent experts from the National Center for Population Study estimated that, without the population living in the separatist territories, the Georgia population in 1999 was approximately 4.1 million inhabitants, far less than the SDS projections after Abkhazia and Tskhinvali (South Ossetia) regions were excluded (National Center for Population Studies, 1999).



Nevertheless, the difference between the survey estimates and the official rates are too large to be entirely explained by inflated population projections or survey sampling errors. Under-reporting of pregnancy events in the birth registration system is another likely explanation. The total number of live births reported by the State department of Statistics (based on birth certificates issued by the civil registries) is lower than the number reported by the Ministry of Health (MOH) (based on hospital delivery records), sometimes by a considerable margin. For example, the Center of Medical Statistics and Information of the MOH reported in 1997 almost 1,000 births more than the SDS, and in 1999, the difference was about 6,000 births (Center of Medical Statistics and Information, 2000). Overall, the number of live births reported by the MOH for 1997-1999 is 5% higher than the number reported through the vital statistics. This discrepancy is probably rooted in the underreporting of births in civil registries. Because the process of issuing a birth certificate

demands a fee paid by parents and there is no immediate need for those certificates, parents frequently postpone registration through civil registry bureaus until the child reaches the school-age years. Other causes of underreporting that will affect both official systems are under-registration of home deliveries (the survey found approximately twice as many home deliveries as those reported by the MOH) and deliveries that took place in the neighboring countries (Maternal and Child Health Department/MOH, CMSI/MOH, SDS, 2000).

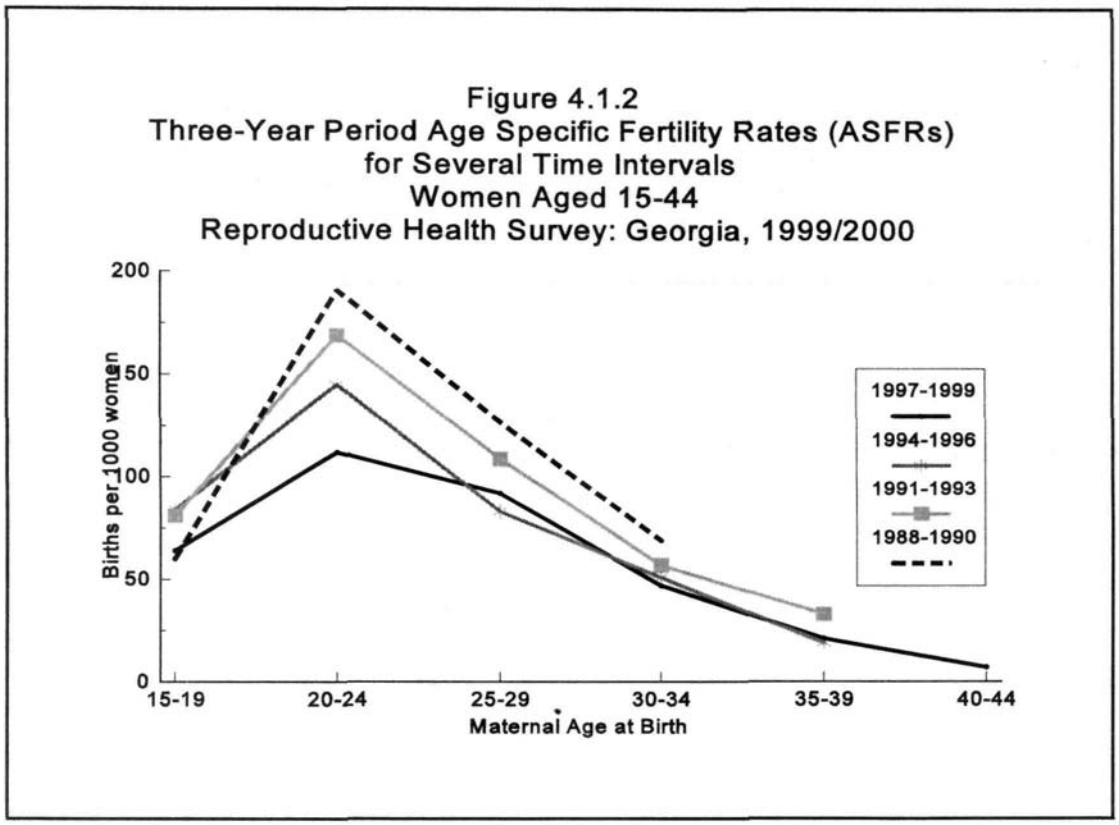
The survey also allows us to document fertility trends over time. According to the vital records, the total fertility rate (TFR) in Georgia decreased slowly from 2.6-2.7 in 1960-1970 to 2.4-2.5 births per woman in 1971-1979 and stabilized around 2.3 births per woman during the 1980-1989 period. After 1993, however, the TFR abruptly fell to 1.2-1.4 and continued to decline to its lowest level in 1999 (1.1 births per woman), although this recent steep decline is questionable (see above). However, evidence of the recent fertility decline in Georgia is also substantiated by the survey results but to a far lesser extent. Table 4.1.3 and Figure 4.1.2 present three-year-period ASFRs between 1988-1999 calculated directly from the information on live births and maternal age (age at outcome) recorded in the respondents' pregnancy histories. Since women 45-49 years of age and women over 49 years of age were not interviewed in the survey, by going farther back in time the rates for older women (age at outcome) represent partial fertility rates due to the truncation of the time exposure (e.g., women aged 35-39 in 1991-1993 would be aged 42-47 in 1999 but only those aged 44 or less would have been selected to participate in the survey).

TABLE 4.1.3
Three-Year* Age-specific Fertility Rates for 1987-1999
By Woman's Age at the Time of Birth
Reproductive Health Survey: Georgia, 1999/2000

Mother's Age at Birth	1997-1999*	1994-1996	1991-1993	1988-1990
15-19	64	84	81	60
20-24	112	145	169	191
25-29	92	83	109	127
30-34	47	51	57	(69)
35-39	21	19	(33)	-
40-44	7	-	-	-

* Live births occurring between January 1997-November 1999

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



Compared to previous years (1991-1996), fertility declines in 1997-1999 are notable in the youngest age groups (women age 20-24 and 15-19, respectively). For example, between 1991-1993 and the most recent three-year period (1997-1999), the ASFRs for 15-29-year-old women have declined by 21%, 34%, and 16%, respectively. Fertility declines among older women, whose contribution to the overall fertility is quite low, were less substantial.

Table 4.1.4 shows the cumulative past fertility of women interviewed in the 99GERHS (calculated as the percent distribution of women by number of live births and stratified by current age of each woman at the time of the interview). Overall, 39% of all women aged 15-44 were childless at the time of the interview, but only 8% of women currently in union had not had their first child. Very few women reported birth before age 20 (8%) whereas by age 29 69% of all women had given birth to at least one child. About one in ten women remained childless at the end of her reproductive-age years. Among currently married women, one of two women 15-19 years of age had already had her first child, 85% of women 20-24 years did, and over 90% of women 30 years of age or older did. Only 3% remained childless by 40—44 years of age.

TABLE 4.1.4
Number of Children Born Alive by Current Age of Respondents
Among All Women and Among Women Currently in Union Aged 15–44
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

	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	39.3	91.6	56.5	31.1	17.4	13.0	11.4
1	18.8	6.8	24.2	25.2	22.0	17.4	20.8
2	29.1	1.6	17.2	34.9	43.3	44.4	40.7
3	10.4	0.0	2.0	7.6	14.3	20.5	20.9
4 or more	2.4	0.0	0.1	1.1	3.1	4.7	6.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,798	1,142	1,246	1,312	1,419	1,523	1,156

	Women in Union						
Number of Children Born Alive		Age Group (Current Age)					
0	8.1	45.9	15.0	8.5	3.6	3.8	3.1
1	27.0	43.9	47.0	31.7	23.5	17.5	19.3
2	44.8	10.2	33.8	47.5	51.3	50.0	45.8
3	16.3	0.0	4.1	10.7	17.7	23.2	24.5
4	3.8	0.0	0.2	1.6	3.8	5.5	7.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	5,177	227	673	975	1,134	1,251	917

4.2 Fertility Differentials

Table 4.2 shows the age-specific fertility rates and total fertility rates among different subgroups. Fertility among women living in Tbilisi or other urban areas was, on average, 25% less than among rural women in the three-year period preceding the interview. With the exception of age group 40-44, all age-specific fertility rates were higher among rural residents than among urban residents; the differences are particularly important among younger women (15-19 and 20-24 years of age). By region, women living in Tbilisi had the lowest level of fertility (1.5 births per woman) whereas women living in the North-East and South regions—where a higher percentage of Muslims reside— had the highest fertility rate (1.9 births per woman). Again, most differences in age-specific fertility rates by region were among young adults.

There is little variation in the TFR by education level. Fertility differences according to education are slightly more notable among younger women and diminish among older women. Generally, women with the highest educational attainment had the peak of their fertility at ages 25-29 whereas women with lower education reached their highest fertility at 20-24 years of age. Women with low SES had, on average, two births* per woman, compared with 1.5 and 1.7 births per woman, respectively, among women with middle and high SES. Azeri women had the highest fertility rate among women aged 15-19 (189 births per 1000), four times higher than the ASFR of Georgian or Armenian women; for other ethnic groups fertility peaks at age 20-24 (Figure 4.2).

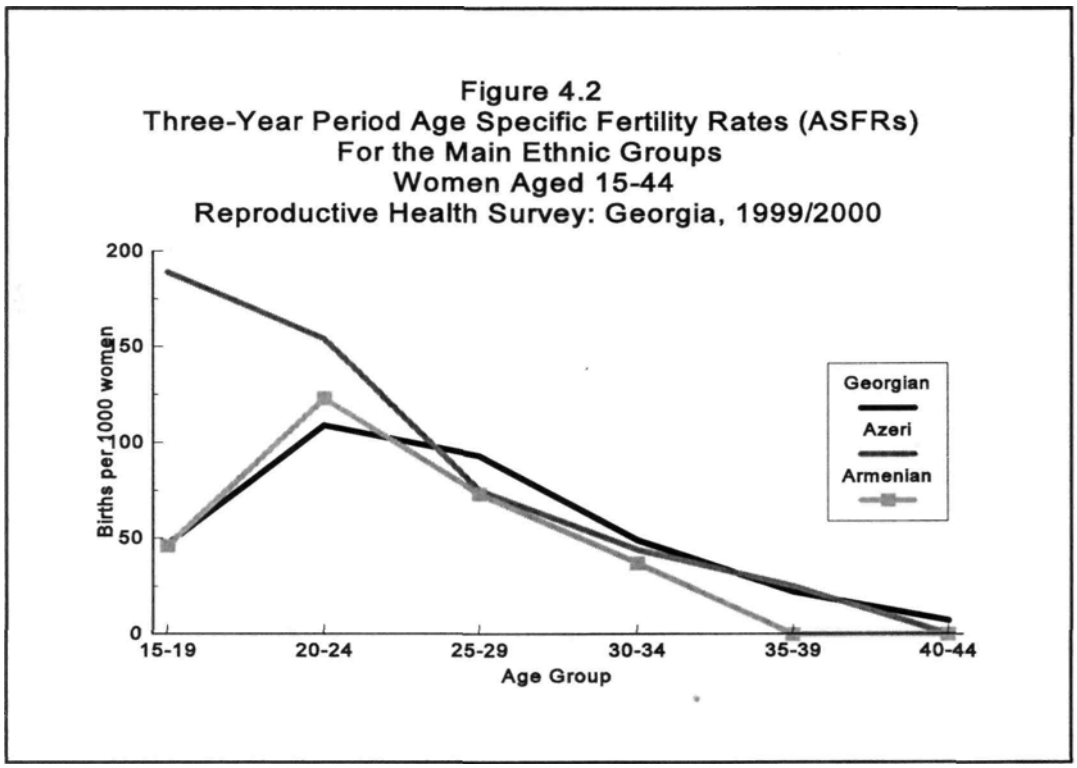


TABLE 4.2

Three-year* Age-specific Fertility Rates and Total Fertility Rates Among All Women Aged 15-44, by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Age-Specific Fertility Rate†						Total Fertility Rate
	15-19	20-24	25-29	30-34	35-39	40-44	
Total	**64**	**113**	**92**	**48**	**21**	**7**	**1.7**
Residence							
Urban	49	93	91	43	19	8	**1.5**
Rural	84	142	92	55	25	6	**2.0**
Region							
Tbilisi	47	97	90	49	17	9	**1.5**
Imereti	40	106	101	48	32	5	**1.7**
North-East	96	113	84	57	27	7	**1.9**
South	102	126	103	40	12	3	**1.9**
West	49	132	87	47	22	8	**1.7**
Education							
Secondary or Less	67	122	78	40	17	3	**1.6**
Technicum	65	121	95	48	27	9	**1.8**
University/Postgraduate	46	100	103	58	21	11	**1.7**
Socioeconomic Status							
Low	78	139	102	58	36	6	**2.1**
Middle	59	98	86	42	14	8	**1.5**
High	52	121	89	49	16	6	**1.7**
Ethnicity							
Georgian	47	109	93	49	22	7	**1.6**
Azeri	189	154	75	44	25	0	**2.4**
Armenian	46	123	73	37	0	0	**1.4**
Other‡	113	98	149	48	24	24	**2.3**
IDP Status							
IDP	60	141	111	58	17	0	**1.9**
Non-IDP	65	112	91	48	22	1	**1.7**

* Live births occurred between December 1996-November 1999.

† Age at Pregnancy Outcome.

‡ Includes Russians, Ossetians, Kurds (Iezidi), Kistians, Avarkans, Chechnians, Greeks, Ukrainians and other ethnic groups.

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. At the time the 99GERHS was carried out, almost two thirds (61%) of women aged 15-44 were currently married (60%) or living in a consensual union (1%) (Table 4.3). Six percent of women were widowed, divorced, or separated (from a spouse, or a partner in a consensual union), subgroups that collectively constitute the category of "previously married". One in three women (33%) had never been married or lived with a partner.

Women living in rural areas were more likely to be currently married (either legal or consensual marriage) than urban women (65% vs. 57%). The proportion who were previously married was slightly higher in urban areas than in rural areas (7% vs. 5%). Thus, urban women are less likely than rural women to be married and less likely to stay married. Women residing in Tbilisi were less likely to be currently in a marital relationship although they were the most likely to have consensual unions.

The proportion of all women who were in a formal or consensual union starts at almost 15% among 15-19-year-olds, increased rapidly to 48% among women aged 20-24 and to 70% among 25-29-year-olds; it reached a maximum of about 80% for women aged 35-44. Consensual unions were uncommon across all age groups. Separation, divorce and widowhood increased with age, reaching a maximum of 12% among women aged 40-44. The proportion of never-married women decreased abruptly with age, from 84% among 15-19-year-olds, to 48% among women aged 20-24, 23% among women aged 25-29, and 13% among women aged 30-34. Among women aged 35 or older, about 8% 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 (36%) than among women with a secondary complete or higher education (61% or higher). However, after controlling for current age, a quite different pattern was observed. Among older women, the likelihood of being in a marital relationship, either consensual or formal, was inversely correlated with education. For example, over 80% of 20-24-year-old women who did not complete high school were in union, compared to 44%-47% of 20-24-year-olds with postsecondary education; the same pattern was observed at older ages. The only women for which marital status did not vary by education was the group of 15-19-year-olds, whose likelihood of being married was equally low (16%), regardless of their educational attainment. Since 63% of women with less than complete secondary education were 15-19 years of age, most of them had not yet completed their schooling and had not yet married, reflecting the fact that women tend to delay marriage until after completing their education (data not shown).

TABLE 4.3

Current Marital Status for Women Aged 15–44 Years by Selected Characteristics Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Marital Status: Married	Consensual Union	Previously Married	Never Married	Total	Unweighted No. of Cases
Total	**60.0**	**0.8**	**6.0**	**33.3**	**100.0**	**7,798**
Residence						
Urban	56.3	1.0	7.1	35.6	100.0	4,759
Rural	64.7	0.5	4.5	30.3	100.0	3,039
Region						
Tbilisi	54.1	1.4	8.4	36.1	100.0	2,029
Imereti	58.4	0.5	4.1	37.1	100.0	1,590
North-East	64.2	1.2	4.7	29.9	100.0	1,259
South	65.5	0.4	7.4	26.7	100.0	1,017
West	60.6	0.2	4.6	34.7	100.0	1,903
Age Group						
15–19	14.8	0.7	0.2	84.2	100.0	1,142
20–24	48.2	0.5	3.7	47.5	100.0	1,246
25–29	69.7	1.1	6.2	23.1	100.0	1,312
30–34	78.5	0.7	7.2	13.7	100.0	1,419
35–39	81.6	0.7	8.7	8.9	100.0	1,523
40–44	79.3	1.0	11.7	8.0	100.0	1,156
Education						
Secondary Incomplete or Less	35.9	1.0	3.5	59.6	100.0	991
Secondary Complete	61.0	0.7	6.2	32.0	100.0	2,664
Technicum	73.7	0.8	6.6	18.9	100.0	2,058
University/Postgraduate	61.5	0.7	6.6	31.2	100.0	2,085
Socioeconomic Status						
Low	60.3	0.6	6.5	32.5	100.0	3,276
Middle	59.6	0.8	6.0	33.6	100.0	3,654
High	60.6	1.2	4.4	33.8	100.0	868
Ethnicity						
Georgian	58.8	0.6	5.3	35.3	100.0	6,700
Azeri	66.4	1.4	8.4	23.9	100.0	589
Armenian	64.4	0.8	9.5	25.3	100.0	300
Other	64.7	2.3	12.7	20.3	100.0	209
IDP Status						
IDP	59.3	0.6	5.8	34.3	100.0	1,828
Non-IDP	60.0	0.8	6.0	33.2	100.0	5,970

TABLE 4.4.1
Percent of Women Aged 15-44 Who Had Their First Sexual Relation, First Union, and First Birth Before Selected Ages, By Current Age
Reproductive Health Survey: Georgia, 1999/2000

Current Age	Age at First Sexual Intercourse					Has Had Sexual Intercourse	Never Had Intercourse	Median Age	N° of Cases*
	<15	<18	<20	<22	<25				
15-19	2.5	(13.8)	(15.8)	NA	NA	15.8	84.2	†	1,142
20-24	2.2	24.5	39.5	(49.5)	(52.7)	52.7	47.3	†	1,246
25-29	0.8	20.3	43.7	58.1	71.2	77.0	23.0	20.9	1,312
30-34	0.6	14.4	36.6	55.2	72.5	86.7	13.3	21.4	1,419
35-39	0.4	12.3	34.9	52.5	71.2	91.0	9.0	21.7	1,522
40-44	0.4	12.0	32.1	51.5	68.4	92.1	7.9	21.8	1,154
Total	**1.2**	**16.2**	**33.1**	**45.8**	**56.8**	**66.8**	**33.2**	**21.5**	**7,795**

Current Age	Age at First Union					Ever In Union	Never In Union	Median Age	N° of Cases*
	<15	<18	<20	<22	<25				
15-19	2.5	(13.8)	(15.8)	NA	NA	15.8	84.2	†	1,142
20-24	2.2	24.2	39.2	(49.1)	(52.7)	52.5	47.5	†	1,246
25-29	0.6	20.0	42.7	57.9	71.1	76.9	23.1	20.9	1,312
30-34	0.6	13.0	34.9	54.7	71.9	86.3	13.7	21.5	1,419
35-39	0.5	11.9	34.6	51.6	70.9	91.0	9.0	21.8	1,521
40-44	0.6	11.0	29.9	50.4	67.6	92.0	8.0	21.9	1,156
Total	**1.2**	**15.7**	**32.3**	**45.3**	**56.5**	**66.7**	**33.3**	**21.6**	**7,796**

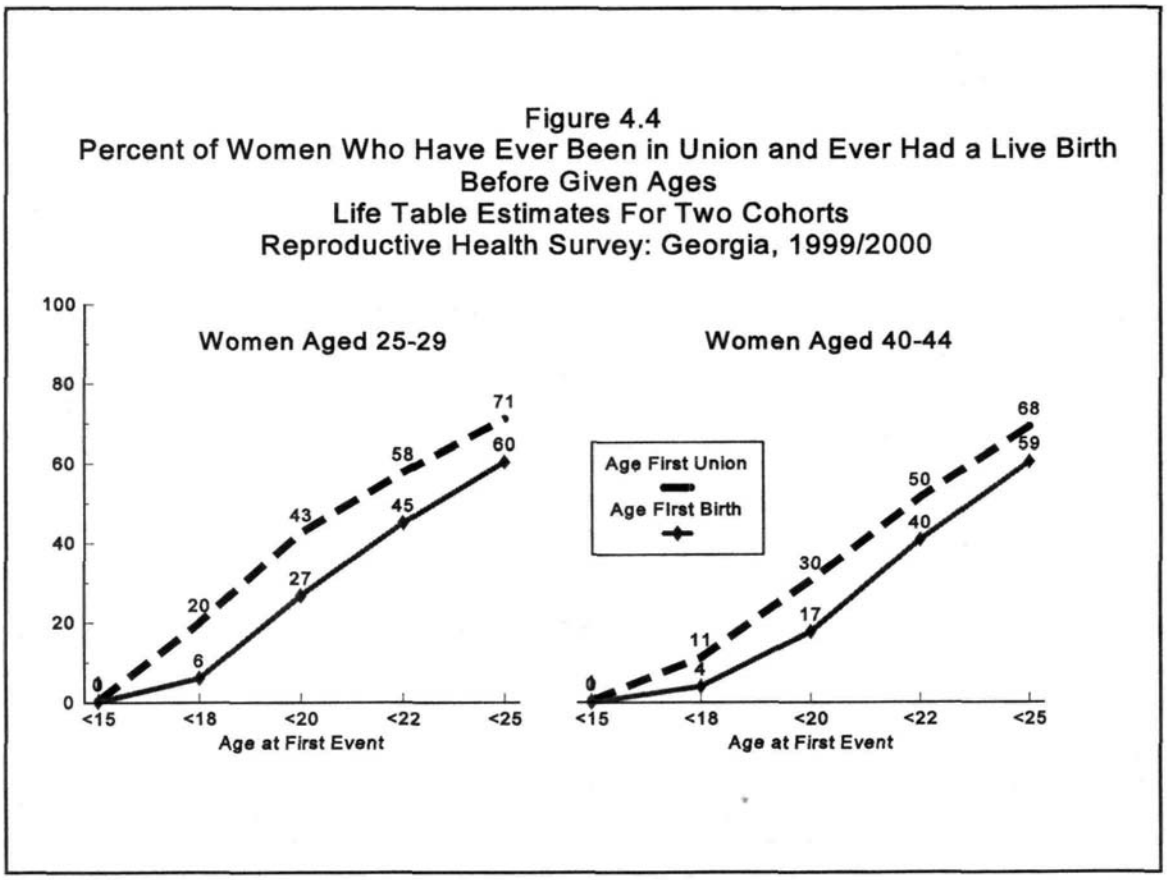
Current Age	Age at First Live Birth					Has Had Live Birth	Never Had Live Birth	Median Age	N° of Cases*
	<15	<18	<20	<22	<25				
15-19	0.5	(6.2)	(8.4)	NA	NA	8.4	91.6	†	1,142
20-24	0.1	11.1	30.7	(39.1)	(43.4)	43.5	56.5	†	1,246
25-29	0.2	6.1	26.8	45.1	60.4	68.9	31.1	22.8	1,312
30-34	0.2	4.0	20.5	42.1	64.9	82.5	17.5	22.7	1,419
35-39	0.1	3.3	19.7	40.0	61.7	87.0	13.0	23.3	1,523
40-44	0.1	3.9	17.3	39.9	59.1	88.3	11.7	23.4	1,156
Total	**0.2**	**5.8**	**20.2**	**34.7**	**47.9**	**60.6**	**39.4**	**23.0**	**7,798**

( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis
NA Not Applicable
* Excludes three cases not reporting the date of first sexual intercourse and two cases not reporting date of first union.
† Omitted because less than 50% in that age group had married by the age at the beginning of the interval.

4.4 Age at First Sexual Intercourse, Union and Birth

Age at first union and age at first sexual intercourse plays 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 overall fertility since postponing the first birth may contribute to the decline of the total fertility rate.

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 (Table 4.4.1) . The left side of the table shows the proportion of respondents within each age cohort (five year age group) 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 respondents categorized by their current ages it is possible to detect whether the age of occurrence of each event has been changing over time. For example, the proportion of women who had sexual intercourse before age 20 has increased from



32% among 40-44 year olds to 40% among 20-24 year-olds; however, the proportion who reported premarital sexual experience remained essentially unchanged between these two cohorts, since age at first intercourse and age at first union are virtually identical in all cohorts.

In Georgia sexual abstinence before marriage was and still is a common practice. Women have traditionally been considered keepers of community and social values. Apparently, traditional norms are very strong and have not been altered by recent changes that have influenced young adult reproductive behaviors in the industrialized world. Although the profound political transformations in the countries of eastern Europe and former Soviet Union have deeply affected every aspect of life, including reproductive health perceptions and behaviors, the age patterns of sexual activity, marriage, and motherhood in Georgia have changed very little.

As shown in Table 4.4.1, premarital sexual intercourse is uncommon throughout all cohorts, demonstrated by virtual identical median ages at first intercourse and first marriage for each cohort. Regardless of her age, a typical Georgian woman spends about a month, if any, between first intercourse and first marriage. Although young women aged 25-29 were initiating sexual activity about a year earlier than older women (e.g., women aged 40-44) they also marry a full year earlier. Thus, there are essentially no differences across subgroups in the time interval between the first intercourse and the first union.

The most notable change between cohorts (e.g., 25-29- and 40-44-year-olds) is manifested in the pattern of marital relationships (see also Figure 4.4). As mentioned previously, a higher proportion of women in the younger cohorts have had their first marriage before age 20 (39% among 20-24-year-olds and 44% among 25-29-year-olds) compared to the older cohorts (32% among 40-44-year-olds). Consequently, there has been a decrease in the median age at first union by a full year, from 21.9 to 20.9, between the 40-44-year-old cohort and the 25-29-year-old cohort.

The age at first birth has also decreased for younger cohorts, paralleling the decrease in the age at first union. However, the time interval between the first union and the first birth within each cohort has gradually increased. For example, the median age at first birth among 25-29-year-olds was 1.9 years later than their median age at first union, whereas median age at first birth among 40-44 year olds was 1.5 years later than their median age at first union. These findings suggest that younger cohorts tend to marry younger than older cohorts but the onset of childbearing is slightly later than for the older cohorts. Overall, among all reproductive age women, 83% have already had their first union by age 30 and 78% already had their first live birth (data not shown).

Table 4.4.2 presents the median age at first sexual intercourse, union, and birth for women aged 15—44 by selected background characteristics. Urban women initiate sexual activity, union and

childbearing at a slightly older age than rural women. The median age at first intercourse, first union and first birth are delayed by about 1.5 years for women residing in urban settings than for women living in rural areas. The median age at first birth for women residing in Tbilisi is postponed even further (two years). However, the intervals between these events are similar for urban and rural residents, which may explain the lack of significant differences in fertility rates by residential area. Differentials in median age of experiencing these events are even greater for different levels of education. The median age at first intercourse and first marriage were 4.6 years older for women with university education than for those with less than complete secondary education; similarly, median age at first birth was 5.8 older for better educated women. Ethnic Georgian women exhibit consistently older median ages at first intercourse, union and birth whereas Azeri women exhibit the youngest ages at either of these events (2.6 and 2.3 years between these two groups in the median ages at first union and first birth, respectively).

TABLE 4.4.2
Median Age at First Sexual Intercourse, First Union and First Birth by Selected Characteristics
Women Aged 15-44
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Median Age at First Intercourse	Median Age at First Union	Median Age at First Birth
Total	**21.5**	**21.6**	**23.0**
Residence			
Urban	22.1	22.2	23.7
Rural	20.6	20.7	22.1
Region			
Tbilisi	22.6	22.6	24.2
Imereti	22.0	22.0	23.5
North-East	20.9	20.9	22.3
South	20.1	20.2	21.7
West	21.6	21.6	23.1
Education			
Secondary Incomplete or Less	19.0	19.2	20.4
Secondary Complete	20.1	20.2	21.3
Technicum	21.5	21.5	22.9
University/Postgraduate	24.6	24.7	26.2
Ethnicity			
Georgian	21.9	22.0	23.4
Azeri	19.3	19.4	21.1
Armenian	20.0	20.1	21.2
Other	20.9	21.0	22.6

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 therefore in need of contraceptive services. It also has major implications in the selection of a contraceptive method that best suits the reproductive behavior and fertility preferences of each individual. Detailed information about the proportion of women in need of family planning services and their contraceptive choices is presented in Chapter IX.

As shown in Table 4.5, 67% of all women aged 15-44 who were interviewed in the 99GERHS reported they had previously had sexual intercourse but only 49% were currently sexually active (within the month preceding the interview). If we exclude respondents who have never had intercourse, 77% of sexually experienced women were currently sexually active. Almost 4% of all women were pregnant and 4% reported postpartum abstinence at the time of the interview.

In Table 4.5 information on sexual activity status is presented by marital status and by current age. Among women who were married or living with a partner, 80% reported having intercourse at least once within the past month and 5% had intercourse two or three months previously. Conversely, only 3% of previously married women were in a current sexual relationship. The

Figure 4.5
Reported Sexual Activity Status, Women Aged 15-44
Reproductive Health Survey: Georgia, 1999/2000

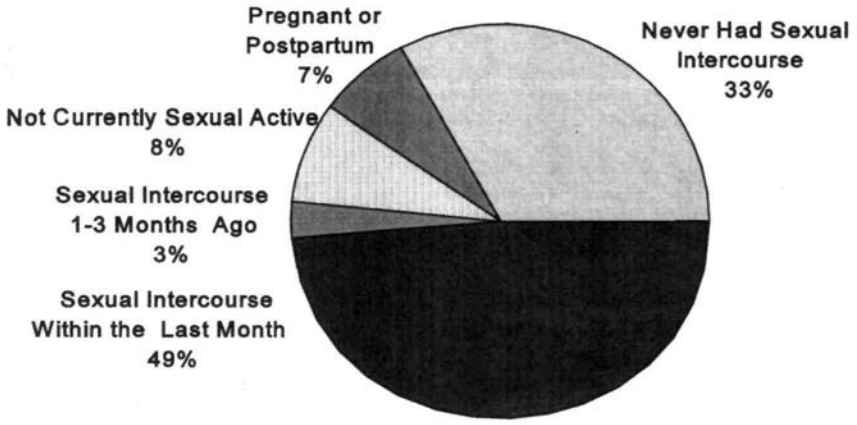


TABLE 4.5

Sexual Activity Status by Current Marital Status and by Current Age
Women Aged 15-44 Years
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status		
Sexual Activity Status	**Total**	**Married/ In Union**	**Previously Married**	**Never Married**
Never Had Intercourse	33.1	0.0	0.0	99.6
Currently Pregnant	3.6	5.9	0.0	0.0
Postpartum	3.7	5.5	5.0	0.0
Ever Had Intercourse				
• Within the Last Month	48.9	80.3	2.8	0.0
• 1-3 Months Ago	3.0	4.5	4.6	0.0
• Over 3 Month Ago but Within Last Year	1.8	2.2	7.0	0.0
• One Year or Longer	5.5	1.4	76.7	0.2
• One Month or Longer-Unknown Interval	0.4	0.2	3.9	0.1
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,798	5,177	517	2,104

		Age Group		
Sexual Activity Status	**Total**	**15-24**	**25-34**	**35-44**
Never Had Intercourse	33.1	67.3	18.1	8.5
Currently Pregnant	3.6	4.9	4.7	0.9
Postpartum	3.7	4.6	4.9	1.5
Ever Had Intercourse				
• Within the Last Month	48.9	20.4	60.9	70.1
• 1-3 Months Ago	3.0	0.9	3.5	5.0
• Over 3 Month Ago but Within Last Year	1.8	0.8	1.8	2.9
• One Year or Longer	5.5	1.1	5.7	10.5
• One Month or Longer-Unknown Interval	0.4	0.1	0.4	0.6
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,798	2,388	2,731	2,679

majority of previously married women (77%) reported that their last sexual intercourse was one or more years ago. Less than one percent of never-married women reported that they have ever had sexual experience and none of them reported current sexual activity.

Only one of three young adult women (15-24 years of age) reported sexual intercourse and only 62% of those who were sexually experienced reported their last sexual encounter within the past 30 days. Almost 10% were currently pregnant or postpartum. Among women aged 25 years or older, over 80% reported sexual experience. Of those, three fourths had had intercourse within the past month. About 7% of sexually experienced women aged 25 years or older had had their last intercourse one or more years ago.

4.6 Planning Status of the Last Pregnancy

For each pregnancy ended since January 1994, all respondents were asked about the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either planned (wanted at the time it occurred), mistimed (occurring earlier than intended), unwanted (the respondent wanted no more children), or unsure. Mistimed and unwanted pregnancies together constitute unintended pregnancies (Westoff, 1976). This report includes only estimates of the planning status for the last pregnancy in this time period. One common problem in collecting data about planning status of pregnancies is that self-reported induced abortions, especially those performed outside medical facilities, are often under-estimated. Consequently, unintended pregnancies are under-reported to the extent that abortions are under-reported. Another problem that might occur for pregnancies that end in live births is postpartum rationalization. Some women may change their opinion about pregnancy intendedness after the child is born or may be reluctant to admit that it was an unintended pregnancy. Therefore, the planning status of the last pregnancy almost certainly represents an underestimate of mistimed and, particularly, unwanted conceptions, for pregnancies ended either in abortions or in live births. Despite the potential under-reporting of unintended conceptions, the figures in Table 4.6 show some important differences in the level of pregnancy intendedness according to pregnancy outcome and background characteristics. These data may underscore the need to address the risk of unintended pregnancy differently for various subgroups.

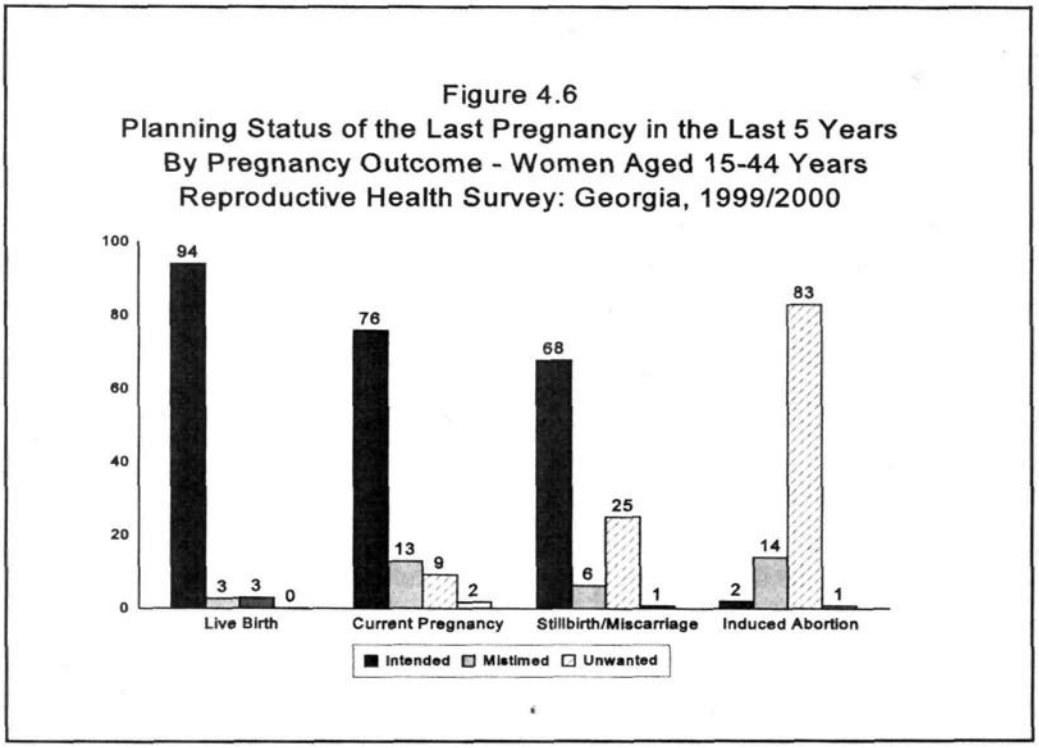
Less than one of two women of childbearing age (40%), regardless of their marital status, said their most recent pregnancy was intended at the time of conception; 10% reported it as mistimed (wanted at a later time) and 49% reported it as unwanted. Thus, 59% of women reported their last pregnancy as unintended and the majority of them (83%) reported it was unwanted rather than mistimed. Almost all women whose last pregnancies resulted in live births said those births were

TABLE 4.4

Planning Status of the Last Pregnancy Among Women 15-44 Years of Age With at Least One Pregnancy Since January 1994 by Selected Characteristics Reproductive Health Survey: Georgia, 1999/2000

	Planning Status of the Last Pregnancy					
Characteristic	**Intended**	**Mistimed**	**Unwanted**	**Not Sure**	**Total**	**No. of Cases**
Total	**40.4**	**10.1**	**48.9**	**0.7**	**100.0**	**3,406**
Pregnancy Outcome						
Current Pregnancy	75.9	13.0	9.3	1.8	100.0	305
Live Birth	94.0	2.8	3.0	0.2	100.0	1,079
Induced Abortion	2.0	14.1	83.1	0.8	100.0	1,864
Other Pregnancy Outcomes*	67.9	6.3	25.1	0.7	100.0	158
Residence						
Urban	39.0	11.2	49.3	0.5	100.0	1,960
Rural	41.9	8.9	48.3	0.9	100.0	1,446
Age Group†						
15-24	61.9	14.5	22.9	0.8	100.0	1,065
25-34	34.9	10.2	54.1	0.8	100.0	1,676
35-44	19.1	3.2	77.4	0.3	100.0	665
Marital Status						
Currently Married/In Union	39.9	10.1	49.4	0.7	100.0	3,295
Previously Married	54.2	10.7	34.4	0.7	100.0	108
Never Married	‡	‡	‡	‡	‡	3
No. of Living Children						
None	90.7	4.5	3.1	1.7	100.0	184
One	58.6	21.0	19.3	1.0	100.0	926
Two	28.4	8.0	63.3	0.4	100.0	1,639
Three or More	30.4	2.5	66.5	0.6	100.0	657
Education Level						
Secondary Incomplete or Less	50.4	6.8	41.3	1.5	100.0	312
Secondary Complete	38.6	10.0	50.6	0.7	100.0	1,171
Technicum	35.0	9.5	55.0	0.5	100.0	969
University/Postgraduate	43.8	12.0	43.7	0.5	100.0	954
Ethnic Group						
Georgian	39.7	10.6	49.0	0.6	100.0	2,868
Azeri	49.6	6.7	43.1	0.6	100.0	303
Armenian	30.0	8.1	60.5	1.3	100.0	139
Other	40.7	11.4	47.0	1.0	100.0	96
IDP Status						
IDP	42.2	10.1	47.6	0.3	100.0	680
Non-IDP	40.3	10.1	48.9	0.7	100.0	2,726

* Includes pregnancies resulting in stillbirth, miscarriage or ectopic pregnancy
† Age of the woman at the time of pregnancy outcome
‡ Fewer than 25 cases in that category



intended (94%). As shown in Figure 4.6, very few women reported that their last births were either mistimed (3%) or unwanted (3%). Conversely, all but a small percentage of women whose last pregnancy ended in induced abortion reported their conceptions were unintended. It should be noted that a relatively high proportion (25%) of women whose last pregnancy ended in miscarriage or stillbirth reported it was an unwanted conception; this is eight times the proportion of women with live births who reported an unwanted pregnancy. Although some of this difference may underscore the negative influence of unintendedness on pregnancy outcome, it is also plausible that some of these outcomes may have been induced abortions that were reported as spontaneous abortions or stillbirths.

Planning status of the last pregnancy did not vary by residence but unintended pregnancies increased with age and parity. Young adults were less likely to report unintended pregnancies (38%) than women aged 25-34 (65%) or 35-44 years of age (81%). Among 15-24 year olds, many unintended pregnancies were mistimed rather than unwanted. The unwanted-to-mistimed ratio for these women was 1.6:1 compared to a ratio of 5.4:1 among 25-34 year old women and 24:1 among women aged 35 years or older. Thus, mistimed pregnancies are rapidly replaced by unwanted pregnancies with the increase in maternal age, primarily because spacing failure is replaced by the desire to terminate childbearing; as a result, virtually all unintended pregnancies were unwanted at

older ages. A similar pattern can be seen when the planning status of the last pregnancy is examined by the number of living children. Women who had never had a live birth and women with one child were less likely to report that their last pregnancies were unwanted than were women with two or more live births. Although young women reported slightly more mistimed pregnancies, the relatively high proportion of unwanted pregnancies among this subgroup may reflect poor understanding of the survey question, conflicting or ambivalent feelings about the last pregnancy, or indecision about childbearing (Kaufman et al., 1997). The level of unintended pregnancy did not vary significantly with education.

4.7 Future Fertility Preferences

Table 4.7.1 shows the distribution of women currently in union by their fertility preferences according to the number of living children and their current age. Knowledge about fertility expectations in a population is essential for helping couples to avoid unintended pregnancies and attain their desired family size. Public health officials and health care providers should always consider fertility preferences in their efforts to lower the rates of unintended pregnancy and induced abortion. As shown in Figure 4.7, among women currently married or in consensual union more

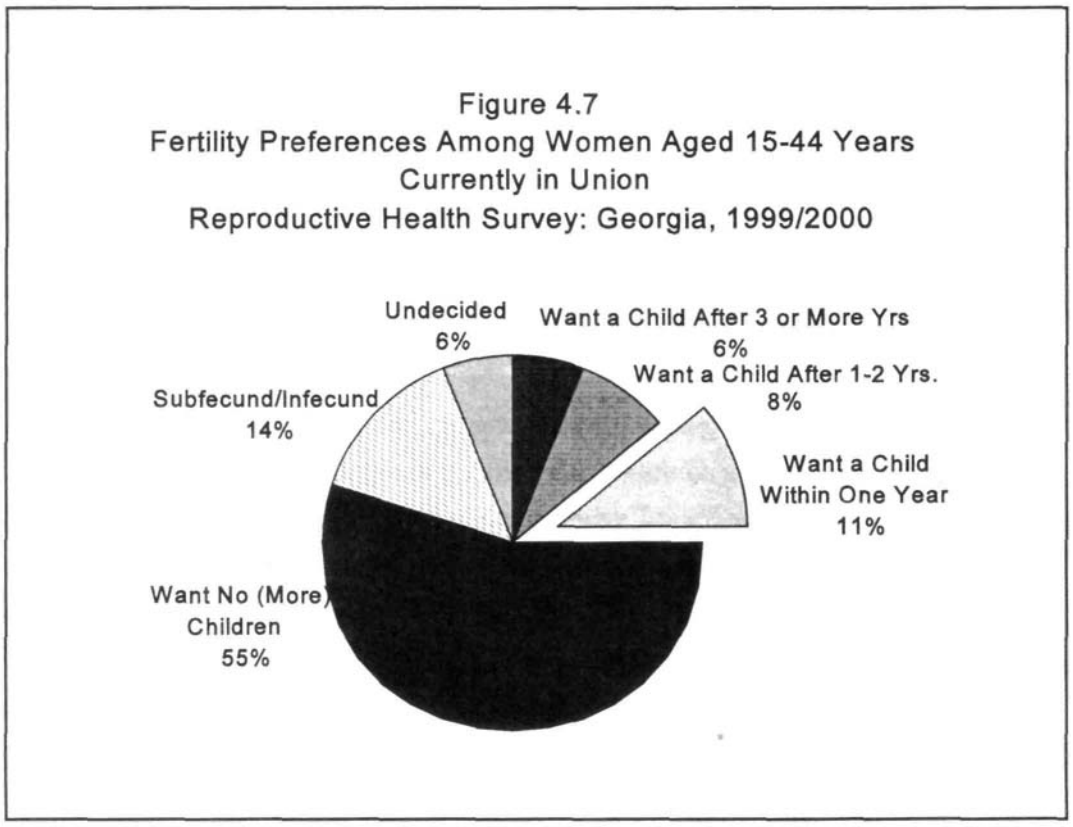


TABLE 4.7.1

Fertility Preferences by Number of Living Children and By Age Group
Women Currently In Legal or Consensual Marriage Aged 15-44 Years
Reproductive Health Survey: Georgia, 1999/2000

Desire For Children	Total	Number of Living Children*			
		None	One	Two	Three or More
Want now	**7.1**	52.6	12.1	2.0	1.0
Want a Child Within an Year	**3.1**	8.2	8.5	1.5	0.3
Want a Child After 1-2 Years	**8.3**	1.8	26.6	4.8	1.0
Want a Child After 3-5 Years	**4.2**	0.0	13.0	2.8	0.4
Want a Child Later than Five Years	**1.9**	0.7	5.5	1.2	0.8
Undecided if She Wants or Not	**5.7**	0.7	5.8	7.3	3.8
Want No More Children	**55.2**	0.3	16.2	68.2	77.9
Subfecund/Infecund	**14.4**	35.7	12.4	12.0	14.8
Total	**100.0**	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**5,177**	298	1,125	2,614	1,140

Desire For Children	Total	Age Group					
		15-19	20-24	25-29	30-34	35-39	40-44
Want now	**7.1**	31.6	13.6	7.6	6.0	3.0	1.4
Want a Child Within an Year	**3.1**	9.8	5.5	4.6	3.4	1.0	0.5
Want a Child After 1-2 Years	**8.3**	19.7	18.7	14.2	7.4	2.5	0.3
Want a Child After 3-5 Years	**4.2**	11.0	14.7	6.9	1.5	0.2	0.1
Want a Child Later than Five Years	**1.9**	6.4	3.9	3.6	1.4	0.5	0.0
Undecided if She Wants or Not	**5.7**	4.9	10.1	10.1	7.2	2.7	1.1
Want No More Children	**55.2**	13.6	28.3	44.4	64.7	72.7	63.6
Subfecund/Infecund	**14.4**	2.8	5.1	8.5	8.4	17.2	32.9
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**5,177**	227	673	975	1,134	1,251	917

* Women currently pregnant at the time of the interview were classified as having one more living child than the actual number

than half (55%) do not want any more children. An additional 6% were unsure if they wanted to have more. A substantial proportion (14%) reported that either they or their partners are subfecund or infecund. Those women were not asked about their future fertility preferences. Only 25% of women said they would like to have a (another) child in the future, including 10% who want a child soon (within a year) and 8% who want to wait one or two years before having a (another) child.

The figures presented in Table 4.7.1 suggest that women infrequently want more than two children. The intention to have any (more) children decreases rapidly with increasing number of living children. Among those with no living children (the top panel of the table) almost two of three women (63%) would want a child in the future; virtually all of them reported they would want to get pregnant right away (within one year). Likewise, the proportion of one-child women who want a (another) child is 66%, but the majority of them would want to wait at least one year before having another child. The desire for additional children drops abruptly after having two children. Only 12% of women who have already attained the two-child family size and only 3% of those with three or more children want to have another child. The primary conclusion to be drawn from these figures is that most women, regardless of their residence, age, or education level, have no more than one or two children and there appears to be little desire to have more.

TABLE 4.7.2
Percentage of Fecund Women in Union Reporting They Want No More Children by Number of Living Children and Selected Characteristics
Fecund Women 15–44 Years of Age
Reproductive Health Survey: Georgia, 1999/2000

	Total	Number of Living Children*			
Characteristic		**0**	**1**	**2**	**3+**
Total	**64.2**	0.5	18.3	77.5	90.9
Unweighted No. of Cases	**4,470**	186	991	2,303	990
Residence					
Urban	64.2	1.0	22.8	80.7	91.7
Rural	65.6	0.0	14.1	74.0	90.4
Age Group†					
15–24	27.1	0.0	7.6	58.1	71.1
25–34	60.4	0.0	16.6	70.2	86.0
35–44	89.4	†	57.6	93.4	96.1
Education Level					
Secondary or Less	65.0	0.0	18.7	77.0	90.6
Technicum	70.7	2.9	23.3	81.0	91.7
University/Postgraduate	57.9	0.0	19.2	75.9	90.2

* 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.

Younger women were much more likely than older women to want more children (bottom panel of Table 4.7.1). The intention to have more children decreased from 79% among the youngest age group to 56% for women aged 20-24, 34% among 25-29-year-olds, 20% among women aged 30-34, 7% among women aged 35-39 and only 2% for women aged 40 and older. Of those who desire additional children, very young women were the most likely to want a child within one year (41% of 79%=52%). The desire to have a child within a year is lower among 20-29 year olds (35%), presumably because they want to space the next pregnancy, and increases again to 50% among women aged 30 or older. These findings are very important for the family planning program, which should consider spacing methods for younger women and long-term or permanent methods for older women.

Table 4.7.2 presents the proportion of fecund women in union who do not want any more children, by number of living children and selected background characteristics. Overall, 63% of Georgian women who can conceive reported that they do not want to have more children. Only 17% of those with one living child wanted no more children, contrasting with 77% among two-child women and 90% among women with three or more children. The desire to terminate childbearing does not vary significantly by residence and education at any parity but is directly correlated with age. Women younger than 35 years of age were less likely to report that they wanted to terminate childbearing at any parity.

CHAPTER V

INDUCED ABORTION

For many years, induced abortion, not contraception, has been the main method of fertility control in the 15 independent countries that emerged from the collapse of the U.S.S.R. In most of these countries, the abortion-to-live-birth-ratios in 1989 were higher than one abortion to every live birth, although systematic induced abortion under-reporting was very likely (Popov, 1996). In addition, economic, social and cultural differences between these countries were likely to have contributed to differences in abortion reporting making comparisons between countries very difficult to interpret. For the entire Soviet Union, there was a birth for each 1.3 abortions, the general abortion rate in 1989 was 96/1000 women aged 15-49, and the lifetime induced abortion rate was 3.3 abortions per woman; Russia, Belarus, and Ukraine consistently reported the highest rates of abortion whereas the rates in central Asia were substantially lower (Goskomstat USSR, 1990).

Several factors are widely believed to have contributed to the widespread use of abortion and underutilization of modern contraception. The relative isolation of the U.S.S.R. from the contraceptive advancements in Western countries affected both the knowledge about and the availability of high-quality contraceptive methods. In addition, relative ignorance and fatalistic attitudes toward health issues, a medical system that promoted curative rather than preventive care, compounded by a widespread availability of abortion services and high tolerance for pregnancy termination, have contributed further to the high reliance on induced abortion (Remennick L, 1991, Popov A, 1996). These patterns were further shaped by a climate of strong moralistic principles, which condemned premarital and extramarital pregnancies, disapproved of sex education in school, and discouraged open discussions about sex-related issues. Some of these factors have been changing in recent years, but the extent to which various factors continue to play a role in the use of induced abortion varies from one country to another, now that each of them is in the process of developing new reproductive health policies and programs.

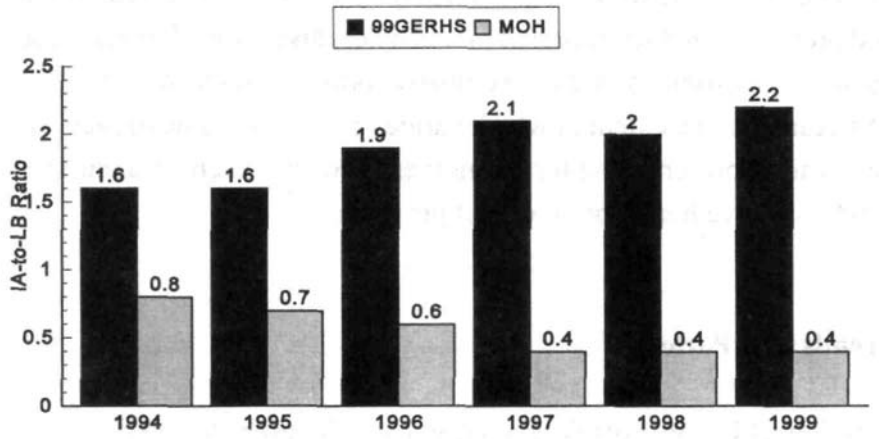
5.1 Abortion Trends and Patterns

Before the Soviet Union's breakup, Georgia had the highest abortion rate in the Caucasus region (51 abortions per 1000 women aged 15-49 compared to 31 per 1000 in Armenia and 23 per

1000 in Azerbaijan), but significantly lower than the Russian Federation (Goskomstat USSR, 1990). Induced abortion rates continue to be very high in Georgia although, according to the Ministry of Health reports, the rates have abruptly declined from 51 abortions per 1000 in 1989 to 14 abortions per 1,000 in 1999 (CMSI/MOH, 2000). There is a general consensus, however, that official statistics may substantially understate the true levels of abortion, partly because of unreliable population projections and partly because of widespread under-reporting of abortions performed in medical facilities (either state-run or private) and those performed outside clinical settings. National sample surveys on reproductive health, that could have provided information about induced abortion levels based on women's self-reports, have never been carried out in Georgia. The 99GERHS is the only population-based source of information about induced abortion levels in Georgia. Policy makers in Georgia are eager to learn more about the levels and determinants of induced abortion so they can define appropriate policies toward replacing abortion with contraception under the current health care reform process.

Based on 99GERHS data, the general abortion rate in 1999 was 135 abortions per 1000 women aged 15-44, almost ten times higher than the official rate of 14 abortions per 1000 women aged 15-49. Similarly, the abortion-to-live-birth ratio calculated from information collected in the respondents' pregnancy history was two abortions for each live birth (2.1:1 in 1997, 2.0:1 in 1998, and 2.2:1 in 1999) whereas official statistics showed ratios of only 0.4 abortions for each live birth for each of the past three years, as shown in Figure 5.1.1 (CMSI/MOH, 2000).

Figure 5.1.1
Induced Abortion to Live Birth Ratio— Women Aged 15-44
Reproductive Health Survey: Georgia 1999/2000 and Official Statistics



Note: livebirths and abortions reported by MOH are for all women, regardless of their age

Table 5.1.1
Three-Year* Age-Specific Induced Abortion (IA) Rates and Total IA Rates per 1000 Women Aged 15–44
Reproductive Health and Demographic Health Surveys in Selected Eastern European and Former Soviet Union Countries, 1993–2000

Country	Age Specific Abortion Rate (per 1000)†						Total IA Rate‡
	15–19	20–24	25–29	30–34	35–39	40–44	
Eastern European Region							
Czech Republic, 1993	NA	NA	NA	NA	NA	NA	**1.6**
Romania, 1993	32	153	209	167	79	40	**3.4**
Romania, 1999	26	101	119	105	58	21	**2.2**
Russia (three oblasts§), 1996	45/57/30	132/153/148	124/181/129	93/108/81	54/62/49	34/39/20	**2.4/3.0/2.3**
Russia (three oblasts§), 1999	43/63/26	143/169/98	91/141/83	96/120/134	51/73/67	34/58/19	**2.3/3.1/2.1**
Moldova, 1997	12	74	81	46	31	16	**1.3**
Ukraine, 1999	13	91	91	69	33	18	**1.6**
Caucasus Region							
Georgia, 1999-2000	30	164	192	180	123	50	**3.7**
Armenia, 2000	6	99	175	131	82	30	**2.6**
Central Asian Region							
Kazakhstan, 1995	15	78	104	75	50	18	**1.7**
Kazakhstan, 1999	12	57	87	65	44	20	**1.4**
Uzbekistan, 1996	2	18	32	36	23	15	**0.6**
Kyrgyz Republic, 1997	6	57	77	81	58	22	**1.5**
Turkmenistan, 2000	1	18	48	49	35	18	**0.9**

* Three years prior to the interview.
† Age at Pregnancy Outcome
‡ Abortions per Woman.
§ Yekaterinburg, Perm, and Ivanovo, respectively.
Source: Goldberg et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu et al. 1994, 1998, 2001.

The large differences between the abortion rates found by the 99GERHS and the official estimates are due, in part, to the use of inaccurate population projections as the denominator available for official estimates. The significant gap between these estimates, however, is largely the result of a substantial under-reporting of induced abortions (far more under-reported than live births),

a fact illustrated by comparing abortion-to-live-birth ratios, that are not dependent on population denominators (Figure 5.1.1). For example, the estimated number of induced abortions based on survey results was 122,424 in 1999, almost seven times higher than the 18,306 abortions reported by the Ministry of Health.

Table 5.1.1 shows abortion rates based on data from recent reproductive or demographic health surveys conducted in Eastern European countries and Newly Independent states (Goldberg et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu et al. 1994, 1998, 2001). With the exception of Romania, where abortion was illegal until 1990, most of these countries had some of the highest abortion rates in the world for several decades. The 99GERHS showed that abortion rates in Georgia are 40%-50% higher than those found in the Russian Federation (urban sample) and Romania in 1999 and in Armenia in 2000 and much higher than most other former Soviet-bloc countries.

The age-specific abortion rates in Tables 5.1.1 and 5.1.2 represent the proportion of women in a specific age group who terminated pregnancy by induced abortion within the three-year period

Figure 5.1.2
Three-Year Period Age Specific Fertility (ASFR) and Induced Abortion Rates (ASIAR) — Women Aged 15-44
Reproductive Health Survey: Georgia 1999/2000

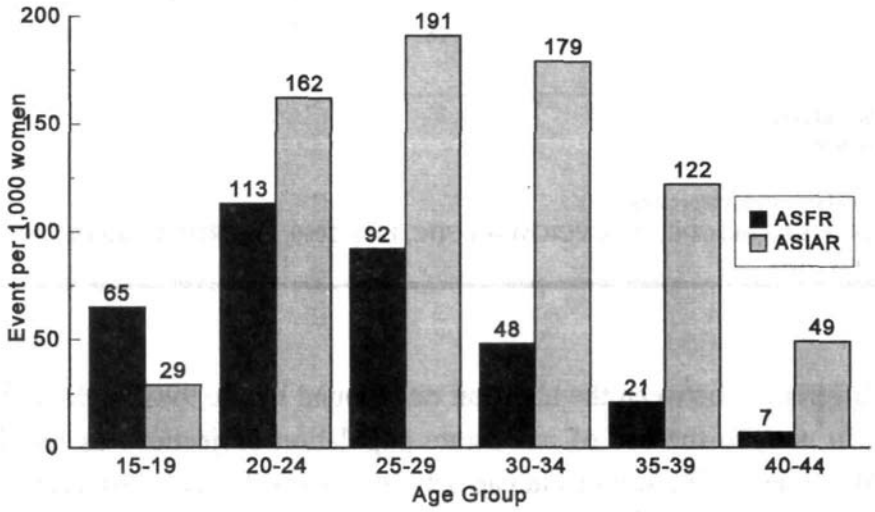


TABLE 5.1.2
Three-year* Age-specific Induced Abortion (IA)* Rates Among All Women and Among Ever Married Women
Reproductive Health Survey: Georgia, 1999/2000

Age-Specific Abortion Rates (per 1,000)†	All Women	Ever Married Women‡
15-19	29	172
20-24	162	285
25-29	191	246
30-34	179	204
35-39	122	135
40-44	(49)	(53)
Total Induced Abortion Rate (per woman)	**3.7**	**5.5**

* Induced abortions occurring between December 1996- November 1999
† Age at Pregnancy Outcome.
‡ Excludes induced abortions occurring before the date of first union for ever married women.
( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis.

preceding the survey. These rates were calculated by using the age of the woman at the time of pregnancy termination. The total induced abortion rate (TIAR) was calculated by summing the age specific induced abortion rates for the same three-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 in her lifetime under the current age-specific abortion rates.

The TIAR was more than two times higher than the TFR during the three years prior to the survey (3.7 vs. 1.7). Unlike fertility, the age pattern of abortions in Georgia is concentrated at 25-29 years of age (191 induced abortions per 1,000 women) and 30-34 years of age (179 per 1,000), accounting for 50% of the TIAR (see also Figure 5.1.2). The third highest age-specific abortion rate occurred among women 20-24 years of age. Except for the youngest age group, age-specific abortion rates are significantly higher than age-specific fertility rates. These findings suggest that Georgian women complete their desired family size at young ages, after which most pregnancies are unintended and are intentionally terminated. The benefit of permanent methods of contraception for these women is obvious, but fewer than two percent of women in union were using contraceptive sterilization, indicating that an information campaign is needed to explain the advantages of permanent methods.

A comparison of age-specific marital induced abortion rates reveals that induced abortion rates for married women were higher than those for all women and, by implication, higher than those for unmarried women. Since 83% of women were married by age 29, marital abortion rates differed little from abortion rates for all women aged 30 and above. The difference between marital and total IA rates was greatest for young adults (15-24 years of age).

5.2 Induced Abortion Differentials

As shown in Table 5.2.1, the abortion rates are equally high and vary little by background characteristics. There were basically no differences in abortion rates between Tbilisi and other urban and rural residents. Women residing in the south and the northeastern part of the country reported at least one lifetime abortion more than women living in the western part of the country. The TIAR was lowest for women with a university education; on average, women with a secondary or technical education reported one abortion more than women with postgraduate education (4.0 vs. 3.2 abortions per woman). Most of the variation in abortion rates by education was the result of higher age specific abortion rates among women aged 20-34 years with less than a university education. Internally displaced women (IDPs) reported a lower TIAR than non-IDP women (3.1 vs. 3.7) and, with the exception of the rates for adolescents, all age specific abortion rates among H)P women were lower than among non-IDPs.

As shown in Table 5.2.1, recourse to abortion is about 20% higher among Azeri and Armenian women than among Georgians (TIAR=4.4 and 4.3, respectively vs. 3.6 abortions per woman), except for the youngest and oldest age group. This difference is largely the result of higher age specific abortion rates among Azeri and Armenian women aged 20-34 (Figure 5.2.1).

One means to reduce unintended pregnancies resulting in abortion is through the provision of family planning services. Not surprisingly, a larger share of the potential demand for family planning services is among subgroups of women who have also reported higher rates of induced abortion (rural women, those less educated, women with two or more children, Azeri women) indicating that access to services is not equal and that the family planning program needs to expand its reach. Meeting the unmet need for modern contraception will require a substantial increase in programmatic and financial support compared with current levels of effort (see also Chapter XI).

TABLE 5.2.1
Three-year* Age-specific Induced Abortion (IA) Rates and Total IA Rates Among All Women Aged 15-44, by Selected Characteristics Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Age-Specific Abortion Rate†						Total IA Rate
	15-19	20-24	25-29	30-34	35-39	40-44	
Total	**29**	**162**	**191**	**179**	**122**	**49**	**3.7**
Residence							
Urban	26	155	181	182	129	50	**3.6**
Rural	34	172	202	175	114	48	**3.7**
Region							
Tbilisi	26	161	160	204	133	48	**3.7**
Imereti	23	138	236	156	112	78	**3.7**
North-East	49	222	184	234	137	49	**4.4**
South	20	199	257	170	139	27	**4.1**
West	30	107	161	137	91	47	**2.9**
Education							
Secondary or Less	25	190	221	197	123	43	**4.0**
Technicum	46	182	223	196	110	51	**4.0**
University/Postgraduate	50	117	136	142	135	54	**3.2**
Socioeconomic Status							
Low	31	182	188	160	102	45	**3.5**
Middle	30	153	209	191	130	50	**3.8**
High	24	157	130	175	139	52	**3.4**
Ethnicity							
Georgian	27	152	188	170	120	53	**3.6**
Azeri	25	231	238	205	150	34	**4.4**
Armenian	25	198	200	256	140	43	**4.3**
Other‡	157	195	88	210	66	0	**3.6**
IDP Status							
IDP	35	151	185	155	74	21	**3.1**
Non-IDP	29	163	191	181	125	51	**3.7**

* Induced abortions occurring between December 1996- November 1999
† Age at Pregnancy Outcome
‡ Includes Russians, Ossetians, Kurds (Iezidi), Kistians, Avarkans, Chechnians, Greeks, Ukrainians and other ethnic groups.

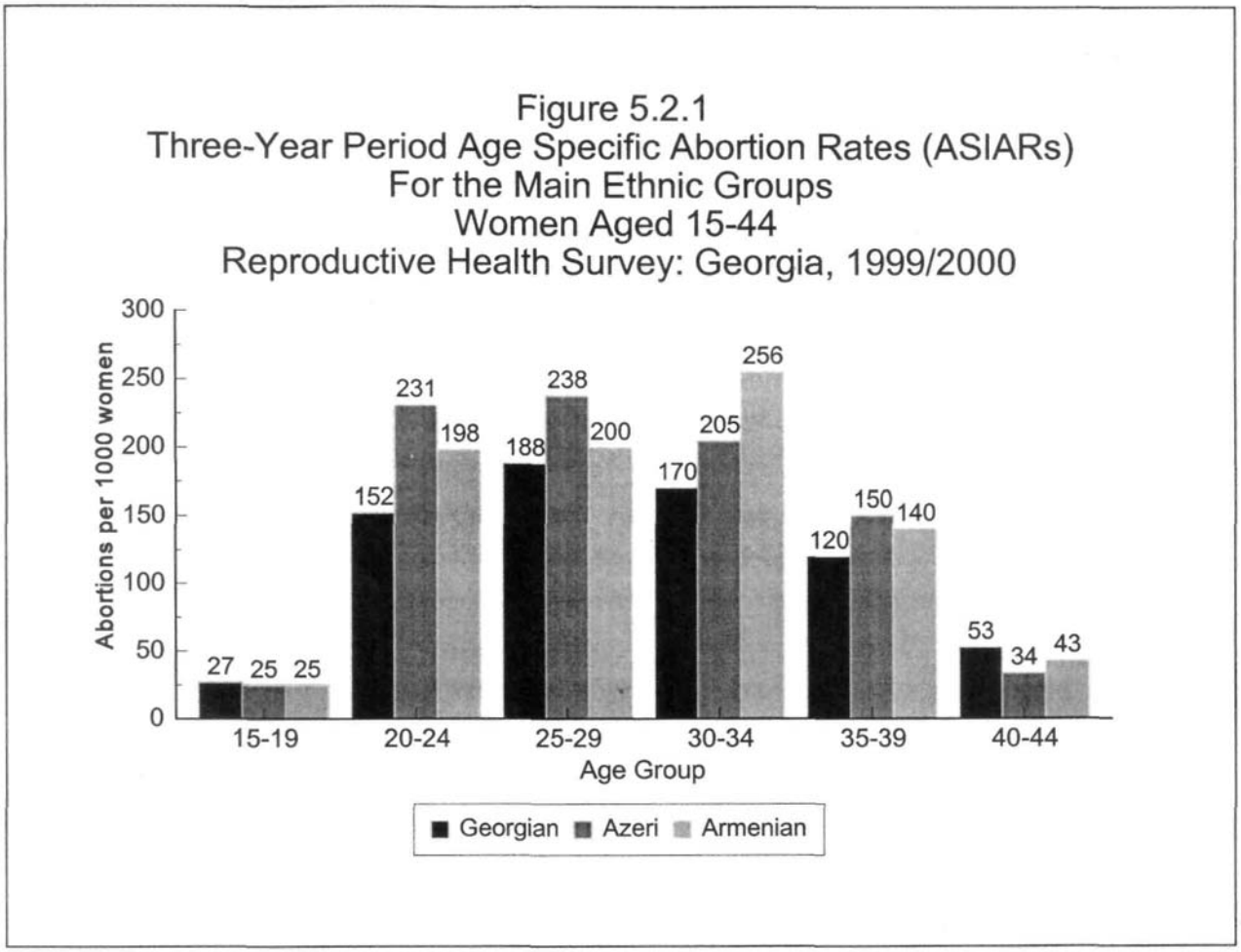


Table 5.2.2 shows that almost one of two women of reproductive age (43%) reported having had at least one induced abortion. Among currently married women , this proportion rises to 66%. The likelihood of having an abortion is positively associated with age—as exposure to pregnancy, particularly unintended pregnancy, increases with age. Although very few adolescents reported any abortions (2%), by ages 20-24 the percentage rises to 21% and it increases to over 50% among 25-34-year-olds and 70% among women aged 35 and older. The likelihood of having an abortion is also positively associated with the number of living children, which is also a strong predictor of unintendedness, since women in Georgia achieve their desired family size of one or two children fairly rapidly. The likelihood of having at least one abortion does not vary significantly by residence and education.

TABLE 5.2.2
Women Aged 15–44 Who Had at Least One Abortion and Number of Lifetime Abortions among Women Who Ever Had an Abortion by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

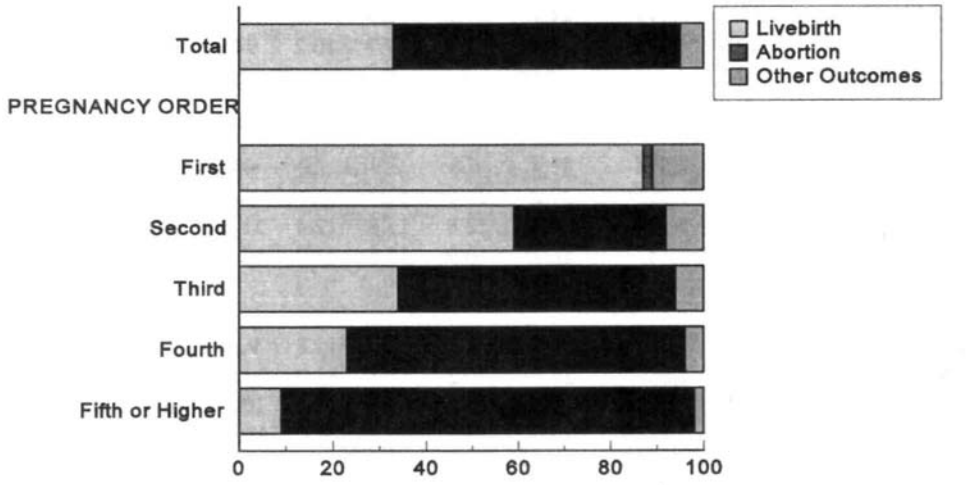
	Ever Had an Abortion		Number of Lifetime Induced Abortions Among Women Who Have Ever Had An Abortion								
Characteristic	%	No. of Cases	1	2	3	4	5-6	7-9	10+	Total	No. of Cases
Total	**43.0**	**7,798**	**22.5**	**21.3**	**16.6**	**11.5**	**10.7**	**9.2**	**8.4**	**100.0**	**3,658**
Residence											
Urban	43.4	4,759	21.1	21.7	17.5	12.4	9.6	9.8	7.9	100.0	2,211
Rural	42.6	3,039	24.4	20.6	15.3	10.2	12.1	8.3	9.0	100.0	1,447
Region											
Tbilisi	42.8	2,029	20.8	22.1	17.9	12.9	10.2	8.4	7.7	100.0	910
Imereti	42.5	1,590	23.1	22.1	15.5	11.1	9.6	9.9	8.8	100.0	776
North-East	48.6	1,259	20.5	21.3	15.7	10.3	13.4	9.1	9.8	100.0	674
South	42.8	1,017	22.3	16.8	17.8	11.9	12.4	10.0	8.8	100.0	479
West	39.3	1,903	26.5	22.9	15.5	10.8	8.1	8.9	7.2	100.0	819
Age Group											
15–19	1.7	1,061	*	*	*	*	*	*	*	100.0	22
20–24	20.6	1,239	41.8	27.8	13.7	10.1	4.5	2.1	0.0	100.0	278
25–29	41.7	1,315	30.8	28.1	16.8	9.7	6.6	5.5	2.5	100.0	579
30–34	60.7	1,396	24.3	22.5	19.4	9.9	10.3	8.6	4.9	100.0	869
35–39	70.9	1,527	16.1	21.5	15.3	13.3	12.2	11.4	10.2	100.0	1,058
40–44	69.5	1,260	16.2	13.8	16.2	12.3	14.0	11.8	15.7	100.0	852
Marital Status											
Currently Married/In Union	65.9	5,177	21.7	21.2	16.5	11.6	10.8	9.7	8.6	100.0	3,403
Previously Married	49.9	517	32.4	22.6	17.7	10.2	9.2	2.2	5.7	100.0	253
Never Married	0.1	2,104	*	*	*	*	*	*	*	*	2
No. of Living Children											
None	0.8	2,598	81.4	6.8	3.9	7.9	0.0	0.0	0.0	100.0	25
One	47.2	1,316	37.2	24.0	18.3	8.1	6.8	3.9	1.7	100.0	607
Two	77.3	2,737	20.3	22.8	15.8	12.4	11.1	9.6	8.1	100.0	2,108
Three or More	80.3	1,147	16.7	16.9	17.5	11.7	12.5	11.6	13.2	100.0	918
Education Level											
Secondary Incomplete or Less	21.3	991	24.7	22.2	13.7	11.8	9.9	7.7	9.8	100.0	264
Secondary Complete	43.0	2,664	22.8	20.2	15.5	11.7	11.1	9.6	9.2	100.0	1,271
Technicum	56.9	2,058	19.5	19.8	17.1	13.2	10.7	10.5	9.3	100.0	1,185
University/Postgraduate	44.3	2,085	25.0	24.0	18.2	9.1	10.4	7.5	5.8	100.0	938

* Fewer than 25 cases in this category.

As shown in Figure 5.2, the use of abortion was also heavily influenced by pregnancy order (pregnancy order refers to all prior pregnancies, including live births, induced abortions, miscarriages, or other outcomes). Women with no prior pregnancies were the least likely to have pregnancies ending in abortion (2%) and the most likely to have a live birth (87%). The likelihood of abortion increases rapidly if a woman had any prior pregnancies. If a woman with one prior pregnancy has a likelihood of abortion lower than that of having a live birth, once she has two or more prior pregnancies the likelihood to resort to abortion is significantly higher than that of carrying the pregnancy to term. Thus, the induced abortion to live birth ratio is directly correlated with pregnancy order, increasing from 0.5/1 among women with no prior pregnancy, to about 2/1 among women with two prior pregnancies, to about 4/1 among women with four prior pregnancies, and 10/1 among those with five or more prior pregnancies.

Because not all women were exposed to the risk of an unintended pregnancy and a subsequent abortion, in the right panel of Table 5.2.2 we restricted the denominator to include only women who have ever had an abortion. Almost one of four women (23%) reported they had only one abortion, 21% had two abortions, 17% had three abortions, and 40% four or more abortions, including eight percent who had ten or more lifetime abortions. Women who reported multiple abortions were more likely to be older, less educated and of higher parity.

Figure 5.2
Percent Distribution of Pregnancies by Pregnancy Outcome by Pregnancy Order
Pregnancies in the 5 Years Prior to the Survey: Georgia, 1999/2000



5.3 Abortion Services

As is the case with all of the former Soviet republics, Georgia was subject to the liberal abortion legislation and regulations issued by the former U.S.S.R. Abortion on request has been available within the first 12 weeks of gestation since the Soviet decree issued in November 1955. With several additions and modifications, this law remained in force essentially unchanged until 1987 when early abortions by electric vacuum aspiration after obligatory pregnancy testing were authorized by the Order of the Ministry of Health of the USSR No. 757 of June 5, 1987. Called "mini-abortions" and performed when pregnancy duration is less than 7 weeks, these procedures were allowed to be performed outside hospitals in ambulatory clinics for the first time by the same order. Additional regulations were issued to permit induced abortion during the first 28 weeks of gestation on medical and social grounds (Order No. 1342 of December 1987, USSR MH) and to briefly legalize "commercial" abortions in private clinics and "for-fee" sections of state hospitals (legalized on March 1988 by the MOH and outlawed in December 1988 by a Decree issued by the Council of Ministers).

After the break-up of the Soviet Union, the USSR abortion legislation continued to be valid until Georgia adopted the WHO live birth and still birth definitions in November 1993 (Order No 334/o, No 134, No 95/s, Ministry of Health, Ministry of Justice, and Georgian Committee for Social and Economic Information). The new definition of live births directly influenced the age limit until which late abortions could be performed (22 weeks of gestation instead of 28 weeks in the Soviet law). Abortion on request continued to be provided up to 12 weeks of gestation. Recently, the Georgian Ministry of Health ratified a revised list of medical and social grounds for late abortions (up to 22 weeks of gestation) and issued new regulations about miniabortions performed in outpatient clinics (Orders 30/o of 19 March 2000 and 136/o of June, 2000). In December 2000, a new abortion law reflecting these changes was submitted to Parliament for approval (245/N of 7 December, 2000).

Under the current law, induced abortion can be performed only by Ob/Gyns by 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. Abortion on request is performed after compulsory screening for syphilis, gonorrhea, and other genital infections. **All** genital infections should be treated before the abortion procedure.

The 99GERHS collected information on the last four abortions performed since January 1994 in a detailed abortion history, which included questions about the reason for abortion, 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 released in the same day of the intervention if they do not have post-abortion complications), and the presence or absence of early and late abortion complications. Data were collected starting with the most recent procedure in an attempt to minimize recall biases. Of the 5,627 abortions reported since January 1994 in the lifetime pregnancy history, 4,871 (87%) were recorded in the abortion history. Detailed information about the majority of induced abortions occurring in 1996-1999 (over 90%) were captured in the abortion history but one fourth of abortions performed in 1994-1995 were not included; abortion omission in the detailed history was due to the fact that some women had more than four induced abortions during the six years preceding the survey and, given the retrospective fashion of recording information on pregnancy events (from the most recent to the most distant in time), abortions completed in 1994-1995 had a greater likelihood to be followed by four or more other induced abortions than those completed in the more recent years.

Almost all abortions (90%) were reported to be completed in the first trimester of gestation (data not shown). However, respondent reports on this issue are subject to several possible biases, including irregular menses, problems in recalling the event and reluctance to admit abortions beyond the legal gestational limit. One in two abortions (50%) were reported to be performed between 7 and 12 weeks of gestation, 40% under 7 weeks, and 10% were reported as late abortions (13 weeks or more). Numbers are too small to draw any statistical conclusions but late abortions were reported more often by rural women and were inversely correlated to woman's education and socioeconomic status; late abortions were slightly more common among women of Azeri ethnic background (13%).

Until 1987, the classical method of termination of pregnancy in the first trimester was dilatation and curettage (D&C). By Order no. 757 of June 1987 issued by the Ministry of Health of the USSR, early pregnancy termination by vacuum aspiration was officially recognized as a legal abortion procedure. Mini-abortion, also known as menstrual regulation or menstrual extraction, is performed by vacuum aspiration (using a manual or electrical device) in women whose menstrual period is no more than 20 days overdue (roughly corresponding to maximum 6 weeks of pregnancy); typically, it is not performed under anesthesia and does not require dilatation of the cervix. According to the WHO definition, menstrual regulation, often performed in countries with restrictive abortion legislation, 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 (electrical) is performed after pregnancy was confirmed, its primary intent is to terminate an unintended pregnancy (thus, such procedures were labeled "miniabortions"), and is required to be reported in the abortion statistics.

TABLE 5.3.1

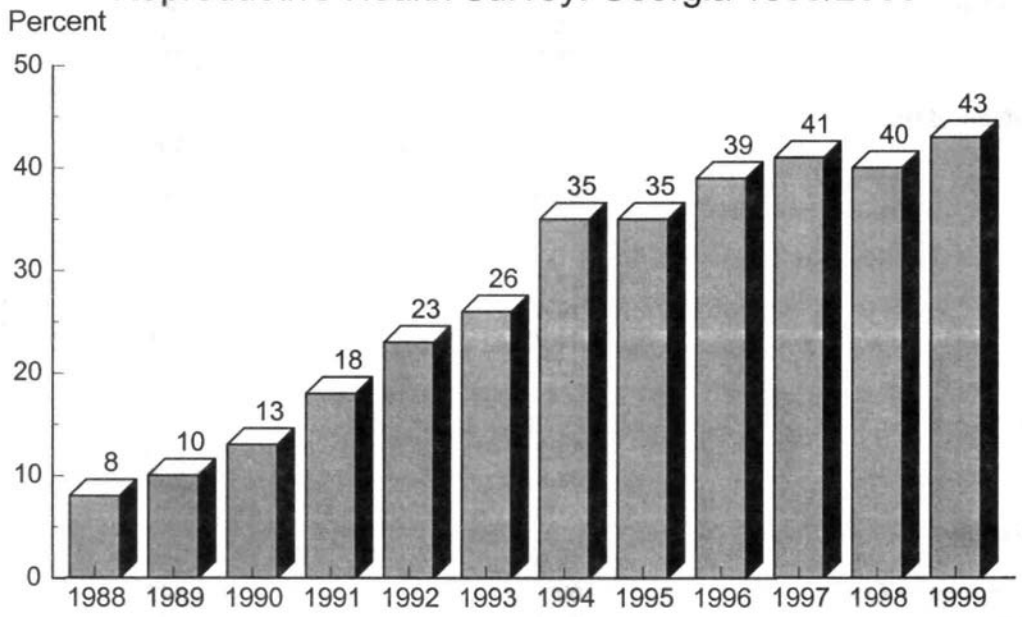
Induced Abortions Reported to Be Miniabortions by Selected Characteristics
Pregnancies Ended in Abortion Between 1994–1999
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	% Miniabortions	Unweighted No. of Cases
Total	**39.5**	**4,845**
Residence		
Urban	53.8	2,904
Rural	20.5	1,941
Region		
Tbilisi	67.7	1,283
Imereti	30.2	972
North-East	32.7	973
South	25.9	693
West	25.7	924
Age Group(at Abortion)		
15-24	38.6	1,354
25-34	40.1	2,562
35-44	39.1	929
Education Level		
Secondary Incomplete	22.9	391
Secondary Complete	31.9	1,662
Technicum	39.8	1,515
University	53.7	1,277
Socio-Economic Status		
Low	25.9	1,906
Medium	43.5	2,388
High	55.9	551
Ethnicity		
Georgian	42.0	4,075
Azeri	14.4	403
Armenian	44.9	228
Other	42.7	139
IDP-Status		
IDP	33.2	876
Non-IDP	38.8	3,969
Abortion Facility		
Hospital	28.9	3,251
Women's Consultation Center	60.5	1,342
Private Clinic	81.4	87
Outside a Medical Facility*	35.2	165

* Over 90% of pregnancy terminations that took place outside a medical facility were performed by either D&C (56%) or vacuum-aspiration (36%), presumably by a physician, "at woman's home" or "other residence".

Table 5.3.1 shows that of all abortions reported by survey respondents since 1994, approximately 40% were miniabortions (from 14% to 68% were reported to be miniabortions depending upon characteristics of the women). Miniabortions were twice as prevalent among urban respondents than among rural residents (54% vs. 21%) and was highest among women living in Tbilisi (68%). The proportion of abortions classified as miniabortions was not correlated with woman's age and increased directly with education and socioeconomic status. Miniabortions were the least prevalent among Azeri women (14%) whereas among other ethnic groups they represent almost one-half of the abortion procedures reported (42%-45%). Miniabortions were slightly less prevalent among IDP women who decided to terminate childbearing during the past six years. Although ambulatory clinics are not licensed to perform D&C, miniabortions represented only 61% and 81%, respectively of induced abortions performed in women's consultation clinics and private clinics. Thus, D&C abortions performed in ambulatory clinics, along with abortions performed

Figure 5.3.1
Proportion of Miniabortions By Year As a Percentage of Pregnancies Ended in Induced Abortion Between 1988-1999
Reproductive Health Survey: Georgia 1999/2000



outside medical facilities, are likely to substantially contribute to the under-registration of abortion reported by the Ministry of Health.

As shown in Figure 5.3.1, the proportion of induced abortions terminated by vacuum aspiration increased more than five times between 1988 (the first year after the procedure became legal) and 1999. The percentage of pregnancy terminations by the means of vacuum aspiration increased directly with the induced abortion order (data not shown), since first order abortions were more often performed at gestational ages of 7 weeks or more (33% of first-time abortions were performed before seven weeks of gestation compared to 44% of abortions of rank three or higher). Virtually all miniabortions were performed to terminate pregnancies before 7 weeks of gestation (98%); for such early pregnancies, vacuum aspiration accounted for 96% of the abortion procedures (data not shown).

By law, all abortions should be performed in hospitals or ambulatory clinics or cabinets by obstetric-gynecologists. As shown in Table 5.3.2, the majority of induced abortions reported since 1994 were performed in gynecological wards (65%). Less than a third of them (29%) were performed in state-run ambulatory units (e.g., women's consultation clinics) and only 2% were performed in private clinics. Abortions performed in women's consultation clinics (WCC) were more prevalent in urban areas (37%) than in rural areas (19%). In Tbilisi abortions performed in WCCs outnumbered those performed in hospitals (49% vs. 46%). Abortions performed in private clinics increased with education and socioeconomic levels and most of them were miniabortions. Only Georgian women reported induced abortions in the private sector, probably because of their higher socioeconomic status and their greater likelihood to obtain early abortions. Early abortions (miniabortions) performed by vacuum aspiration were almost equally divided between hospital wards and outpatient medical facilities (45% and 5%, respectively, were performed in WCC and private clinics). Although most induced abortions at seven weeks or more were performed in hospital wards (76%), 20% were reported to be performed in ambulatory units (19% in WCC and one percent in private clinics), and 4% were performed outside medical facilities. Recently, the proportion of abortions performed in outpatient medical facilities (either state-run or private clinics) increased slightly but hospital abortions continue to account for over 60% of abortions performed between 1996-1999.

Only 4% of pregnancy terminations were reported to take place outside the health system. However, the majority of these abortions (90%) were performed by either D&C or vacuum aspiration, suggesting that they were performed by qualified physicians either at their homes or the respondents' home. Since abortions performed outside medical facilities (either self-induced, performed by lay persons, or performed by doctors outside the health system) are illegal, it is very

TABLE 5.3.2
Place of Pregnancy Termination for Abortions Performed Between 1994 and 1999 by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Place of Pregnancy Termination: Gynecologic Ward	Women's Consultation Clinic	Private Clinic	Outside a Medical Facility*	Total	Unweighted No. of Cases
Total	**65.0**	**29.2**	**2.2**	**3.6**	**100.0**	**4,845**
Residence						
Urban	56.6	36.7	2.9	3.8	100.0	2,904
Rural	76.2	19.2	1.3	3.2	100.0	1,941
Region						
Tbilisi	45.6	48.9	1.1	4.4	100.0	1,283
Imereti	79.8	18.3	0.1	1.8	100.0	972
North-East	63.8	26.4	3.1	6.8	100.0	973
South	65.9	26.0	5.5	2.6	100.0	693
West	82.0	15.5	1.7	0.8	100.0	924
Education Level						
Secondary Incomplete or Less	71.5	22.3	0.5	5.6	100.0	391
Secondary Complete	63.5	28.6	2.7	5.3	100.0	1,662
Technicum	66.5	29.8	1.4	2.3	100.0	1,515
University	63.1	31.5	3.1	2.3	100.0	1,277
Socio-Economic Status						
Low	69.2	25.5	0.8	4.5	100.0	1,906
Medium	64.2	29.6	2.9	3.4	100.0	2,388
High	58.6	36.9	2.6	1.9	100.0	551
Ethnicity						
Georgian	65.9	28.5	2.7	2.9	100.0	4,075
Azeri	74.2	20.7	0.0	5.1	100.0	403
Armenian	42.0	48.4	0.0	9.7	100.0	228
Other	52.8	42.6	0.0	4.5	100.0	139
IDP-Status						
IDP	70.4	25.1	0.8	3.8	100.0	876
Non-IDP	64.8	29.4	2.3	3.5	100.0	3,969
Type of Abortion						
Induced Abortion	76.4	19.1	0.7	3.8	100.0	3,015
Miniabortion	47.5	44.8	4.5	3.2	100.0	1,830
Year of Abortion						
1994–1995	69.4	26.5	1.4	2.7	100.0	1,211
1996–1997	63.4	31.2	2.4	3.0	100.0	1,729
1998–1999	63.8	29.0	2.5	3.6	100.0	1,905

* Over 90% of pregnancy terminations that took place outside a medical facility were performed by either D&C (56%) or vacuum-aspiration (36%), presumably by a physician, "at woman's home" or "other residence".

likely that women were reluctant to admit these outcomes, in spite of the interviewer's assurance of anonymity, and this figure is probably an underestimate of the proportion of abortions performed outside the health facilities. Women residing in the North-East region, those with lower education levels (secondary complete or less), and low socio-economic status (SES), and ethnic Armenian women were slightly more likely to report abortions performed outside certified health facilities.

According to the abortion legislation, all induced abortions should be performed only after the pregnancy was confirmed (by a pregnancy test or an ultrasound pelvic exam) and the woman was laboratory tested for STDs (blood and vaginal bacteriologic tests). These investigations are supposed to be included in the abortion charges. However, if abortion payments are unofficial, laboratory tests are unlikely to be performed prior to the abortion procedure. Table 5.3.3 shows that only 28% of induced abortions performed between 1994-1999 were preceded by exploratory investigations that confirmed the pregnancy status—26% of pregnancies were confirmed by ultrasound diagnostic, 1% by pregnancy testing and 1% by both investigations. Both confirmation of pregnancy and STD screening prior to the abortion procedure were more prevalent among urban women, especially those residing in Tbilisi, among women with university education, and those with high socio-economic status. Miniabortions were three times and two times, respectively, as likely as induced abortions to be performed after pregnancy was confirmed (45% vs. 16%) and after STD screening (10% vs. 5%). Diagnostic tests did not increase in the most recent years. Tests for pregnancy confirmation were more likely to be performed when abortion procedures took place in ambulatory settings (either WCC or private clinics) than in hospital gynecologic wards.

Table 5.3.3 also shows that, according to the respondents, 70% of induced abortions were registered in the hospital or the clinic registries. Awareness of abortion registration did not vary significantly by respondents' background characteristics, with the exception of under-registration reported by women with less education and women of Azeri ethnic background (whose awareness of registration procedures may have been limited because of language barriers).

Although abortion registration was reported for most induced abortions between 1994-1999, payment receipts were issued for less than one in four abortions (23%). In Georgia, except for very narrow social circumstances, all abortions are performed for a fee (which varies from one facility to another). Reports of abortion payments were lower among rural women than urban women, among residents of the South and North-East regions, and increased directly with education and SES. Azeri women were the least likely to report payment receipts (9%). Apparently, both abortion registration and payment receipts are lacking for abortions performed in private clinics. Both registration and receipt issuance do not vary significantly by the year when abortions were performed.

TABLE 5.3.3
Diagnostic Tests and Abortion Registration Prior to the Abortion Procedure for Abortions Performed Between 1994 and 1999, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Diagnostic Tests		Abortion Registration		Unweighted No. of Cases
	Pregnancy Confirmation	STD Screening	Abortion Registration	Payment Receipt	
Total	**27.6**	**6.8**	**70.2**	**22.7**	**4,845**
Residence					
Urban	37.8	9.0	74.4	26.7	2,904
Rural	14.0	3.8	64.6	17.3	1,941
Region					
Tbilisi	58.6	15.4	79.5	33.7	1,283
Imereti	14.9	2.8	77.3	20.0	972
North-East	16.7	4.5	60.7	17.5	973
South	17.7	2.9	61.5	13.8	693
West	14.3	3.6	69.2	22.8	924
Education Level					
Secondary Incomplete	12.6	3.7	51.2	12.7	391
Secondary Complete	22.5	4.4	63.4	19.4	1,662
Technicum	22.1	7.1	77.6	24.1	1,515
University	44.8	10.2	76.1	28.3	1,277
Socio-Economic Status					
Low	13.4	3.0	65.7	17.2	1,906
Medium	29.5	7.5	70.8	24.6	2,388
High	54.4	13.1	78.7	28.1	551
Ethnicity					
Georgian	29.4	7.3	72.6	24.8	4,075
Azeri	9.5	1.1	49.8	8.6	403
Armenian	30.0	6.5	69.5	17.3	228
Other	32.6	12.2	72.4	21.0	139
IDP-Status					
IDP	21.3	5.4	67.8	17.1	876
Non-IDP	27.9	6.8	70.3	22.9	3,969
Type of Abortion					
Induced Abortion	16.1	4.9	65.9	18.0	3,015
Miniabortion	45.3	9.7	76.7	29.8	1,830
Year of Abortion					
1994–1995	25.7	7.8	71.1	19.7	1,211
1996–1997	26.5	6.7	70.1	24.9	1,729
1998–1999	29.8	6.3	69.7	22.5	1,905
Abortion Facility					
Gynecologic Ward	23.2	6.3	72.2	22.7	3,251
WCC	37.1	8.3	79.5	27.2	1,342
Private Clinic	58.7	8.3	0.0	0.0	87
Outside a Medical Facility	11.6	1.8	0.0	0.0	165

TABLE 5.3.4
Cost of Abortions Performed Between 1996–1999 by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Cost of Abortion (in lari)*									
Characteristic	Mean Payment†	None	≤20	21–30	31–50	≥51	Gifts Only	Do Not Remember‡	Total	No. of Cases
Total	**25.2**	**2.7**	**38.4**	**39.0**	**9.9**	**2.4**	**1.6**	**6.0**	**100.0**	**3,634**
Residence										
Urban	26.3	3.3	34.5	39.7	12.6	3.2	2.1	4.6	100.0	2,162
Rural	23.6	1.9	43.6	38.0	6.3	1.3	1.0	7.8	100.0	1,472
Region										
Tbilisi	29.9	3.9	17.8	47.7	18.3	5.1	1.7	5.4	100.0	965
Imereti	23.7	2.3	50.6	33.6	6.2	1.4	1.8	4.1	100.0	728
North-East	22.1	3.2	46.8	37.4	4.3	1.4	1.3	5.7	100.0	720
South	22.0	0.9	54.3	29.0	2.7	1.4	1.3	10.4	100.0	530
West	25.6	2.1	34.7	41.5	13.4	1.4	2.2	4.9	100.0	691
Education Level										
Secondary Incomplete or Less	23.8	0.6	49.7	34.4	6.9	1.3	0.9	6.1	100.0	302
Secondary Complete	23.6	1.8	43.2	35.8	8.0	1.5	1.3	8.3	100.0	1,269
Technicum	25.6	2.3	38.7	40.8	9.9	2.1	1.8	4.4	100.0	1,120
University	27.0	4.8	28.3	42.6	13.1	4.2	2.1	4.8	100.0	943
Socio-Economic Status										
Low	23.3	2.1	47.8	35.3	7.1	1.2	1.5	5.0	100.0	1,406
Medium	25.4	2.0	37.2	40.5	10.0	2.2	1.2	6.9	100.0	1,822
High	28.5	6.9	20.7	41.6	16.3	6.4	3.6	4.5	100.0	406
Ethnicity										
Georgian	25.4	2.8	37.6	40.6	10.3	2.6	1.7	4.5	100.0	3,043
Azeri	21.9	2.2	52.2	30.6	3.4	1.1	0.8	9.6	100.0	319
Armenian	24.5	1.6	32.2	41.3	6.9	0.0	0.5	17.5	100.0	174
Other	32.8	2.5	22.7	20.1	27.4	8.3	5.7	13.3	100.0	98
IDP-Status										
IDP	24.5	7.1	42.8	28.7	10.7	3.0	3.0	4.8	100.0	639
Non-IDP	25.2	2.5	38.2	39.5	9.8	2.4	1.6	6.0	100.0	2,995
Gestational Age										
≤ 6 weeks	23.5	2.7	41.2	41.3	7.0	1.0	1.8	5.0	100.0	1,466
7–12 weeks	25.2	2.8	38.2	37.4	10.2	2.3	1.5	7.6	100.0	1,807
≥13 weeks	31.7	2.2	27.7	37.3	20.3	8.7	1.4	2.5	100.0	361
Abortion Facility										
Gynecologic Ward	25.8	2.4	36.7	37.6	11.0	2.9	2.1	7.3	100.0	2,392
WCC	24.9	2.6	37.6	44.9	8.6	1.5	0.8	3.9	100.0	1,032
Private Clinic	21.6	4.8	47.8	37.7	6.0	2.4	0.0	1.2	100.0	74
Outside a Medical Facility§	21.0	3.6	68.3	18.5	4.4	1.8	1.7	1.8	100.0	123

* At the time of the survey approximately 2 lari = $US 1.00.
† Mean payment per abortion does not include non-monetary payments or payments of unknown amount.
‡ Includes 94 abortions paid in other currency.
§ Excludes 13 abortions performed by empirical methods.

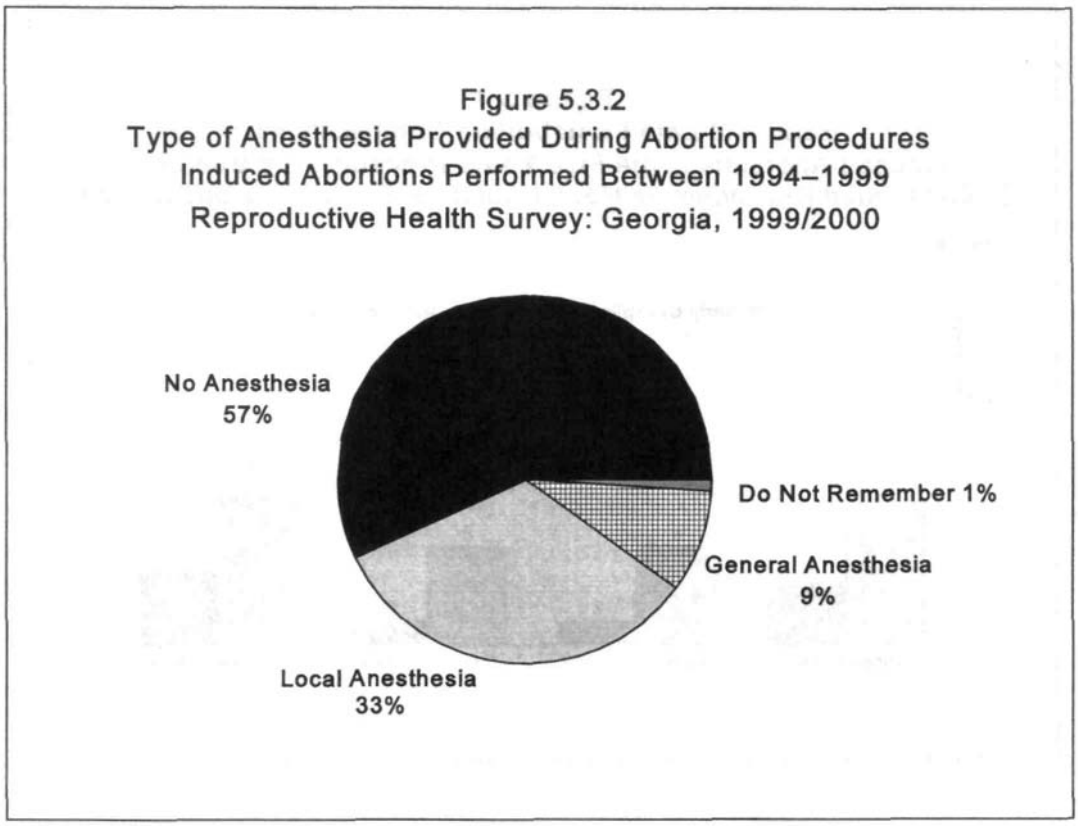
At the time of the survey, charges for an abortion procedure were about 20 lari (about 10.00 USD). Table 5.3.4 presents the distribution of abortion payments by selected characteristics for abortion procedures performed between 1996-1999. Abortions performed in 1994-1995 were not included in this table because the national currency was introduced at the end of 1995.

The 99GERHS found that, overall, the average amount paid for an abortion performed between 1996-1999 was 25 lari, ranging from no payment to 215 lari (one case). Only 3% of abortions were performed at no charge; 38% of abortion payments were 20 lari or less, 39% were between 21-30 lari and 12% were over 50 lari. Less than 2% of women reported that abortion payments were only gifts of unknown amount and 6% could not remember the amount paid.

Women in urban areas, including those living in Tbilisi, those with university training, and those with high SES, were more likely to make, on average, larger abortion payments than other women. The cost of late abortions was 25% higher than abortions performed in the first 12 weeks of pregnancy. The average abortion payments did not vary significantly between different medical facilities where abortions were performed.

Generally, abortion performed after 6 weeks of gestation is an inpatient procedure but patients are released within the same day and do not have to spend the night in the hospital. Survey results confirmed that virtually all women (99%) who had abortions since 1994 had been released within the same day of the abortion procedure (data not shown). Only 1% of women with abortions had to be hospitalized for at least one night; the length of hospital stay varied with gestational age, and presence or absence of abortion complications.

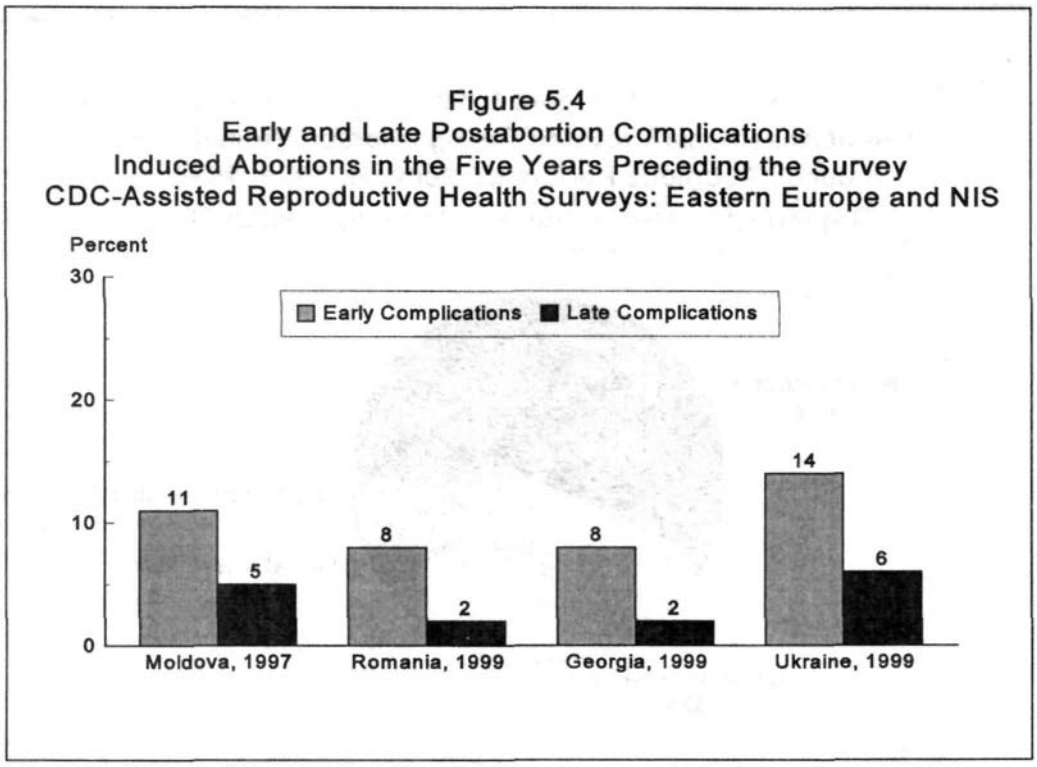
As shown in Figure 5.3.2, over one in two abortion procedures (57%) between 1994-1999 were performed without any anesthesia; one-third were performed with local (cervical) anesthesia and 9% with intravenous anesthesia. The likelihood of receiving anesthesia did not vary significantly by respondents' background characteristics but was influenced by gestational age, abortion method and the type of facility where abortion procedure was performed (data not shown). Early abortions (under 7 weeks) were the least likely to be performed under anesthesia (29%), while almost one-half of abortions performed at a gestational age of 7 weeks received anesthesia; similarly, the likelihood of anesthesia for abortions performed by D&C was almost twice as high as the likelihood for anesthesia prior to vacuum aspiration (52% vs. 28%). Women having hospital-performed abortions (more likely to be performed after 6 weeks and by D&C) were significantly more likely to receive anesthesia than those who obtained abortions in a WCC or private clinic (50% vs. 30% and 33%, respectively), or outside a medical facility (29%).



5.4 Abortion Complications

Legally induced abortions are associated with a certain risk of postoperative complications, whose incidence and severity is strongly correlated with age of gestation, parity, woman's age, surgical procedure and operator's skills, type of anesthesia and preexisting pathology (Henshaw, 1990). For example, abortions performed at 7-9 weeks of gestation have significantly fewer complications than those performed between 10 and 14 weeks. Early abortions performed by D&C under 7 weeks of pregnancy have a slightly higher risk of complications than those performed from 7 to 9 weeks. Abortions performed by vacuum aspiration, with or without cervical dilatation, have fewer complications compared with the classic sharp curettage. First-trimester abortion complication rates from studies performed in developed countries ranged from 0.9 per 100 abortion procedures in the U.S. (Hakim-Elahi E. et al., 1990) to 6.1 per 100 in Denmark (Heisterberg L. and Kringlebach M., 1989) but, in the absence of an international standard definition of abortion morbidity, comparisons between countries are difficult to interpret.

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 Table 5.4.1, 10% of all abortions performed since 1994 were followed by immediate complications (8%) or late sequelae (2%). This is consistent with the level of postabortion complications documented by other reproductive health surveys conducted in Eastern European countries with high abortion rates, as shown in Figure 5.4. Early complications were slightly more prevalent among women living in the North-East region, among Georgian women and women of other ethnic background than among Azeri and Armenian women and among women with late abortions (13%). As expected, abortions with early complications were more likely to be also followed by late sequelae (at six months or more after the abortion was performed) compared to abortions without any immediate health problems (22% vs. 1%).

Most of the early complications involved prolonged pelvic pain (67%), severe or prolonged bleeding (59%), high fever (34%), and pelvic infection (21%); only one percent of complicated abortions had perforations of the uterus (Table 5.4.2). With the exception of uterine perforation, it is difficult to assess how serious the other early complications might have been. An indirect approach to measure their severity is to consider early complications as serious when they required overnight hospitalization or were followed by late complications. As shown previously, very few immediate complications required one or more nights of hospitalization and 22% were associated with late complications. The prevalence of early complications almost doubles after 13 weeks of gestation.

Table 5.4.1
Induced Abortions Performed Between 1994–1999 Treated with Antibiotics and Induced Abortions with Early and Late Complications by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Antibiotic Treatment	Early Complications		Late Complications*	
	%	%	N	%	N
Total	**24.3**	**7.5**	**4,845**	**2.3**	**4,700**
Residence					
Urban	29.6	6.8	2,904	2.2	2,825
Rural	17.3	8.6	1,941	2.4	1,875
Region					
Tbilisi	40.7	7.6	1,283	2.9	1,251
Imereti	22.1	6.5	972	1.6	938
North-East	22.0	10.2	973	3.5	944
South	11.0	6.5	693	1.8	679
West	16.3	5.9	924	1.0	888
Education Level					
Secondary Incomplete or Less	10.2	6.9	391	3.4	376
Secondary Complete	16.6	7.1	1,662	2.3	1,615
Technicum	23.1	8.1	1,515	2.1	1,468
University	39.5	7.7	1,277	2.2	1,241
Socio-Economic Status					
Low	14.2	6.6	1,906	2.4	1,843
Medium	26.7	7.7	2,388	1.7	2,318
High	39.0	8.9	551	4.3	539
Ethnicity					
Georgian	26.8	8.1	4,075	2.3	3,949
Azeri	6.5	4.2	403	2.7	395
Armenian	16.0	3.6	228	0.4	224
Other	28.6	11.0	139	4.0	132
IDP-Status					
IDP	21.0	7.9	876	2.2	843
Non-IDP	24.5	7.5	3,969	2.3	3,857
Gestational Age					
≤ 6 weeks	30.3	6.8	1,877	1.9	1,820
7–12 weeks	18.9	7.1	2,507	2.1	2,436
≥13 weeks	27.0	13.0	461	5.2	444
Abortion Facility					
Gynecologic Ward	23.7	7.6	3,251	2.6	3,159
WCC	25.7	7.2	1,342	1.7	1,304
Private Clinic	22.0	10.3	87	2.3	79
Outside a Medical Facility	25.7	6.4	165	1.9	158
Early Complications					
Absent	21.5	0.0	4,498	0.6	4,395
Present	58.7	100.0	347	22.1	322

TABLE 5.4.2
Induced Abortions Performed Between 1994–1999 with Early Complications by Type of Complication and Gestational Age
Reproductive Health Survey: Georgia, 1999/2000

		Gestational Age (in weeks)		
Type of Early Complications	**Total**	**≤ 6**	**7-12**	**13+**
Prolonged Pelvic Pain	66.8	60.9	67.3	77.9
Severe or Prolonged Bleeding	59.4	56.3	61.8	59.2
High Fever (over 38°C)	34.3	30.1	36.8	36.2
Infectious Vaginal Discharge	20.8	25.7	15.9	24.0
Uterine Perforation	0.6	0.8	0.6	0.0
No. of Abortions with Early Complications	347	115	180	52

5.5 Reasons for Abortion

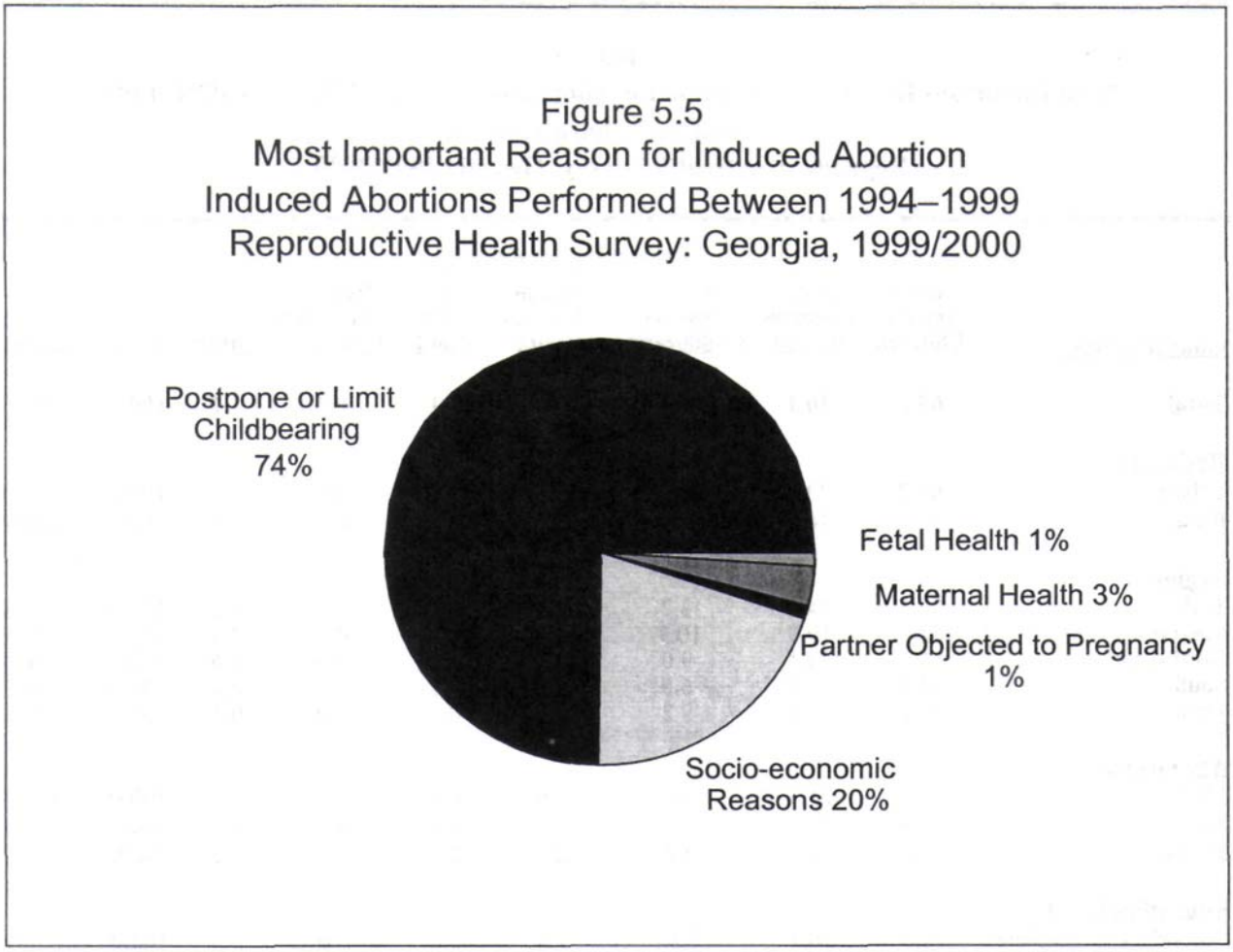
Table 5.5 and Figure 5.5 show that most induced abortions (74%) were motivated by reasons related to fertility control: for 65% of abortions, the decision to terminate pregnancy was made because the woman wanted no (more) children and 9% because she wanted to postpone childbearing. Moreover, 70% of abortions were obtained by women who have been pregnant four or more times (data not shown). One in five (20%) abortions was obtained because of economic or social reasons (low income, unemployment, fear of losing the job, crowded living conditions), less than one percent for partner related reasons (partner objected to a pregnancy intended by respondent), and only 3% and 1%, respectively, for maternal health reasons (pregnancy was threatening the woman's physical or mental health) and fetal defects or potential risks for the baby.

The use of abortion for fertility control was mentioned slightly more often by rural women (who already have a higher mean number of living children than urban women), women who reside in the South (with a higher concentration of Azeri population) or the Western part of the country, women over 34 years of age (who also have more children), and by Azeri women; this reason was strongly correlated with pregnancy order, from 26% among first time pregnant women (data not shown), to 66% among those with two previous pregnancies, and 78% among those with three or

TABLE 5.5
Most Important Reason for Abortion for Abortions Performed Between 1994–1999 by Selected Characteristics
Reproductive Health Survey: Georgia 1999/2000

Characteristic	Reason for Abortion: Want No (more) Children	Socio-Economic Reason	Want to Postpone Childbearing	Risk to Maternal Health	Risk to Fetal Health	Partner Objected to Pregnancy	Other	Total	No. of Cases
Total	**65.8**	**20.1**	**8.6**	**2.7**	**1.1**	**0.5**	**1.2**	**100.0**	**4,845**
Residence									
Urban	62.2	22.6	8.8	3.5	1.3	0.6	1.0	100.0	2,904
Rural	70.6	16.9	8.2	1.7	0.8	0.3	1.5	100.0	1,941
Region									
Tbilisi	59.5	24.7	7.7	4.3	1.5	1.1	1.2	100.0	1,283
Imereti	62.6	19.9	10.7	3.2	1.0	0.2	2.4	100.0	972
North-East	66.1	20.1	9.0	1.8	1.2	0.3	1.6	100.0	973
South	73.1	17.0	6.6	1.5	0.7	0.5	0.4	100.0	693
West	71.2	16.3	9.2	2.0	0.7	0.0	0.5	100.0	924
Age Group*									
15–24	64.0	21.5	9.0	2.9	0.8	0.4	1.5	100.0	1,354
25–34	60.4	22.7	11.1	2.6	1.2	0.4	1.5	100.0	2,562
35–44	81.6	12.0	1.6	2.7	1.1	0.8	0.2	100.0	929
Education Level									
Secondary Incomplete	72.9	16.1	8.9	1.8	0.0	0.0	0.3	100.0	391
Secondary Complete	71.8	17.7	7.3	1.1	0.6	0.3	1.1	100.0	1,662
Technicum&University	61.3	22.1	9.2	3.7	1.5	0.6	1.4	100.0	2,792
Socio-economic Status									
Low	68.2	21.2	7.5	1.2	0.4	0.1	1.4	100.0	1,906
Middle	65.8	20.6	8.5	2.5	1.1	0.6	0.9	100.0	2,388
High	60.0	15.4	11.4	7.3	2.8	1.0	2.0	100.0	551
Ethnicity									
Georgian	64.3	20.8	8.7	3.1	1.2	0.5	1.5	100.0	4,075
Azeri	77.9	11.9	7.4	1.5	1.3	0.0	0.0	100.0	403
Armenian	71.0	21.4	6.8	0.0	0.0	0.0	0.8	100.0	228
Other	57.6	26.6	12.8	1.5	0.0	1.5	0.0	100.0	139
Pregnancy Order									
First	†	†	†	†	†	†	†	†	23
Second	21.9	38.2	31.9	4.7	0.6	0.5	2.3	100.0	395
Third	50.1	26.3	15.9	2.3	2.0	0.8	2.7	100.0	700
Fourth or Higher	73.8	17.1	4.7	2.3	0.9	0.4	0.8	100.0	3,727

* Age at pregnancy termination.
† Fewer than 25 cases in this category.



more previous pregnancies. Socioeconomic reasons were reported more often in urban areas, including Tbilisi (25%) where life is more expensive and adequate housing is an increasing problem. Partner's objection to pregnancy was an uncommon reason for the respondent's decision to not carry a pregnancy to term, regardless of the respondent background characteristics, presumably because the majority of women were married at the time of having the abortion and the couple was in agreement with the abortion decision. Maternal health related reasons were more often reported by urban residents, the best educated women (university education) and those with high socioeconomic status. Similarly, the risk of birth defects was mentioned more often by urban women and increased with education and socioeconomic level. Almost one out often first pregnancies were terminated due to fetal health reasons.

CHAPTER VI

MATERNAL AND INFANT HEALTH

Maternal and infant mortality are measures of a nation's health and world-wide indicators of social well-being. Maternal mortality ratio in Georgia, as reported to the World Health Organization (WHO), was 22 deaths per 100,000 live births in 1995, lower than in many former Soviet Union countries (e.g., 50 maternal deaths per 100,000 live births in the Russian Federation) but high compared to European standards. The official infant mortality rate was 18 per 1,000 in 1999, the fourth highest rate in Eastern Europe and Caucasus regions after Romania, Albania, and Moldova (World Health Organization, 1999 and 2001). However, similar to underreporting of abortion and birth data, the number of deaths and information about causes of death may also be incomplete. Due to severe underreporting in the official reporting system, Georgia's ability to produce accurate maternal and infant mortality statistics comparable with the international community is likely to be limited.

Adequate perinatal care is an essential step in safe motherhood programmes. In Georgia, women's access to perinatal care was free of charge for many years. Currently, under the new health care reform, it is included in the basic health care package. It consists of three components: preconception care, prenatal care, and postnatal care. Preconception and prenatal care counseling are generally offered by primary care providers and consist of a wide array of information, including risks associated with pregnancies, health risk factors that can affect the development of the fetus (e.g. tobacco and alcohol), maternal infection (such as rubella, toxoplasma, HIV and other STDs), risks associated with maternal health conditions, and risks associated with genetic conditions. Unfortunately, preconception counseling is offered only to young couples prior to marriage, without any follow-up before they plan to start childbearing. Preconception counseling is not provided during routine health care visits in spite of the essential role the primary care provider could play in modifying women's health behaviors (many healthy behaviors must be in place before pregnancy is recognized) and identifying medical conditions that may require special attention during pregnancy.

The use of timely and periodic prenatal care can effectively reduce perinatal mortality and morbidity. Prior to 1995, the Georgian Ministry of Health recommended at least 10 prenatal visits for women with uncomplicated pregnancies carried to term. Under the state subsidized prenatal care

program implemented in 1995, the State Medical Insurance Company covers only 4 free prenatal care visits (at 13, 20, 30, and 36 weeks of gestation). Two more visits are allowed under a co-payment plan. Additional visits, if needed, are entirely supported as out-of-pocket expenses. Prenatal care is supposed to include a general health risk assessment consisting of medical examination and a series of laboratory investigations (blood, urine, vaginal bacteriological exams, screening for STDs and isoimmunization Rh) that will be repeated periodically.

The purpose of this chapter is to examine selected aspects of maternal and child care in Georgia (e.g., sources of health care, utilization of maternal care services, quality of care), to identify subgroups with specific needs of care, and to investigate maternal and child health outcomes which may be related to the availability and quality of maternity care services. All this information can be used to help direct or modify program interventions.

6.1 Prenatal Care

This section describes the use of prenatal care for all pregnancies carried to term (either live births or still births) since January 1994. Women were asked in what week or month of gestation did they have their first visit for prenatal care (not counting a visit that was just for a pregnancy test or just for the delivery) and the number of prenatal care visits during pregnancy. Of the 3,050 pregnancies carried to term during the six years prior to the survey, the majority of women (91%) had received some prenatal care but less than two-thirds (63%) had made their first prenatal care visit in the first trimester (Table 6.1.1). Approximately 25% of them had their first visit during the second trimester and 3% during the third trimester.

The level of any prenatal care within different subgroups varied sometimes by a considerable margin (between 70% and 98%). Rural women, residents of the South region, those who did not complete secondary education, women with higher birth order and Azeri women, were more likely to not have any prenatal care. Similarly, the percentage of infants whose mothers entered prenatal care in the first trimester varied widely, from a low of 43% to a high of 74%. Women living in urban areas were more likely to start prenatal care earlier than women in rural areas (68% vs. 58%). Early entry into prenatal care was lowest among women living in the South and North-East regions (49% and 59%, respectively) and highest among women in Tbilisi (70%). The likelihood of early prenatal care was slightly higher among young adults (67%) than among older women. Early entry into prenatal care was highly correlated with mother's education; women who had not completed high school had a 50% lower likelihood of initiating prenatal care early compared with women with highest education level (43% vs. 74%). In addition, 30% of these women had reported no prenatal care, whereas only 2% of women with a university education had no prenatal care. Similarly, women

TABLE 6.1.1

Trimester of Pregnancy at the First Prenatal Care Visit and Number of Prenatal Visits
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

	Trimester of First Visit				Number of Prenatal Visits							
Characteristic	No Visits	1st	2nd	3rd	0	1–3	4–6	7–9	10+	Don't Know	Total	No. of Cases
Total	**9.2**	**62.6**	**24.6**	**2.9**	**9.2**	**14.7**	**39.2**	**20.1**	**16.3**	**0.5**	**100.0**	**3,050**
Residence												
Urban	4.2	67.7	24.8	2.7	4.2	9.5	37.1	24.4	24.3	0.4	100.0	1,584
Rural	13.9	57.9	24.4	3.1	13.9	19.5	41.2	16.1	8.8	0.5	100.0	1,466
Region												
Tbilisi	5.0	70.1	20.9	2.8	5.0	7.8	33.5	23.1	30.1	0.5	100.0	646
Imereti	4.8	67.5	25.5	2.1	4.8	10.0	41.0	24.6	19.6	0.0	100.0	612
North-East	9.3	59.1	27.5	3.1	9.3	17.7	46.1	17.3	9.5	0.2	100.0	569
South	19.1	48.6	29.0	3.3	19.1	19.3	36.5	17.1	7.1	1.0	100.0	483
West	8.8	66.2	21.6	3.0	8.8	18.6	39.8	18.8	13.4	0.6	100.0	740
Age Group (at Birth)												
15-24	7.2	67.3	21.5	3.1	7.2	12.0	40.8	22.1	17.6	0.3	100.0	721
25–34	9.7	61.2	26.1	2.5	9.7	15.4	38.9	19.5	16.0	0.6	100.0	2,144
35–44	11.5	62.1	19.0	7.4	11.5	16.9	37.1	20.1	14.4	0.0	100.0	185
Education Level												
Secondary Incomplete	30.1	43.2	23.2	2.4	30.1	14.8	34.7	12.7	5.8	2.0	100.0	342
Secondary Complete	11.5	56.5	28.0	3.7	11.5	21.3	38.1	17.3	11.5	0.2	100.0	1,052
Technicum	4.0	67.4	24.9	3.3	4.0	15.2	43.2	19.8	17.3	0.6	100.0	805
University	2.1	74.2	21.0	1.8	2.1	6.4	39.0	26.9	25.5	0.0	100.0	851
Ethnicity												
Georgian	5.7	67.2	24.0	2.4	5.7	12.1	41.2	22.3	18.2	0.4	100.0	2,522
Azeri	28.2	40.7	26.5	4.3	28.2	27.4	28.9	8.8	5.8	1.0	100.0	326
Armenian	9.5	47.5	38.6	4.3	9.5	16.3	50.0	13.8	10.4	0.0	100.0	114
Other	13.6	65.8	14.0	6.6	13.6	21.4	22.8	22.0	20.2	0.0	100.0	88
IDP Status												
IDP	4.8	74.0	20.0	1.1	4.8	6.6	41.5	20.6	26.4	0.2	100.0	558
Non-IDP	9.5	62.1	24.9	3.0	9.5	15.1	39.1	20.1	15.7	0.5	100.0	2,492
Birth Outcome												
Live Birth	9.1	62.6	24.8	2.8	9.1	14.5	39.4	20.1	16.3	0.5	100.0	2,999
Stillbirth	14.9	65.2	13.8	6.1	14.9	26.4	29.0	17.5	12.2	0.0	100.0	51
Birth Order												
First	5.6	70.3	21.4	2.1	5.6	11.0	36.9	25.1	21.0	0.5	100.0	1,326
Second	8.1	61.9	26.7	2.5	8.1	16.3	43.2	17.8	14.1	0.5	100.0	1,122
Third or Higher	19.2	47.3	27.9	5.3	19.2	19.9	37.2	13.4	9.9	0.4	100.0	602

with low SES had much lower likelihood of initiating prenatal care early. Among various ethnic groups, Georgian women had the highest rates of early prenatal care (67%) while Azeri women had the lowest rate (41%). IDP women were less likely than non-IDP women to report no prenatal care (5% vs. 10%) but more likely to initiate prenatal care in the first trimester, if they had any prenatal care. Women with births preceded by one or two previous births (birth order three or higher) were the most likely to not have any prenatal care (19%) and had the lowest rate of early prenatal care (47%). Although the number of pregnancies ended in still births was rather small, those pregnancies were more likely than pregnancies ended in live births to be associated with no prenatal care. Low birth weight, however, was inversely correlated with prenatal care, probably because these pregnancies were more likely to be associated with complications during pregnancy which required close medical supervision (data not shown).

Prenatal care should not only start early but also should continue throughout pregnancy according to recommended standards of periodicity. Therefore, in order to assess the adequacy of prenatal care it is necessary to monitor not only the time of first visit but also the number of prenatal care visits once the care has begun (Table 6.1.1, right panel). Overall, women with pregnancies ending since 1994 averaged 6 prenatal visits, and ranged from no visits to 40 visits (data not shown). Among women with any prenatal care, the average number of prenatal care visits was 6.6 visits. Until 1995, pregnant women in Georgia were supposed to make monthly prenatal care visits within the first five months of pregnancy and bi-monthly visits during the remaining four months of pregnancy; thus, for a woman who had her first prenatal care visit in the first trimester, the adequate number of visits would be 10 or more visits. Starting with 1995, the State Medical Insurance Company covers only 4 free prenatal care visits (at 13, 20, 30, and 36 weeks of gestation) and two more visits are allowed under a co-payment plan. Additional visits, if needed, are entirely supported by out-of-pocket expenses. Thus, the average number of prenatal care visits found by the 99GERHS is actually slightly higher than the number of visits covered by the state health insurance probably because women decide to cover extra-visits at their own expense.

As shown in the right panel of Table 6.1.1, 15% of women had only 1-4 visits, more than a third had 4-6 visits (39%), one in five had 7-9 visits and one in six had 10 or more prenatal care visits. Less than 1% of respondents stated they "don't remember" the number of prenatal care visits. Women who had an adequate number of prenatal visits are generally the same women who started prenatal care early, since the number of visits is correlated with the month of initiation of care.

However, if we compare the prenatal care utilization with the standards applied in the United States, the majority of women do not meet the criteria of adequate prenatal care. One way to assess the adequacy of prenatal care is to use the Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck index. This index assesses the adequacy of initiation of prenatal care

TABLE 6.1.2
Adequacy of Prenatal Care Utilization Index* by Selected Characteristics
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

	Adequacy of Prenatal Care Utilization Index						
Characteristic	**Inadequate**	**Intermediate**	**Adequate**	**Adequate +**	**Unknown**	**Total**	**No. of Cases**
Total	**47.4**	**31.8**	**13.5**	**6.7**	**0.5**	**100.0**	**3,050**
Residence							
Urban	33.6	37.7	18.0	10.2	0.4	100.0	1,584
Rural	60.2	26.4	9.4	3.5	0.5	100.0	1,466
Region							
Tbilisi	33.8	32.4	19.3	14.0	0.5	100.0	646
Imereti	37.7	37.6	18.2	6.6	0.0	100.0	612
North-East	57.8	28.3	10.0	3.7	0.2	100.0	569
South	59.2	27.3	8.8	3.7	1.0	100.0	483
West	49.3	33.9	11.5	4.6	0.6	100.0	740
Age Group (at Birth)							
15-24	44.7	33.3	14.3	7.4	0.3	100.0	721
25–34	47.9	31.5	13.6	6.4	0.6	100.0	2,144
35–44	51.9	29.8	10.2	8.1	0.0	100.0	185
Education Level							
Secondary Incomplete	63.0	26.0	5.7	3.4	2.0	100.0	342
Secondary Complete	55.8	26.8	12.2	4.9	0.2	100.0	1,052
Technicum	45.4	33.1	15.4	5.6	0.6	100.0	805
University	32.5	39.2	17.0	11.3	0.0	100.0	851
Socio-Economic Status							
Low	61.8	24.2	10.2	3.0	0.8	100.0	1,392
Medium	40.5	36.2	15.8	7.2	0.3	100.0	1,357
High	28.2	39.3	15.3	17.1	0.0	100.0	301
Ethnicity							
Georgian	43.0	34.1	15.2	7.4	0.4	100.0	2,522
Azeri	71.0	20.7	4.3	3.0	1.0	100.0	326
Armenian	53.2	29.4	12.2	5.2	0.0	100.0	114
Other	47.6	28.0	15.8	8.6	0.0	100.0	88
IDP Status							
IDP	36.6	36.2	15.7	11.4	0.2	100.0	558
Non-IDP	48.0	31.6	13.4	6.5	0.5	100.0	2,492
Birth Order							
First	38.4	35.9	16.1	9.1	0.5	100.0	1,326
Second	50.8	30.3	13.3	5.2	0.5	100.0	1,122
Third or Higher	61.0	25.8	8.5	4.4	0.4	100.0	602

* Also known as the Kotelchuck Index, it is a measure of adequacy of prenatal care based on initiation of such care (no prenatal care automatically warrants "inadequate" level) and the number of required visits adjusted for the length of gestation and the gestational age at first visit. It replaces the Kessner Index.

(month when prenatal care begins) combined with the adequacy of utilization of services (percentage of recommended visits received) once the care has begun; this last component of the index is calculated by comparing actual utilization with the recommended number of visits (based on the American College of Obstetricians and Gynecologists recommendations), adjusted for the length of gestational period and the gestational age at initiation of care. These two dimensions are combined into a single utilization index with four levels: inadequate, intermediate, adequate or adequate plus. Inadequate utilization is defined as either late prenatal care or less than 50% of recommended visits and includes births without any prenatal care. The three remaining levels require early initiation of care (by the fourth month of gestation). Intermediate care requires 50%-79% of the recommended number of visits, adequate care requires 80%-109% and adequate plus requires 110% or more of the recommended visits (Kotelchuck M, 1994).

By applying this index to data from the 99GERHS we found that only one in five mothers (20%) within the past six years received adequate or adequate plus care (Table 6.1.2). Almost half of mothers (47%) had inadequate prenatal care. Inadequate prenatal care was more prevalent in rural areas (60%) than in urban areas (34%), in the North-East or the South regions (58% and 59%, respectively), and among Azeri women (71%). The percentage of women with inadequate care decreased with the increase in mother's education (from 63% among women who did not complete a secondary education to 32% among those with university education) and with the increase in the household socio-economic status (from 62% among low SES households to 28% among high SES); inadequate care was less prevalent among first births (38%) and increased directly with the birth order. These same groups are consistently reporting high rates of maternal and infant mortality. Targeting the groups that did not receive prenatal care in the first trimester or who had fewer than recommended visits can help improve both pregnancy and infant outcomes and help Georgia lower perinatal mortality and morbidity.

Prenatal care (PC) in Georgia is provided mostly through primary health care centers (urban circumscriptions or rural dispensaries) and polyclinics (women's consultation centers, only in urban areas). Prenatal care is seldom provided by the private medical sector. The principal source of prenatal care according to the survey reports, is shown in Table 6.1.3. Overall, three out of four women have received prenatal care in women's consultation clinics (73%), followed by a maternity hospital (14%), a primary health care center, either a "medical circumscription" (5%) or a rural dispensary (6%). Only one percent of women sought prenatal care in a private clinic. The source of most prenatal care did not vary much by respondent's background characteristics. For the majority of women, WCCs represent the most significant source of prenatal care, maternities are a distant second source, and primary health care clinics rank third in providing PC. Only rural women (19%), women with less than complete secondary education (19%), residents of the North-East or South regions (18% and 17%, respectively), and Azeri women (25%) mentioned the primary health care

TABLE 6.1.3
Use of Prenatal Care and Place of Most Prenatal Visits by Selected Characteristics
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

	Any Prenatal Care		Place of Most Prenatal Visits						
Characteristic	%	No. of Cases	Rural Dispensary	Medical Circumscription	WCC (Polyclinic)	Private Clinic/Office	Maternity Hospital	Total	No. of Cases*
Total	**90.8**	**3,050**	**6.2**	**4.8**	**73.3**	**1.4**	**14.2**	**100.0**	**2,801**
Residence									
Urban	95.8	1,584	0.3	2.7	82.5	2.0	12.5	100.0	1,516
Rural	86.1	1,466	12.3	7.0	63.9	0.8	16.0	100.0	1,285
Region									
Tbilisi	95.0	646	0.2	2.6	77.5	3.8	15.9	100.0	612
Imereti	95.2	612	2.4	4.5	82.1	0.8	10.2	100.0	593
North-East	90.7	569	7.6	10.8	68.2	1.1	12.4	100.0	525
South	80.9	483	12.9	4.5	71.0	0.2	11.3	100.0	393
West	91.2	740	9.4	2.2	68.7	0.6	19.1	100.0	678
Age Group (at Birth)									
15–24	92.8	721	6.5	3.7	74.8	1.5	13.6	100.0	670
25–34	90.3	2,144	6.2	5.1	72.8	1.3	14.6	100.0	1,965
35–44	88.5	185	6.1	5.9	74.0	2.8	11.2	100.0	166
Education Level									
Secondary Incomplete	69.9	342	10.4	8.4	67.7	0.0	13.6	100.0	250
Secondary Complete	88.5	1,052	9.1	4.1	72.4	0.6	13.8	100.0	951
Technicum	96.0	805	4.2	5.5	75.2	2.0	13.1	100.0	769
University	97.9	851	3.7	3.8	74.5	2.3	15.8	100.0	831
Socio-Economic Status									
Low	82.9	1,392	7.2	7.2	70.1	0.7	14.8	100.0	1,213
Medium	95.1	1,357	6.8	3.4	75.4	1.7	12.7	100.0	1,293
High	98.8	301	1.5	3.9	74.0	2.2	18.4	100.0	295
Ethnicity									
Georgian	94.3	2,522	4.6	4.5	74.6	1.1	15.1	100.0	2,384
Azeri	71.8	326	18.0	7.3	60.0	4.6	10.1	100.0	235
Armenian	90.5	114	8.5	1.9	83.7	0.0	5.8	100.0	103
Other	86.4	88	3.6	7.8	72.4	0.0	16.2	100.0	79
IDP Status									
IDP	95.2	558	4.9	3.2	76.0	1.2	14.7	100.0	540
Non-IDP	90.5	2,492	6.3	4.9	73.2	1.5	14.2	100.0	2,261
Birth Order									
First	94.4	1,326	4.7	4.8	74.0	1.4	15.0	100.0	1,260
Second	91.9	1,122	6.3	5.1	74.8	1.7	12.0	100.0	1,043
Third or Higher	80.8	602	9.9	4.2	68.5	0.9	16.5	100.0	498

* Excludes eight women who received most of their prenatal care at home

network as their second source of prenatal care. Generally, general practitioners ("therapeuts") and midwives cover most of prenatal care in ambulatories and obstetricians provide most care in women's consultation clinics (WCC) and hospitals.

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 include information about maternal behaviors and exposures that may affect the health of the fetus, nutrition, rest, and early signs and symptoms of pregnancy complications. In addition, approaching the time of delivery, counseling should prepare women for what they will face when giving birth, distribute accurate information regarding labor and delivery, and advice about techniques to reduce the 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.

Because the initiation and frequency of prenatal care visits evaluate only one dimension of the prenatal care (i.e., adequacy of utilization of services), the 99GERHS included additional questions aimed at assessing information received during the prenatal visits (adequacy of content of prenatal care). Table 6.1.4 and Figure 6.1 show the percentage of pregnant women that received some information about specific educational topics during prenatal care.

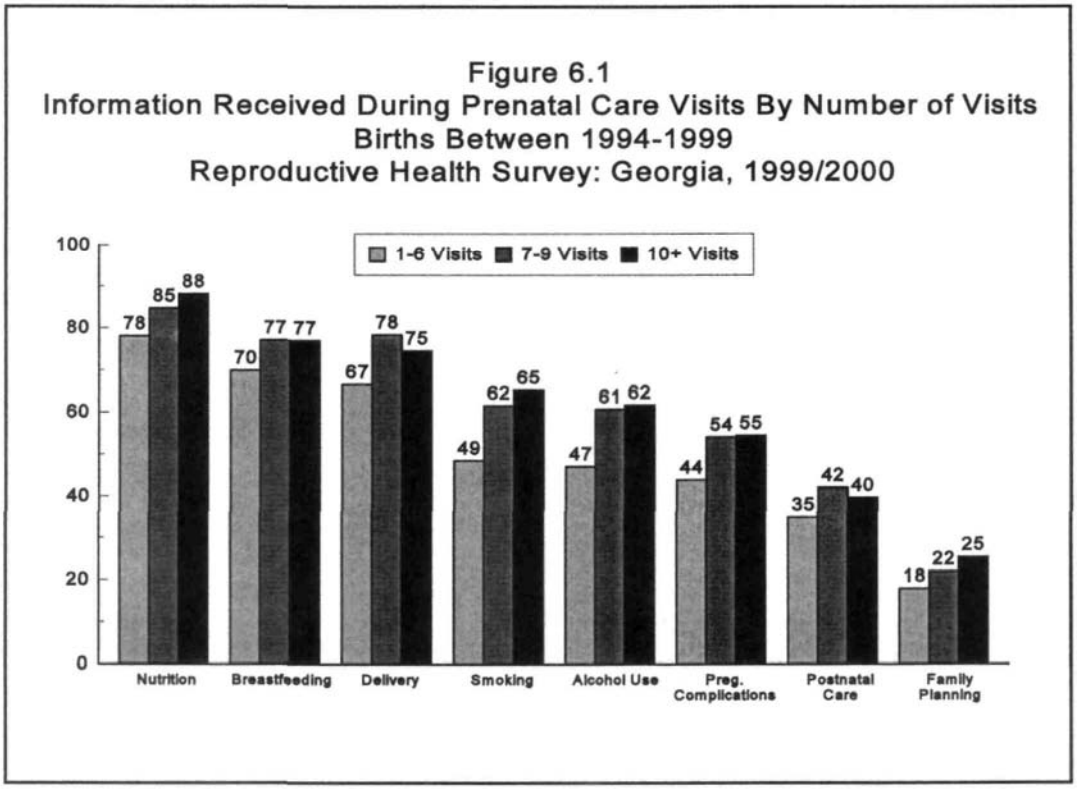


TABLE 6.1.4
Percentage of Women Who Received Pregnancy Counseling During Prenatal Visits by Selected Characteristics
Births in the Six Years Prior to the Survey with Any Prenatal Care
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Nutrition	Breast-Feeding	Delivery	Effects of Smoking	Effects of Alcohol	Pregnancy Complications	Postnatal Care	Family Planning	No. of Cases
Total	**81.2**	**72.6**	**70.5**	**54.3**	**52.6**	**47.8**	**37.2**	**20.1**	**2,809**
Residence									
Urban	84.0	73.4	72.2	57.9	55.2	51.7	38.2	20.2	1,523
Rural	78.3	71.8	68.7	50.5	49.9	43.9	36.2	19.9	1,286
Region									
Tbilisi	83.6	72.1	69.2	59.7	56.5	53.6	36.0	20.0	615
Imereti	83.9	79.2	76.0	51.8	51.4	50.8	43.5	19.0	593
North-East	80.6	72.9	67.5	54.7	52.8	46.2	34.3	23.2	526
South	71.5	64.7	61.2	48.9	46.7	40.9	34.2	21.1	393
West	84.3	73.6	76.9	53.9	53.4	46.1	38.6	17.5	682
Age Group (at Birth)									
15–24	83.1	72.7	70.8	54.3	52.1	50.3	37.8	20.5	672
25–34	80.5	72.4	69.9	54.5	53.0	46.6	36.6	19.8	1,970
35–44	83.4	74.5	76.3	50.8	49.4	53.1	42.5	21.8	167
Education Level									
Secondary Incomplete	77.0	70.1	65.5	52.0	51.5	43.7	33.6	14.4	253
Secondary Complete	79.6	71.1	66.8	50.5	48.0	43.4	35.7	23.8	952
Technicum	81.4	72.1	72.2	53.1	52.3	49.6	39.2	18.2	771
University	84.1	75.4	74.5	60.1	58.0	52.3	38.3	19.4	833
Ethnicity									
Georgian	82.5	73.7	72.7	55.3	53.5	49.0	37.6	19.3	2,392
Azeri	70.7	62.8	55.8	40.9	39.1	34.9	27.2	16.7	235
Armenian	81.7	78.0	69.4	65.5	66.5	60.9	56.2	43.5	103
Other	83.5	71.4	66.2	59.0	57.6	44.9	39.5	22.8	79
IDP Status									
IDP	84.9	71.9	74.1	55.0	51.4	53.9	42.2	17.9	541
Non-IDP	81.0	72.6	70.3	54.2	52.6	47.5	37.0	20.2	2,268
Number of PC Visits*									
1-6	78.1	69.9	66.6	48.5	47.1	43.9	35.0	17.9	1,645
7-9	84.7	77.1	78.4	61.6	60.7	54.1	42.1	22.0	625
10+	88.1	77.0	74.6	65.3	61.7	54.5	39.7	25.4	524
Place of Most PC†									
Dispensary	74.9	69.0	65.0	41.8	42.2	32.0	24.6	15.9	299
Polyclinic	82.4	74.3	72.3	58.1	56.4	51.4	41.3	22.8	2,085
Private Clinic	85.9	50.4	53.1	32.4	32.4	42.1	25.9	8.1	33
Maternity Hospital	80.3	69.5	68.0	47.2	43.7	43.0	27.5	11.1	384

* Excludes 15 pregnancies with unknown number of visits.
† Excludes eight pregnancies for which prenatal care visits took place at home

Overall, most women who attended prenatal care clinics have received some counseling about nutrition during pregnancy (81%), breastfeeding (73%), and delivery (71%); about one in two women received information about the negative effects of smoking and alcohol (54% and 53%, respectively) and 48% of women were counseled about early signs of complications during pregnancy. About one third of women were told about postnatal care (37%) and only one in five 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 the South region, less than complete secondary education, Azeri ethnic background, having less than seven prenatal visits, and receiving most of the prenatal visits in primary health care clinics (rural dispensaries or medical circumscriptions). The proportion receiving information during prenatal care visits is correlated with the number of visits (Figure 6.1).

Ultrasound imaging has been increasingly used in perinatal care but debate still exists about routine ultrasound screening. Survey data do not allow us to differentiate between use for selected specific indications (e.g., confirmation of gestational age, assessment of fetal viability, fetal malformations, fetal growth, fetal presentation, and multiple pregnancy, examination of the placenta, and assessment of amniotic fluid) or for routine screening, either during early pregnancy (16-20 weeks) or in late pregnancy (after 20 weeks).

Table 6.1.5 shows the prevalence of ultrasound exams during pregnancies that ended between 1994 and 1999. Overall, almost two out of three pregnancies (60%) had had at least one ultrasound exam. Maternal characteristics associated with higher levels of ultrasound exams include: urban residence (74%), residence in Tbilisi (87%), University education (79%), high SES (86%), having four or more prenatal care visits (not shown), and having most of prenatal visits in a private clinic (89%). Lower prevalence of ultrasound exams was associated with rural residence (46%), living in the South region (39%), having less than complete secondary education (42%) or a low SES (40%), and having most prenatal care in an urban or rural dispensary (43%).

Slightly more than half of women (55%) had their first ultrasound exam in the second half of pregnancy, suggesting the use of ultrasound for specific indications rather than for screening (the main reason for starting screening in late pregnancy is to assess fetal growth and abnormal presentations or positions that may benefit from caesarian delivery). However, women in urban areas, including Tbilisi, those with high educational attainment, those with seven or more prenatal care visits (data not shown), and those whose primary source of prenatal care was a maternity hospital were slightly more likely than other women to have their first ultrasound exam during the first 20 weeks of pregnancy.

TABLE 6.1.5

Use of Ultrasound Exams During Pregnancy By Time of the First Exam, by Selected Characteristics
Births in the Six Years Prior to the Survey with Any Prenatal Care
Reproductive Health Survey: Georgia, 1999/2000

	Had Ultrasound Exam		Time of First Exam			
Characteristic	%	No of Cases	4-20 Weeks	21 or More Weeks	Total	No of Cases
Total	**59.9**	**2,809**	**45.1**	**54.9**	**100.0**	**1,657**
Residence						
Urban	73.7	1,523	48.6	51.4	100.0	1,065
Rural	45.7	1,286	39.4	60.6	100.0	592
Region						
Tbilisi	86.8	615	56.1	43.9	100.0	520
Imereti	64.0	593	38.0	62.0	100.0	372
North-East	53.6	526	38.6	61.4	100.0	270
South	38.8	393	47.5	52.5	100.0	154
West	49.7	682	37.4	62.6	100.0	341
Age Group (at Birth)						
15–24	66.5	672	49.5	50.5	100.0	433
25–34	57.2	1,970	42.8	57.2	100.0	1,113
35–44	67.4	167	52.1	47.9	100.0	111
Education Level						
Secondary Incomplete	41.6	253	40.6	59.4	100.0	109
Secondary Complete	47.8	952	37.1	62.9	100.0	454
Technicum	59.6	771	41.3	58.7	100.0	451
University	78.9	833	53.5	46.5	100.0	643
Socio-Economic Status						
Low	39.7	1,214	37.8	62.2	100.0	533
Medium	67.5	1,298	45.0	55.0	100.0	865
High	86.4	297	55.1	44.9	100.0	259
Ethnicity						
Georgian	63.3	2,392	45.7	54.3	100.0	1,471
Azeri	36.3	235	32.7	67.3	100.0	81
Armenian	44.8	103	46.7	53.3	100.0	46
Other	75.3	79	54.4	45.6	100.0	59
IDP Status						
IDP	65.0	541	38.7	61.3	100.0	334
Non-IDP	59.6	2,268	45.5	54.5	100.0	1,323
Place of Most PC*						
Dispensary	43.2	299	26.4	73.6	100.0	132
Polyclinic	61.6	2,085	45.4	54.6	100.0	1,270
Private Clinic	88.9	33	27.1	72.9	100.0	27
Maternity Hospital	61.6	384	56.6	43.4	100.0	223

* Excludes eight pregnancies for which prenatal care visits took place at home

6.2 Intrapartum Care

The Georgian Ministry of Health recommends that all births should occur in medical facilities where adequately trained personnel can monitor the progress of labor and delivery. The majority of deliveries in Georgia take place in maternities or hospitals with inpatient obstetrical care. Births delivered outside medical facilities are rare and, in the rare event when a home delivery occurs, both the mother and her baby are immediately referred to a hospital or maternity to be supervised for at least five postpartum days.

Survey data confirmed that the majority of women gave birth in a maternity or a hospital obstetrical ward (92%) and only eight percent of deliveries occur outside the hospital (Table 6.2.1). Almost all these women delivered at home and very few delivered in a private clinic. However, home deliveries reached a significant proportion among some subgroups. They were significantly higher among rural residents than among urban residents (13% vs. 2%), among residents of the South region (16%), among women aged 35 years or older (11%), those with low levels of education or low SES (25% and 15%, respectively), among Azeri women (26%), and those with two or more prior births (17%).

Self-reports about onset and duration of labor are not very reliable because of a wide individual variation in contraction frequency and in perception of uterine activity. Thus, there is often uncertainty about the beginning of labor, particularly of the latent phase. Although the 99GERHS included questions about the duration of labor (defined as the interval between the beginning of periodic contractions every five minutes or less and the time of delivery), respondents' reports were too low for both nulliparous (2.6 hours, on average) and multiparous women (1.7 hours, on average). According to data published in the literature the average duration of labor is between ten hours for nulliparous women and six hours for multiparous women (Duig, 1975). Because of the limitations of self-reported duration of labor, this report includes data on the duration of the hospital stay prior to delivery as a proxy for the labor duration. Table 6.2.2 shows the 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 almost 12 hours (ranging from less than an hour to six days). However, half of the respondents were admitted to the hospital within four hours prior to delivery (data not shown), presumably well after the onset of labor. The average time spent in the hospital prior to delivery was shorter for less educated women, women of Azeri or Armenian descent, multiparous women and women with no prenatal care (data not shown). Women with any pregnancy complications, those who gave birth to low weight babies, and those who delivered by C-section were more likely to report a long pre-delivery hospital stay, probably because closer monitoring of pregnancy, medical temporization of delivery, and use of C-section to end long labors.

TABLE 6.2.1

Place of Delivery for the Most Recent Birth By Selected Characteristics

Births in the Six Years Prior to the Survey

Reproductive Health Survey: Georgia, 1999/2000

	Place of Delivery for the Most Recent Birth				
Characteristic	**Hospital/Maternity**	**Private Clinic**	**Home***	**Total**	**No. of Cases**
Total	**92.0**	**0.2**	**7.8**	**100.0**	**3,050**
Residence					
Urban	98.0	0.2	1.8	100.0	1,584
Rural	86.5	0.3	13.3	100.0	1,466
Region					
Tbilisi	99.0	0.2	0.8	100.0	646
Imereti	95.7	0.2	4.1	100.0	612
North-East	90.9	0.5	8.6	100.0	569
South	83.6	0.0	16.4	100.0	483
West	90.1	0.2	9.7	100.0	740
Age Group (at Birth)					
15–24	92.9	0.6	6.5	100.0	721
25–34	91.9	0.1	7.9	100.0	2,144
35–44	89.2	0.0	10.8	100.0	185
Education Level					
Secondary Incomplete	74.6	0.0	25.3	100.0	342
Secondary Complete	89.9	0.0	10.1	100.0	1,052
Technicum	97.7	0.2	2.1	100.0	805
University	97.1	0.6	2.3	100.0	851
Socio-Economic Status					
Low	84.5	0.4	15.1	100.0	1,392
Medium	96.3	0.1	3.6	100.0	1,357
High	99.1	0.3	0.6	100.0	301
Ethnicity					
Georgian	95.1	0.3	4.6	100.0	2,522
Azeri	73.6	0.0	26.4	100.0	326
Armenian	90.6	0.0	9.4	100.0	114
Other	96.5	0.0	3.5	100.0	88
IDP Status					
IDP	97.7	0.6	1.7	100.0	558
Non-IDP	91.7	0.2	8.1	100.0	2,492
Birth Order					
First	96.1	0.2	3.7	100.0	1,326
Second	92.1	0.2	7.7	100.0	1,122
Third or Higher	82.8	0.4	16.9	100.0	602

* Includes four pregnancies delivered while on their way to the hospital.

TABLE 6.2.2
Average Number of Hours Between Admission and Delivery and Time Interval Between Delivery and Hospital Discharge (in Nights) by Selected Characteristics Births in the Six Years Prior to the Survey Delivered in Medical Facilities Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Average No. of Hours From Admission to Delivery	Nights Spent in a Medical Facility Between Delivery and Discharge					
		≤4	5	6–7	≥8	Total	No. of Cases
Total	**11.6**	**19.9**	**37.4**	**31.7**	**11.0**	**100.0**	**2,850**
Residence							
Urban	12.1	21.8	37.8	29.4	11.0	100.0	1,556
Rural	11.1	17.8	37.0	34.1	11.0	100.0	1,294
Age Group (at Birth)							
15–24	10.6	20.1	34.8	34.2	10.9	100.0	680
25–34	11.7	20.2	38.1	31.1	10.7	100.0	1,999
35–44	14.6	15.3	40.8	28.5	15.4	100.0	171
Education Level							
Secondary Incomplete	9.7	25.1	38.4	30.9	5.6	100.0	262
Secondary Complete	10.0	20.0	38.8	32.5	8.6	100.0	962
Technicum	12.5	20.8	37.4	30.0	11.6	100.0	790
University	13.2	17.1	35.7	32.4	14.8	100.0	836
Ethnicity							
Georgian	12.5	17.9	37.2	32.7	12.2	100.0	2,420
Azeri	6.5	30.5	42.1	21.9	5.4	100.0	240
Armenian	8.7	26.6	36.0	34.6	2.9	100.0	105
Other	11.2	25.1	30.4	33.9	10.7	100.0	85
IDP Status							
IDP	11.1	10.8	39.0	33.4	16.8	100.0	550
Non-IDP	11.6	20.4	37.4	31.6	10.7	100.0	2,300
Birth Order							
First	13.4	16.9	35.8	33.2	14.1	100.0	1,287
Second	9.5	22.5	38.1	30.4	9.0	100.0	1,046
Third or Higher	11.2	22.1	40.2	30.3	7.4	100.0	517
Baby Weight at Birth							
<2,500 grams	17.9	23.2	25.6	31.6	19.6	100.0	163
≥2,500 grams	11.2	19.7	38.1	31.7	10.5	100.0	2,687
Type of Delivery							
Vaginal	10.1	21.1	39.7	31.8	7.4	100.0	2,656
Caesarean	34.0	2.3	3.9	29.7	64.1	100.0	194
Preg. Complications							
Any Complications	23.7	18.0	26.6	32.9	22.5	100.0	387
No Complications	9.8	20.2	39.1	31.5	9.2	100.0	2,463

About half of women who gave birth in a medical facility were discharged in the first 5 days after delivery (57%), including 20% who were discharged within the first four days of the postpartum period. One in three women (32%) was discharged after 6-7 days and 11% of women spent eight or more days in the hospital after delivery (15%). Women with low education and low SES (not shown), those of Azeri or Armenian ethnic background, and those with two or more prior births were more likely to be discharged after a shorter postpartum hospital stay. As expected, women with low birth weight babies, women with complications during pregnancy (23%) or early postpartum complications (data not shown), and those with C-sections (64%) had much longer stays compared with other new mothers.

Practically all births delivered in medical facilities were assisted by obstetricians (not shown). Of the eight percent of deliveries that took place at home, 59% were assisted by a midwife, 19% by a physician, and only 22% were assisted by traditional birth attendants, including 2% un-attended.

Table 6.2.3 presents the percentage of births delivered by C-section between 1994-1999. The Caesarean section (C-section) rate varies considerably among countries, from about 5% to more than 20% of all deliveries. The optimal rate is not known, but little improvement in birth outcomes has been demonstrated if the rate is higher than 7%. In addition to unequivocal obstetrical indications, C-section is often performed in less clear situations (e.g., prolonged labor), and often if a previous C-section was performed, which is rarely an adequate indication by itself. In Georgia, the overall prevalence of Caesarean deliveries among all deliveries that occurred between 1994 and 1999 was 6%. Caesarean deliveries were more prevalent in Tbilisi, Imereti and the West regions than in the North-East and Southern regions. Women aged 35 years or older reported C-section deliveries much often than women aged 15-24 or 25-34 years (17% vs. 8% and 5%, respectively). The C-section rate increased directly with education and socio-economic status, suggesting that financial considerations may sometimes be more important than obstetrical indications for Caesarean delivery. As expected, although the numbers are small, women who experienced prolonged labor (over 20 hours for nulliparous women and over 14 hours for multiparous women) were more likely to have C-section deliveries than those with average length labors. However, the majority of C-sections were performed prior to the onset of labor, suggesting that obstruction of labor is not the most common indication for C-section.

TABLE 6.2.3
Percentage of Caesarean Deliveries by Selected Characteristics
Births in the Six Years Prior to the Survey Delivered in Medical Facilities
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	% Caesarean Deliveries	Unweighted No. of Cases
Total	**6.4**	**2,850**
Residence		
Urban	7.4	1,556
Rural	5.4	1,294
Region		
Tbilisi	7.2	642
Imereti	8.2	593
North-East	3.6	530
South	4.0	407
West	8.5	678
Age Group (at Birth)		
15–24	7.7	680
25–34	5.1	1,999
35–44	17.4	171
Education Level		
Secondary Incomplete	2.3	262
Secondary Complete	4.1	962
Technicum	6.7	790
University	10.1	836
Socioeconomic Status		
Low	3.9	1,233
Middle	6.5	1,318
High	13.2	299
IDP Status		
IDP	6.5	550
Non-IDP	6.4	2,300
Birth Order		
First Birth	7.6	1,287
Second Birth	6.1	1,046
Third or Higher	4.2	517
Pregnancy Complications		
Any Complications	7.4	163
No Complications	6.4	2,687
Baby Weight at Birth		
2,500 grams or More	14.8	387
<2,500 grams	5.1	2,463
Prolonged Labor		
No	1.4	2,620
Yes	9.3	39
No Labor	78.1	191

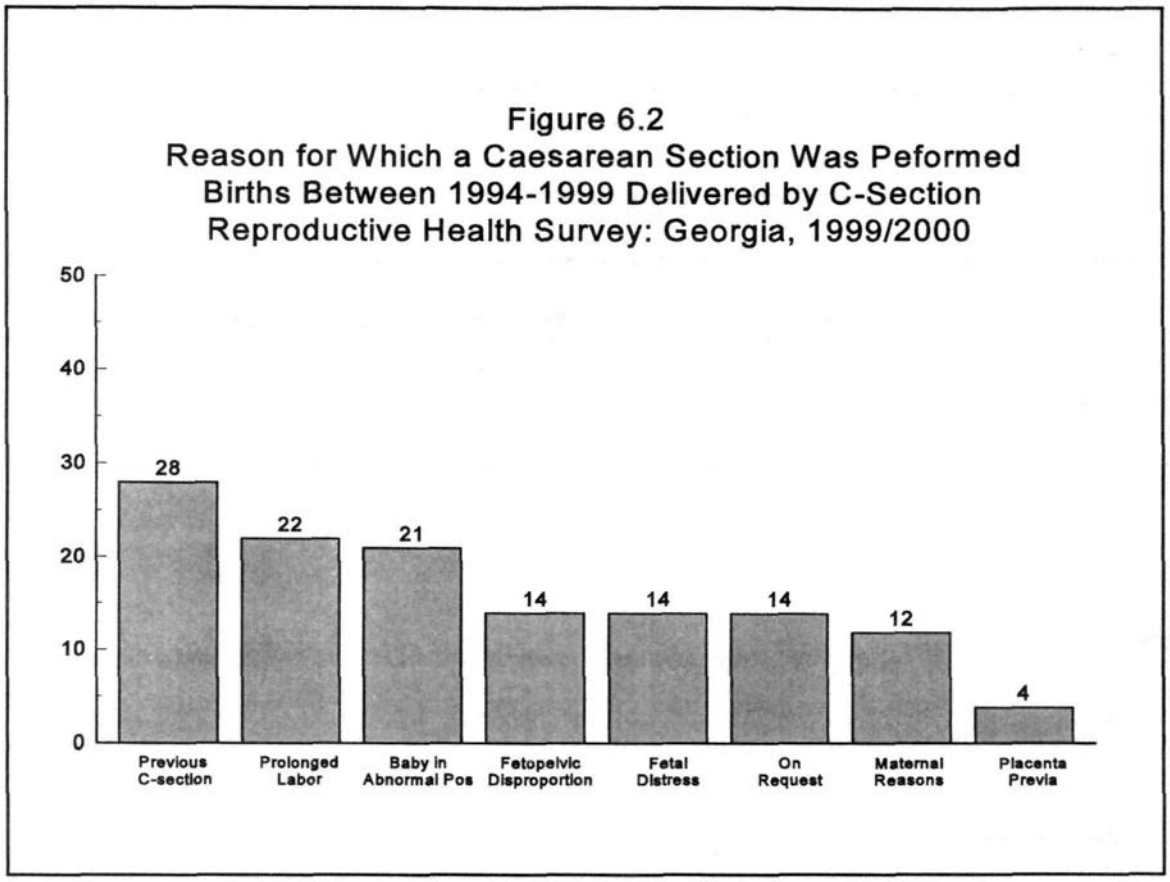


Figure 6.2 shows the most often cited reasons for having had a Caesarean delivery. The sum of reasons exceeds 100% because some respondents gave more than one reason. Overall, the most cited reasons were that a previous birth was delivered by C-section (28%), prolonged labor (22%), and abnormal position of the baby (21%). Other often mentioned reasons were fetopelvic disproportion and fetal distress (14%). One in seven respondents who delivered by C-section reported that they requested this type of delivery whereas 12% stated maternal pre-existing health conditions (e.g., cardiovascular problems) as the main reason for C-section delivery. Only 5% of women stated that C-section was performed because of placenta previa.

6.3 Postnatal Care

During postnatal care it is important to assess the health of both the mother and her infant and provide counseling about breast-feeding, nutrition, and family planning. Postnatal care in Georgia is initiated soon after the new mother is discharged from the maternity where she delivered and consists mostly of home visit(s) provided by a midwife. The postnatal period is a critical

TABLE 6.3
Use of Postnatal Care and Information Received During Postnatal Visit(s) by Selected Characteristics
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

	Postnatal Care		Information Received During Postnatal Care						
Characteristic	%	No. of Cases*	Immuni-zation	Child Care	Nutrition	Breast-Feeding	Breast Care	Family Planning	No. of Cases
Total	**10.6**	**2,999**	**89.6**	**89.0**	**88.9**	**88.2**	**88.3**	**19.7**	**326**
Residence									
Urban	12.2	1,555	89.1	89.1	86.7	88.5	85.6	20.0	196
Rural	9.2	1,444	90.1	88.8	91.7	88.0	91.6	19.3	130
Region									
Tbilisi	11.2	632	76.4	77.8	79.4	82.2	72.2	15.5	79
Imereti	10.9	598	93.6	92.1	91.8	93.6	89.9	31.6	69
North-East	9.4	560	88.8	90.7	83.1	81.1	88.8	15.6	50
South	8.7	479	91.2	86.8	95.6	88.9	93.4	13.4	37
West	12.3	730	98.4	97.1	95.9	94.7	98.4	22.3	91
Age Group (at Birth)									
15–24	12.7	714	90.3	87.8	84.2	81.8	86.7	12.7	95
25–34	10.1	2,102	89.0	89.6	90.5	90.4	88.6	23.9	214
35–44	9.2	183	†	†	†	†	†	†	17
Education Level									
Secondary Incomplete	4.2	338	†	†	†	†	†	†	18
Secondary Complete	9.1	1,030	98.8	97.7	95.5	96.5	97.7	25.1	84
Technicum	11.0	794	91.2	88.1	90.3	84.3	89.0	15.6	100
University	14.9	837	80.6	82.0	83.8	85.3	79.7	20.1	124
IDP Status									
IDP	13.6	550	95.6	95.6	96.9	96.5	96.0	37.9	79
Non-IDP	10.5	2,449	89.2	88.5	88.4	87.7	87.8	18.5	247
Birth Order									
First	13.1	1,300	91.7	92.6	91.7	91.7	91.7	24.1	178
Second	9.4	1,106	87.6	87.1	83.6	86.4	83.5	19.8	108
Third or Higher	7.6	593	86.2	79.9	90.7	79.7	86.2	2.8	40
Type of Delivery									
Vaginal	10.0	2,807	90.2	89.9	87.9	87.9	88.4	19.1	288
C-Section	20.1	192	84.5	81.6	96.8	90.9	87.5	23.8	38
Postpartum Complications									
Any Complications	19.9	502	76.8	79.9	79.8	78.7	83.0	16.3	103
No Complications	8.7	2,497	94.6	92.1	94.1	92.6	91.7	21.1	223

* Excludes 51 pregnancies resulting in stillbirths.
† Fewer than 25 observations in this category.

opportunity to evaluate the physical and psychosocial health of a new mother and her infant, to detect and treat postpartum complications, and to provide the counseling and support needed to address any specific problems related to child care and family planning. The survey provided information about the use of postnatal care and the content of postnatal counseling (Table 6.3).

Overall, postnatal care was substantially less utilized than prenatal care (11% vs. 91%), in spite of the official recommendations. Its use was slightly higher among urban residents than among rural women and increased directly with the maternal education level. Birth order was inversely correlated with the use of postnatal care, as we have seen previously with the use of prenatal care: women with at least two previous births had lower rates of care compared to first or second time mothers. Lower utilization of maternal care services among high-parity women has long been recognized and explained through greater responsibilities within the household related to child rearing compounded with greater confidence and experience among these women. The use of C-section for delivery was associated with much higher rates of postnatal care use (20% vs. 10%) probably because the overlap with post-surgical care.

Most women who received postnatal visits were counseled about child immunization(90%), child care (89%), nutrition (89%), breastfeeding and breast care (88%). However, counseling about planning for future pregnancies and methods of birth control was uncommon (20%). The type of health advice given during postnatal care did not vary significantly with maternal characteristics, with the exception of being IDP or residing in the Imereti region, both associated with more advice, particularly contraceptive advice.

6.4 Smoking and Drinking During Pregnancy

The use of tobacco and alcohol during pregnancy are major risk factors for poor pregnancy outcomes. Smoking during pregnancy has been linked to low birth weight (LBW) babies, preterm deliveries, sudden infant death syndrome (SIDS), and respiratory problems in newborns. The damaging effects of alcohol use during pregnancy include fetal growth retardation, mental retardation, physical abnormalities, especially dysmorphic facial features, and altered neonatal behaviors. Developmental abnormalities occur in approximately 35%-40% of infants born to alcoholic mothers and are associated with consumption of at least two drinks per day (Coles CD, 1993).

Overall, only 4% of births between 1994-1999 occurred to mothers who were smokers at the time they found out about their pregnancies; half of these women quit smoking during pregnancy while 2% continue to smoke during pregnancy (data not shown). The proportion of women who

smoked prior to getting pregnant or during pregnancy was much higher in urban areas than in rural areas (8% vs. 1% and 5% vs. 0.2%, respectively); the highest smoking prevalence prior and during pregnancy was reported by women residing in Tbilisi (16% and 9%, respectively). Smoking before and during the pregnancy increased directly with maternal education level and SES. Similarly, drinking alcohol during pregnancy was very uncommon (3%).

6.5 Pregnancy and Postpartum Complications

Routine measurement of blood pressure during pregnancy is an essential component of health risk assessment during pregnancy. However, as is the case with other health measurements and diagnostics, self-reports of medical conditions are greatly influenced by background characteristics and differentials found in the survey may reflect a combination of risk factors and differences in reporting. As shown in Table 6.5.1, the majority of women with recent births (96%) had routine measurement of their blood pressure during pregnancy and 8% were identified as having high blood pressure (HBP). Only 3% of pregnant women were treated for HBP (not shown) and less than one percent were hospitalized due to HBP during pregnancy. Routine measurement of the blood pressure during pregnancy was less likely to be performed among women with less than complete secondary education, Azeri women, those with less than four prenatal care visits (not shown), and those who received most of the prenatal care in dispensaries (rural or urban). The prevalence of HBP during pregnancy was higher among women residing in Tbilisi (11%), those aged 35 years or older (12%), and those with high SES (11%). HBP was also reported more often by women with ten or more prenatal care visits (data not shown) and by those who received most prenatal care in hospitals or the private sector, either because frequent routine measurements of BP increased the likelihood of HBP diagnostics or because these women had been found early to have HBP and were advised to have frequent and specialized prenatal care visits.

About one in eight women with recent births (13%) reported pregnancy complications that required medical attention, including 3% who have to be hospitalized for these complications (data not shown). The conditions mentioned most often were the risk of preterm labor (4%) and water retention or edema (4%), followed by pregnancy associated anemia (3%), HBP (3%), and bleeding (2%) and risk of miscarriage (2%). Pregnancy complications that required medical attention were slightly more prevalent among women residing in urban areas than in rural areas (15% vs. 10%), those residing in Tbilisi (18%), and those with high education level (19%) and high SES (18%). Women who had ten or more prenatal care visits were three times more likely to report pregnancy complications compared to women with less than four visits, since the likelihood of being diagnosed with a pregnancy complication increases with the frequency of attendance of prenatal care and early diagnosis of pregnancy complications may require more frequent prenatal care visits.

TABLE 6.5.1
Routine Measurement of Blood Pressure (BP) During Pregnancy, High Blood Pressure (HBP) During Pregnancy, and Percentage of Pregnancies Hospitalized for HBP
Births in the Six Years Prior to the Survey That Had Prenatal Care
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Routine Measurement of BP During Pregnancy	HBP During Pregnancy	% Pregnancies Hospitalized for HBP
Total	**96.0**	**8.0**	**0.8**
Residence			
Urban	97.1	8.9	1.0
Rural	95.0	7.2	0.7
Region			
Tbilisi	96.2	11.3	1.5
Imereti	96.5	8.3	1.0
North-East	95.5	7.6	0.4
South	95.8	6.8	0.2
West	96.2	5.9	0.7
Age Group (at Birth)			
15–24	97.5	8.2	0.6
25–34	95.7	7.7	0.7
35–44	94.2	11.8	3.6
Education Level			
Secondary Incomplete	91.8	10.6	1.6
Secondary Complete	94.8	4.4	0.2
Technicum	97.2	10.9	0.5
University	97.7	8.7	1.5
Socioeconomic Status			
Low	95.0	6.3	0.9
Middle	96.5	8.5	0.7
High	97.0	11.3	1.2
Ethnicity			
Georgian	97.2	8.1	0.8
Azeri	90.7	9.2	1.4
Armenian	96.2	4.0	0.1
Other	84.4	7.8	0.0
Birth Order			
First	95.9	9.1	0.9
Second	95.9	7.1	0.5
Third or Higher	96.6	7.2	1.3
Place of Most Prenatal Care			
Dispensary	91.8	5.9	0.0
Polyclinic	97.5	7.5	0.8
Private Clinic	94.8	16.6	0.0
Maternity Hospital	92.9	11.3	1.1

Table 6.5.2
Postpartum Complications by Selected Characteristics
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Any Compli-cation	High Fever (>39 C°)	Severe Uterine Pain	Breast Infection	Severe Vaginal Bleeding	Infectious Vaginal Discharge	Dysuria	Infection of the Surgical Wound	Loss of Conscious-ness
Total	**17.0**	**7.3**	**6.9**	**6.0**	**3.4**	**3.1**	**2.8**	**2.2**	**1.0**
Residence									
Urban	19.0	8.3	6.8	7.2	3.0	3.0	2.7	2.2	0.9
Rural	15.1	6.4	7.0	4.8	3.8	3.1	3.0	2.2	1.1
Region									
Tbilisi	25.1	8.8	10.1	9.2	3.1	5.0	4.0	2.1	0.8
Imereti	15.3	8.9	4.3	4.8	4.1	3.0	2.1	2.0	1.3
North-East	15.2	5.6	7.7	6.3	3.7	3.3	3.9	2.3	1.3
South	11.9	5.4	4.2	3.5	2.5	1.7	1.5	1.4	0.4
West	15.7	7.6	6.9	5.2	3.8	2.1	2.2	3.0	1.1
Age Group (at Birth)									
15–24	19.9	8.5	9.4	8.3	4.4	3.0	2.9	2.6	1.0
25–34	16.1	7.2	6.3	5.2	3.2	3.2	2.8	2.2	1.0
35–44	16.0	4.0	4.9	6.8	2.7	2.2	2.4	1.1	1.1
Education Level									
Secondary Incomplete	10.1	7.5	2.8	5.6	2.3	2.1	1.3	0.5	0.3
Secondary Complete	12.1	4.1	4.8	3.9	2.6	1.9	1.9	1.3	0.6
Technicum	19.8	8.6	8.6	6.6	4.4	4.4	4.0	2.6	1.7
University	23.2	9.8	9.6	8.0	4.0	3.8	3.7	3.6	1.1
Socio-economic Status									
Low	12.5	5.6	5.1	4.7	3.1	2.5	2.3	1.5	1.1
Middle	18.5	7.9	8.0	6.1	3.6	3.3	3.1	2.6	1.0
High	25.4	10.5	8.2	9.6	3.9	4.3	3.7	3.0	0.6
Ethnicity									
Georgian	18.4	7.9	7.1	6.6	3.8	3.6	3.0	2.7	1.1
Azeri	9.5	4.5	5.2	2.0	2.5	1.0	2.2	0.2	0.5
Armenian	16.2	5.8	8.7	5.9	0.9	1.8	0.9	0.0	0.0
Other	15.4	7.2	6.0	7.0	2.6	1.1	2.5	2.3	1.4
Pregnancy Complications									
Any Complications	30.5	12.6	13.4	8.8	5.1	8.2	5.7	4.6	2.1
No Complications	15.0	6.5	6.0	5.6	3.2	2.3	2.4	1.9	0.8
Prolonged Labor									
Yes	38.3	22.3	24.1	5.2	14.0	22.1	11.7	4.9	2.6
No	16.7	7.1	6.6	6.0	3.3	2.8	2.7	2.2	1.0
Type of Delivery									
Vaginal	16.0	7.0	6.4	5.7	3.4	2.9	2.7	2.0	1.0
Cesarean	32.7	12.5	13.8	10.7	4.2	5.2	4.8	5.9	1.3

Postpartum complications reported by women who gave birth in the six years prior to the survey are shown in Table 6.5.2. Overall, 17% of women experienced at least one postpartum complication. Reports of postpartum complications were more frequent among residents of Tbilisi (25%) and increased with maternal education and socioeconomic status. Women who developed complications during pregnancy were twice as likely to report postpartum complications as those with uncomplicated pregnancies. Similarly, women with prolonged labor and C-section deliveries were much more likely to report postpartum complications. Reported postpartum complications ranged from 7% of women who experienced high fever and severe uterine pain to 1% who experienced loss of consciousness.

6.6 Poor Birth Outcomes

Poor birth outcomes during the six years preceding the survey are shown in Table 6.6. According to the respondents' reports, the stillbirth rate for all births during 1994-1999 was 17 per 1,000. All births known to the respondents as being delivered with no signs of life with a gestational age of at least 22 weeks were classified as stillbirths. Since 1994, the same definition is used for the official statistics, after the Ministry of Health (MOH) adopted the internationally-accepted definition of live-birth and stillbirth (MOH, Order 334/o of September 1993). Prior to 1994, newborns without any sign of life and with gestational age of 22-27 weeks were declared abortions rather than stillbirths. Thus, survey reports are comparable with the official stillbirth rate reported by the Ministry of Health (18.4 stillbirths per 1,000 births, on average, between 1995-1999) and the small difference observed is well within the sampling error. The stillbirth rate did not vary much by women's background characteristics but was influenced by prenatal care attendance, complications during pregnancy, and the duration of labor. The stillbirth rate was higher among pregnancies with no or late prenatal care (28 per 1,000 and 36 per 1,000, respectively) and among those with less than four prenatal care visits (data not shown). As expected, complicated pregnancies that required medical attention were more likely to have poor birth outcomes, including a higher stillbirth rate (37 per 1,000). Prolonged labor was the strongest predictor of a stillbirth outcome, although very few births reported in the survey have been defined as having delivered after prolonged labors. The stillbirth rate among those births was more than ten times higher than among births with labor duration within normal limits (126 per 1,000 vs. 16 per 1,000).

The incidence of low birth weight (under 2,500 grams) or prematurity was 6% among all births in the same period of time. Higher rates of low birth weight (LBW) and prematurity were reported by the same groups of women who were more likely to report stillbirths, with the exception of those who reported prolonged labor.

Table 6.6
Poor Birth Outcomes by Selected Characteristics
Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Stillbirth Rate (per 1,000 births)	% Low Birth Weight Births (<2,500 grams)	% Preterm Birth (<37 weeks)	Unweighted No. of Cases
Total	**17.1**	**5.5**	**6.2**	**3,050**
Residence				
Urban	19.7	6.1	7.7	1,584
Rural	14.7	4.9	4.8	1,466
Region				
Tbilisi	23.9	7.9	8.8	646
Imereti	23.7	5.6	5.9	612
North-East	15.7	5.3	6.8	569
South	9.8	5.0	5.0	483
West	12.8	3.6	4.2	740
Age Group (at Birth)				
15–24	7.0	4.5	4.9	721
25–34	20.7	5.8	6.5	2,144
35–44	12.5	5.7	7.6	185
Ethnicity				
Georgian	18.1	5.2	6.5	2,522
Azeri	10.0	5.2	3.7	326
Armenian	0.0	6.1	4.3	114
Other	45.6	13.5	12.4	88
IDP Status				
IDP	19.8	5.2	6.4	558
Non-IDP	17.0	5.5	6.2	2,492
Birth Order				
First Birth	21.7	6.5	7.3	1,326
Second Birth	14.3	4.5	5.3	1,122
Third or Higher	12.2	5.1	5.3	602
Trimester of First Visit				
No Prenatal Care	27.7	10.1	5.3	241
1st	17.8	5.0	7.1	1,938
2nd	9.6	4.2	3.9	773
3rd	35.9	9.3	6.6	83
Pregnancy Complications				
Any Complications	37.4	11.6	17.3	393
No Complications	14.2	4.6	4.6	2,657
Prolonged Labor				
Yes	126.2	5.3	12.8	43
No	15.5	5.5	6.1	3,007

6.7 Breastfeeding

Breast milk is the most complete food an infant can receive during the first few months of life. Breastfeeding is associated with a wide range of benefits for infant health, growth, immunity, and development. These benefits include decreased incidence and severity of diarrhea (Dewey KG et al., 1995; Popkin BM et al.,1990), respiratory and ear infections (Kovar MG et al, 1984; Howie PW et al., 1990), longer birth intervals (by delaying the return of ovulation), and reduced cost to the family. In addition, breastfeeding has been shown to improve maternal health by reducing postpartum bleeding (Chua S et al., 1990), allowing an earlier return to prepregnancy weight (Dewey et al., 1993), and reducing the risks of premenopausal breast cancer (Newcomb PA et al., 1994) and osteoporosis. The 99GERHS included questions about breastfeeding patterns and duration. As shown in Table 6.7.1, most babies (87%) born during the past six years were breastfed at least for short periods of time. The percentage of babies ever breastfed varies little by selected characteristics. Rates of breastfeeding were slightly lower among women living in urban areas, including Tbilisi (82%) and decreased with the increase in maternal age. Low-birth weight babies and those delivered by C-section had a significantly lower chance of being breastfed compared to normal weight babies and those delivered vaginally. These findings are consistent with reports in the literature showing that if the mother breastfeeds immediately after she gives birth, the nipple stimulation during suckling triggers the release of oxytocin, initiates lactation, and helps reduce postpartum bleeding. Sedatives and analgesics given during labor alter the behavior of newborns and can compromise the essential role of the baby in the initiation of lactation. Similarly, low birth weight babies, too weak to initiate suckling, are less likely to be breastfed later compared to those with those who weight 2,500 grams or more at birth.

According to the World Health Organization (WHO) recommendations, early suckling (within the first hour post-delivery) should be promoted following all spontaneous deliveries. Table 6.7.1 (right panel) also shows the time elapsed between delivery and initiation of breastfeeding. Of infants who were breastfed, only 5% began breastfeeding during the first hour after birth and 28% of children began breastfeeding between one hour and the completion of the first day. Most babies were breastfed for the first time during the second day of life (37%) or later (30%). Breastfeeding initiation within the first hour was slightly more prevalent among women living in the South region (8%) and among Azeri women (8%). In terms of babies' characteristics, low birth weight and Caesarean delivery substantially reduced the likelihood of early breastfeeding. For these infants, breastfeeding is more likely to be initiated after two days, if ever. Indeed, 40% of low birth weight babies and 60% of babies delivered by Caesarean section had initiated breastfeeding only after 48 hours of life.

WHO also recommends that all infants should be fed exclusively on breast milk from birth

TABLE 6.7.1
Percentage of Children Ever Breastfed And Initiation of Breastfeeding
By Selected Characteristics
Live Births in the Six Years Prior to the Survey
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Children Ever Breastfed		Initiation of Breastfeeding						
	%	No. of Cases*	Within 1 Hour	1–23 Hours	24–47 Hours	48 Hours or More	Unknown	Total	No. of Cases
Total	**86.7**	**2,999**	**4.6**	**27.8**	**37.1**	**29.5**	**0.9**	**100.0**	**2,608**
Residence									
Urban	84.2	1,555	4.7	29.5	34.1	30.3	1.3	100.0	1,326
Rural	89.0	1,444	4.6	26.3	39.8	28.8	0.5	100.0	1,282
Region									
Tbilisi	81.8	632	4.1	36.6	26.9	29.7	2.8	100.0	529
Imereti	85.7	598	2.3	19.9	36.7	41.1	0.0	100.0	514
North-East	88.4	560	5.5	27.1	34.1	32.9	0.4	100.0	495
South	91.3	479	7.7	26.2	43.4	21.6	1.1	100.0	437
West	87.1	730	3.3	27.2	44.3	25.0	0.0	100.0	633
Age Group (at Birth)									
15–24	88.4	714	4.4	29.7	30.9	32.4	2.6	100.0	629
25–34	86.5	2,102	4.6	27.3	39.5	28.2	0.4	100.0	1,830
35–44	82.6	183	5.7	26.7	33.3	34.3	0.0	100.0	149
Education Level									
Secondary Incomplete	94.3	338	3.9	26.0	45.6	23.0	1.5	100.0	315
Secondary Complete	87.1	1,030	5.7	28.5	37.6	27.7	0.5	100.0	907
Technicum	85.1	794	3.3	26.5	37.2	32.1	0.7	100.0	675
University	84.3	837	4.8	29.0	32.3	32.7	1.2	100.0	711
Ethnicity									
Georgian	85.2	2,479	4.0	27.8	34.6	32.7	0.8	100.0	2,127
Azeri	94.7	322	8.0	25.9	44.7	20.1	1.3	100.0	307
Armenian	89.6	114	1.0	29.2	52.4	16.4	1.0	100.0	104
Other	85.6	84	7.4	36.9	41.8	14.0	0.0	100.0	70
Birth Order									
First	85.1	1,300	5.1	25.5	36.6	31.9	0.9	100.0	1,120
Second	87.3	1,106	4.1	28.2	38.6	27.8	1.1	100.0	965
Third or Higher	89.0	593	4.6	31.7	35.6	27.6	0.4	100.0	523
Type of Delivery									
Vaginal	87.5	2,807	4.8	28.6	37.7	27.9	0.9	100.0	2,465
Caesarian Section	74.7	192	0.7	12.3	26.7	60.2	0.0	100.0	143
Weight at Birth									
<2,500 grams	58.1	153	2.7	23.1	30.1	40.2	2.6	100.0	96
2,500 grams or more	88.1	2,846	4.7	28.0	37.4	29.2	0.8	100.0	2,512

* Excludes 21 babies who died soon after birth.

to at least 4 months of age and that breastfeeding should continue "for at least one year and preferably up to two years or beyond" (World Health Organization, 1991).

Table 6.7.2 shows the mean duration of breastfeeding for children under 60 months of age. Mean durations of breastfeeding are given for the age until which the children were breastfed. An infant is considered to be exclusively breastfed if he/she receives only breast milk. The infant is considered almost exclusively or predominantly breastfed if he/she receives breastmilk accompanied by water or other liquids excepting other types of milk. Children with exclusive or almost exclusive breastfeeding are considered to be fully breastfed (Labbok MH and Krasovec K., 1990). These indicators are recommended by WHO to assess the adequacy of breastfeeding practices in a population and to allow for international comparisons among countries collecting the same type of breastfeeding information.

In order to calculate the mean duration, the proportion of births that were still breastfed at the time of the interview was calculated by single month of age (0-59 months); the denominator included all live births in those five years (regardless of survival). These proportions were summed together to calculate the mean duration of breastfeeding. This method is known as the "current status mean" method (World Health Organization, 1991). Durations of exclusive and full breastfeeding were calculated the same way, where babies who did not yet initiate any other liquids or food were classified as exclusively breastfed and those who were either exclusively breastfed or started to receive liquids but no other food were classified as fully breastfed.

The mean duration of any breastfeeding was 10.6 months. For most of this time, however, breastfeeding was only partial. The mean duration of exclusive breastfeeding was 1.5 months. Obviously, very few children in Georgia received the WHO recommended type of breastfeeding (at least 4 months of exclusive breastfeeding). Women residing in the North-East and the South regions, those who gave birth after the age of 34, and IDP women were less likely to exclusively breastfeed. In addition, babies delivered by C-section and those with low birth weight were less likely to be exclusively breastfed compared to babies delivered vaginally and normal birth-weight babies. Mean duration of full breastfeeding was 3.7 months. The duration of any breastfeeding was about a month longer for rural women and women residing in the South region. The duration of any breastfeeding increased with maternal age and the birth order and was substantially higher among women with less than complete secondary education (14.5 months). IDP women were reporting, on average, breastfeeding durations two months shorter than non-IDP women. Babies who were delivered vaginally had been, on average, breastfed for twice as long as babies delivered by C-section. Similarly, low birth weight babies had a much shorter duration of breastfeeding than normal birth

TABLE 6.7.2
Mean Duration of Breastfeeding In Months, by Type of Breastfeeding, by Characteristics
Live Births in the Six Years Prior to the Survey Who Were Breastfed
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Exclusive Breastfeeding	Full Breastfeeding*	Any Breastfeeding
Total	**1.5**	**3.7**	**10.6**
Residence			
Urban	1.4	3.6	10.0
Rural	1.9	4.0	11.0
Region			
Tbilisi	1.9	4.0	10.6
Imereti	1.5	2.9	10.0
North-East	0.7	3.3	10.2
South	0.9	5.0	11.7
West	1.5	2.8	10.0
Age Group (at Birth)			
15–24	1.3	4.0	10.1
25–34	1.6	3.2	10.5
35–44	0.0	3.8	12.7
Education Level			
Secondary Incomplete	1.1	4.0	14.5
Secondary Complete	1.6	3.8	10.8
Technicum	1.6	3.7	9.9
University	1.6	3.9	9.5
Ethnicity			
Georgian	1.5	3.4	9.9
Azeri	1.5	4.4	13.2
Armenian	2.0	4.3	7.5
Other	1.0	2.6	5.3
IDP Status			
IDP	0.7	3.6	8.6
Non-IDP	1.5	3.7	10.7
Birth Order			
First	1.4	3.7	8.9
Second	1.8	4.2	11.3
Third or Higher	1.4	2.9	12.6
Type of Delivery			
Vaginal	1.5	3.9	11.9
Caesarian Section	1.0	2.3	5.4
Weight at Birth			
<2,500 grams	1.0	4.2	7.1
2,500 grams or more	1.5	3.8	10.9

* Children with exclusive (only breast milk) or almost exclusive (breast milk and other liquids excepting formula or other milk) breastfeeding.

TABLE 6.7.3
Most Common Cited Reasons for Stopping Breastfeeding
By Age of the Child at Weaning
Live Births in the Six Years Prior to the Survey Who Were Not Currently Breastfed
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

		Age at Weaning (in Months)				
Reasons	**Total**	**0-1**	**2-4**	**5-11**	**12-23**	**24-59**
Insufficient Milk	**59.6**	82.3	83.0	68.8	7.6	1.1
Reached Age to Be Weaned	**27.9**	0.4	3.0	14.7	88.1	96.6
Child Refused	**3.3**	1.6	3.4	5.3	2.8	1.2
Breast Problems	**3.0**	8.0	3.4	2.0	0.4	0.0
Mother Became Ill	**1.8**	2.4	1.6	3.4	0.0	0.0
Child Became Ill or Died	**1.4**	2.8	1.4	1.9	0.0	0.0
Mother Preferred Formula Milk	**1.0**	0.9	2.1	0.6	0.0	0.0
Became Pregnant	**0.9**	0.0	0.4	2.6	0.7	0.0
Mother Needed to Work	**0.8**	0.4	1.5	0.3	0.4	1.1
Other	**0.3**	1.2	0.0	0.3	0.0	0.0
Total	**100.0**	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**1,550**	266	525	372	289	98

weight babies.

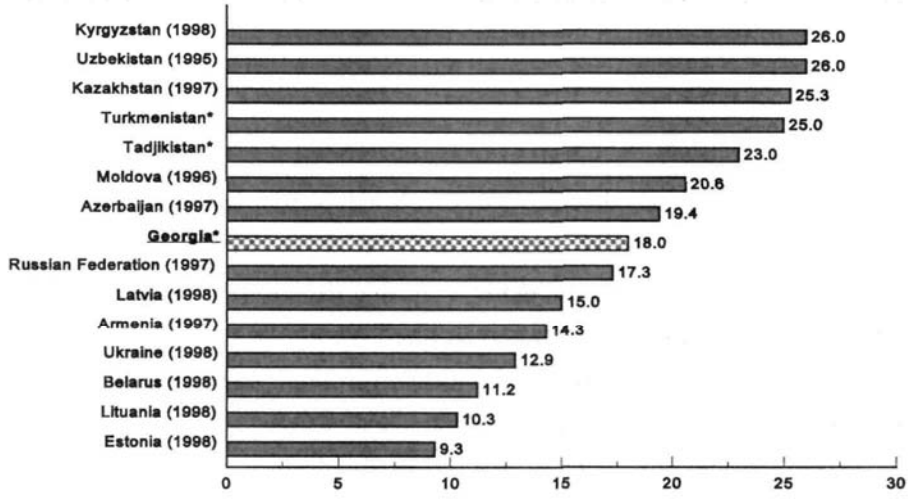
Table 6.7.3 shows the percent distribution of children ever breastfed who were no longer breastfed by the age when the child was weaned and the main reason given by the mother for stopping breastfeeding. The most common reasons were that the mother did not have sufficient milk to breastfeed the baby (60%) and that the child had reached the age to be weaned (28%). Insufficient milk was particularly the most common response for children weaned during the first month of age or before reaching five months of age (82% and 83%, respectively).

6.8 Infant and Child Mortality

Although higher than in most of the former Soviet-bloc countries of the Central and Eastern Europe, the infant mortality rate in Georgia is comparable with the rates reported by other Newly Independent States (Figure 6.8.1). However, the wide-spread under-reporting of registered events in Georgia is likely to significantly affect the actual infant and child mortality levels.

The registration process of infant deaths in Georgia is similar to that of live birth registration. Currently there are two official counts of infant deaths: one through the Center for Medical Statistics and Information of the Ministry of Health (CMSI) and one through the State Department for Statistics of Georgia (SDS). As was the case with the birth counts (see also Chapter IV), the number of infant deaths reported in the two systems differ by a considerable margin. CMSI receives infant mortality data on aggregate data forms from medical facilities (monthly from maternity hospitals and annually from pediatric wards and polyclinics). Data are first compiled at the facility level from log books and then sent on aggregate forms to the CMSI. SDS receives mortality data from urban and rural civil registry bureaus (CRBs), where the medical death certificates filled out by physicians in hospitals or ambulatory units are submitted by relatives in order to obtain official death certificates needed for burial. The original medical death certificates are submitted to SDS where demographic data are processed and cause of death codes are applied, according to the 10th revision of the International Classification of Diseases (ICD10) adopted by Georgia in 1998.

Figure 6.8.1
Infant Mortality Rates (Infant Deaths per 1,000 Live Births)
in the Newly Independent States
Most Recent Data Reported to the WHO



*/ Countries that did not report mortality data to WHO and 2001PRB estimates are displayed here.

The discrepancy in reporting between the two systems was recently documented in a study conducted jointly by the two agencies responsible for birth and death surveillance, CMSI and SDS, with financial support of WHO/EURO. One of the purposes of the study was to evaluate the completeness of birth and death registration at the civil registries level compared to the registration at the medical facility level. This study, conducted in several cities (a district of Tbilisi, Rustavi, and Gori) and regions (Mtskheta, Marneuli), revealed that between 28%-30% of all births and deaths were not registered in the civil registries. In addition, the study found that none of the maternal deaths reported by the medical facilities in the study had been recorded by the regional civil registries. Based on this study, the MOH adopted new recommendations on "implementation and calculation of child health indicators," a new format of the Medical Death Certificate and instructions on completing and issuing the certificate (Order No. 141 of Oct. 2000 and No 94/0 of Dec. 2000).

Thus, it is not surprising that the infant mortality rate (IMR) reported by the CMSI for the past five years was, on average, 53% higher than that reported by the SDS (23.7/1000 vs. 13.1/1000 in 1995, 29.2/1000 vs. 17.4/1000 in 1996, 23.8/1000 vs. 16.3/1000 in 1997, 21.3/1000 vs. 15.2/1000 in 1998, and 23.3/1000 vs. 17.2/1000 in 1999). Although the CMSI reporting system appears to be more complete, both systems are subject to under-reporting of birth and death events which occur outside medical facilities.

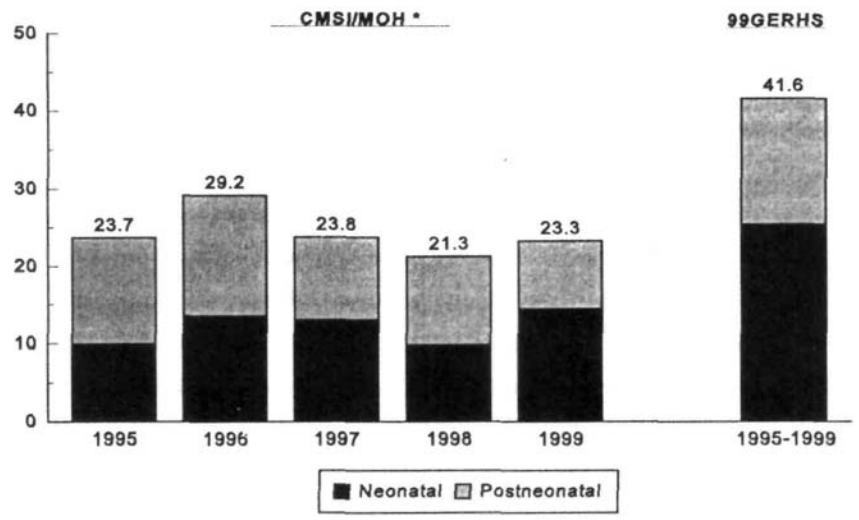
One of the principal objectives of the 99GERHS was to estimate levels and trends in infant and child mortality, particularly since infant mortality in Georgia is known to be substantially under-reported. The survey questionnaire included a series of questions in the pregnancy history, obtaining for each live birth: the date of occurrence, sex of the child, survival status, and for children who had died, the age at death. Respondents were asked to report pregnancy outcomes (e.g., stillbirths and live births) according to international definitions. Thus, a live birth was defined as any birth, irrespective of the duration of the pregnancy, that breathes or shows any other signs of life after separation from the mother. This definition differs only slightly from the modified WHO definition adopted in Georgia since January 1994 (22 weeks or 500 grams and any signs of life).

This information allows the calculation of infant and child mortality rates for precise periods of time, which are calculated by means of life tables. Survey data were used to calculate mortality levels among respondents' children: infant mortality (deaths before the first birthday), child mortality (deaths between 12 and 59 completed months of age), and child-under-five mortality (deaths before the fifth birthday). Infant mortality was further divided into two periods: neonatal (0-28 days) and postneonatal (29 days to 11 completed months). Table 6.8 presents the mortality rates estimated for the period January 1990-December 1999 by different maternal background characteristics. The infant mortality rate for this period was estimated at 40.7 per 1,000 live births and the mortality rate

for under five years was 44.8 per 1,000 (i.e., almost 45 of each 1,000 live births die before their fifth birthday). In this ten-year interval, the neonatal and postneonatal mortality rates were 25.0 per 1,000 and 15.7 per 1,000, respectively. In this type of survey underestimation of neonatal mortality tends to be greater than underestimation of child mortality at older ages. When the death occurred in the first few days of life, some women, especially those without formal education and those who have had many births, do not always consider their births to be live births. For this reason, the estimated neonatal mortality rate of 25.0 and implicitly the infant mortality rate of 40.7 should be considered as minimum values for this period of time. Nonetheless, in western Europe where vital records are relatively complete, the proportion of all infant deaths that occur in the neonatal period was typically 60%, for comparable levels of IMR (Demographic Yearbook, 1974). The ratio between neonatal and infant mortality rate based on 99GERHS estimates (61%) was consistent with these figures, suggesting little survey under-reporting of neonatal deaths.

The overall IMR of 41.6 per 1,000 live births estimated from 99GERHS for the most recent five-year period was about 70% higher than the average IMR reported by MOH for January 1995-December 1999 (Figure 6.8.2). The statistical standard error (SE) for the survey period estimate was 5.7 percentage points, calculated as SE=rate/(square root of number of deaths)* 1.4, where 1.4 represents the design effect needed because the 99GERHS employed a cluster sampling

Figure 6.8.2
Infant Mortality Rates (Infant Deaths per 1,000 Live Births) in Georgia Reproductive Health Survey: 99GERHS and MOH Official Estimates



* CMSI Annual Statistic Reports, 1996-2000, Tbilisi, Georgia

design. Standard errors can be used to calculate confidence intervals around the IMR within which we can say with 95% confidence that the true value of the population IMR lies. Thus, the point estimate of 41.6 per 1,000 should not be considered as the exact value of the IMR, that would have been in theory possible to calculate if all women of reproductive age would have been interviewed. The true rate could be higher or lower and its value lies between a 95% confidence interval from 30.4 to 52.8 per 1,000 (CI=±1.96*SE). The lower limit of 30.4 was still about 26% higher than the average of 24.2 per 1,000 reported by the MOH for 1995-1999 and almost twice as high as the State Department for Statistics estimates.

Based on the 99GERHS, the estimated neonatal death rate was 25.4 per 1,000, about twice as high as the official average rate of 12.1 per 1,000 for 1995-1999 (ranging from 9.9 per 1,000 in 1995 to 13.5 in 1996, 13.0 in 1997, 9.8 in 1998, and 14.4 in 1999, as shown in Figure 6.8.2). Similarly, the survey postneonatal mortality of 16.2 was 34% higher than the official average of 12.1 per 1,000. Thus, the difference between the survey estimates and the official data was observed in both the levels of neonatal and postneonatal mortality rates but much more for neonatal deaths. As a result, neonatal deaths contributed to 47% of the infant mortality rate for 1995-1999, according to the Ministry of Health data, whereas neonatal deaths reported in respondents' histories accounted for most of the infant deaths during the first year of life (61%). In conclusion, despite potential underreporting of early child deaths among survey respondents, the survey estimates of neonatal deaths were substantially higher than the official data. Presumably higher underreporting of these deaths exists within the vital records reporting system.

Differentials in infant and child mortality by area of residence, age, education level, and ethnic background of the mother, birth order, birth intervals, and sex of the child are presented in Table 6.8. Neither infant nor child mortality rates differed significantly by mother's residence or by period of time. Mortality differentials by age of the mother at the time of birth showed that the highest infant and child-under-five mortality rates were found among births to women under 20 years of age (45 per 1,000 and 48 per 1,000, respectively). Infant mortality, classified by education level of the mother, was higher among mothers without postsecondary education than among those with a postsecondary education. The greatest differentials were observed in the levels of postneonatal mortality; children born to women without postsecondary education had a two times and four times, respectively, higher likelihood to die between 28-264 days of age than children born to women with technical college or university education.

Infant mortality differentials by maternal ethnic background illustrate that the rates for infants born to Azeri women were 43% higher than among Georgian infants. Part of this difference is probably due to lower education attainment, younger initiation of childbearing, higher fertility rate,

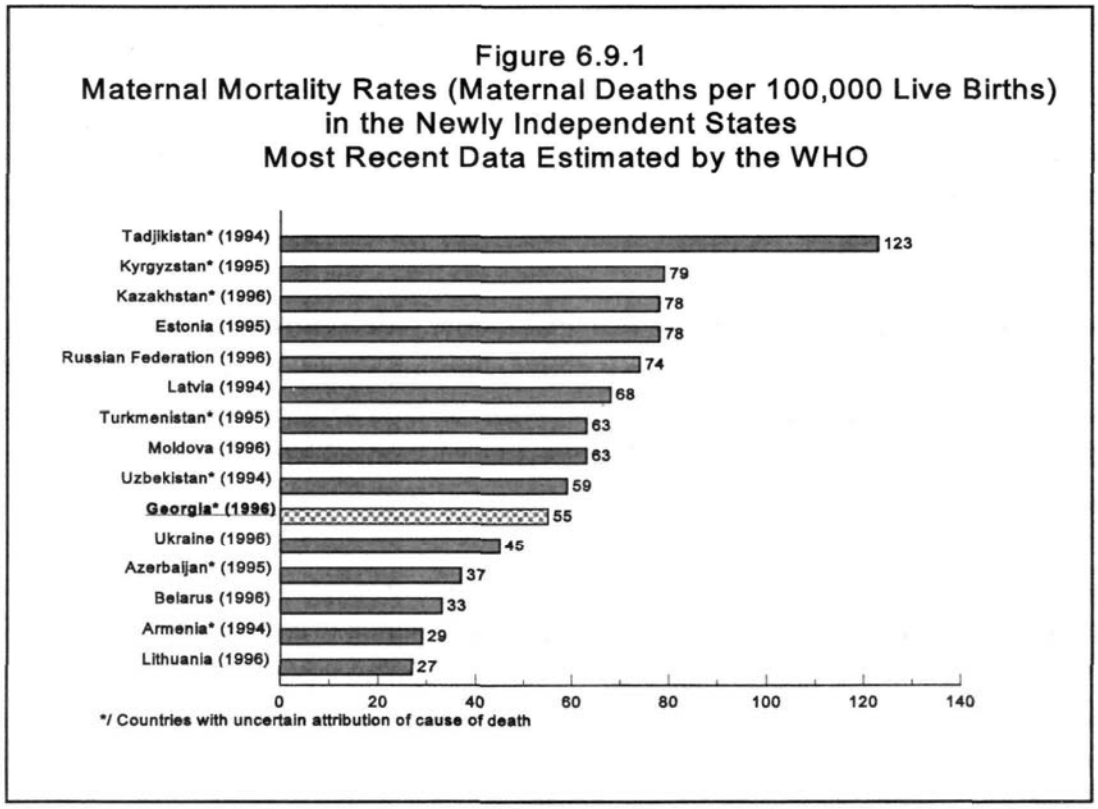
Table 6.8
Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)
by Selected Characteristics
Children Born Between January 1990 and December 1999
Reproductive Health Survey: Georgia, 1999/2000

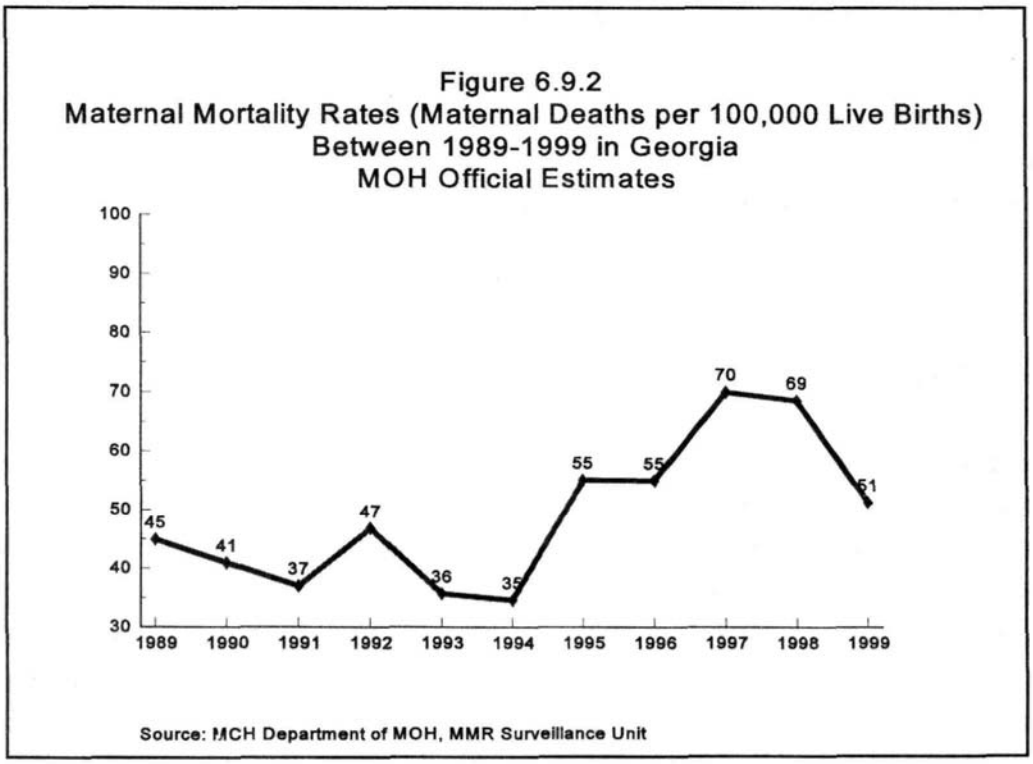
	Infant Mortality			Child Mortality	Total	Unweighted
Characteristic	Total	Neonatal	Postneonatal	(1-4 Years)	(0-4 Years)	No. of Cases
Total	**40.7**	**25.0**	**15.7**	**4.2**	**44.8**	**5,605**
Period of Exposure						
January 1990/December 1994	39.9	24.7	15.2	4.8	44.5	3,098
January 1995/December 1999	41.6	25.4	16.2	3.8	45.3	2,507
Residence						
Urban	40.7	28.8	11.9	5.2	45.6	3,037
Rural	40.8	21.3	19.5	3.3	43.9	2,568
Age Group (at Birth)						
Less than 20	44.5	28.6	15.8	4.1	48.4	1,070
20-29	39.0	22.3	16.7	5.1	44.0	3,500
30 or More	41.9	30.0	12.0	0.1	42.0	1,035
Education Level						
Secondary or Less	48.5	24.8	23.7	5.7	54.0	2,467
Technicum	37.7	26.2	11.5	3.2	40.8	1,621
University	31.2	24.1	7.1	3.0	34.1	1,517
Ethnic Group						
Georgian	38.3	25.8	12.5	4.3	42.4	4,719
Azeri	54.8	19.4	35.5	3.4	58.0	522
Armenian	49.0	22.7	26.2	7.6	56.3	218
Other	37.9	30.3	7.5	0.0	37.9	146
Birth Order						
First Birth	36.3	25.2	11.1	4.0	40.1	2,453
Second Birth	44.6	24.9	19.7	3.3	47.7	2,076
Third or Higher	43.2	24.8	18.4	6.7	49.6	1,076
Birth Interval						
First Birth	36.3	25.2	11.1	4.0	40.1	2,453
Less than 2 years	52.8	28.2	24.7	2.5	55.2	1,300
2-4 years	43.2	21.3	21.9	7.7	50.5	973
More than 4 years	32.5	24.1	8.4	4.5	36.9	788
Child Gender						
Male	48.3	31.5	16.8	4.8	52.9	2,972
Female	31.5	17.1	14.5	3.6	35.1	2,622

overcrowding, and lower access and utilization of health services. The infant mortality rate among infants born after short birth intervals (less than two years) was higher than among those spaced 2-4 years or more than four years (53 per 1,000 vs. 43 per 1,000 and 33 per 1,000, respectively). Male infant mortality (48 per 1,000) is about 50% higher than the rate for females (32 per 1,000), reflecting the sex differential in neonatal mortality. Child mortality generally exhibited the same differentials by maternal and birth characteristics as did infant mortality.

6.9 Maternal Mortality in Georgia

Considering European standards, many former Soviet Union countries, including Georgia, have very high levels of maternal mortality. The most recent WHO estimates for the maternal mortality rates in the Newly Independent States are shown in Figure 6.9 (Hill, et. Al., 2001). Data for Georgia are reported by the Department of Maternal and Child Health (MCH) within the Ministry of Health, that maintains an active surveillance of all the pregnancy-related deaths. Maternal mortality information is supposed to be reported to the Ministry of Health within 24 hours of occurrence with a detailed report of the circumstances surrounding the death. Notifications of maternal deaths are received from various sources within the health care system (maternity hospitals,





other hospitals, or other medical facilities). In the past, each case was thoroughly reviewed on site and disciplinary actions against physicians were sometimes issued. Currently, the MCH department reviews the reports and calls with questions to identify ways to prevent maternal deaths. The leading causes of maternal deaths are bleeding, that contributes to 40% of the MMR, on average, embolism, accounting for 17-20% of MMR, and sepsis (18%). Up to 13% of all maternal deaths are directly attributed to abortion, although deaths caused by bleeding and sepsis may also be the result of induced abortion.

As is the case with infant deaths, maternal mortality is also reported based on the death certificates issued by the civil registries (see above) but this source is subject to serious under-reporting because incomplete information, coding errors and the absence of a pregnancy check-box on the death certificate. The new medical death certificate forms (MOH, Order 94/o of December 2000) includes such a check-box in an attempt to improve maternal death reporting.

As shown in Figure 6.9.2, maternal mortality rate per 100,000 live births (MMR) gradually increased at the beginning of the 1990s, peaked in 1998 and started to decline afterwards. The recent decline is attributed to a new case management and referral system introduced by the MOH in 1998. Currently, any maternal complications admitted or occurring in obstetrical wards may benefit from emergency dispatching of specialized medical assistance or referral to a tertiary-level facility.

CHAPTER VII

CONTRACEPTIVE AWARENESS AND KNOWLEDGE OF USE

As shown in Chapter V, Georgian women report more than two abortions for every live birth, owing mostly to low use of effective contraception and a high reliance on traditional methods, public lack of knowledge and mistrust of modern methods, and underutilization of family planning services recently made available in the country. Lack of or misleading information about family planning methods and their side effects and little knowledge about the places where methods can be obtained, are important barriers to consistent and correct use.

Under the UNFPA funded program launched in 1996, Georgian Ministry of Health set up 40 family planning clinics in 4 regions of Georgia (Tbilisi, Imereti, Shida Kartli, and Rustavi), staffed them with recently trained doctors, and acquired new equipment and 2-years worth of contraceptive supplies (pills, condoms, and IUDs) to be distributed free of charge. Until recently, however, no large mass media campaign to promote these services had been organized and many of the newly founded clinics remained underutilized. In 1999, the Centers for Population Communication Services of the John Hopkins University (JHU/PCS) initiated a series of IEC activities with USAID funding support: 1) organized quality customer service and family planning counseling training courses for medical staff working in these clinics; 2) set up a hot-line for FP information; and 3) launched a national Family Health Campaign ("Care for Each Other") between June-December 2000. The campaign used television and radio spots aired on national and regional stations, community events, and posters aimed at promoting modern contraceptives, family planning services, and the newly established toll-free hotline (hosted by "Claritas", one of the Georgia's leading reproductive health NGO's). Another reproductive health hot-line, currently managed by a local NGO, "Tanadgoma", was started in 1999 by Medicine Sans Frontiere Greece.

Data from the survey provide for the first time nationally representative information about family planning awareness and use. These data will constitute the baseline for evaluating the information-education-communication (IEC) efforts launched recently by the MOH in collaboration with international donors (e.g., UNFPA, USAID) and by several private voluntary organizations. For example, a follow up survey among 1,000 women of reproductive age living in Tbilisi was implemented in December 2000 by JHU/PCS to help measure the impact of the family health Campaign. With the 99GERHS providing a comprehensive baseline, the follow-up effort will be

used to gauge changes in topics of interest during the interval between the surveys.

Until the 99GERHS was conducted, data on contraceptive knowledge and use in Georgia were scarce and often conflicting. The few KAP surveys conducted since 1991 were either limited in geographic scope or not intended to be representative of the country as a whole. Among recent efforts, it is worth mentioning a family planning and reproductive health survey conducted in 1996 by the Curatio International Foundation (CIF) with UNDP funding. The survey, conducted in 9 regions, consisted of 1,455 interviews among women and men of childbearing age (14-49 years). The questionnaire included a series of questions on use of contraception, knowledge and opinions about family planning, utilization of reproductive health and family planning services, and other reproductive health topics. The survey found relatively high levels of contraceptive awareness (best known methods being the condom, the IUD, and the pill) but the survey report did not include data on current contraceptive prevalence.

7.1 Contraceptive Awareness and Knowledge of Use

One of the main objectives of the 99GERHS was to explore the level of knowledge of family-planning methods and their source of supply among women of reproductive age. In reference to 10 modern and traditional contraceptive methods, respondents were asked, if they had ever heard about each, from whom, if they knew to use them and if they knew where they could be obtained.

Table 7.1.1 summarize the findings on contraceptive awareness by IDP status, residence and region. The majority of Georgian women (95%) have heard of at least one modern method of contraception and over two-thirds (69%) a traditional method. Awareness of intrauterine devices (IUDs) and condoms was very high (93% and 88%, respectively), followed by awareness of pills (68%), periodic abstinence (65%) and withdrawal (50%). Contraceptive female sterilization (tubal ligation) was known by only 44% of women. The least-known methods were vasectomy (12%), spermicides (11%), injectables and emergency contraception (4%). Overall, the average number of modern methods a woman is aware of is about three modern methods.

IDP women were slightly more likely than non-IDP women to have heard of a modern method (99% vs. 95%), particularly of condoms and pills, but there was no difference in their awareness of traditional methods. The level of awareness of either modern or traditional methods was lower among rural residents than among urban women. Awareness of IUDs was 8 percentage points higher among urban residents than among rural residents; awareness of pills was 44% higher and of female sterilization was 32% higher, awareness of spermicides, vasectomy and injectables is more than two times higher, and awareness of emergency contraception was three times higher.

TABLE 7.1.1
Percentage of Women 15–44 Years of Age Who Have Heard of Specific Contraceptive Methods by Residence and by Region
Reproductive Health Survey: Georgia, 1999/2000

				Residence		Region				
Contraceptive Method	**Total**	**IDP**	**Non-IDP**	**Urban**	**Rural**	**Tbilisi**	**Imereti**	**North East**	**South**	**West**
Any Method	**95.1**	98.9	94.9	98.2	91.3	97.8	98.3	94.3	84.7	97.8
Any Modern Method	**94.9**	98.9	94.7	98.0	90.9	97.7	98.0	94.1	84.0	97.7
IUD	**92.6**	97.1	92.4	95.9	88.3	94.4	97.0	92.7	80.3	95.8
Condom	**88.5**	96.2	88.1	95.6	79.4	96.2	93.8	87.9	68.2	90.3
Pills	**67.5**	76.6	67.1	77.7	54.5	83.3	71.2	68.3	39.4	65.9
Tubal Ligation	**43.5**	46.6	43.3	48.6	36.9	46.1	51.4	43.2	22.2	49.8
Vasectomy	**12.4**	14.3	12.3	17.0	6.6	23.2	10.7	9.5	4.9	8.9
Spermicides	**11.3**	13.6	11.1	14.7	6.9	16.0	11.7	9.3	5.2	11.4
Injectables (Depo-Provera)	**4.3**	6.1	4.3	5.8	2.5	8.7	2.8	2.2	1.7	4.0
Emergency Contraception	**4.1**	5.1	4.0	6.0	1.6	9.8	1.9	1.8	1.4	2.8
Average# of Modern Met.	**3.2**	3.6	3.2	3.6	2.8	3.8	3.4	3.2	2.2	3.3
Any Traditional Method	**69.4**	71.8	69.2	74.0	63.4	75.2	73.1	71.5	53.0	69.8
Calendar (Rhythm Met.)	**64.9**	67.6	64.7	71.0	57.0	71.8	70.5	68.1	44.6	64.5
Withdrawal	**50.3**	49.7	50.4	53.7	46.1	54.0	52.7	50.8	42.5	49.6
Unweighted No. of Cases	**7,798**	1,828	5,970	4,759	3,039	2,029	1,590	1,259	1,017	1,903

Contraceptive awareness was the lowest among women living in the southern region, who were the least likely to have heard of either modern or traditional methods. Their awareness of modern methods was 11%-14% lower than in any other region; similarly, the awareness of traditional methods was 24%-30% lower.

TABLE 7.1.2
Percentage of Women Aged 15–44 Who Have Heard of Specific Contraceptive Methods by Marital Status and by Age Group
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status			Age Group		
Contraceptive Method	**Total**	**Currently Married**	**Previously Married**	**Never Married**	**15–24**	**25–34**	**35–44**
Any Method	**95.1**	**97.8**	**95.6**	**90.1**	**90.3**	**97.8**	**98.1**
Any Modern Method	**94.9**	97.4	95.6	90.1	90.0	97.4	98.0
IUD	**92.6**	96.5	94.7	85.1	85.5	96.5	96.9
Condom	**88.5**	90.8	88.9	84.1	83.4	92.4	90.4
Pills	**67.5**	73.0	70.1	57.1	55.9	76.4	72.3
Tubal Ligation	**43.5**	51.3	48.4	28.3	26.3	52.4	54.5
Vasectomy	**12.4**	14.3	16.7	8.1	7.1	15.7	15.4
Spermicides	**11.3**	13.5	13.1	6.8	6.3	13.7	14.6
Injectables (Depo-Provera)	**4.3**	4.6	6.2	3.6	2.4	5.8	5.1
Emergency Contraception	**4.1**	4.5	7.6	2.6	1.4	5.8	5.4
Average # of Modern Met.	**3.2**	3.5	3.5	2.8	2.7	3.6	3.5
Any Traditional Method	**69.4**	85.0	79.1	39.1	43.6	83.0	85.7
Calendar (Rhythm Met.)	**64.9**	79.6	75.1	36.1	39.0	78.4	81.4
Withdrawal	**50.3**	66.3	60.2	19.3	25.4	62.8	66.7
Unweighted No. of Cases	**7,798**	5,177	517	2,104	2,388	2,731	2,679

Table 7.1.2 shows women's level of contraceptive awareness by marital status and by age. Virtually all currently married or cohabitating women (women in union) as well as previously married women have heard of at least one modern method (97% and 96%, respectively) and they also have a high awareness of traditional methods (85% and 79%, respectively). There was no significant difference in awareness of specific methods between currently and previously married

women. Never married women had much lower contraceptive awareness and their awareness of traditional methods was less than half that of modern methods (90% vs. 39%). Compared to ever married women, never-married women have lower awareness of all contraceptive methods, particularly contraceptive sterilization, spermicides, emergency contraception and withdrawal.

The overall contraceptive awareness was lower among the youngest women, particularly for traditional methods (44% vs. 83% and 86%, respectively). Since age and marital status are directly correlated and never-married women are more likely to be young, the pattern of knowledge of specific methods among young women is similar with that for never-married women, with higher awareness of IUD and condom and lower awareness of other modern methods. Similarly, their awareness of withdrawal is significantly lower when compared with older women (26% vs. 63% and 67%, respectively). Contraceptive awareness does not vary significantly for women aged 25 or more.

As shown in Figure 7.1.1 and Table 7.1.3, contraceptive awareness is strongly correlated with educational attainment. The average number of modern methods known (both in terms of awareness and knowledge of use) is at least twice as high among women with postgraduate education compared with women who did not complete secondary education.

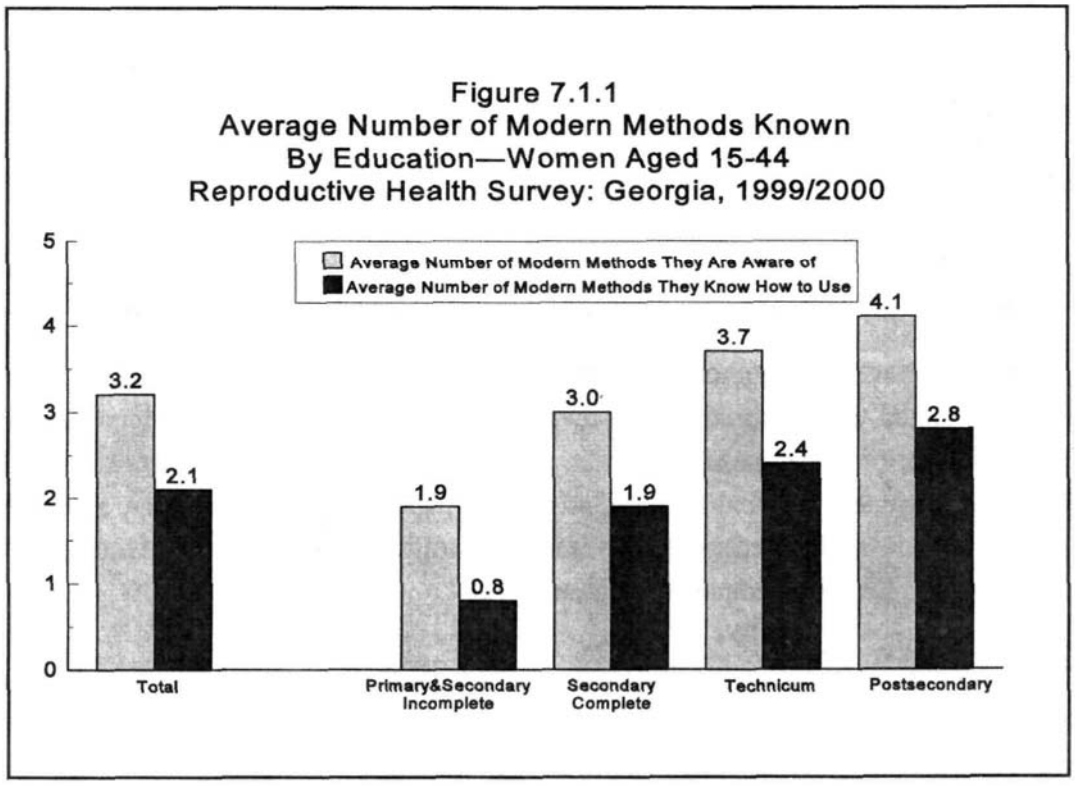


Figure 7.1.1
Average Number of Modern Methods Known
By Education—Women Aged 15-44
Reproductive Health Survey: Georgia, 1999/2000

TABLE 7.1.3
Percentage of Women Aged 15–44 Who Have Heard of Specific Contraceptive Methods by Education
Reproductive Health Survey: Georgia, 1999/2000

		Education Level			
Contraceptive Method	**Total**	**Secondary Incomplete or Less**	**Secondary Complete**	**Technicum**	**University**
Any Method	**95.1**	**81.7**	**95.4**	**99.6**	**99.4**
Any Modern Method	**94.9**	81.2	95.0	99.5	99.3
IUD	**92.6**	74.5	92.4	99.0	98.6
Condom	**88.5**	64.7	87.5	95.9	98.1
Pills	**67.5**	33.4	60.5	78.9	87.9
Tubal Ligation	**43.5**	11.4	36.4	58.6	59.2
Vasectomy	**12.4**	1.6	8.2	13.3	24.0
Spermicides	**11.3**	2.3	7.0	14.3	19.6
Injectables (Depo-Provera)	**4.3**	0.6	2.3	5.1	8.7
Emergency Contraception	**4.1**	0.1	2.1	4.0	9.2
Average # of Modern Met.	**3.2**	1.9	3.0	3.7	4.1
Any Traditional Method	**69.4**	30.0	65.6	84.6	85.5
Calendar (Rhythm Met.)	**64.9**	24.2	59.2	81.5	83.0
Withdrawal	**50.3**	21.6	44.6	62.5	65.0
Unweighted No. of Cases	**7,798**	991	2,664	2,058	2,085

Table 7.1.3 shows that women's level of awareness of both modern and traditional methods was directly correlated with their education level. Among women with secondary incomplete or lower levels of education, awareness of specific methods was the lowest. Particularly notable was the much lower awareness of tubal ligation, vasectomy, spermicides, injectables, and emergency contraception among less-educated women. Similarly, the awareness of traditional methods was also substantially lower among less educated women.

Awareness of any contraceptive methods was substantially lower among Azeri women than among any other ethnic groups; with the exception of IUD, condom, and the pill known by 70%, 47%, and 18%, respectively, awareness of other modern methods was between l%-8%. Even their

awareness of traditional methods was substantially lower compared to Georgian, Armenian or other ethnic groups (23% for rhythm method and 25% for withdrawal) (data not shown). Contraceptive awareness was generally higher among IDP women than among non-IDP women, particularly for condoms (96% vs. 88%) and the pill (77% vs. 67%) (Serbanescu et. al., 2000).

Awareness of contraceptive methods, often used interchangeably with knowledge of methods, is typically higher than contraceptive knowledge. The level of contraceptive knowledge among survey respondents was further explored to assess the extent of the information possessed by those who can identify contraceptive methods (e.g., by asking how each method or procedure is used). Their level of knowledge of use was significantly lower than contraceptive awareness (Table 7.1.4 and Figure 7.1.2). Overall, knowledge of use of any modern or traditional method was lower than the corresponding awareness (74% vs. 95% and 52% vs. 69%, respectively). Although awareness of both IUD and condoms was very high (93% and 88%, respectively), less than two-thirds of women (62%) said they actually knew how condoms were used. Additionally, although 67% heard of the pill, only 30% knew how the method is used. A similar gap in knowledge was obvious for tubal ligation, spermicides, and injectables, further narrowing the proportion of women who potentially may be able to start using these methods. The gap between awareness and knowledge of use was also present for the calendar method (65% vs. 43%) and, to a lesser extent, for withdrawal (50% vs. 38%).

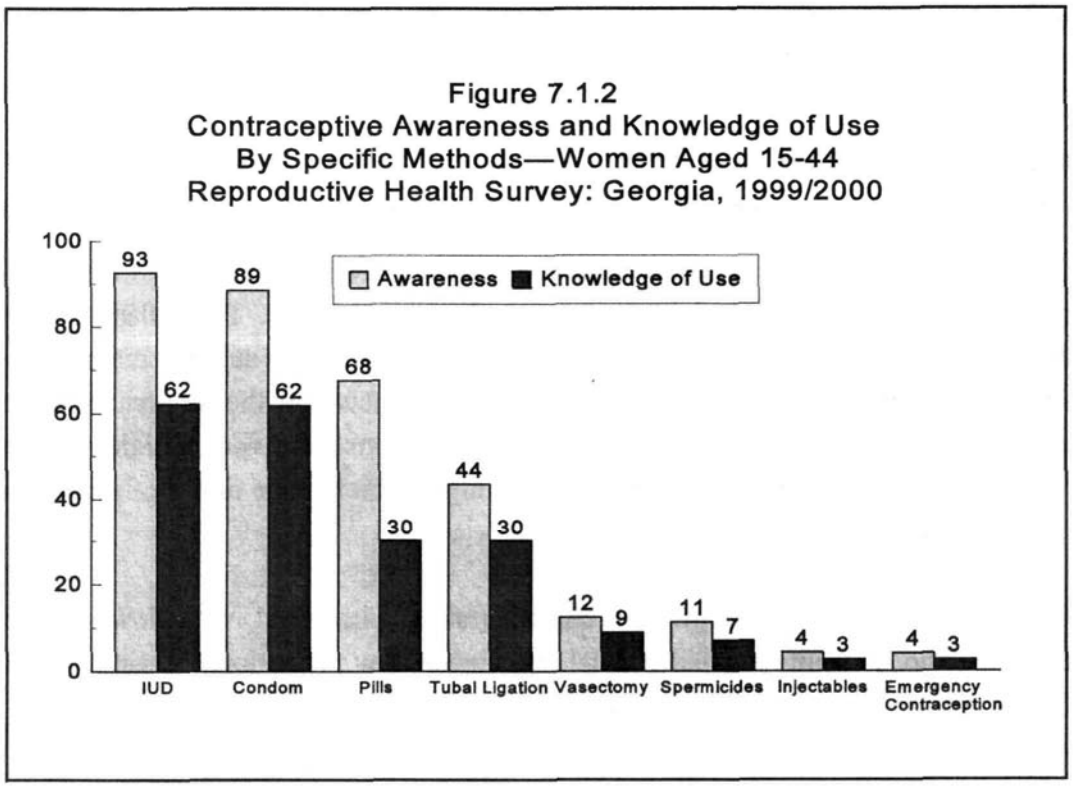


TABLE 7.1.4

Percentage of Women 15–44 Who Say They Know How Specific Contraceptive Methods are Used by Marital Status and by Age Group

Reproductive Health Survey: Georgia, 1999/2000

				Marital Status			Age Group		
Contraceptive Method	Total	IDP	Non-IDP	Currently Married	Previously Married	Never Married	15–24	25–34	35–44
Any Method	**77.9**	81.9	77.7	88.8	77.9	57.9	63.5	86.5	86.1
Any Modern Method	**73.5**	80.0	73.2	82.3	73.4	57.4	61.3	81.9	79.3
Condom	**62.2**	68.9	61.5	68.2	61.4	51.3	54.9	68.7	64.2
IUD	**61.8**	67.9	61.9	71.3	64.7	44.0	47.8	70.8	69.1
Pills	**30.1**	34.2	29.9	37.1	32.7	16.9	20.6	36.7	34.7
Tubal Ligation	**30.1**	33.3	30.0	36.3	35.2	17.9	17.4	36.7	38.3
Vasectomy	**8.9**	10.3	8.8	10.1	13.5	5.8	5.0	11.0	11.3
Spermicides	**7.0**	8.8	6.9	8.3	8.7	4.3	3.5	8.3	9.8
Emergency Contraception	**2.7**	3.9	2.5	2.9	5.4	1.9	1.0	3.7	3.8
Injectables (Depo-Provera)	**2.6**	3.5	2.7	2.6	5.2	2.2	1.5	3.5	2.9
Any Traditional Method	**52.1**	53.0	52.1	69.3	57.7	19.7	27.3	64.0	68.9
Calendar (Rhythm Met.)	**43.0**	43.8	43.0	56.7	49.1	16.8	21.3	53.1	58.0
Withdrawal	**37.9**	38.1	37.9	52.0	44.8	10.8	17.4	47.8	51.7
Unweighted No. of Cases	**7,798**	1,828	5,970	5,177	517	2,104	2,388	2,731	2,679

Never-married women and the youngest women were less likely to know how any method of contraception was used (58% and 64%, respectively) (Table 7.1.4). Particularly worrying was their lack of knowledge about condoms and pills, traditionally the most suitable methods for young women. Only one in two of young or never married women knew how the condom is used and only 21% and 17%, respectively, knew how the pill is used. Consistent with a higher awareness of modern contraception, the IDP women demonstrated higher knowledge of use of modern methods compared to non-IDP women.

Generally, the same background characteristics associated with low awareness of contraceptive methods (young age, no marital experience, low educational attainment, low SES, Azeri ethnicity) were also associated with low knowledge about the method use and with a wider gap between awareness and knowledge of use. The only notable exception was the gap between

TABLE 7.1.5
Percentage of Women 15–44 Who Know Where to Get Specific Contraceptive Methods by Marital Status and by Age Group
Reproductive Health Survey: Georgia, 1999/2000

				Marital Status			Age Group		
Contraceptive Method	Total	IDP	Non-IDP	Currently Married	Previously Married	Never Married	15–24	25–34	35–44
Any Modern Method	**77.5**	85.0	77.1	84.2	77.4	65.3	67.2	84.8	82.2
IUD	**67.9**	76.2	67.5	75.9	70.3	52.9	54.9	76.8	74.2
Condom	**65.8**	76.2	65.3	69.7	67.9	58.3	58.9	72.6	67.1
Pills	**45.8**	52.1	45.5	52.2	48.5	33.6	34.6	54.5	50.0
Tubal Ligation	**34.0**	39.2	33.8	40.7	38.6	21.1	19.6	41.6	43.3
Vasectomy	**9.4**	11.4	9.3	10.8	12.9	6.3	5.0	11.6	12.3
Spermicides	**8.4**	10.5	8.3	10.1	9.8	5.0	4.5	10.0	11.3
Emergency Contraception	**2.9**	4.2	2.8	3.3	5.2	1.8	1.1	3.9	4.0
Injectables (Depo-Provera)	**2.6**	4.8	2.5	2.6	4.6	2.2	1.6	3.2	3.1
Unweighted No. of Cases	**7,798**	1,828	5,970	5,177	517	2,104	2,388	2,731	2,679

Azeri women's awareness and knowledge of use about withdrawal that was narrower than among other ethnic groups (data not shown).

Another indicator commonly used to evaluate IEC efforts is the knowledge about source(s) of contraception. The 99GERHS found that about three fourths (77%) of women could name at least one source for supplied contraceptive methods (Table 7.1.5). Respondents were more likely to know a source for condoms (68%) and IUDs (66%) than for other modern methods. Less than one in two women (46%) could tell where pills can be obtained and only one in three women knew where tubal ligations are performed. For the most widely known modern contraceptive methods there was a serious gap between awareness of the method and knowledge of where the procedure or product could be obtained; the gap ranged from 9 percentage points for tubal ligation to 22-25 percentage points for the pill, IUD, and condom. Very few respondents knew where vasectomies are performed or where to get spermicides, injectables or emergency contraception. The knowledge about a source of contraception was slightly higher among IDP than among non-IDP women (85% vs. 77%), among currently or previously married women than among never married women (84% and 77% vs. 65%), and increased with the respondent's age (from 67% among women aged 15-24 to 82%-85% among women aged 25-44 years).

Evidence regarding the alarmingly low level of knowledge about a source of contraceptive methods was also documented in a recent survey conducted in the Imereti and Samtskhe-Javaketi regions by the Family Planning Association of Georgia (FPG); according with the study results, only 21% and 7%, respectively, of fertile women were aware that family planning clinics have been opened in the country (FPG, 2000a).

7.2 First Source of Information about Contraception

As shown in Table 7.2 and Figure 7.2, the 99GERHS found that among women 15-44 years of age the main source of information about contraceptive methods was a friend or acquaintance (51%), followed by a relative other than a parent (14%), mass-media (5% audio-visual media, 5% books, and 3% print media), and a physician (11%). Young women, 15-24 years of age, reported similar first sources as older women but they were almost three times less likely to mention a physician as the main source of contraceptive information (5% vs. 13%). Similarly, only 1% of never-married women mentioned this source compared to 14% of ever married women. Almost one in two young women (49%) found out about contraception in discussions with a friend or acquaintance, 15% from mass-media or books, and 7% from a health care provider. Only 9% of the young women surveyed said that they had first heard about contraception from one of their parents (7% from their mothers). Only 4 % of young women cited the school as their first source of

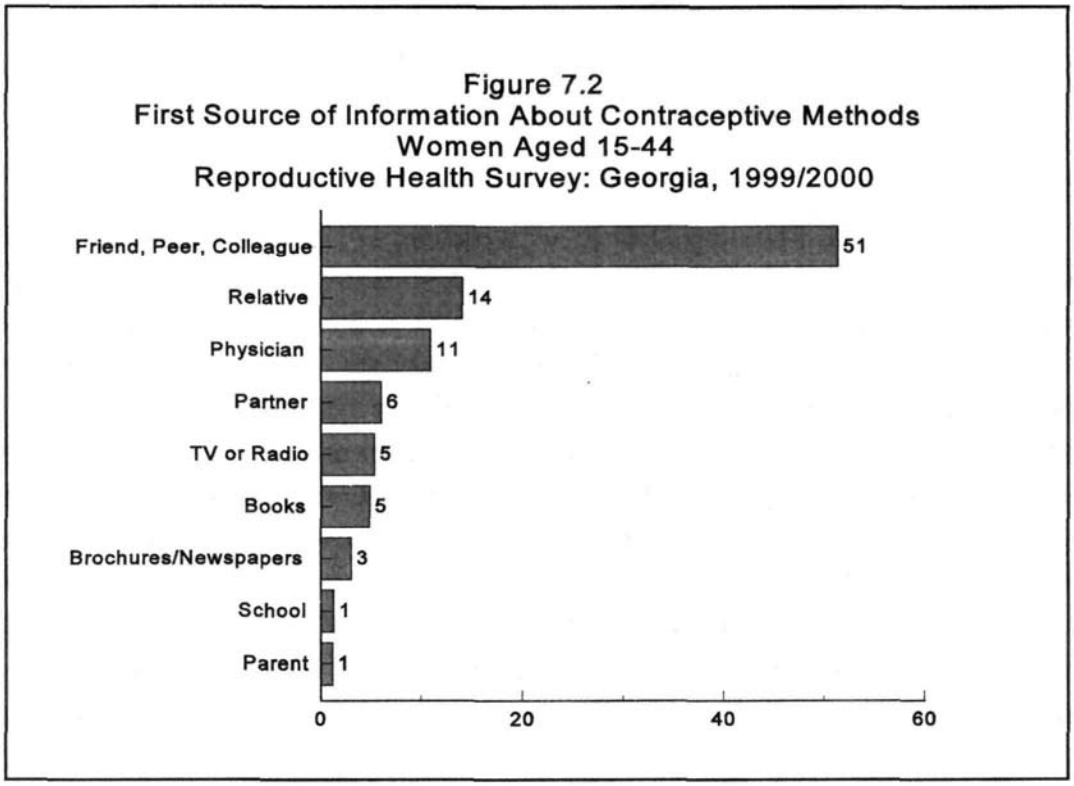


TABLE 7.2
First Source of Information about Contraception by Specific Method
Women Aged 15–44 Who Have Heard about Specific Methods of Contraception
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

First Source of Information About Contraception	Contraceptive Method						
	Total	IUD	Condom	Pills	Tubal Ligation	Calendar	Withdrawal
Friend, Peer, Colleague	**51.4**	51.7	52.1	54.0	45.8	60.1	48.2
Relative	**14.1**	19.2	7.5	15.2	15.3	20.0	11.3
Physician	**11.0**	20.1	2.4	12.2	18.3	7.5	1.5
Partner	**6.1**	0.1	11.6	0.3	0.1	0.3	31.3
TV or Radio	**5.4**	1.2	18.7	5.3	1.6	0.2	0.9
Books	**4.9**	2.6	1.7	4.5	9.3	5.3	3.5
Brochures/Newspapers/Magazines	**3.1**	1.4	3.3	4.1	4.4	1.6	1.4
School	**1.3**	0.8	0.5	1.5	2.8	0.9	0.6
Mother or Father	**1.2**	2.0	0.2	1.1	1.1	2.8	0.3
Nurse/Midwife or Pharmacist	**0.5**	0.4	0.4	1.0	0.3	0.3	0.1
Other	**0.2**	0.3	0.3	0.5	0.2	0.2	0.2
Do Not Remember	**0.7**	0.3	1.4	0.3	0.9	0.9	0.7
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0

contraceptive information. It is worth noting the slightly higher importance of mass-media as a first source of information for young women compared to women aged 15-44 years (data not shown).

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

7.3 Knowledge about Contraceptive Effectiveness

Correct information about contraceptive effectiveness can also greatly influence a couple's decision about how to protect against unintended pregnancies. It is not realistic to expect individuals to make the correct decision if they have gaps in their knowledge about all possible

contraceptives available and if adequate access to comprehensive family-planning services is lacking. Women's lack of knowledge about contraceptive effectiveness is an indirect indicator of the failure of adequate counseling and information/education programs.

The survey included a series of questions in which each respondent was asked to indicate whether specific contraceptive methods (shown on a card) have high, medium, or low effectiveness in preventing pregnancy when used consistently and correctly. The methods are listed in descending order of effectiveness (Hatcher et al., 1998) (Table 7.3). This ranking is based on studies of unintended pregnancies among users of various family-planning methods in the first 12 months of using that method (method failure), with the exception of emergency contraception for which such analysis does not apply. According to these studies, vasectomy and Norplant (whose specific effectiveness was not explored in the survey because it is largely unavailable in Georgia) are the most effective methods, with a rate of failure at one year of use of only 0.1 pregnancy per 100 women. They are followed by injectables, female sterilization, and IUDs, with rates of failure between 0.3 and 0.6 pregnancy per 100 women. Combined oral contraceptives have failure rates comparable to Norplant and vasectomy (0.1 pregnancy per 100 women) when used correctly and consistently, but their actual failure rate, as commonly used, is much higher (6-8 pregnancies per 100 women). For this reason we listed oral contraceptives after the IUD, although its theoretical

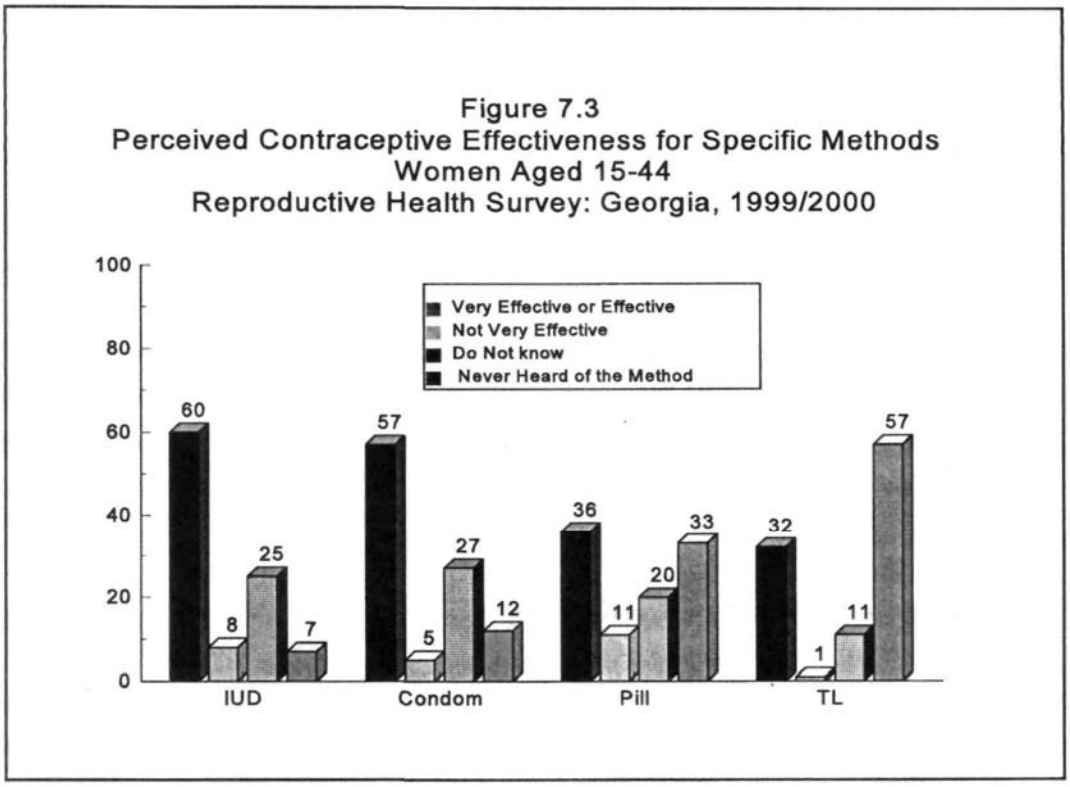


TABLE 7.3
Percent Distribution of Women 15–44 Years of Age by Their Opinion About Contraceptive Effectiveness If the Method Is Used Correctly and Consistently
Reproductive Health Survey: Georgia, 1999/2000

	Contraceptive Effectiveness						
Contraceptive Method*	Very Effective	Effective	Less or Not Effective	Do Not Know	Never Heard of the Method	Total	No. of Cases
Vasectomy	8.5	1.3	0.2	2.5	87.6	100.0	7,798
Injectables	0.6	1.5	0.8	1.5	95.7	100.0	7,798
Tubal Ligation	28.0	3.8	0.5	11.1	56.5	100.0	7,798
IUD	31.4	28.3	7.8	25.0	7.4	100.0	7,798
Pill	8.5	27.2	11.4	20.4	32.5	100.0	7,798
Emergency Contraception†	0.2	1.7	0.9	1.3	95.9	100.0	7,798
Condom	28.0	28.8	4.9	26.8	11.5	100.0	7,798
Spermicides	0.7	4.8	2.5	3.3	88.7	100.0	7,798
Calendar	8.0	18.2	23.1	15.6	35.1	100.0	7,798
Withdrawal	7.0	16.8	13.4	13.1	49.7	100.0	7,798

* Listed in the descending order of contraceptive effectiveness when the method is used correctly and consistently, excepting emergency contraception (Hatcher et al., 1998).
† Effectiveness cannot be assessed through the same lifetable technique used for the other methods.

effectiveness during ideal use is somewhat higher than for the IUD. Condoms and other barrier methods are considered to be of moderate effectiveness, with failure rates of 3%-6% during correct use and 14%-26% as commonly used. The calendar method can be moderately effective if used correctly. Finally, withdrawal was listed as less effective than all other methods. Thus, as shown also in Figure 7.3, most Georgian women (60% and 57%, respectively) have trust in the IUD and condom's pregnancy prevention effectiveness but their correct knowledge about effectiveness of pills and tubal ligation is very low (36% and 32%, respectively).

Overall, no modern method was recognized as very effective by a majority of women, partly because substantial numbers of women lack awareness of modern methods. In addition, a substantial proportion of women who were aware of specific methods could not say how effective they are. Even when women who had never heard of a specific method were excluded, only the IUD was

correctly recognized as highly effective. About two-thirds of women who were aware of IUDs considered the method very effective or effective. However, almost one in four women could not assess its effectiveness. Only half of women who have heard of pills considered the method very effective or effective whereas almost one in three did not know if the method was reliable. Periodic abstinence and withdrawal were qualified as very effective or effective by less than a half of those who had heard of these methods, whereas at least one in four respondents did not know how effective they are.

In conclusion, Georgian women demonstrate a high level of family planning awareness, contrasting with their low prevalence of modern contraceptives (see Chapter VIII); almost all women declared that they had heard about at least one modern method and 78% knew where to get the procedure or product. However, for the most widely known modern contraceptive methods there was a serious gap between awareness of the method and knowledge of where the procedure or product could be obtained; the gap ranged from 9 percentage points for tubal ligation to 22-25 percentage points for the pill, IUDs, and condoms. Unfortunately, their awareness of the source is not enough to change contraceptive behaviors, especially when suspicion and misconceptions about modern methods are common among both the public and the health care professionals.

Excepting knowledge about IUD's and condom's contraceptive effectiveness, the majority of women lack knowledge about the effectiveness of other modern methods. Even correct knowledge about the effectiveness of IUD and condoms was reported by less than two thirds of women. Only 1% of the women said that they first heard about contraception from their mother or in school, reflecting that both parental discussions and school lectures on this topic are almost non-existent (see also Chapter XIV). Overall, the first source of information about any contraceptive method was a friend or acquaintance (51%), followed by audio-visual or print media (13%), a relative other than a parent (14%), and a physician (11%). Thus, mass media played a minor role in the contraceptive educational efforts, either because it may be less interested in health issues than in political and economical topics or because it may lack media experts to educate the public about family planning in nontechnical terms. The national media campaign launched between June-December 2000 with USAID support was designed to change the interest of mass media to pursue reproductive health topics and to increase the public's overall interest in family planning issues. Increasing IEC efforts through official channels (mass media, school, health providers) are needed to ensure that the public and particularly the youth receive correct information about the benefits of contraception and the availability of family planning products and services. These efforts, however, should take into account the relatively low viewing and listening attendance probably determined by widespread electricity shortage (only 46% of women watched television daily and only 30% listened to the radio daily). Not surprising, only 16% and 6% of respondents reported seeing or hearing family planning messages on the television or radio (data not shown).

CHAPTER VIII

CURRENT AND PAST CONTRACEPTIVE USE

At the breakup of the Soviet Union, the overall contraceptive prevalence in the USSR was estimated to be around 30%, lower in the Caucasus and Central Asian republics and higher in the eastern European republics. In most Soviet-bloc countries of central and Eastern Europe, isolated from advanced contraceptive technology of the industrialized countries, the use of modern contraceptives was low and reliance on induced abortion was high. Despite the difficult economic transition that former Soviet-bloc countries have been experiencing since 1990, the use of contraception, particularly modern methods, has increased once national and international family planning initiatives have been introduced and access to contraceptive information and services has been improved. As Table 8.1.1 shows, recent national reproductive health (RHS) and demographic surveys (DHS) conducted in several former Soviet-bloc countries in the mid to late 1990's have documented a higher than expected use of contraception, especially use of modern contraceptives, although only few countries conducted follow-up surveys that allow for examination of trend data (e.g., Kazakhstan, Russia, Romania).

As mentioned in Chapter VII, there have been several recent efforts to improve the reproductive health status in Georgia under the UNFPA-funded program (development of family planning infrastructure, training, and contraceptive supplies) and under the USAID Reproductive and Sexual Health Project—rehabilitation of the family planning and health information systems (with technical assistance from CDC), development of hospital partnerships (focusing on health management, medical education, health policies), IEC activities, and humanitarian aid. In addition, the World Bank's Healthy Children and Safe Motherhood sub-component aimed at promoting integrated FP and STD services in primary MCH services. The UNHCR was primarily active in promoting increased access to family planning services to IDP women. This year the Government of Georgia, with technical assistance from USAID, UNFPA, UNICEF, UNHCR, WHO, and the World Bank, formulated Year 2010 reproductive health objectives, which include lowering maternal and infant mortality by 15%. To attain these objectives, the government plans to adopt new strategies, including reorganizing and optimizing family planning services at the regional level, introducing family life education in school, developing an IEC system with a focus on family planning and other reproductive health issues, and a continuous medical education system for the health personnel.

Table 8.1.1
Current Contraceptive Prevalence Among Currently Married Women of Reproductive Age
Reproductive Health Surveys (RHS) and Demographic Health Surveys (DHS)
In Selected Eastern European and Former Soviet Union Countries, 1993-2001

Country	Type of Survey	Any Method	Modern Method	% Modern Methods of Total Prevalence	Most Used Method
Eastern European Region					
Czech Republic, 1993	RHS	69	45	65	Withdrawal
Romania, 1993	RHS	57	14	25	Withdrawal
Romania, 1999	RHS	64	30	47	Withdrawal
Russia (three oblasts*), 1996	RHS	69–77	50–59	73–77	IUD
Russia (three oblasts*), 1999	RHS	70–75	49–58	70–77	IUD
Moldova, 1997	RHS	74	50	68	IUD
Ukraine, 1999	RHS	67	39	49	IUD
Caucasus Region					
Georgia, 1999–2000	RHS	41	20	49	Withdrawal
Armenia, 2000	DHS	61	22	36	Withdrawal
Azerbaijan, 2001†	DHS	56	12	21	Withdrawal
Central Asian Region					
Kazakhstan, 1995	DHS	59	46	78	IUD
Kazakhstan, 1999	DHS	66	54	82	IUD
Uzbekistan, 1996	DHS	56	51	91	IUD
Kyrgyz Republic, 1997	DHS	60	49	82	IUD
Turkmenistan, 2000	DHS	62	53	85	IUD

* Yekaterinburg, Perm, and Ivanovo.
† Preliminary data.
Source: Goldberg et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1995-2001; Serbanescu et al. 1994, 1998, 2001.

The very high levels of induced abortions (many not recorded by the health statistics reporting system) demonstrate that couples still lack information about and access to a wide array of contraceptive choices. Between 1996-1999, IUD, condoms and pills donated by the UNFPA and IPPF have been distributed free-of-charge in state-run clinics (WCC and maternity houses) and through local NGOs (one NGO is headed by the First Lady), under MOH supervision. However, lack of funds have prevented the newly established state health insurance agency from including family planning services in its basic benefit package and, with the exception of increasingly scarce free supplies, contraceptive services are largely out-of-pocket expenses. New IEC efforts for RH are likely to increase the demand for modern contraceptives. There is a clear need in the future for

increased resources for the national family planning program to help women successfully plan their births and reduce the risk of unintended pregnancies and subsequent abortions.

8.1 Current Contraceptive Prevalence

This section focuses mostly on women in legal and consensual marriages because they represent 87% of sexually experienced women (the majority of which are currently sexually active), have greater frequency of intercourse, have higher fertility and risk of unintended pregnancies (see also Chapter IV), and constitute the common denominator for most national and international studies of contraceptive prevalence. However, in order to present a complete picture of contraceptive prevalence in Georgia, all women who have ever had sexual relations were asked a series of questions about their current and past contraceptive use.

TABLE 8.1.2
Current Use of Contraception Among All Women by Marital Status
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status			IDP Status	
Use of Contraception	Total	Currently Married&In Union	Previously Married	Never Married	IDP	Non-IDP
Currently Using	**24.7**	**40.5**	**2.7**	**0.0**	**23.0**	**24.9**
Modern Methods	12.1	19.8	2.7	0.0	12.5	12.2
IUD	5.9	9.7	0.7	0.0	7.8	5.8
Condom	3.9	6.3	1.1	0.0	2.7	4.0
Female Sterilization	1.0	1.6	0.9	0.0	1.0	1.0
Pill	0.6	1.0	0.0	0.0	0.1	0.7
Emergency Contraception	0.6	1.0	0.0	0.0	0.7	0.6
Other Modern Methods	0.1	0.1	0.0	0.0	0.2	0.1
Traditional Methods	12.6	20.7	0.0	0.0	10.5	12.7
Withdrawal	6.4	10.5	0.0	0.0	6.8	6.4
Calendar (Rhythm Met.)	6.2	10.2	0.0	0.0	3.7	6.3
Not Currently Using	**75.2**	**59.5**	**97.4**	**100.0**	**76.9**	**75.2**
Total	100.0	100.0	100.0	100.0	4.9	95.1
Number of Cases	7,798	5,177	517	2,104	1,828	5,970

As can be seen in Table 8.1.2, the overall contraceptive prevalence is very low (25%). The majority of previously married women were not currently sexually active and virtually all never-married women reported that they have never had sexual intercourse; therefore, very few of these women are currently in need of contraception (see Chapter IX). Less than 3% of previously married women and none of never-married women reported they are currently using contraception. All previously married women currently using contraception reported using modern methods, approximately equally split between IUDs, condoms, and female sterilization. Contraceptive prevalence among IDP women is very similar to the prevalence among non-IDPs.

As shown in Table 8.1.3 and Figure 8.1, prevalence of contraceptive use among women currently in legal or formal unions was 41% and only a half of it (20%) is represented by modern methods. The proportion of women in union currently using any form of contraception ranged from 5%, among childless women, to 49%, among women with university education. For the entire country, the proportion of all contraceptive users who use a modern method is 20%, ranging between 4% for those who have no children and 28% for those with the highest levels of educational attainment. The proportion using any contraceptive method was slightly higher in Tbilisi (45%) and other urban areas (42%) than in rural areas (37%), among 30—39-year-olds (47%), and among those with two children (49%); the proportion increased directly with educational and socio-economic levels. Modern contraceptive use follows a similar pattern. It was significantly lower in rural areas

Figure 8.1
Current Use of Specific Contraceptive Methods
Women Currently In Union
Reproductive Health Survey: Georgia, 1999/2000

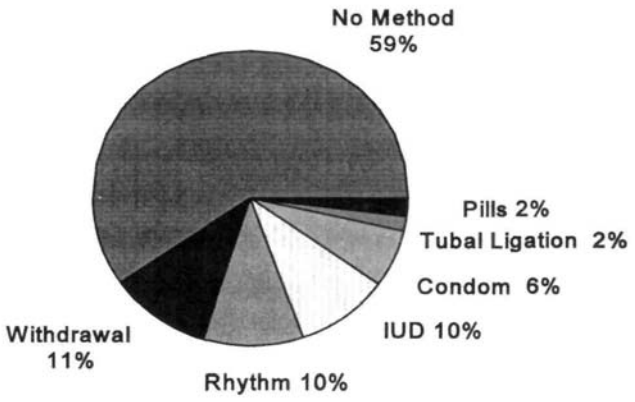


TABLE 8.1.3
Current Use of Modern and Traditional Methods by Selected Characteristics Among Women in Union Aged 15–44 Years
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Any Method	Modern Methods	Traditional Methods	Percent Using a Modern Method	No. of Cases
Total	**40.5**	**19.8**	**20.7**	**49**	**5,177**
Residence					
Tbilisi	44.9	25.2	19.7	**56**	1,214
Other Urban	42.3	22.0	20.3	**52**	1,766
Rural	37.2	15.7	21.5	**42**	2,197
Age Group					
15–19	15.3	10.0	5.3	**65**	227
20–24	33.4	19.7	13.7	**59**	673
25–29	43.0	23.4	19.6	**55**	975
30–34	47.1	24.3	22.8	**52**	1,134
35–39	46.8	19.1	27.7	**41**	1,251
40–44	35.1	15.0	20.1	**43**	917
No. of Living Children					
None	5.1	4.1	1.0	**80**	415
One	34.4	20.2	14.2	**59**	1,125
Two	49.4	23.9	25.5	**48**	2,551
Three or More	40.8	16.7	24.1	**41**	1,086
Education Level					
Secondary Incomplete	24.8	8.4	16.4	**34**	445
Secondary Complete	37.1	16.7	20.4	**45**	1,808
Technicum	41.8	19.4	22.4	**47**	1,567
University	49.4	28.4	21.0	**57**	1,357
Socio-economic Status					
Low	34.1	13.7	20.4	**40**	2,137
Middle	43.5	20.9	22.6	**48**	2,444
High	44.4	30.1	14.3	**68**	596
Ethnic Group					
Georgian	42.1	21.0	21.1	**50**	4,369
Azeri	24.1	11.3	12.8	**45**	435
Armenian	45.3	14.5	30.8	**32**	221
Other	47.3	26.1	21.6	**56**	152
IDP Status					
IDP	38.6	21.0	17.6	**54**	1,109
Non-IDP	40.5	19.7	20.9	**49**	4,068

Table 8.1.4
Current Use of Specific Contraceptive Methods by Selected Characteristics
Among Women in Union Aged 15–44 Years
Reproductive Health Survey: Georgia, 1999/2000

		Specific Contraceptive Method Use								
				Supplied Methods				Traditional Methods		
Characteristic	Any Method	IUD	Condom	Tubal Ligation	Pills	Postinor	Other Modern	Withdrawal	Calendar	No. of Cases
Total	**40.5**	**9.7**	**6.3**	**1.6**	**1.0**	**1.0**	**0.1**	**10.5**	**10.2**	**5,177**
Residence										
Tbilisi	44.9	7.4	14.5	0.2	1.7	1.2	0.2	4.6	15.1	1,214
Other Urban	42.3	12.4	5.7	1.7	0.9	1.2	0.2	10.2	10.1	1,766
Rural	37.2	9.2	2.6	2.2	0.8	0.8	0.1	13.7	7.8	2,197
Age Group										
15–19	15.3	4.1	3.1	0.0	0.9	1.9	0.0	4.6	0.8	227
20–24	33.4	8.7	6.4	0.3	2.6	1.7	0.0	9.8	3.9	673
25–29	43.0	11.6	9.0	0.6	1.4	0.7	0.1	11.1	8.4	975
30–34	47.0	12.3	8.7	1.3	0.9	1.1	0.1	12.0	10.6	1,134
35–39	46.8	9.1	5.1	2.9	0.6	1.0	0.3	12.5	15.1	1,251
40–44	35.1	8.0	3.6	2.6	0.3	0.4	0.1	7.8	12.4	917
No. of Living Children										
None	5.1	0.3	2.5	0.0	1.2	0.0	0.0	0.5	0.5	415
One	34.4	8.8	8.6	0.6	1.1	1.1	0.0	7.6	6.6	1,125
Two	49.4	12.3	7.2	1.9	1.2	1.1	0.2	11.7	13.7	2,551
Three or More	40.8	8.5	3.8	2.5	0.7	0.9	0.1	14.4	9.7	1,086
Education Level										
Secondary Incomplete	24.8	5.5	0.8	1.0	0.6	0.4	0.0	14.5	1.9	445
Secondary Complete	37.1	8.7	4.3	1.5	0.8	1.2	0.1	12.8	7.6	1,808
Technicum	41.8	10.8	4.6	1.9	1.1	1.1	0.0	9.8	12.5	1,567
University	49.4	11.4	12.8	1.6	1.5	0.8	0.3	6.9	14.2	1,357
Socio-economic Status										
Low	34.1	7.9	2.4	1.9	0.5	0.8	0.1	13.8	6.6	2,137
Middle	43.5	10.6	6.5	1.5	1.2	1.1	0.1	10.2	12.4	2,444
High	44.4	10.6	15.0	1.2	2.0	1.0	0.3	3.8	10.4	596
Ethnic Group										
Georgian	42.1	10.1	6.9	1.7	1.2	1.1	0.2	9.7	11.3	4,369
Azeri	24.1	8.2	1.5	1.2	0.4	0.0	0.0	10.5	3.4	435
Armenian	45.3	8.1	3.8	0.8	0.4	1.3	0.0	23.9	6.8	221
Other	47.3	8.3	13.6	1.4	0.7	2.0	0.0	9.0	11.4	152
IDP Status										
IDP	38.6	13.0	4.5	1.7	0.2	1.2	0.3	11.4	6.2	1,109
Non-IDP	40.5	9.5	6.4	1.6	1.1	1.0	0.1	10.4	10.4	4,068

than in Tbilisi and other urban areas (16% vs. 25% and 22%, respectively), among the youngest women (10%) and women aged 40 or over (15%), among childless women (4%), among women who had not completed a secondary education (8%), among women living in households with low socioeconomic level (13%),and among women of Azeri descent (11%). Among only very few subgroups did the use of modern methods surpass the use of traditional methods by a considerable margin (women aged 15-29 years of age, the most educated women, and women with high SES).

As shown in Table 8.1.4, the most prevalent methods in use among women in union were withdrawal (11%), which accounts for 26% of contraceptive prevalence, periodic abstinence (10%), and the IUD (10%). Condoms, which are used by 6% of women in union is the next most used method. Thus, with the exception of IUD, which accounts for 24% of contraceptive prevalence, and condom (16% of total prevalence), the other modern methods are only seldom used. Tubal ligation, despite an overwhelming desire by most women not to have any more children (see Chapter IV), is used by only 2% of women currently in union. The pill and Postinor, a postcoital progesterone-only method, were used by only 1% of women in union.

The choice of a specific method by background characteristics sometimes differs by a considerable margin. The use of condoms is more than two times as high as the average in Tbilisi (15%), as well as among those with a high level of education (13%) or with high socioeconomic status (15%). Condom use is very low in rural areas (3%), among childless women (3%), among less educated women (1%), among those with low SES (3%) and women of Azeri descent (2%). Pill use is so low that there are no significant variations. The use of other modern methods varies less by background characteristics. The use of withdrawal was significantly higher among rural residents (14%), among women with three or more children (15%), among women who did not complete high school (15%) and women of Armenian descent (24%). The use of periodic abstinence (the calendar method) was higher among urban women, especially in Tbilisi, and generally increased with age, number of living children, educational attainment, and SES.

8.2 Source of Contraception

To assess sources of contraceptive methods for women currently in union, the 99GERHS included questions about where current users of supplied contraceptive methods obtain their contraceptives. As shown in Table 8.2, the public medical sector was the most important source of suppling contraceptives in the country (54%). Hospitals supplied 30% of women currently in union with their current method of contraception—hospitals with gynecologic wards supplied 21% and maternity hospitals supplied 9% of their clients. Additionally, women's consultation clinics supplied 21% of women whereas polyclinics and rural dispensaries supplied only 3% of women. Commercial

sales in general are the second largest source of contraception. Pharmacies, in particular, are the most important source of contraception for women in union, supplying 36% of current users. Because pharmacies are the subject of a rapid process of privatization, it is very difficult to differentiate between public, private, and mixed ownership status. Other commercial sales outlets (stores or street markets) were the source of contraception for only 1% of women. Private medical clinics or doctors constitute an emerging source of contraception, particularly for IUDs, but currently they supply only 1% of users. Other sources, such as partners, friends, and relatives, supplied 8% of female users, principally condom users.

TABLE 8.2
Source of Supply of Modern Contraceptive Methods by IDP Status and Specific Method
Women Aged 15–44 Currently in Union Who Are Using Selected Contraceptive Methods,
Reproductive Health Survey: Georgia, 1999/2000

Source	Total*	IDP	Non-IDP	IUD	Condom	Tubal Ligation	Pills	Postinor	Other Modern*
Public Medical Sector	**53.9**	**63.6**	**53.3**	**93.7**	**2.5**	**99.7**	**18.4**	**8.5**	**24.8**
Hospital (Ob/Gyn Ward)	21.2	18.0	21.4	34.3	0.7	61.2	9.8	0.2	7.9
WCC	21.0	35.3	20.2	42.0	0.7	0.0	6.1	2.6	6.3
Maternity	8.6	5.7	8.8	11.9	0.9	38.5	0.1	3.6	8.5
Polyclinic	1.9	4.4	1.7	3.2	0.2	0.0	1.6	2.1	2.1
Rural Dispensary ("FAP")	1.2	0.2	1.2	2.3	0.0	0.0	0.8	0.0	0.0
Private Clinic/Office	**1.1**	**2.2**	**1.0**	**2.3**	**0.0**	**0.3**	**0.1**	**0.0**	**0.0**
Commercial Sales	**37.1**	**27.9**	**37.7**	**3.2†**	**75.9**	**0.0**	**79.3**	**79.2**	**68.6**
Pharmacy	36.1	27.7	36.6	2.8	74.2	0.0	78.5	79.2	61.2
Store/Kiosk	1.0	0.2	1.1	0.4	1.7	0.0	0.8	0.0	7.4
Other	**7.2**	**6.2**	**7.1**	**0.7**	**20.0**	**0.0**	**0.8**	**10.3**	**6.6**
Partner	6.1	3.2	6.2	0.0	19.1	0.0	0.0	2.0	4.3
Friend or Relative	1.1	3.0	0.9	0.7	0.9	0.0	0.8	8.3	2.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	**1,553**	**359**	**1,194**	**794**	**436**	**92**	**132**	**54**	**45**

* Includes women using spermicides and injectables
† Prescription to buy the IUD at pharmacy and bring it to clinic/maternity for insertion

Sources varied greatly according to the contraceptive method used. Public hospitals (gynecologic wards and maternities) and women's consultation clinics were the primary source of IUDs suppling practically almost all users (46% and 42%, respectively). Pharmacies were the principal provider of condoms, pills, and spermicides, supplying more than 75% of condoms, pills, and Postinor (emergency contraception). Pharmacies also supplied 3% of the IUDs (with a prescription issued by the OB/Gyn), but the IUD must be inserted at a medical facility. Gynecologic wards were the second source of pills, supplying almost 10% of women in union. Not surprisingly, partners constituted the second source for condoms for women (19%). Very few women reported obtaining condoms in a women's consultation clinic. Virtually all contraceptive sterilization procedures took place in maternity hospitals.

8.3 Dissatisfaction with the Current Method and Preference for Other Methods

The percentage of women who reported having problems or concerns about their current method of contraception was considerably lower than the percentage who wanted to switch to a different method. Overall, about 1 of 7 current users said they had problems or concerns about their current method of contraception. The most important reasons for their dissatisfaction is presented by specific methods in Table 8.3.1.

TABLE 8.3.1
Satisfaction With Currently Used Contraceptive Method by Specific Method Used and Reason for Dissatisfaction, Women Aged 15–44 Currently in Union Who Are Currently Using Contraception Reproductive Health Survey: Georgia, 1999/2000

		Current Method					
	Total	IUD	Condom	Pill	Other Modern	Withdrawal	Rhythm Method
Satisfied with Current Method	**85.2**	**90.3**	**86.3**	**76.8**	**89.7**	**79.5**	**85.2**
Dissatisfied with Current Method and Main Reason of Dissatisfaction*	**14.8**	**9.7**	**13.7**	**23.2**	**10.4**	**20.4**	**14.8**
Difficult or Unpleasant to Use	6.8	0.0	6.6	0.0	0.0	13.5	9.1
Side Effects or Health Concerns	3.8	9.3	1.0	23.2	9.7	0.7	0.0
Not Very Effective, Had Already Failed	2.8	0.4	1.8	0.0	0.6	4.0	5.3
Access/Cost	0.8	0.0	3.4	0.0	0.1	0.4	0.4
Partner Complains About the Method	0.6	0.0	0.9	0.0	0.0	1.8	0.0
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**2,136**	551	317	48	151	560	509

* Includes women who have had side effects related to the use of their method.

The pill and withdrawal were methods with which respondents were the least satisfied. All pill users cited as the main reason for dissatisfaction experience of side effects and health concerns. Users of traditional methods were dissatisfied with their methods mainly because they are difficult to use and they have low use-effectiveness. Similarly, women whose partners were using condoms reported that the main reason for dissatisfaction was related to difficulty or unpleasantness when using the method.

To assess method acceptability, all current users of contraception were asked if they preferred to be using some other method of preventing pregnancy. Overall, almost one of five users answered positively (Table 8.3.2). However, the percentages differ considerably depending on the method used. Respondents were the least satisfied with withdrawal, hormonal methods, condoms, and the calendar method; about one of four women who were using any of these methods reported dissatisfaction with its use. The only methods with low proportions of users who preferred other methods were female sterilization (8%) and the IUD (4%), consistent with the fact that only few users reported problems with these methods.

TABLE 8.3.2
Women Aged 15–44 Who Are Currently Using a Contraceptive Method and Would Prefer to Use a Different Method by Current Method Used and Preferred Method
Reproductive Health Survey: Georgia, 1999/2000

		Preferred Method					
Current Method	Total*	IUD	Pill	Condom	Tubal Ligation	Other Modern	No. of Cases
Any Method†	**19.1**	**12.4**	**2.4**	**2.0**	**1.1**	**1.2**	**2,136**
Withdrawal	28.8	20.2	4.1	2.7	1.0	0.8	560
Emergency Contraception	25.7	21.6	0.0	0.0	1.9	2.2	53
Condom	24.7	19.4	3.1	0.0	0.9	1.3	317
Pills	24.1	8.2	0.0	2.0	4.1	9.8	48
Calendar	21.4	13.1	2.8	3.7	1.4	0.4	509
Tubal Ligation	7.7	2.7	0.0	0.0	0.0	5.0	92
IUD	3.6	0.0	0.6	1.6	0.6	0.8	551

* Includes 13 women who said they want to switch to a traditional method.
† Includes six women using other modern methods.

TABLE 8.3.3
Women Aged 15–44 Who Are Currently Using a Contraceptive Method and Want to Switch to Another Method by Reason for Not Using the Preferred Method by Preferred Method
Reproductive Health Survey: Georgia, 1999/2000

		Preferred Method			
Most Important Reason	**Total***	**IUD**	**Pill**	**Condom**	**Other Modern**
Cost	**23.6**	29.6	16.1	12.4	9.2
Fear of Side Effects	**23.5**	25.1	35.9	0.0	23.5
Still Thinking About it	**22.7**	23.3	25.6	13.9	23.9
Doctor Did Not Recommend It	**10.6**	14.8	4.1	0.0	4.4
Partner Opposes	**7.3**	0.4	0.0	51.8	13.1
Difficult to Obtain the Method	**5.6**	3.2	11.8	14.9	3.9
Difficult to Use	**1.1**	0.4	2.2	2.5	2.3
Does Not Know Where to Get the Method	**1.0**	0.0	2.1	0.0	6.2
Other Reasons	**4.4**	3.2	2.2	4.5	13.5
Total	**100.0**	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**410**	269	56	41	44

* Includes 13 women who would prefer to switch to a traditional method.

The IUD is the method of choice for those who would like to switch to other methods (accounting for 65% of the preferred methods), especially among users of Postinor, condoms and of traditional methods. Only 6% of women who wanted to switch to another method indicated that they preferred female sterilization.

Table 8.3.3 presents the most important reasons why women did not switch to their preferred method. Overall, the main three reasons for which women who would like to use another method were unable to do so were the cost associated with their preferred method (24%), the concerns about potential side effects associated with the preferred method (24%), and the inability to decide about switching to another method (23%). Partner opposition and lack of availability of the preferred method was mentioned by only 7% and 6% of respondents who wanted to switch to another method, respectively.

A majority of women preferring the IUD, the method preferred to the greatest extent, said they were not using it either because its cost (30%) or because they feared side effects (25%). Fear of side effects was also the most important reason for those women who preferred pills (36%), followed by the method's cost and accessibility (28%), and user's indecision (26%). Preference for condom use was mentioned by a number of women, for whom the most frequent reasons for nonuse were partner opposition (52%) and method's cost or accessibility (27%).

8.4 Users of Non-Supplied Methods

Every respondent who was currently using any non-supplied method (calendar method and withdrawal) was asked whether a number of factors were "important" or "somewhat important" in their decision not to use a more effective method. These factors included: fear of health or side effects that may be associated with the use of modern methods; lack of knowledge about other methods; partner preference; cost or availability of other methods; religious beliefs, and medical recommendation against modern methods. As shown in Table 8.4.1 and Figure 8.4, most women stated that fear of side effects (87%), lack of or little knowledge about modern methods (70%)

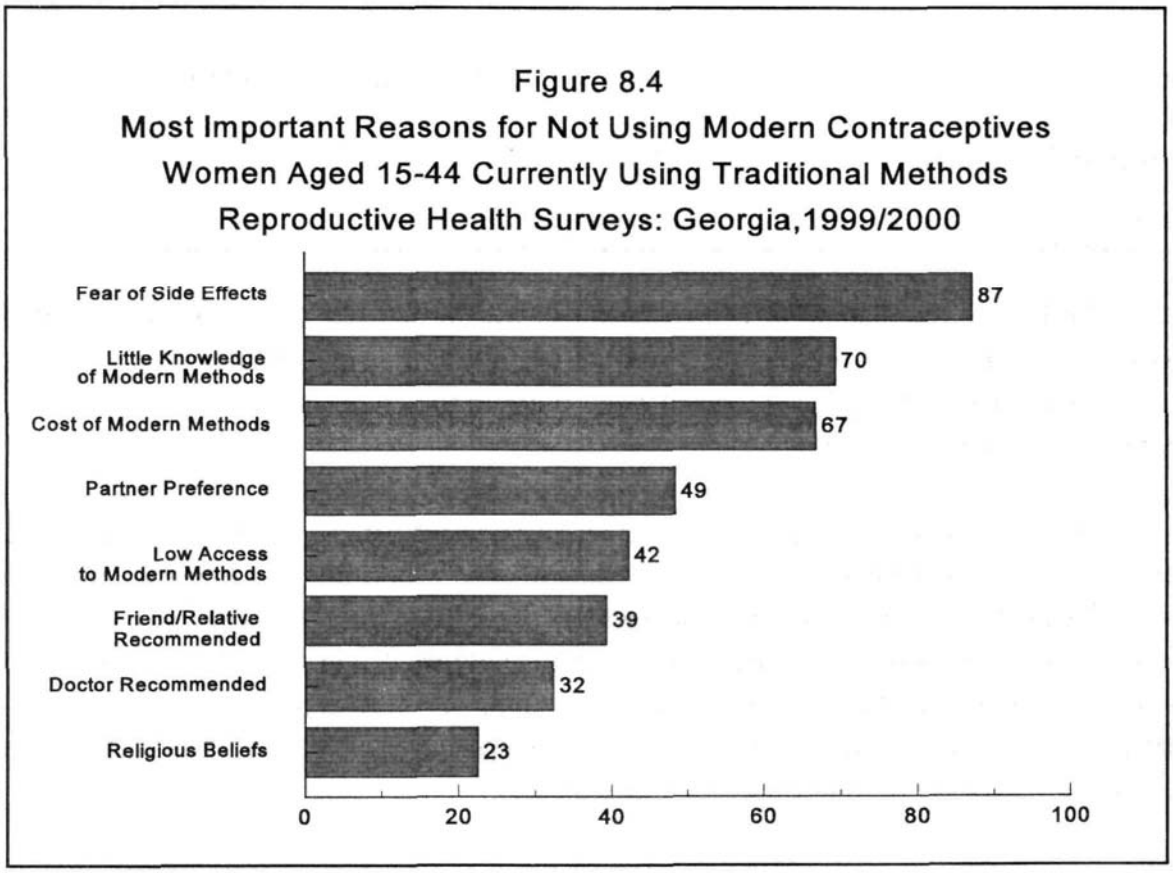


TABLE 8.4.1
Contraceptive Method Users Who Stated that Selected Factors Were Important or Somewhat Important When Deciding To Use a Non-Supplied Method Instead of a Modern Method, by Selected Characteristics
Women Aged 15–44 Currently Using Traditional Methods
Reproductive Health Survey: Georgia, 1999/2000

	Selected Factors								
Characteristic	Fear of Health/Side Effects	Lack of Knowledge	Cost of Other Methods	Partner Preference	Difficult to Get Other Methods	Other Person Recomm.	Doctor Recommen-dation	Religious Beliefs	No. of Cases
Total	**87.3**	**69.5**	**66.9**	**48.5**	**42.3**	**39.4**	**32.4**	**22.5**	**1,069**
Method Used									
Withdrawal	83.8	78.6	73.6	56.9	46.6	40.9	29.3	21.8	560
Rhythm Method	91.0	60.1	60.0	39.9	38.0	37.8	35.6	23.1	509
Residence									
Tbilisi	85.4	62.2	57.7	49.2	30.7	35.8	28.9	17.9	226
Other Urban	93.2	67.1	68.8	47.4	42.7	42.3	40.1	21.4	362
Rural	84.8	74.2	70.0	48.8	47.5	39.3	29.5	25.2	481
Age Group									
15–24	79.5	74.6	64.7	56.2	43.2	41.2	32.1	23.1	111
25–34	87.2	70.3	72.8	50.3	46.0	36.9	32.8	23.3	441
35–44	89.0	67.7	62.6	45.5	39.3	41.0	32.2	21.7	517
Education Level									
Secondary Complete	84.7	77.9	72.0	51.7	46.6	41.4	29.8	22.6	433
Technicum	88.3	68.7	67.9	44.9	42.3	37.5	29.8	19.8	345
University	90.3	57.5	57.9	47.8	35.9	38.5	39.4	25.3	291
Socio-economic Status									
Low	86.0	76.0	73.1	50.6	48.6	42.7	25.6	22.3	437
Middle	87.2	68.7	67.2	47.8	41.2	38.3	35.8	23.3	543
High	92.7	51.9	44.2	45.5	28.5	34.9	35.0	17.6	89
Ethnic Group									
Georgian	89.3	67.5	65.7	44.9	40.4	39.1	32.8	20.8	912
Azeri	63.1	79.4	61.5	74.0	51.9	29.9	27.4	35.2	55
Armenian	89.1	85.0	80.9	68.3	54.6	49.3	27.3	28.7	70
Other	89.3	61.0	78.6	38.7	41.0	45.0	45.3	20.9	32
IDP Status									
IDP	89.1	66.5	75.0	56.1	38.7	33.9	33.8	21.5	203
Non-IDP	87.3	69.6	66.5	48.2	42.5	39.6	32.3	22.5	866

cost (67%), partner preference for traditional methods (49%), or availability (42%) of modern methods were the major factors influencing their decision not to use a modern method. About one of three women considered a friend (39%) or a doctor's advice (32%) as important factors in their decision to use traditional methods and one of four women mentioned their religious beliefs as a reason to not use a modern method (23%).

Among users of non-supplied (traditional) methods there were few differences in the proportion mentioning specific reasons for not using a modern method, by background characteristics. Fear of side effects was more common among women who were using periodic abstinence and urban women; fear of side effects increased with age, education level, and SES. Lack of knowledge was more often mentioned by women using withdrawal, women in rural areas, 15-24-year-olds, those without postsecondary education, women with low SES and Azeri or Armenian women. Partner preference was more often mentioned by women whose partners were using withdrawal, women aged 15-24 and Azeri or Armenian women. The cost and availability of modern methods was mentioned more often by women with lower education or low SES. Religious beliefs were more important for Azeri and Armenian women. In conclusion, a substantial number of factors mentioned as important in their decision-making by women who chose to use traditional methods could in fact be influenced by adequate contraceptive counseling and improved access to family planning services.

Table 8.4.2 presents the opinions of women using non-supplied (traditional) methods regarding the effectiveness of their current method relative to "modern methods like the IUD or the pill." It is notable that more than three-fourths consider their method more effective (35%) or equally effective (43%) compared with modern methods and only 11% recognized that the IUD or the pill are more effective methods in preventing pregnancy. In addition, 11% admitted that they did not know if their method is more or less effective. Beliefs in high relative effectiveness (this category includes women who think their method is more or equally effective) of traditional methods were not significantly influenced by background characteristics, including education of the respondents. Perceived relative effectiveness was inversely associated with the desire to use another method in the future. Women who did not want to change their current traditional method were more likely to think highly of its effectiveness (85%). Those who said their preference for a future method would be the IUD were the least likely to believe that their current method is relatively effective (55%). To increase the use of more effective methods, the national family planning program should concentrate on heightening public awareness of the relative effectiveness of various types of contraception, including contraceptive sterilization, disseminating information about the health effects of various methods, including their health benefits, and improving access to modern methods. Renewed international donors' support is needed to increase the IEC efforts and train family planning and health care providers.

TABLE 8.4.2
Perceived Effectiveness of Traditional Methods Compared to Modern Methods by Selected Characteristics
Women Aged 15–44 Currently Using a Traditional Method
Reproductive Health Survey: Georgia, 1999/2000

	Perceived Effectiveness of Traditional Methods Compared to Modern Methods					
Characteristic	**Current Method More Effective**	**Current Method Equally Effective**	**Current Method Less Effective**	**Do Not Know**	**Total**	**No. of Cases**
Total	**35.0**	**43.1**	**10.7**	**11.2**	**100.0**	**1,069**
Method Used						
Withdrawal	37.0	43.0	10.6	9.4	100.0	509
Calendar (Rhythm) Method	33.1	43.2	10.7	13.0	100.0	560
Residence						
Tbilisi	42.0	34.3	13.6	10.1	100.0	226
Other Urban	27.9	51.3	10.9	9.9	100.0	362
Rural	36.0	42.3	9.1	12.5	100.0	481
Age Group						
15–24	33.9	40.1	12.2	13.7	100.0	111
25–34	29.3	46.6	12.9	11.3	100.0	441
35–44	39.8	40.9	8.6	10.6	100.0	517
Education Level						
Secondary Complete or Less	34.2	41.2	9.6	15.0	100.0	433
Technicum	35.7	43.5	12.5	8.2	100.0	345
University	35.5	45.3	10.1	9.0	100.0	291
Socio-economic Status						
Low	34.3	39.3	9.6	16.8	100.0	437
Middle	34.7	45.4	10.8	9.1	100.0	543
High	39.4	41.7	13.8	5.2	100.0	89
Ethnic Group						
Georgian	32.7	44.8	11.7	10.8	100.0	912
Azeri	42.5	38.3	4.1	15.0	100.0	55
Armenian	54.7	26.1	6.9	12.4	100.0	70
Other	33.5	49.8	6.7	10.0	100.0	32
IDP Status						
IDP	37.4	46.0	10.9	5.7	100.0	203
Non-IDP	34.9	43.0	10.7	11.5	100.0	866
Preference for Other Method						
IUD	8.5	46.0	35.2	10.3	100.0	184
Pill	27.8	46.2	23.0	3.0	100.0	39
Other Method†	16.5	47.7	33.8	2.0	100.0	53
Does Not Want To Change	42.5	42.0	3.1	12.4	100.0	793

† Includes four women who want to switch to another traditional method.

8.5 Reasons for Not Using Contraception

As shown in Table 8.5, women currently in union mention a broad variety of reasons for not currently using contraception. The most common reasons given are related to pregnancy (i.e., currently pregnant or breastfeeding or desired pregnancy), which accounts for 19% and 13%, respectively. The second most important reason was related to fertility impairment, of either respondent (23%)—6% reported PID and 17% other medical reasons which prevent them getting pregnant— or of her partner (0.3%) Negligence was mentioned by about one of seven women as the most important reason to not use contraception. Almost one in ten women reported lack of current sexual activity (within the last month) as the most important reason for not using a method. Very few women reported personal or program-related reasons as contributing to their decision not to use a method: personal or partner opposition to contraceptive methods (5%), fear of side effects (4%), and lack of access to family-planning services (3%).

TABLE 8.5
Most Common Cited Reasons for Not Currently Using Contraception by Age Group
Women in Union Aged 15–44 Years
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

		Age Group		
Reason	**Total**	**15-24**	**25-34**	**35-44**
Currently Pregnant or Postpartum	**18.7**	41.6	21.9	3.9
Female Infecundity/Subfecundity	**17.0**	4.2	11.0	28.9
Neglected to use	**14.3**	10.6	16.9	14.0
Wants to Get Pregnant Soon	**12.7**	27.4	13.3	4.3
No Sexual Intercourse Within the Last Month	**8.8**	2.7	9.2	11.7
Pelvic Inflammatory Disease	**6.1**	0.4	3.5	11.3
Personal or Partner Opposition to Family Planning	**4.6**	3.1	5.4	4.6
Fear of Side Effects	**4.1**	1.6	6.5	3.4
Respondent doubts that she can get pregnant	**3.3**	0.6	2.4	5.6
Lack of Access to or Knowledge of FP Services	**2.9**	4.0	3.9	1.5
Approaching Menopause	**2.6**	0.0	0.0	6.2
Male Infertility	**0.3**	0.2	0.2	0.5
Other reasons	**2.5**	1.8	3.2	2.3
Does not Know	**2.2**	1.7	2.7	1.9
Total	**100.0**	100.0	100.0	100.0
Unweighted No. of Cases	**3,051**	636	1,158	1,257

Reasons for not using a method differed sharply by current age. Younger women in union were more likely to be either pregnant or in the postpartum period (41%) or were seeking to become pregnant (28%), whereas women aged 40-44 years were more likely to not be able to get pregnant (40%), to neglect using a method (14%) or to not be sexually active (11%).

8.6 Intention to Use Contraception among Nonusers

The 99GERHS asked all women who were not using any contraceptive methods at the time of the interview if they plan to use any contraception in the next 12 months or later. Intention to use contraception in the future among non-users has to be taken into account when forecasting potential need for family planning services. Table 8.6.1 presents this intention among fecund women who are currently married or in consensual union according to the number of living children they have.

Overall, only about a third of fecund currently in union female non-users (38%) plan to use a contraceptive method in the future, including 22% who would like to start the use within the next 12 months and 16% who prefer to start using a method at a later time. About one in four women (29%) were unsure if they want to use contraception in the future.

TABLE 8.6.1
Desire to Use Contraception in the Future by Number of Living Children
Fecund Women Aged 15-44 Who Are Currently in Union Who Are Not Using Contraception
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

	Total	Number of Living Children*				
Desire to Use Contraception		None	One	Two	Three	Four or More
Want to Use a Method Within 12 Months	**22.4**	2.4	25.7	24.6	20.9	23.1
Want to Use a Method Later	**15.9**	30.0	24.2	13.1	9.2	5.4
Undecided	**28.8**	50.1	28.9	26.9	25.9	23.9
Do not Want to Use Contraception	**32.9**	17.5	21.1	35.4	44.1	47.5
Total	**100.0**	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**2,411**	158	599	1,097	439	118

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

Intention to use contraception is influenced by the number of living children. Nonusers who intend to begin contraceptive use tend to have one or two children (49% and 36%, respectively). However, almost one in three childless nonusers (31%) plan to use contraception in the future, but very few of them would like to start within the next 12 months (2%). Conversely, most nonusers with one or more children who said that they would use contraception, want to start within the next year.

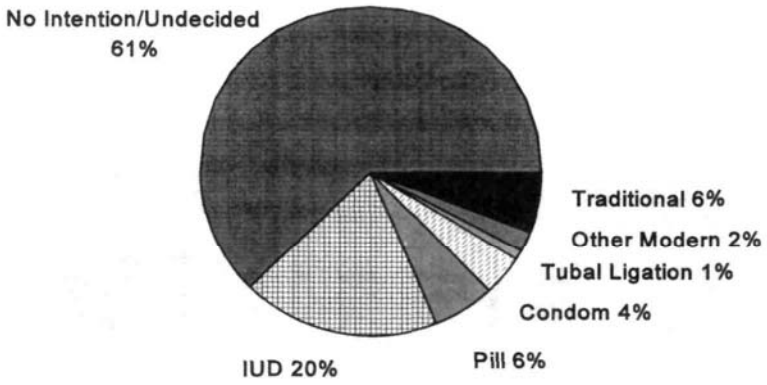
As shown in Table 8.6.2, future fertility preferences have un unexpected influence on intention to use contraception in the future among fecund female nonusers: only 32% of those who desire no more children plan to use contraception compared to 46% among those who do not want to terminate fertility. This finding is probably related to the fact that more than a half of women who do not want to have any more children are 35 years of age or older and 60% of women in this age group do not intend to use contraception at any time in the future (data not shown).

On a positive note, the majority of women who plan to use contraception in the future would like to start using a modern method (Figure 8.6). Half of them would use the IUD, one in six would start using the pill, and one in ten would use condoms. Only 15% said that they would use a traditional method. Preference for a particular method is not influenced by their fertility preferences.

TABLE 8.6.2
Desire to Use Contraception in the Future by Fertility Preferences
Fecund Women Currently in Union Who are Not Using Any Contraception
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

	Total	Desire for (Additional) Children	
Desire to Use Contraception		**Want More Children**	**No More Children**
Want to Use a Method Within 12 Months	**22.4**	21.3	23.2
Want to Use a Method Later	**15.9**	25.2	9.0
Undecided	**28.8**	33.5	25.4
Do not Want to Use Contraception	**32.9**	20.1	42.5
Total	**100.0**	100.0	100.0
Unweighted No. of Cases	**2,411**	1,011	1,400

Figure 8.6
Percentage of Fecund Women Currently in Union Who Are Not Using Contraception
By Their Intention to Use Specific Contraceptive Methods
Reproductive Health Survey: Georgia, 1999/2000



8.7 Recent Trends in Contraceptive Use

The 99GERHS questionnaire included a detailed contraceptive "calendar" where the contraceptive use, pregnancy events, and marital status were recorded monthly starting with January 1994 to the date of the interview. As shown in Table 8.7 and Figure 8.7.1, these data were used to compute mid-year contraceptive prevalence rates for 1994-1999, using the reported prevalence in the month of July in each year. During this time frame, there has been a steady but relatively moderate increase in the overall contraceptive prevalence among women in formal or consensual unions. Between July 1994 and July 1999, contraceptive prevalence rose from 35% to 41%. However, the increase in use was almost parallel for both modern (from 18% to 20%) and traditional (from 18% to 21%) methods. As a result, contraceptive method mix remained essentially unchanged.

Overall, most of the increase in modern prevalence was due to a net growth in condom use, while the use of IUD and the pill has shown little change. Nonetheless, in the past three years, there was little change in the modern prevalence, which flattened at about 20%. Renewed efforts are needed by the national family planning program to regain momentum.

Figure 8.7
Mid-Year Prevalence of Traditional and Modern Methods (1994-1999)
Reproductive Health Survey: Georgia, 1999/2000

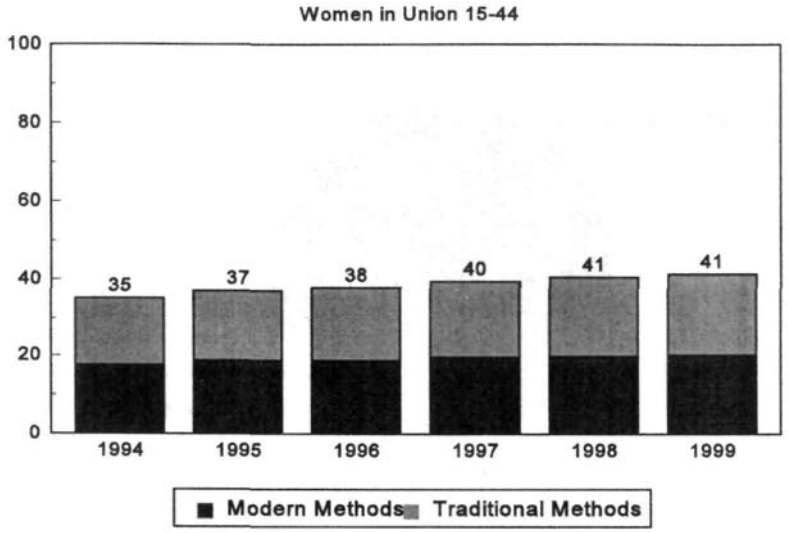


TABLE 8.7
Mid-Year Contraceptive Prevalence At One-Year Interval 1994-1999
Among Women In Formal or Consensual Unions
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

	1994	1995	1996	1997	1998	1999
Any Method	**35.2**	**37.1**	**37.9**	**39.5**	**40.6**	**41.4**
Modern Methods	17.6	18.7	18.7	19.6	19.9	20.2
IUD	11.3	11.5	11.2	10.9	10.4	10.1
Condom	3.4	4.1	4.5	5.3	5.8	6.2
Pill	1.2	1.3	1.0	1.2	1.1	1.2
Female Sterilization	1.1	1.2	1.3	1.4	1.5	1.5
Other	0.6	0.6	0.7	0.8	1.1	1.2
Traditional Methods	17.6	18.4	19.2	19.9	20.7	21.2
Withdrawal	7.4	8.0	8.7	9.2	9.9	10.6
Calendar (Rhythm Met.)	10.2	10.4	10.5	10.7	10.8	10.6
No Method	64.8	62.9	62.1	60.5	59.4	58.6

8.8 Contraceptive Failure and Discontinuation

Contraceptive failure rates (probability of becoming pregnant while using a contraceptive method) and discontinuation rates (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 history starting with January 1994. If, as is usually the case, some women did not report pregnancies ending in abortions and they had been using contraception at the time of conception, these rates may be underestimated. Thus, the rates reported here are minimum estimates, and the true rates are probably somewhat higher than those shown in Table 8.8.1.

Life table analysis of segments of contraceptive use was employed to estimate the monthly probabilities of failure and of discontinuing contraceptive use for all women using a contraceptive method during the observed period (January 1994-November 1999). Linking these probabilities, 12-, 24-, and 36-month contraceptive failure and discontinuation rates can be calculated. These rates represent the proportion of users who stop using their method within the first year, second year or third year of use for any reason (discontinuation rate) or because they become pregnant while using the method (failure rate). The one-, two-, and three-year 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 in which she had used another or no method. When more than one method had been used during any month, that month's contraceptive experience was assigned only to the more effective of the two methods (e.g., many periodic abstinence users reported use of condoms during the period of maximum fertility and were classified as condom users).

Overall, 13% of women became pregnant during the first year, 20% after two years, and 24% after three years while using a method. Failure rates varied considerably by the contraceptive method used. The IUD had the lowest failure rate at one, two, and three years. Between 1.9% and 2.6% of IUD users became pregnant while using this method. Although the one-year IUD failure rate was very low, it was twice as high as the most recent data published in the literature—0.8 failures per 100 women using the method (Hatcher RA et al., 1997). Condom users reported failure rates of 9% during the first year and 18% and 21%, respectively, after two and three years. The relatively high failure rate reported for the condom is consistent with its reported contraceptive efficacy (14%, according to the same reference). The failure rate for oral contraceptives was higher but consistent with the published one-year failure rates for common use (6%-8%). Almost 5% of pill users became pregnant in the first 12 months of use, and 11% and 17%, respectively became pregnant after two or three years of use. The highest failure rates at 12,24 and 36 months of use were reported by users of periodic abstinence (19%, 32%, and 40%, respectively) and withdrawal (17%, 26%, and 30%, respectively), underlining the need of increased IEC efforts to promote modern, more effective contraceptive methods.

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 1994
Reproductive Health Survey: Georgia, 1999/2000

	Failure Rates					
	All Methods	Contraceptive Method				
Duration		IUD	Condom	Pill	Rhythm Method	Withdrawal
One Year	**12.6**	1.9	9.1	4.6	19.3	16.9
Two Years	**20.1**	1.9	17.5	10.8	32.3	25.6
Three Years	**24.3**	2.6	20.9	17.4	40.4	30.1
No. of Segments	**3,902**	649	841	341	973	939

	Discontinuation Rates					
	All Methods	Contraceptive Method				
Duration		IUD	Condom	Pill	Rhythm Method	Withdrawal
One Year	**40.5**	10.4	54.0	73.3	39.8	37.4
Two Years	**58.6**	20.1	71.8	89.1	62.2	58.9
Three Years	**69.1**	31.2	81.7	96.6	73.1	71.8
No. of Segments	**3,902**	649	841	341	973	939
%Discontinuation due to Method Failure (12 months)	**31.1**	18.3	16.9	6.3	48.5	45.2

Although the overall and method-specific failure rates (excluding users of non-supplied methods) were within expected levels, the survey data showed considerably high discontinuation rates. Overall, 41% of women discontinued their method within one year, 59% within two years, and 69% within three years of use. Over two thirds of discontinuations after 12 months of use were caused by reasons other than method failure (method failures accounted for 13/41 x 100=31% of discontinuations after one year). Of the five methods shown in Table 8.8.1, the IUD was the only one with a low discontinuation rate at one year (10%), but three times as many IUD users stopped using the method within three years (31%). However, only 18% of IUD users discontinued to use the method because the method failed. By contrast, three fourths (73%) of pill users discontinued their method during the first year and only 3% of women continued to use the pill after three years despite its low failure rate. Condom discontinuation shows a similar pattern. Less than one in two women (46%) used the condom for more than one year and less than one in five (18%) used it for more than three years. Interestingly, for all these methods, method failure played a minor role in the women's decisions to stop using the method after one year, accounting for 18% (for IUD), 17% (for condoms) and 6% (for pills), of the discontinuation reasons. Conversely, for withdrawal and the calendar (rhythm) method, associated with very high discontinuation rates at one (37%-40%), two (59%-62%), and three years (72%-73%), method failure accounted for almost one half of discontinuation reasons.

In addition to method failure, women using contraception discontinue their method for many other method-specific reasons. Table 8.8.2 presents some other reason-specific discontinuation rates at one year for the five most commonly used methods. After method failure, the most cited discontinuation reason was negligence (12%), accounting also for 30% of the reasons for discontinuation. Cost or availability (4%) constituted the third main reason for discontinuing the use of a modern method. Intention to become pregnant (4%), health concerns or experience of side effects (3%), and desire to switch to another method (3%) were other frequent cited reasons to discontinue contraceptive use.

The main reason for discontinuation varies greatly with the contraceptive method used at that time. The IUD discontinuation rate in the first year of use, the lowest among all contraceptive methods, is heavily influenced by side effects associated with method use. About a third of IUD users discontinued for this reason, while only 18% discontinued because they got pregnant using the method and 17% because a doctor recommended the IUD removal. The experience of side effects was also the principal reason for discontinuing pill use— 45% of women who stopped using the pill (33% of 73%=45%) did so because of side effects. Medical advice against pill's use and the high cost or lack of availability of pills accounted for most of the other discontinuation reasons for this method (26%). About one of two women whose partners were using condoms discontinued use because their partner neglected to use the method and a fourth mentioned the high cost associated with the method or its lack of availability as the main discontinuation reason.

TABLE 8.8.2
Contraceptive Discontinuation Rates After One Year By Main Reason of Stopping Contraception For Selected Methods of Contraception
All Segments of Contraceptive Use Initiated Since January 1994
Reproductive Health Survey: Georgia, 1999/2000

		Contraceptive Method				
Reason For Discontinuing Contraception*	**All Methods**	**IUD**	**Condom**	**Pill**	**Rhythm Method**	**Withdrawal**
Total†	**40.5**	**10.4**	**54.0**	**73.3**	**39.8**	**37.4**
Method Failure (Became Pregnant Using)	**12.6**	1.9	9.1	4.6	19.3	16.9
Neglected to Use (Respondent or her Partner)	**11.9**	0.0	22.9	10.5	13.6	11.4
Cost/Availability	**4.2**	0.0	12.6	18.7	0.0	0.0
Desire to Become Pregnant	**3.9**	0.7	7.2	10.8	3.4	3.2
Side Effects	**3.3**	3.5	0.2	33.0	0.0	0.0
Switch to Other Method	**3.0**	0.2	6.0	3.3	3.7	2.3
Partner Related Reasons	**2.2**	0.3	3.4	1.1	0.5	5.1
Doctor's Advice	**2.1**	1.8	2.1	19.3	0.1	0.6
Other Reasons	**1.9**	0.4	2.3	2.6	1.7	2.7
No. of Segments	**3,902**	649	841	341	973	939

* gross discontinuation rates
† net discontinuation rates

Method failure, desire to get pregnant, and starting a new method accounted for most of the other reasons. Method failure was by far the most important reason for discontinuation of the calendar (rhythm) method and withdrawal. The second most important reason for both methods, was negligence to use. Partner-related reasons was the other important reason to discontinue withdrawal.

CHAPTER IX

NEED FOR CONTRACEPTIVE SERVICES

9.1 Potential Demand and Unmet Need for Contraception

A standard approach to assess the potential demand for family-planning services, other than analysis of contraceptive behaviors among women in union, is to define the contraceptive needs of women in relation to their fecundity and stated reproductive preferences, regardless of their marital status. 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). The conventional definition of unmet need includes women currently married or in consensual unions, who are currently sexually active (within the past month), are currently exposed to the risk of pregnancy (women not sexually active, currently pregnant women, women in postpartum abstinence or amenorrhea are excluded), are fecund (neither they nor their partners have any subfecundity conditions), do not currently want to become pregnant, and are not using any form of pregnancy prevention (Westoff C.F. and Ochoa L.H., 1991). Essentially, the unmet need for contraception is a very specific tool that measures the gap between desired fertility and contraceptive practices adopted to ensure that fertility preferences are met in a population. In recent years, it has proved to be a worldwide indicator in identifying subgroups that should be targeted by family planning programs, planning program strategies, allocating resources and evaluating program outcomes (Bongaarts J., 1991).

In this report, the standard formulation of unmet need was extended to all women, rather than restricting it to women in union. The survey asked all women questions about their sexual, contraceptive, and reproductive behaviors, and about their fertility preferences, allowing for a broader examination of unmet need among unmarried respondents. The level of unmet need is likely to be higher among married respondents, since they are more likely to be currently sexually active and generally have a higher risk of unintended pregnancy and a higher potential demand for family planning methods. However, by excluding unmarried respondents, some of them with special family planning needs (e.g., adolescents), the level of unmet need in a population may be underestimated and may diminish the value of this indicator for programmatic purposes. This approach may have less programmatic value in countries with strong traditions that support delaying sexual intercourse until a woman's marriage; in these countries many unmarried women may practice sexual abstinence

and those who do not may be less inclined to report premarital sexual activity.

In addition to the unmet need for any family planning, the 99GERHS estimates the unmet need for modern contraception—an indicator also used in other Eastern European surveys that expands the standard definition to include users of non-supplied methods in the category of unmet need. In countries with high use of non-supplied methods (withdrawal, periodic abstinence, and traditional/folk methods), the standard definition of unmet need masks the real need for more effective contraception because these methods tend to have high failure rates (see also Chapter VIII). For these countries it is more useful to estimate the unmet need for modern contraception, despite the small risk of overstating the unmet need in some cases when users of traditional methods are using their method effectively. However, for the purpose of international comparisons, both indicators are shown for all women, regardless of marital status. Among all countries in Central and Eastern Europe where complex reproductive health or fertility surveys have been recently conducted, Georgia has the fourth highest unmet need for modern contraception (27%), after Ukraine and Bulgaria. Unmet meet for a modern method among all women, estimated by the Fertility and Family Surveys (FFS) project, ranges from 12% in Hungary, to 15% in Czech Republic, 17% in Latvia, 19% in Slovenia, 23% in Lituania, and 36% in Bulgaria (Klijzing E., 2000). CDC assisted Reproductive Health Surveys (RHS) have found the unmet need for modern methods to be 23% in Moldova, 25%-29% in Russia, 29% in Romania, and 35% in Ukraine (Serbanescu et al. 1998,2000; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000).

Table 9.1.1 show the percent distribution of survey respondents by their need for family planning services. The upper panel of the table displays respondents not in need of contraception and the bottom panel shows the two components of the potential demand: met and unmet need. Overall, slightly more than one of three women (39%) has a potential demand for contraception, including 12% of current users of modern methods, 12% of current users of traditional methods and 15% of women in need of any contraception (defined according to the conventional definition mentioned above). According to the modified definition, the unmet need for any or more effective contraception increases to 27% among all women and 44% among married women.

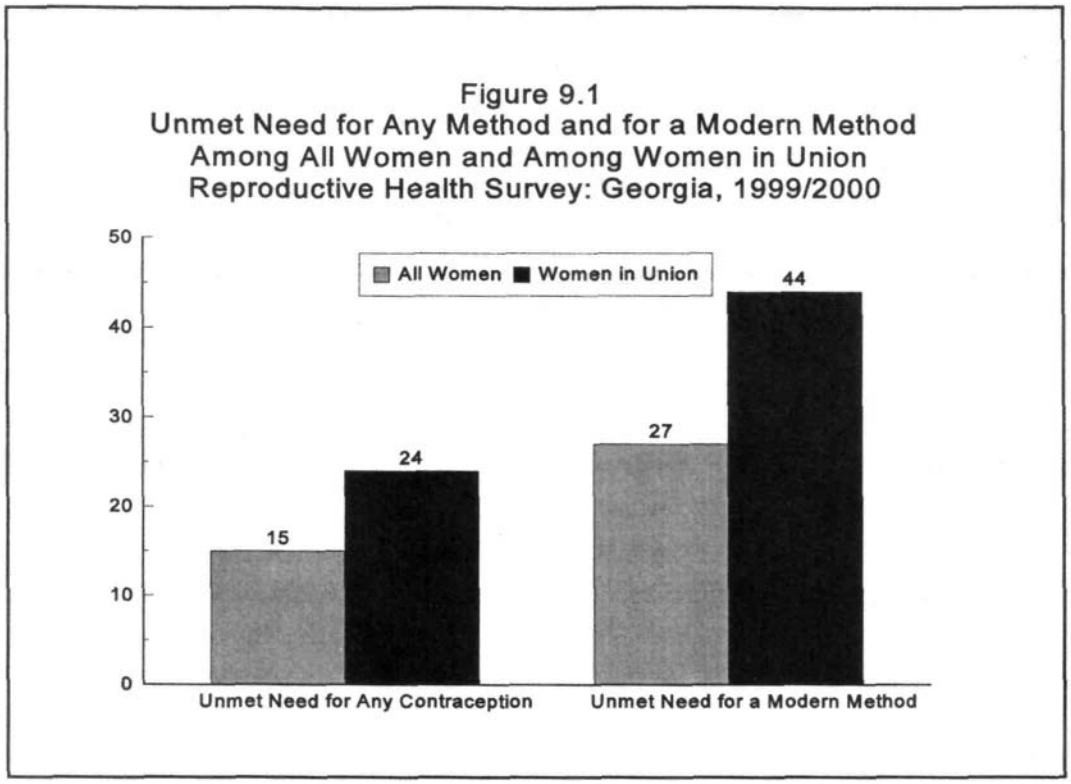
According to the population figures used by MOH, the unmet need level of 27% translates into an estimate of about 314,000 women aged 15-44 years in need of modern contraception. Since 12% of women (about 140,000 women aged 15-44) have their need of modern methods already satisfied, the total potential demand for family-planning services (met and unmet need) exceeds 450,000 women of reproductive age yearly.

As shown in the right side of Table 9.1.1 and Figure 9.1, the unmet need is much higher among those currently married or in consensual unions—24% have an unmet need of any

TABLE 9.1.1
Need for Family-planning (Fp) Services among Women Aged 15–44 Years by Marital Status
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

Need for FP Services	Total	Marital Status: Married/ In Union	Previously Married	Never Married
Women Not Currently in Need of FP Services	**61.0**	36.6	93.1	99.8
Never Had Sexual Intercourse	33.1	0.0	0.0	99.6
Not Currently Sexually Active*	8.5	5.9	81.2	0.2
Currently Pregnant or Postpartum	7.2	11.4	5.0	0.0
Seeking to Get Pregnant†	4.1	6.5	1.6	0.0
Infecund/Subfecund‡	8.1	12.8	5.3	0.0
Potential Demand for Family-Planning Services	**38.9**	63.3	6.9	0.1
Current Users of a Modern Contraceptive Method	11.8	19.2	2.6	0.0
Current Users of a Traditional Contraceptive Method	12.3	20.3	0.0	0.0
Nonusers at Risk of Unintended Pregnancy	14.8	23.8	4.3	0.1
Total	**100.0**	100.0	100.0	100.0
Unmet Need for a Modern Contraceptive Method §	**27.1**	44.1	4.3	0.1
Unweighted No. of Cases	**7,798**	5,177	517	2,104

* Within the past month.
† Want to get pregnant right away; include 73 respondents who answered "when God wants".
‡ Women with sterilization surgery for noncontraceptive reasons, medical conditions that preclude pregnancy, women whose partners are infertile, and menopausal women.
§ Include nonusers at risk of unintended pregnancy and current users of traditional contraceptive methods.



contraceptive methods and 44% have unmet need for modern methods. Since most unmarried women are not currently sexually active (see also Chapter IV), the unmet need for previously married or never-married women is negligible.

Table 9.1.2 presents comparative data on women in need for any contraception and women in need for modern contraception by selected characteristics and by marital status. Both definitions were used to define proportions of women in need of family-planning services. Generally, women in rural areas and women residing outside Tbilisi or Imereti region have higher unmet need of contraception. The need for any and more effective contraception among all women increases markedly with age, from 6% and 10%, respectively, among women aged 15-24, to 19% and 35%, respectively, among women 25-34 years of age, and to 20% and 40%, respectively among those aged 35-44. The same trend is obvious among married women.

The unmet for modern contraception increased with number of living children, from less than one percent among childless women to 49% and 52%, respectively, among women with two or three or more children. Unmet need, particularly among married women, was inversely correlated with socioeconomic status; married women with a low SES had the highest unmet need levels (50%) whereas those with high SES had the lowest unmet need of any and more effective contraception (32%).

TABLE 9.1.2

Unmet Need for Any Contraceptive Method and Unmet Need for a Modern Method Among Women 15–44 Years by Selected Characteristics by Marital Status Reproductive Health Survey: Georgia, 1999/2000

	All Women			Women in Union		
Characteristic	Need of Any Method	Need of a Modern Method	No. of Cases	Need of Any Method	Need of a Modern Method	No. of Cases
Total	**14.8**	**27.1**	**7,798**	**23.8**	**44.1**	**5,177**
Residence						
Urban	12.8	24.0	4,759	21.7	41.3	2,980
Rural	17.3	31.1	3,039	26.1	47.3	2,197
Region						
Tbilisi	11.8	22.6	2,029	20.8	40.1	1,214
Imereti	13.1	25.0	1,590	22.2	42.5	1,057
North-East	18.1	31.0	1,259	27.3	47.0	903
South	17.2	30.3	1,017	25.1	45.0	740
West	14.8	28.3	1,903	23.9	46.2	1,263
Age Group						
15–24	6.0	9.5	2,388	19.1	30.5	900
25–34	19.3	34.8	2,731	25.3	46.0	2,109
35–49	20.4	39.9	2,679	24.5	48.3	2,168
No. of Living Children						
None	0.6	0.7	2,598	2.5	3.3	415
One	15.0	26.6	1,316	17.1	30.7	1,125
Two	25.8	49.3	2,737	27.3	52.4	2,551
Three or More	29.4	52.1	1,147	30.6	54.3	1,086
Education Level						
Secondary or Less	15.1	25.4	3,655	28.3	44.7	445
Technicum	17.7	34.1	2,058	27.2	47.4	1,808
University	11.4	23.9	2,085	20.9	42.0	2,924
Socio-economic Status						
Low	18.6	30.8	3,276	29.7	49.8	2,137
Middle	13.5	26.8	3,654	21.9	44.0	2,444
High	10.7	19.5	868	17.3	31.6	596
Ethnic Group						
Georgian	13.9	26.1	6,700	22.9	43.4	4,369
Azeri	21.9	31.2	589	31.2	44.9	435
Armenian	14.7	34.8	300	22.1	52.9	221
Other	16.5	30.2	209	24.6	45.1	152
IDP Status						
IDP	16.8	27.0	1,828	27.9	45.0	1,109
Non-IDP	14.6	27.1	5,970	23.6	44.1	4,068

9.2 Potential Demand for Family Planning Services According to Fertility Preferences

In addition to measuring the potential demand for family planning services, the survey allows for estimates of met and unmet need according to respondents' fertility preferences. Among respondents with potential demand for any contraception (standard definition) and for a modern method (expanded definition), non-users who did not want to get pregnant right away but wanted to have children sometime in the future (including those undecided 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 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 met need for spacing and met need for limiting births (Table 9.2).

TABLE 9.2
Met and Unmet Need for Family Planning Services
Among All Women and Among Women in Union Aged 15–44
According to Their Future Fertility Preferences
Reproductive Health Survey: Georgia, 1999/2000

	All Women		Women In Union	
	Any Method	A Modern Method	Any Method	A Modern Method
Unmet Need For FP				
For Spacing	3.5	6.1	5.7	9.9
For Limiting	11.2	21.0	18.1	34.2
Total	**14.8**	**27.1**	**23.8**	**44.1**
Met Need For FP				
For Spacing	6.2	3.7	10.1	5.9
For Limiting	17.9	8.1	29.4	13.3
Total	**24.1**	**11.8**	**39.5**	**19.2**
% Demand Satisfied				
For Spacing	63.9	37.8	63.9	37.3
For Limiting	61.5	27.8	61.9	28.0
Total	**62.0**	**30.3**	**62.4**	**30.3**
No. of Cases	**7,798**	**7,798**	**5,177**	**5,177**

Generally, both met and unmet need for limiting were higher than met and unmet need for spacing. Among women currently in union, contraceptive use for limiting was nearly three times more prevalent than use for spacing. Similarly, the unmet need for limiting was three times higher than the unmet need for spacing, concordant with the low ideal family size and fertility patterns in Georgia. Owing to the low usage of long term and permanent contraceptive methods, unmet need for limiting exceeded the met need by a considerable margin. Only 13% of women in union reported that their needs to limit childbearing through using modern methods had been satisfied whereas 34% reported their needs as still unmet. Thus, of the 47% of women in union who wanted to limit fertility, only slightly more than a fourth (28%) had their demand for modern contraceptives satisfied. Similarly, the unmet need of modern methods for spacing was almost twice as high as the met need (10% vs. 6%). Although the modern contraceptive demand for spacing among married couples was much lower than that for limiting (16% vs. 47%), it was more likely to be satisfied (37% vs. 28%).

The distinction between potential demand for spacing and limiting has important programmatic implications for family planning services and programs that aim at increasing contraceptive use. One reason is the different array of methods required by couples who need contraception for spacing (temporary methods) compared to those who need contraception for limiting births (long term or permanent methods). Another reason is their different demographic characteristics: spacers tend to be younger, childless or with one child, better educated and more affluent than limiters, who are typically 30 years of age and older with two or more children (not shown) and with middle or low SES. Finally, the motivation for not using contraception is different among potential spacers and potential limiters. Although the most important reason for not using contraception in both groups was negligence, women with unmet need for spacing were more likely, to say that they did not use a method because their intention to get pregnant at some point in the future whereas women with unmet need for limiting fertility believed that they were not at risk of getting pregnant (data not shown).

Thus, in order to ensure that the national family planning program can reach the contraceptive needs of couples in Georgia, more efforts should be made to expand the availability of a wide array of effective, high quality, affordable methods, including long-term and permanent methods, and to increase contraceptive awareness among both spacers and limiters. Since a larger share of the unmet need is among rural women, those less educated, less affluent, and those with two or more children, indicating that access to services is not equal, the family planning program needs to expand its reach. Satisfying the unmet need for modern contraception will require a substantial increase in programmatic and financial support compared with current levels of effort.

CHAPTER X

CONTRACEPTIVE COUNSELING

In Georgia, most reproductive health services are provided by doctors who traditionally have received little training in providing client-oriented counseling. An important component of the newly developed reproductive health strategy is to develop family planning programs and train health professionals to provide family planning counseling, particularly postabortion and postpartum counseling. Although recent training efforts under the UNFPA's initiative included providers' training in contraceptive counseling, an official recommendation for counseling to be included in the standards of care for abortion and deliveries is still pending.

The 99GERHS included a series of questions designed to capture the interactions between family planning providers and their clients: specifically, the survey asked about the extent to which health professionals provided basic information and services to women who have used a modern contraceptive method or had an abortion or a birth during the five years prior to the interview.

10.1 Communication with Family Planning Providers

Women who have used at least one modern contraceptive method in the previous five years were asked who advised them to use their last modern method. If the advice came from a health care provider (physician, nurse, or midwife), they were asked if they received any information about other methods, including method-effectiveness and what side effects may be associated with its use. As shown in Table 10.1, almost 60% of women were advised by a health care provider to use her current or last modern method (58% by a physician and 1% by a nurse or midwife). A substantial proportion of women started using their last method at their own counsel (10%) or at the partner's suggestion (17%), bypassing any potential medical advice. In only 1% of cases the choice of the method was made at the suggestion of a pharmacist. In the remaining cases, the choice was suggested by a friend (8%) or a relative (5%).

IDP women were more likely than non-IDPs to receive advice about their contraceptive method from a physician (69% vs. 58%), probably because several family planning clinics supported by the humanitarian community were primarily targeting this population and they were slightly more

likely to be using IUDs.

The source of advice varied widely by last method used. Almost all IUD users and women with tubal ligation had chosen their method at the advice of a heath care provider (88% and 91%, respectively), but only 10% of condom users were advised by a physician or a nurse or a midwife. Most women who had used condoms did so because their partners suggested it (54%) or because they decided to do so themselves (18%). About one of two women (56%) were advised by a health care provider to use the pill or emergency contraception; the second most important source of advice for hormonal methods was a friend (20%).

It is important to know what type of advice these women received from health care providers, as the providers' interactions with their clients and the messages conveyed during these interactions can affect client satisfaction with services, continued use of services in the future, and correct method use. As shown in the bottom panel of Table 10.1 and Figure 10.1, only one of three women (34%) received general information about other contraceptive methods during provider-client interaction. Fewer women (31%) were counseled about the effectiveness of the method they were using compared with other methods. However, most women (70%) reported that the provider had explained possible side effects of the method chosen. IUD users were more likely to be counseled about potential side-effects than other users. Pill and condom users were more likely to be counseled about other contraceptive methods and their effectiveness, although the proportion who received

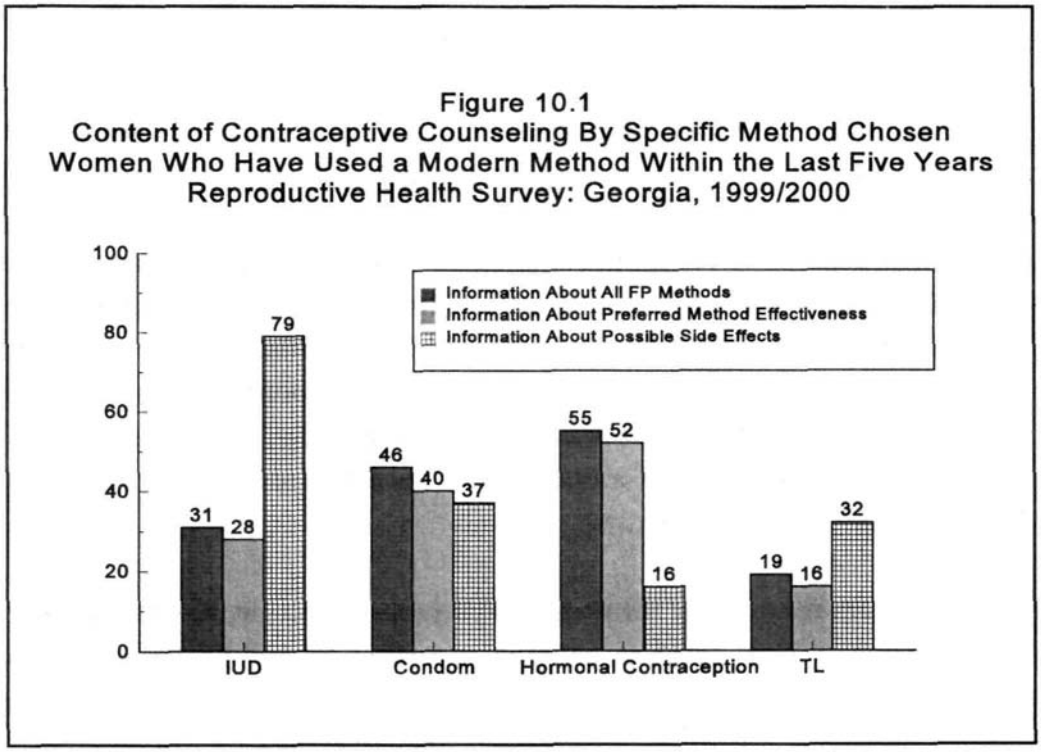


TABLE 10.1
Percent of Women Who Have Used a Modern Contraceptive Method Within the Past Five Years by Who Advised Them to Use the Specific Method and Type of Counseling Received from a Heath Care Provider
Reproductive Health Survey: Georgia, 1999/2000

			Last Used Contraceptive Method				
Who Advised User	**Total***	**IDP**	**Non-IDP**	**IUD**	**Condom**	**Hormonal Contraception†**	**Tubal Ligation**
Ob/Gyn‡	**58.1**	68.5	57.5	87.5	10.1	55.2	91.1
Partner	**16.7**	12.8	17.0	0.4	53.5	0.6	0.0
Nobody	**9.9**	9.5	9.9	6.5	17.8	8.3	3.7
Friend	**8.3**	7.3	8.4	2.3	13.0	20.2	2.6
Mother or Other Relative	**5.1**	1.4	5.3	2.8	4.6	11.6	0.0
Pharmacist	**1.1**	0.3	1.2	0.0	0.5	2.9	0.0
Nurse/Midwife	**0.5**	0.1	0.5	0.4	0.0	1.1	2.6
Other	**0.2**	0.0	0.3	0.0	0.5	0.0	0.0
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**1,553**	359	1,194	794	436	186	92
Type of Counseling	**Total§**	**IDP**	**Non-IDP**	**IUD**	**Condom**	**Hormonal Contraception**	**Tubal Ligation**
General Information About Other Methods	**34.0**	37.0	33.8	30.9	46.3	54.6	18.5
Information About Method's Effectiveness	**30.7**	33.8	30.5	27.5	39.6	52.0	15.8
Information About Possible Side Effects	**70.4**	74.1	70.2	79.3	36.6	61.9	32.2
Unweighted No. of Cases	**948**	243	705	700	43	103	85

* Includes 39 women who said they have used spermicides at the last intercourse.
† Includes women whose last method was either the pill, Postinor, or injectables.
‡ Includes also 5 women advised by general practitioners.
§ Includes only women who were advised by a health professional (an Ob/Gyn, general practitioner, nurse or midwife).

medical advice was low for condom users. Users of hormonal methods were more likely to make an informed choice, since 54% also received information about other methods, 51% were told about the method effectiveness, and 63% received information about possible side effects. Women who have been contraceptively sterilized were the least likely to have made an informed choice because substantially fewer of them received information about other methods, about contraceptive effectiveness of tubal ligation, and about possible side effects.

10.2 Satisfaction with Counseling Services

Women who have used a modern method in the past five years were asked about their satisfaction with the service provider (Table 10.2). Only little over one-third (36%) of modern method users were very satisfied and another 44% were satisfied. Almost one in six women was somewhat satisfied (16%) and 4% were dissatisfied. Satisfaction with counseling services at the time of choosing the last modern method varied little by women's background characteristics.

Although the differences are not statistically significant, women who were counseled about other birth control methods at the time of making their contraceptive decision were slightly more likely to be very satisfied than those who did not receive comprehensive counseling (40% vs. 34%). Similarly, counseling about method-specific effectiveness and side effects were associated with slightly higher satisfaction with counseling (see also Figure 10.2).

Figure 10.2

Satisfaction with Contraceptive Counseling BY Type of Counseling Received

Women Who Have Used a Modern Method Within the Last Five Years

Reproductive Health Survey: Georgia, 1999/2000

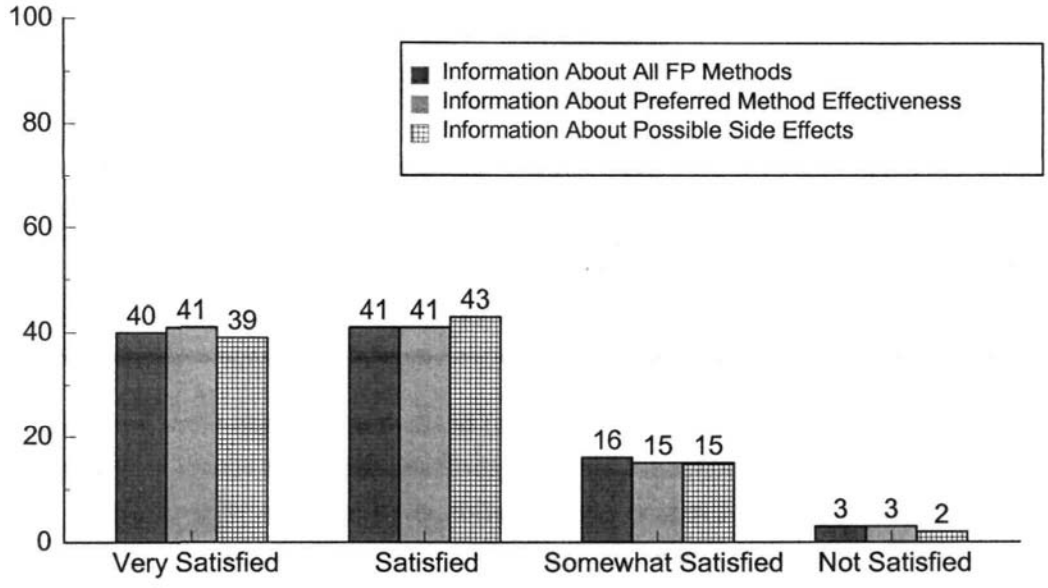


TABLE 10.2

Percent Distribution of Women By Their Satisfaction with Family Planning Services by Selected Characteristics

Women Who Have Used a Modern Contraceptive Method Since January 1994

Reproductive Health Survey: Georgia, 1999/2000

Characteristics	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied	Do Not Remember	Total	No. of Cases
Total	**35.8**	**44.1**	**15.8**	**3.8**	**0.4**	**100.0**	**948**
Residence							
Urban	37.1	41.1	17.8	3.4	0.6	100.0	608
Rural	34.0	48.5	13.0	4.5	0.0	100.0	340
Region							
Tbilisi	33.8	44.2	17.6	4.0	0.5	100.0	235
Imereti	36.0	40.0	19.4	4.0	0.6	100.0	221
North-East	32.9	42.5	19.2	4.7	0.7	100.0	145
South	35.6	51.2	7.1	6.0	0.0	100.0	92
West	39.8	44.8	13.4	2.0	0.0	100.0	255
Age Group							
15-24	31.5	47.3	17.6	3.6	0.0	100.0	115
25-34	33.7	45.4	16.2	4.7	0.0	100.0	441
35-44	39.6	41.7	14.8	3.0	0.9	100.0	392
Education Level							
Secondary Incomplete	42.5	36.7	10.2	10.5	0.0	100.0	50
Secondary Complete	35.6	47.5	12.6	3.8	0.4	100.0	289
University	35.3	43.3	17.7	3.3	0.4	100.0	609
Socioeconomic Status							
Low	36.9	45.0	13.3	4.8	0.0	100.0	342
Middle	35.8	42.6	17.3	3.8	0.4	100.0	458
High	34.6	47.2	14.7	2.9	0.6	100.0	148
IDP							
IDP	33.6	41.5	23.5	1.4	0.0	100.0	243
Non-IDP	36.0	44.3	15.3	4.0	0.4	100.0	705
Counseled About All Methods							
Yes	39.7	41.0	16.4	2.9	0.0	100.0	335
No	33.9	45.7	15.5	4.3	0.5	100.0	613
Discussed Efficacy of Methods							
Yes	41.4	41.0	14.8	2.9	0.0	100.0	303
No	33.4	45.6	16.3	4.3	0.5	100.0	645
Discussed Possible Side Effects							
Yes	39.0	43.2	15.4	2.2	0.2	100.0	685
No	28.4	46.4	16.7	7.7	0.8	100.0	263

10.3 Post-abortion Counseling

As shown in Chapters IV and V, about two-thirds of fecund women in union do not want an(more) children and a very high number of Georgian women resort to legal abortion to delay or avoid having children. Women who recently decided to terminate their pregnancies in abortion and did not adopt an effective contraceptive method afterwards are probably at high risk for another unintended pregnancy and represent an important group whose family planning needs have failed to be satisfied. A wide range of contraceptive methods, together with accurate information, and/or referral for ongoing family planning care should be made available and accessible to all women who have undergone abortions; both abortion providers and family planning health professionals should be able to offer contraceptive counseling and services. Unfortunately, most abortion providers in Georgia either fail to understand the value of postabortion counseling or lack the time and resources to provide this counseling.

In order to document the level and content of the postabortion counseling, all women who have had an abortion since January 1994 were asked if they received any family planning advice before or after the abortion procedure, if they received any contraceptive method or prescription for a method, and if they were referred to a family planning facility following the procedure. Family planning counseling or services offered pre or post-abortion were examined for all pregnancies terminated between January 1994 and November 1999. Table 10.3 shows that only 15% of women with induced abortions in this period had contraceptive counseling before or after the abortion procedure, and typically most of them were counseled only postabortion (8%). The percentage who received a contraceptive method or a prescription for contraceptives was considerably lower (3% and 1%, respectively). Very few women, less than one percent, who underwent abortion procedures were referred to a family planning facility postabortion.

There was not much variation in the proportion of women receiving post-abortion contraceptive counseling by women's background characteristics. Urban women were slightly more likely than rural women to have received pre- or post- abortion counseling (18% vs. 11%) or a contraceptive method (4% vs 2%). Residents of the North-East and the South regions and women of Azeri ethnic background had the lowest likelihood to have received counseling or supplies. Both contraceptive advice and being offered a contraceptive method increased directly with women's education and socioeconomic level. Post-abortion counseling increased slightly since the new family planning program sponsored by UNFPA was implemented in 1996. Women whose last abortion was performed in 1996-1997 and 1998-1999 were slightly more likely than those with earlier abortions to have been told by a health provider about methods of preventing pregnancy (15%-16% vs. 13%). Similarly, distribution of contraceptives post-abortion increased slightly among women with abortion outcomes between 1996-1999 (3%-4% vs. 2%). However, these increases are not statistically significant.

TABLE 10.3
Various Family Planning Services Offered at the Time of Legally Performed Abortions by Selected Characteristics
Legal Abortions Between January 1994–November 1999
Reproductive Health Survey: Georgia, 1999/2000

	Contraception Counseling				Distribution of Contraceptive Methods, Prescriptions for Methods or Referrals			
Characteristic	Total	Pre-Abortion	Post-Abortion	Pre and Post Abortion	Offered a Method	Offered Prescription	Offered Referral	No. of Cases
Total	**15.2**	**3.0**	**8.4**	**3.8**	**3.3**	**1.3**	**0.2**	**4,845**
Residence								
Urban	18.0	3.9	9.4	4.7	3.9	1.6	0.3	2,904
Rural	11.3	1.8	7.0	2.5	2.4	0.8	0.1	1,941
Region								
Tbilisi	18.7	5.3	10.0	3.4	3.3	1.8	0.5	1,283
Imereti	20.0	3.7	8.4	7.9	6.4	1.2	0.1	972
North-East	10.1	1.6	6.0	2.5	2.3	0.4	0.1	973
South	11.1	2.3	7.0	1.8	1.5	0.4	0.0	693
West	15.1	1.2	9.9	4.0	3.0	2.3	0.0	924
Age Group								
15–24	14.8	3.0	8.2	3.6	2.6	1.5	0.2	1,354
25–34	16.0	3.0	9.4	3.6	3.9	1.3	0.2	2,562
35–44	13.1	3.0	5.9	4.2	2.6	0.9	0.1	929
Education Level								
Secondary Incomplete	9.0	2.2	3.7	3.1	1.3	0.5	0.0	391
Secondary Complete	12.9	1.6	8.8	2.5	3.3	1.1	0.4	1,662
Technicum	16.9	3.3	9.1	4.5	3.4	1.6	0.1	1,515
University	17.8	4.6	8.5	4.7	3.6	1.3	0.0	1,277
Socio-economic Status								
Low	10.7	2.0	5.8	2.9	2.5	1.4	0.0	1,906
Middle	17.1	3.3	10.0	3.8	3.5	1.0	0.2	2,388
High	17.7	4.2	7.8	5.7	4.0	1.9	0.7	551
Ethnicity								
Georgian	16.0	3.0	8.8	4.2	3.7	1.3	0.1	4,075
Azeri	6.5	2.0	4.5	0.0	1.4	0.2	0.0	403
Armenian	13.2	5.9	5.3	2.0	0.4	1.6	0.0	228
Other	23.4	0.6	14.0	8.8	3.0	3.2	3.0	139
IDP Status								
IDP	13.8	3.7	7.0	3.1	3.0	0.9	0.0	876
Non-IDP	15.2	3.0	8.4	3.8	3.3	1.3	0.2	3,969
Year of Abortion								
1994–1995	12.8	2.9	6.8	3.1	2.4	0.8	0.0	1,211
1996–1997	15.1	3.5	8.3	3.3	3.4	1.5	0.1	1,729
1998–1999	16.4	2.5	9.3	4.6	3.6	1.3	0.3	1,905

CHAPTER XI

ATTITUDES AND OPINIONS ABOUT CONTRACEPTION

Thanks to recent efforts by a number of international donors and the Georgian Ministry of Health (MOH), both the access to a wider range of modern methods and the delivery of adequate information on modern contraception have improved recently. For example, between 1996-1999, the UNFPA implemented a comprehensive reproductive health (RH) program in Georgia. The main objectives of the program were to assist MOH in developing IEC messages (aimed at promoting contraception use and increasing knowledge on HIV/AIDS and other STDs), to extend access to RH services, including family planning services, and to implement a management information system (MIS) in RH. Under this program, approximately 40 family planning clinics were created all over the country. Brochures, posters and other information materials promoting modern contraceptive methods and STD prevention were published, and RH training courses, including contraceptive technology, were organized. Since 1996, UNFPA provided condoms, IUDs and pills to be distributed through NGOs, WCC, and maternity houses under the control of the MCH department of the MOH. The previous chapters, however, have shown that Georgian women, despite their relatively high awareness of various contraceptive methods, have a low level of knowledge about how methods are used and how effective these methods are. As such, it is important to know in more detail how their level of knowledge influences their attitudes and opinions about contraception and ultimately their contraceptive practices.

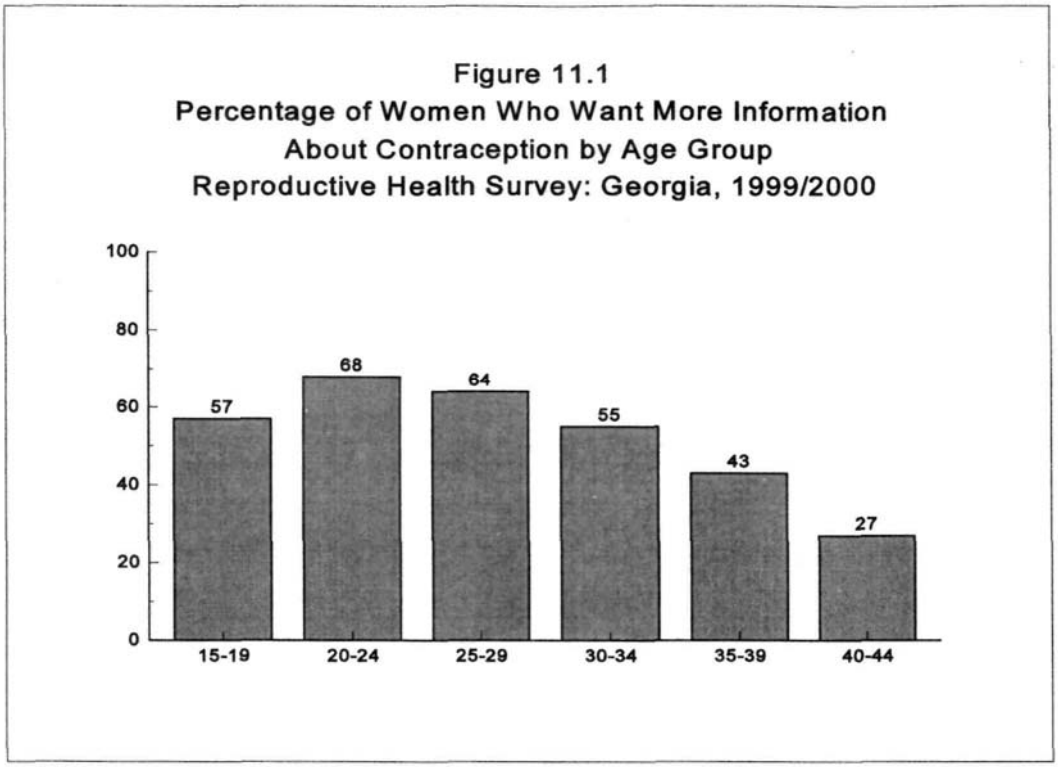
Respondents were asked about their interest in obtaining information about contraceptive methods, the most appropriate information sources, their perception of health risks related to pill, IUD and condom use as well as having an abortion, and the advantages and disadvantages of contraceptive use.

11.1 Interest in More Information on Contraception

A survey objective was to determine which population subgroups are not well informed about contraception, what information is missing and what could be done to target those subgroups with Information, Education and Communication (IEC) activities.

TABLE 11.1
Percentage of Women Who Want More Information about Contraception by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Women Who Want More Information	
	%	N
Total	**53.0**	**7,798**
Residence		
Tbilisi	58.0	2,029
Other Urban	55.8	2,730
Rural	48.1	3,039
Age Group		
15–19	57.4	1,142
20–24	68.0	1,246
25–29	63.7	1,312
30–34	55.2	1,419
35–39	43.0	1,523
40–44	27.3	1,156
Marital Status		
Currently Married or In Union	52.7	5,117
Previously Married or In Union	33.1	517
Never Married or In Union	57.1	2,104
No. of Living Children		
None	56.4	2,598
One	59.7	1,316
Two	51.3	2,737
Three or More	40.6	1,147
Education Level		
Secondary Incomplete	42.9	991
Secondary Complete	52.8	2,664
Technicum	51.6	2,058
University	60.9	2,085
Ethnicity		
Georgian	55.9	6,700
Azeri	29.2	589
Armenian	45.5	300
Others	63.4	209
Current Use of Contraception		
IUD	56.7	551
Condom	72.6	317
Tubal Ligation	16.3	92
Pill	70.5	48
Other Modern Methods	78.3	59
Withdrawal	60.8	560
Calendar	56.8	509
None	50.8	5,662



The relatively low level of interest in additional information on contraception is a matter of concern. In Moldova and Romania, countries with a significantly higher contraceptive prevalence (74% and 64%), the interest for additional information on contraception was 75% and 72%, respectively (Serbanescu et al. 1998 and 2001). Overall, only one of two women (53%) wanted more information on contraception (Table 11.1). A greater proportion of women under the age of 35 (55%-68%), desired more information on contraceptives compared to those aged 35 or older (27%-43%). Higher proportions of women never in union and with no children, who were mostly young women, desired more information on contraception. The desire for more information on contraception was also higher among women with a university education (61%), Georgian women, and users of the pill and condom.

As shown in Chapter VII the main source of information about contraceptive methods was a friend or an acquaintance, whereas a physician was mentioned as a source of information by only one in ten women. Women's knowledge about using specific modern methods varied from 62% of women who knew how the IUD and condom could be used, to 30% who knew how to use the pill or how female sterilization protects against unintended pregnancy, and less than 3% who knew how injectables could be used. The majority of women did not know or had misinformation about the most effective contraceptive methods (i.e., male and female sterilization, injectables). It is somewhat surprising that, given the current level of knowledge about contraceptive options and their effectiveness, the desire for additional information is not stronger.

TABLE 11.2

Women's Opinion on Which Source of Contraception Information Is Most Reliable
Women 15–44 Who Want to Have More Information about Contraception
by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Gynecologist	Mass Media	Books	Friends	Mother/ Relatives	Contraceptive User	Husband/ Partner	Other	Total	No. of Cases
Total	**45.9**	**36.2**	**8.5**	**2.8**	**2.4**	**1.7**	**1.0**	**1.6**	**100.0**	**4,126**
Residence										
Tbilisi	39.8	43.9	7.8	3.3	1.8	0.8	1.3	1.3	100.0	1,178
Other Urban	49.9	32.5	8.8	2.1	2.5	1.7	0.4	2.1	100.0	1,462
Rural	47.1	33.6	8.8	2.9	2.8	2.5	1.1	1.3	100.0	1,486
Age Group										
15–19	29.9	34.9	11.5	7.4	8.4	2.8	1.9	3.8	100.0	686
20–24	50.2	33.0	7.4	2.1	1.6	2.7	1.6	1.4	100.0	872
25–29	49.8	35.7	8.5	2.1	1.1	1.4	0.5	0.9	100.0	843
30–34	53.1	36.0	7.2	1.1	0.3	1.5	0.0	0.9	100.0	802
35–39	50.1	38.9	8.3	0.8	0.0	0.4	0.5	1.0	100.0	645
40–44	47.2	45.8	6.3	0.0	0.3	0.0	0.3	0.0	100.0	278
Marital Status										
Currently Married/In Union	54.7	35.9	5.1	0.8	0.7	1.1	1.1	0.7	100.0	2,733
Formerly Married/In Union	49.3	39.2	7.3	3.6	0.0	0.0	0.0	0.7	100.0	157
Never Married/ In Union	30.6	36.4	14.3	6.0	5.7	3.0	0.9	3.2	100.0	1,236
Education Level										
Secondary Incomplete	36.8	27.9	9.1	6.1	9.9	3.2	2.6	4.5	100.0	442
Secondary Complete	45.7	37.0	7.4	3.5	1.9	1.8	0.8	2.0	100.0	1,371
Technicum	52.5	36.4	5.2	1.9	0.9	1.7	0.9	0.6	100.0	1,054
University	45.1	38.9	12.0	1.2	0.8	1.1	0.5	0.5	100.0	1,259
No. of Living Children										
None	32.9	36.5	13.2	5.4	5.3	2.9	1.2	2.7	100.0	1,488
One	57.6	31.0	6.5	1.6	0.6	0.9	1.2	0.7	100.0	779
Two	54.8	37.9	4.6	0.4	0.2	0.8	0.8	0.5	100.0	1,400
Three or More	53.4	38.2	4.4	0.8	0.4	1.3	0.2	1.3	100.0	459
Current Use of Contraception										
IUD	63.4	31.3	2.7	1.1	0.0	0.4	0.0	0.7	100.0	315
Condom	54.5	38.6	6.4	0.0	0.0	0.0	3.3	0.0	100.0	236
Pill	67.3	30.0	0.0	0.0	0.0	2.8	0.0	0.0	100.0	33
Other Mod. Methods	45.8	41.6	9.2	3.4	0.0	0.0	0.0	0.0	100.0	61
Withdrawal	55.9	33.8	4.8	1.2	0.7	2.4	0.3	0.9	100.0	335
Calendar	51.6	39.5	6.3	0.4	0.0	1.1	1.1	0.0	100.0	287
None	41.9	36.4	9.8	3.5	3.3	2.0	1.2	2.0	100.0	2,859

11.2 Opinions Regarding the Most Reliable Source of Information about Contraception

Respondents were asked what they considered to be the most reliable source of information on contraception. The sources mentioned can be grouped into two major categories: medical sources, that is gynecologists, and nonmedical sources (mass media, parents, books, friends, spouse or partner, etc.). Almost half of women (46%) considered the most appropriate source of information about contraception to be gynecologists (Table 11.2). Except for women under the age of 20, among whom books, their mother, relatives and friends were also an important source of information, this was largely true regardless of socio-economic characteristics. Exceptions were university educated women, for whom books were an important source, and women who did not complete secondary school, for whom their mother, relatives and friends were also an important source. However, a certain percentage of the latter group may be women under the age of 20 still in secondary school. Although all respondents regarded the gynecologist as having the central role in disseminating reliable contraceptive information, IUD and the pill users were more likely to find a gynecologist the most reliable source of information than non-users (63% and 67% vs. 42%).

11.3 Women's Opinions on the Advantages and Disadvantages of Using the Pill and IUD

Respondents who have heard of these methods were asked to agree or disagree with several statements referring to possible advantages and disadvantages of using the pill and the IUD.

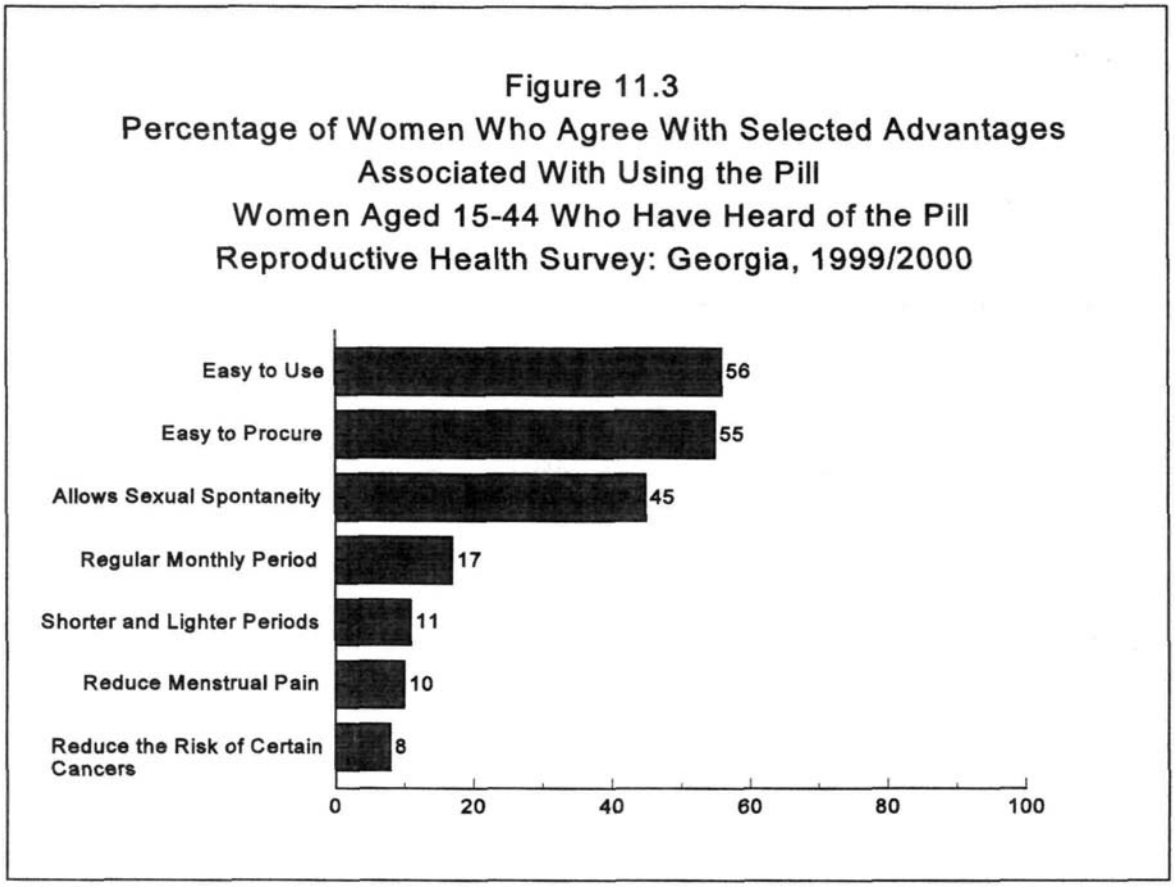
The organization and functioning of family planning services, the geographical and financial accessibility to modern family planning methods, and access to information are factors that may influence women's opinions about the advantages and disadvantages of the different modern contraceptive methods. As a general observation, the percentage of women identifying the advantages of the pill and the IUD was higher in urban areas and among women with more education (Tables 11.3.1 and 11.3.2). This was also true to a lesser extent for the disadvantages of using these methods. Also, women recognized to a greater extent those advantages and disadvantages that could be identified on the basis of general knowledge and to a lesser extent those advantages and disadvantages that required an in-depth knowledge of reproductive physiology and the pharmacology of the pill and IUD.

As shown in Table 11.3.1 and Figure 11.3.1, the advantages most frequently identified for the pill were: "easy to use"and "easy to procure", which were mentioned by more than half (55%-56%) of women who know of the pill. Also, almost half (45%) of these women thought pill use " allows spontaneous intercourse". These proportions were higher in urban areas and among better educated women. Only 17% or less of women agreed that the pill makes menstrual periods

more regular and reduce menstrual bleeding and pain, while less than 10 % agreed that pills "decrease the risk of getting certain cancers". The most frequently mentioned disadvantage of using pills, mentioned by 40% of women who know of the pill, was that remembering to take a pill every day is stressful. About 30% of women who know of the pill, mentioned that pill use may cause weight gain. Less than 15% of women who know of the pill considered the high price of the pill or that it is "bad for blood circulation" (cardio-vascular system) as disadvantages.

TABLE 11.3.1
Percentage of Women Who Agree With Selected Statements Concerning Advantages and Disadvantages Associated With Using the Pill Women 15–44 Who Have Heard of the Pill by Residence and Education Reproductive Health Survey: Georgia, 1999/2000

	Total	Residence		Education Level			
STATEMENTS		**Urban**	**Rural**	**Secondary Incomplete**	**Secondary Complete**	**Technicum**	**University**
Advantages							
Pills Easy To Use	56.4	59.9	50.0	39.9	55.4	55.0	62.4
Pills Easy To Procure	55.2	59.3	47.8	32.6	53.1	55.6	62.3
Allows Spontaneous Intercourse	45.4	48.1	40.4	30.4	41.3	45.7	52.4
Pills Regularize Menstrual Periods	17.1	18.5	14.7	5.9	14.8	18.0	21.2
Pills Reduce Menstrual Bleeding	10.8	11.4	9.8	6.4	9.1	11.2	13.1
Pills Reduce Menstrual Pain	10.0	10.5	9.0	6.1	7.9	10.7	12.2
Decreases Risk of Certain Cancers	8.4	9.0	7.3	4.8	7.4	8.1	10.3
Disadvantages							
Daily Use Stressful To Remember	39.5	41.7	35.4	29.4	35.7	42.2	43.0
Pills May Cause Weight Gain	30.7	33.1	26.3	15.0	26.4	32.2	37.1
Pills Too Expensive	13.8	13.8	13.8	8.3	13.6	15.7	13.9
Pills Bad For Cardio-Vascular System	9.9	9.9	10.0	4.8	6.7	12.2	12.0
Number of Cases	5,470	3,724	1,746	376	1,644	1,623	1,827



The IUD, the most widely used modern method in Georgia, is used by 10% of women in union, though 71% said they know how it is used and 70% know where to procure it (see Chapter VIII). As regards advantages: 46% of women said they considered that the IUD "increases the pleasure of intercourse because one does not have to worry about pregnancy"; 44% said that the IUD should be "easy to use"; 43% said that "it is relatively inexpensive" and 13% perceive the IUD as a means to "reduce the risk of an ectopic pregnancy."

Of women who know of the IUD, about two in five are aware of the increased risk of pelvic inflammatory disease when using the IUD, while only one-fourth agree that it may cause menstrual bleeding problems and one-fifth that it may increase menstrual pain. For both advantages and disadvantages of IUD use, awareness is slightly greater in urban areas and much greater among better educated women.

TABLE 11.3.2
Percentage of Women Who Agree With Selected Statements Concerning Advantages and Disadvantages Associated With Using an IUD Women 15–44 Who Have Heard of the IUD by Residence and Education Reproductive Health Survey: Georgia, 1999/2000

	Total	Residence		Education Level			
STATEMENTS		**Urban**	**Rural**	**Secondary Incomplete**	**Secondary Complete**	**Technicum**	**University**
Advantages							
Increases Sexual Pleasure Since Ends Pregnancy Concerns	46.2	48.8	42.5	34.0	41.9	50.8	52.8
IUD Easy To Use	44.1	46.0	41.4	26.7	41.8	49.1	50.6
IUD Relatively Inexpensive	43.3	44.6	41.4	22.3	39.1	50.3	52.0
Decreases Risk of Ectopic Pregnancy	13.3	14.5	11.6	6.3	11.7	14.4	17.5
Disadvantages							
Increased Risk Of Pelvic Inflammatory Disease	38.6	40.2	36.5	21.5	36.6	43.9	44.5
IUD May Cause Irregular Bleeding	27.6	29.5	25.0	11.3	25.3	33.7	32.7
IUD May Increase Menstrual Blood Loss	26.8	28.7	24.2	10.1	24.3	33.2	31.9
IUD May Increase Painful Menstruation	19.6	20.1	18.9	7.6	18.8	24.1	22.2
Number of Cases	7,395	3,753	2,587	778	2,517	2,041	2,059

In general, the proportion of women who know of the advantages of the pill and the IUD is relatively low (see Tables 11.3.1 and 11.3.2). Clearly, then, there is a need for IEC efforts to increase knowledge about the long-term effectiveness of both methods, since over three-fourths of women in union with two or more children do not want more children but 40% of women who have heard of the pill think taking a pill every day is onerous. Women must also be educated to a greater extent about each method's advantages and disadvantages to increase their ability to make informed choices about modern contraceptive use.

11.4 Opinions on Risks to Women's Health Due to Contraceptive Use

The low use of modern contraceptive methods in Georgia could be due to women's and men's perceptions of the risks to a woman's health associated with contraceptive use. The risk to a woman's health associated with the use of the three modern contraceptive methods most frequently used by Georgian women, the pill, the IUD and the condom, were evaluated by respondents on a scale including "no risk", "low risk", "medium risk" and "high risk" (see Tables 11.4.1,11.4.2, and 11.4.3 and Figure 11.4).

When asked about the health risk of these three methods, high proportions of women did not know whether or not the methods posed a health risk to woman's health (25%-47%). Only between 2% of women thought there was no risk in using an IUD and 6% thought there was no risk in pill use. However, users of these methods were less likely to be ignorant about their method or to perceive that the method used as harmful. For example, only 4% of IUD users, 2% of pill users and 1% of condom users did not know about the health risk of their method. Similarly, those currently using IUD, pills, or condoms were more likely to answer that their method posed no risk to a woman's health.

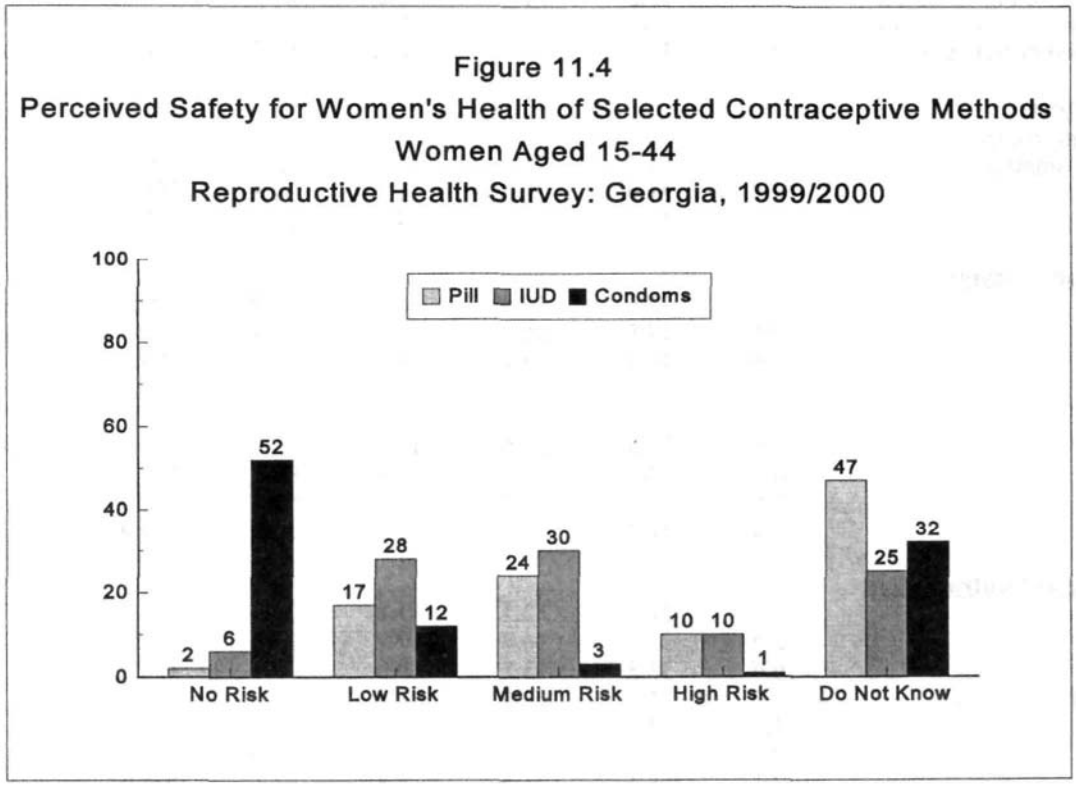


TABLE 11.4.1
Percent Distribution of Women's Opinion of Degree of Risk That Women's Health Will Be Affected by Using the Pill by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	No Risk	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	2.3	17.1	24.4	9.5	46.7	100.0	7,798
Residence							
Tbilisi	3.4	18.9	33.5	12.9	31.4	100.0	2,029
Other Urban	1.8	21.2	26.0	9.3	41.7	100.0	2,730
Rural	2.0	13.3	17.9	7.7	59.2	100.0	3,039
Age Group							
15–19	1.0	8.5	11.7	3.6	75.2	100.0	1,142
20–24	2.4	17.5	24.0	9.1	47.0	100.0	1,246
25–29	3.5	19.5	26.3	12.3	38.5	100.0	1,312
30–34	2.4	21.3	31.1	11.0	34.2	100.0	1,419
35–39	2.1	19.7	30.3	11.5	36.4	100.0	1,523
40–44	2.8	18.1	25.6	11.5	42.1	100.0	1,156
Marital Status							
Currently Married or In Union	2.4	19.3	28.0	11.2	39.1	100.0	5,177
Previously Married or In Union	2.2	20.2	25.7	10.0	42.0	100.0	517
Never Married or In Union	2.1	12.5	17.5	6.4	61.5	100.0	2,104
Education Level							
Secondary Incomplete	1.1	8.1	7.5	2.0	81.4	100.0	991
Secondary Complete	2.1	13.6	21.1	8.1	55.2	100.0	2,664
Technicum	2.5	21.9	29.6	11.2	34.8	100.0	2,058
University	3.2	22.9	34.6	14.8	24.7	100.0	2,085
Socio-Economic Status							
Low	1.7	12.9	17.4	6.2	61.8	100.0	3,276
Medium	2.6	18.8	26.2	10.3	42.1	100.0	3,654
High	2.6	20.4	33.7	14.6	28.7	100.0	868
Ethnicity							
Georgian	2.6	18.8	26.6	10.7	41.4	100.0	6,700
Azeri	0.3	3.4	4.2	1.5	90.7	100.0	589
Armenian	2.8	13.1	21.7	4.0	58.5	100.0	300
Other	1.4	22.0	33.1	11.7	31.9	100.0	209
Current Use of Contraception							
IUD	0.9	21.3	32.1	11.8	34.0	100.0	551
Condom	3.5	27.1	36.7	17.9	14.8	100.0	317
Pill	16.4	38.3	43.2	0.0	2.2	100.0	48
Other Modern Methods	9.0	41.0	25.9	1.3	22.8	100.0	151
Withdrawal	1.8	20.6	21.5	7.9	48.2	100.0	560
Calendar	2.7	14.8	42.6	16.4	23.6	100.0	509
None	2.1	15.4	21.7	8.8	52.1	100.0	5,662

TABLE 11.4.2
Percent Distribution of Women's Opinion of Degree of Risk That Women's Health Can Be Affected by Using An IUD by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	No Risk	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	6.2	28.4	30.2	10.4	24.9	100.0	7,798
Residence							
Tbilisi	6.2	24.5	35.4	13.8	20.2	100.0	2,029
Other Urban	6.6	33.3	31.0	9.9	19.2	100.0	2,730
Rural	6.0	27.3	26.5	8.7	31.6	100.0	3,039
Age Group							
15–19	4.6	18.1	16.6	5.2	55.5	100.0	1,142
20–24	8.1	32.1	28.6	8.7	22.5	100.0	1,246
25–29	6.7	31.5	34.1	10.5	17.2	100.0	1,312
30–34	5.9	31.2	35.1	13.3	14.4	100.0	1,419
35–39	7.1	30.9	34.7	13.1	14.2	100.0	1,523
40–44	4.9	28.4	35.6	12.9	18.3	100.0	1,156
Marital Status							
Currently Married or In Union	7.3	31.0	33.7	11.8	16.2	100.0	5,177
Previously Married or In Union	4.9	28.0	33.9	14.9	18.4	100.0	517
Never Married or In Union	4.5	23.6	23.0	7.0	42.0	100.0	2,104
Education Level							
Secondary Incomplete	5.3	17.2	16.0	4.9	56.6	100.0	991
Secondary Complete	6.2	28.1	28.8	9.4	27.5	100.0	2,664
Technicum	7.3	31.7	34.9	12.5	13.6	100.0	2,058
University	5.8	32.8	36.6	13.3	11.5	100.0	2,085
Socio-Economic Status							
Low	5.9	26.9	25.3	7.4	34.5	100.0	3,276
Medium	6.2	29.2	31.6	12.0	21.1	100.0	3,654
High	7.1	28.6	35.9	11.3	17.1	100.0	868
Ethnicity							
Georgian	6.4	29.0	32.2	11.2	21.3	100.0	6,700
Azeri	3.9	17.9	16.2	5.7	56.4	100.0	589
Armenian	7.2	33.2	20.9	8.1	30.7	100.0	300
Other	8.1	38.1	33.4	6.6	13.9	100.0	209
Current Use of Contraception							
IUD	23.4	51.3	20.4	1.4	3.5	100.0	551
Condom	3.5	29.1	46.8	17.3	3.3	100.0	317
Pill	2.1	32.2	33.5	10.1	22.1	100.0	48
Other Modern Methods	5.3	39.9	36.6	10.3	7.9	100.0	151
Withdrawal	5.0	32.3	36.5	11.9	14.4	100.0	560
Calendar	3.0	25.9	46.1	20.2	4.8	100.0	509
None	5.4	26.1	28.0	9.8	30.7	100.0	5,662

TABLE 11.4.3
Percent Distribution of Women's Opinion of Degree of Risk That Women's Health Can Be Affected by Using Condoms by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	No Risk	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	52.1	12.2	3.1	0.6	32.2	100.0	7,798
Residence							
Tbilisi	65.9	13.1	2.5	0.6	18.0	100.0	2,029
Other Urban	59.1	11.9	2.9	0.5	25.6	100.0	2,730
Rural	39.0	11.8	3.5	0.6	45.1	100.0	3,039
Age Group							
15–19	31.1	6.8	3.7	0.5	58.0	100.0	1,142
20–24	55.0	12.4	3.9	0.4	28.3	100.0	1,246
25–29	62.1	12.1	2.1	0.6	23.2	100.0	1,312
30–34	59.2	13.9	2.7	1.0	23.1	100.0	1,419
35–39	56.5	15.1	2.5	0.7	25.2	100.0	1,523
40–44	53.6	13.9	3.2	0.3	29.0	100.0	1,156
Marital Status							
Currently Married or In Union	56.9	14.1	2.6	0.6	25.8	100.0	5,177
Previously Married or In Union	54.4	12.8	4.7	0.2	27.8	100.0	517
Never Married or In Union	42.9	8.5	3.5	0.5	44.6	100.0	2,104
Education Level							
Secondary Incomplete	24.7	6.8	3.1	0.4	65.0	100.0	991
Secondary Complete	46.6	12.8	3.9	0.6	36.0	100.0	2,664
Technicum	57.6	14.9	3.1	0.6	23.8	100.0	2,058
University	71.4	12.3	1.9	0.6	13.8	100.0	2,085
Socio-Economic Status							
Low	39.1	12.0	2.6	0.6	27.5	100.0	3,276
Medium	56.0	12.5	3.4	0.5	27.7	100.0	3,654
High	67.7	11.4	2.8	0.7	17.5	100.0	868
Ethnicity							
Georgian	56.6	12.3	3.0	0.6	27.5	100.0	6,700
Azeri	12.9	8.9	3.3	0.3	74.6	100.0	589
Armenian	47.6	13.5	5.0	0.6	33.4	100.0	300
Other	61.3	16.2	1.7	0.0	20.8	100.0	209
Current Use of Contraception							
IUD	63.8	15.4	1.5	0.2	19.1	100.0	551
Condom	90.0	8.3	0.3	0.0	1.4	100.0	317
Pill	61.7	14.1	6.2	2.1	16.0	100.0	48
Other Modern Methods	64.4	10.8	3.8	0.1	21.0	100.0	151
Withdrawal	54.6	14.9	3.6	0.6	26.3	100.0	560
Calendar	64.5	18.3	3.1	0.4	13.7	100.0	509
None	47.6	11.4	3.2	0.6	37.2	100.0	5,662

Among the two-thirds of respondents who had an opinion regarding the health risk of using pills, the greatest proportion thought that using the pill posed a "medium risk" to women's health. This was true among those who had an opinion, regardless of socio-economic grouping. However, as mentioned above, it should be noted that there were significantly higher percentages of respondents who "don't know" whether pill use posed a health risk in rural areas and among respondents in lower educational and socio-economic level groups. This reinforces the earlier statement that IEC efforts regarding the characteristics of the pill and other methods must be increased and should target these groups.

A lower proportion of respondents, one in four, "don't know" whether using an IUD posed a health risk for women. Of those who did have an opinion, the greatest proportions of women thought that using an IUD posed a "low risk" or a "medium risk" to women's health. Similar to the pill, this was true among all those who had an opinion about the IUD, regardless of socio-economic grouping, except among women who reported IUD use, among whom the greatest proportion thought that using the IUD posed "no risk" or a "low risk" to women's health. As for the pill, there were higher percentages of women who "don't know" whether IUD use posed a health risk in rural areas and among respondents in lower educational and socio-economic level groups.

Those who "don't know" the advantages and disadvantages of using contraceptive methods and the level of risk of use to a woman's health should constitute "the target population" for future IEC activities of family planning programs. Increasing the percentage of persons informed about the benefits and risks associated with the use of contraceptive methods may lead to an increase in the number of modern contraceptives users, lowering the risk of unintended pregnancies.

11.5 Opinions on Risks to Women's Health Due to Abortion

Abortion is accepted in Georgian society as a means of avoiding births resulting from unintended pregnancies (See Chapter V). Changes in behavior related to the use of contraceptive methods instead of abortion as a means of terminating an unintended pregnancy should be an important program intervention. The solution would not lie in restricting abortion, but in increasing the Georgian population's awareness of effective contraceptive methods as the data in Tables 11.5 show that one in two women men consider abortion to be of high risk to women's health.

As shown in Table 11.5, 50% of women considered abortion to pose a "high risk" to a woman's health. These percentages were somewhat lower among women with less education, those who are members of the Azeri ethnic group and those under the age of 20. These results show that abortion is used in spite of opinions that it poses important health risks to the woman and suggest that Georgian women do not necessarily resort to abortion because they prefer it to effective contraception.

TABLE 11.5
Percent Distribution of Women's Opinion of Degree of Risk That Women's Health Can Be Affected by an Abortion by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	No Risk	Low Risk	Medium Risk	High Risk	Don't Know	Total	No. of Cases
Total	0.7	5.4	24.7	50.4	18.9	100.0	7,798
Residence							
Tbilisi	0.4	3.3	21.5	60.2	14.6	100.0	2,029
Other Urban	0.6	5.1	28.2	51.2	15.0	100.0	2,730
Rural	1.0	6.7	24.1	44.1	24.1	100.0	3,039
Age Group							
15–19	1.2	4.8	17.9	31.0	45.1	100.0	1,142
20–24	0.6	5.8	25.0	50.7	17.9	100.0	1,246
25–29	0.9	4.4	26.7	56.3	11.7	100.0	1,312
30–34	0.3	5.3	26.9	56.5	11.0	100.0	1,419
35–39	0.7	6.4	27.4	56.3	9.2	100.0	1,523
40–44	0.4	5.3	25.6	56.8	11.9	100.0	1,156
Marital Status							
Currently Married or In Union	0.4	6.1	27.6	54.5	11.4	100.0	5,177
Previously Married or In Union	1.4	5.7	28.3	51.1	13.5	100.0	517
Never Married or In Union	1.1	4.0	18.7	42.8	33.5	100.0	2,104
Education Level							
Secondary Incomplete	1.2	4.6	16.9	32.3	44.9	100.0	991
Secondary Complete	0.5	7.0	27.0	44.7	20.9	100.0	2,664
Technicum	0.8	5.3	26.2	57.7	10.1	100.0	2,058
University	0.6	3.9	25.2	62.6	7.8	100.0	2,085
Socio-Economic Status							
Low	0.9	4.8	23.8	44.1	26.4	100.0	3,276
Medium	0.6	5.8	25.4	52.6	15.6	100.0	3,654
High	0.8	5.0	23.8	56.7	13.7	100.0	868
Ethnicity							
Georgian	0.7	4.9	25.6	53.3	15.4	100.0	6,700
Azeri	0.4	5.0	17.5	27.4	49.7	100.0	589
Armenian	1.1	15.3	19.3	44.1	20.2	100.0	300
Other	0.0	3.5	29.2	55.1	12.2	100.0	209
Current Use of Contraception							
IUD	0.5	4.4	32.1	56.3	6.7	100.0	551
Condom	0.0	4.6	26.3	65.9	3.3	100.0	317
Pill	0.0	0.0	32.1	62.0	6.0	100.0	48
Other Modern Methods	2.2	8.6	30.2	53.9	5.1	100.0	151
Withdrawal	0.0	9.1	29.8	57.2	3.9	100.0	560
Calendar	0.2	4.9	31.4	59.9	3.7	100.0	509
None	0.8	5.2	22.8	47.6	23.6	100.0	5,662

CHAPTER XII

REPRODUCTIVE HEALTH ATTITUDES

Georgia's reproductive and birth control patterns have shared similar features with Russia and other countries of the former Soviet Union. Fertility decreased sharply, to below replacement levels, while induced abortion has been the main method of fertility control and modern contraceptives have been underutilized. The relative isolation of the U.S.S.R. from the contraceptive advancements in Western countries affected both the knowledge about and the availability of high-quality contraceptive methods. Compounded by ignorance and fatalistic attitudes toward health issues, and the availability of and high tolerance for pregnancy termination, there was high reliance on induced abortion as the principal means of birth prevention (Remennick L, 1991, Popov A, 1996). These patterns were further shaped by a conservative position toward premarital sexual experience and childbearing, lack of sex education in school, and traditional views about gender roles.

In addition to exploring attitudes about family size and induced abortion, the 99GERHS also included questions related to the attitudes that surround reproductive decision-making, pregnancy resolution, and gender roles in Georgia. The results of questions on these topics should prove useful for developing and modifying elements of reproductive health education programs and curricula.

12.1 Ideal Family Size

Respondents were asked their opinion regarding the "ideal" number of children for a young family in Georgia. This question is meant to explore general attitudes of reproductive-age women and not their personal decisions about ideal family size. Table 12.1 shows the overall mean ideal number of children to be 2.8. This figure contrasts with the total fertility rate in Georgia of 1.7 births per woman (see Chapter IV), which means that in an ideal situation, women of reproductive age would prefer having one child more than they actually have or will have. This difference is, no doubt, due to economic and social constraints which cause women to limit their family size in practice.

TABLE 12.1

Mean Ideal Number of Children for a Young Family in Georgia, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Mean Ideal Number of Children	No. of Cases*
Total	**2.8**	**7,507**
Residence		
Tbilisi	2.7	1,973
Other Urban	2.7	2,609
Rural	2.8	2,925
Age Group		
15-19	2.7	1,100
20-24	2.7	1,209
25-29	2.7	1,260
30-34	2.8	1,362
35-39	2.9	1,470
40-44	2.9	1,106
Marital Status		
Currently Married or In Union	2.8	5,009
Previously Married or In Union	2.7	492
Never Married or In Union	2.7	2,006
Education Level		
Secondary Incomplete	2.8	937
Secondary Complete	2.8	2,561
Technicum	2.8	1,993
University	2.7	2,016
Number of Living Children		
None	2.7	2,480
One	2.6	1,275
Two	2.8	2,659
Three or More	3.1	1,093
Socio-Economic Status		
Low	2.8	3,137
Medium	2.8	3,533
High	2.7	837
Ethnicity		
Georgian	2.8	6,479
Azeri	2.8	540
Armenian	2.7	294
Other	2.5	194
IDP Status		
IDP	2.8	1,767
Non-IDP	2.8	5,740

* Excludes 298 women who answered "How many God wants", "As many as possible" and other non-numeric responses.

In answering this question, respondents may have been influenced by their personal experience, as the reported ideal mean number of children was somewhat higher among women with three or more children (3.1 children), compared to the mean ideal number of children among women with less than three living children (2.8 children or less).

12.2 Knowledge of the Menstrual Cycle

Due to the relatively small proportion of Georgians who have been exposed to sex education, the survey examined respondents' knowledge of basic concepts regarding reproduction and fertility. Table 12.2 shows respondents' opinions as to when during the menstrual cycle a woman is most likely to get pregnant—one of the most common indicators for evaluating sex education.

Forty-four percent of women answered correctly that the highest risk of becoming pregnant is halfway between two menstrual periods, with wide variation between sub-groups. The level of knowledge of the menstrual cycle is directly correlated with educational attainment, as more than four times as many women in the two highest educational groups answered this question correctly, compared to those in the lowest educational group. Also, women in rural areas and lower socio-economic groups have much lower levels of knowledge of the most likely time for a woman to become pregnant. Sex education efforts must be targeted toward Georgian women under the age of 20, as this sub-group had the lowest proportion of those who knew the correct answer to this question, 14%, as well as the highest, 56%, who had no knowledge of when during the menstrual cycle a woman was most likely to get pregnant. These efforts should also target those in lower socio-economic level and education groups.

12.3 Knowledge of the Fertility Effect of Breastfeeding

Similar to the menstrual cycle, women and men were asked their opinion on the degree of risk of a woman getting pregnant while breastfeeding, another basic concept of reproduction and fertility. Fifty-six percent of women correctly knew that there is a lower risk of pregnancy during breastfeeding (Table 12.3). The data also show that women's knowledge of the fertility reduction effect of breastfeeding increased with age. Women under the age of 20 had the highest level, 57%, of those reporting they "do not know" the answer to this question. As was the case with knowledge of the menstrual cycle, this knowledge was also higher among women with more

TABLE 12.2
Percent Distribution of Women's Opinion
About the Most Likely Time During the Menstrual Cycle A Women Can Get Pregnant
by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Week Before Menses	During Menses	Week After Menses	Halfway Between Menses	Anytime	Don't Know	Total	No. of Cases
Total	**2.6**	**0.4**	**23.3**	**44.4**	**6.3**	**23.0**	**100.0**	**7,798**
Residence								
Tbilisi	3.1	0.7	21.5	55.4	5.0	14.4	100.0	2,029
Other Urban	2.4	0.3	22.4	46.9	5.2	22.7	100.0	2,730
Rural	2.5	0.3	25.1	36.0	7.9	28.2	100.0	3,0394
Age Group								
15–19	2.8	0.6	18.6	13.6	8.4	56.0	100.0	1,142
20–24	3.8	0.4	27.0	38.3	6.1	24.4	100.0	1,246
25–29	2.9	0.5	27.4	49.2	6.0	14.0	100.0	1,312
30–34	1.9	0.4	24.4	55.5	6.1	11.7	100.0	1,419
35–39	1.9	0.4	22.5	58.8	5.8	10.7	100.0	1,523
40–44	2.3	0.0	21.1	59.3	5.1	12.3	100.0	1,156
Marital Status								
Currently Married or In Union	2.2	0.3	24.5	57.0	6.2	9.8	100.0	5,177
Previously Married/In Union	3.1	0.2	25.8	49.2	6.2	15.6	100.0	517
Never Married or In Union	3.3	0.5	20.8	20.4	6.7	48.3	100.0	2,104
Education Level								
Secondary Incomplete	1.8	0.2	17.3	13.9	10.5	56.3	100.0	991
Secondary Complete	3.2	0.7	26.6	40.0	7.2	22.3	100.0	2,664
Technicum	2.6	0.4	24.8	55.6	4.6	12.0	100.0	2,058
University	2.3	0.2	21.6	59.2	4.3	12.5	100.0	2,085
Socio-Economic Status								
Low	2.4	0.3	24.1	35.0	7.4	30.7	100.0	3,276
Medium	2.8	0.4	23.4	47.3	6.0	20.1	100.0	3,654
High	2.4	0.4	21.1	55.3	5.1	15.7	100.0	868
Ethnicity								
Georgian	2.7	0.4	23.7	46.6	5.3	21.4	100.0	6,700
Azeri	1.6	0.4	23.4	22.5	12.4	39.8	100.0	589
Armenian	3.6	0.8	22.0	41.2	11.9	20.4	100.0	300
Other	2.4	0.0	15.0	60.9	7.5	14.2	100.0	209
IDP Status								
IDP	2.6	0.2	28.3	40.4	5.5	23.1	100.0	1,828
Non-IDP	2.6	0.4	23.1	44.6	6.4	23.0	100.0	5,970

TABLE 12.3
Women's Opinion on the Risk of Pregnancy When Breastfeeding Compared to When Not Breastfeeding by Selected Characteristics
Reproductive Health Survey: Romania, 1999

Characteristic	Higher Risk	Lower Risk	Same Risk	Don't Know	Total	No. of Cases
Total	**1.0**	**56.2**	**18.3**	**24.5**	**100.0**	**7,798**
Residence						
Tbilisi	1.5	56.8	21.9	19.8	100.0	2,029
Other Urban	0.8	56.9	17.3	25.0	100.0	2,730
Rural	0.9	55.3	16.8	27.0	100.0	3,039
Age Group						
15–19	1.9	27.7	13.5	56.9	100.0	1,142
20–24	1.2	54.6	17.6	26.6	100.0	1,246
25–29	0.9	64.8	18.0	16.3	100.0	1,312
30–34	0.6	63.0	22.0	14.5	100.0	1,419
35–39	0.8	67.1	20.1	12.0	100.0	1,523
40–44	0.6	67.4	19.5	12.4	100.0	1,156
Marital Status						
Currently Married or In Union	0.7	67.4	20.0	11.8	100.0	5,177
Previously Married or In Union	1.8	64.1	19.9	14.3	100.0	517
Never Married or In Union	1.5	34.3	14.7	49.6	100.0	2,104
Education Level						
Secondary Incomplete	0.5	34.0	15.7	49.9	100.0	991
Secondary Complete	1.8	55.0	18.3	24.9	100.0	2,664
Technicum	0.9	64.6	19.6	14.9	100.0	2,058
University	0.6	64.2	18.6	16.6	100.0	2,085
Socio-Economic Status						
Low	1.1	55.0	15.7	28.2	100.0	3,276
Medium	1.0	56.6	18.9	23.6	100.0	3,654
High	1.4	57.4	21.8	19.5	100.0	868
Ethnicity						
Georgian	1.2	56.9	18.1	23.8	100.0	6,700
Azeri	0.5	50.0	15.4	34.1	100.0	589
Armenian	0.8	59.4	20.0	19.7	100.0	300
Other	0.0	51.0	28.7	21.6	100.0	209
IDP Status						
IDP	0.7	54.3	21.8	23.3	100.0	1,828
Non-IDP	1.1	56.3	18.1	24.6	100.0	5,970

education. There was little difference among women according socio-economic Status. These data again point up the need for more sex education, primarily for women under the age of 20, which should include the education of mothers about the lower risk of pregnancy during breastfeeding.

12.4 Attitudes Toward Abortion

Georgia, like all former Soviet Union republics, has a long history of reliance on abortion, which, in combination with traditional methods of contraception, was responsible for the rapid decline in fertility in the 1950s. Legally induced abortion on request was the main method of fertility control in Russia after the Socialist revolution. Even after 1936, when Stalin restricted abortion to narrow medical indications, clandestine abortions, provided by either medical providers or traditional practitioners, were widely used to avert unwanted births. In November 1955, abortion performed in the first trimester again became available "on request" when the restrictive legislation was repealed, largely to prevent illegal abortions and their associated complications. The Soviet Union became the country with the highest abortion rate in Europe; the number of pregnancy terminations exceeded the number of births by a factor of two or more. However, abortion rates varied widely among the Soviet republics and ethnic groups. The Russian Federation, Ukraine, Moldova, Kazakhstan, Latvia and Estonia consistently reported high abortion rates between 1970 and 1985, with over 90 abortions per 1000 women aged 15-49 reported by their respective ministries of health during this period (Remmenick L, 1991). During the same period the induced abortion rate in Georgia was much lower than the countries mentioned above, and for the period 1980-1988 only 57 abortions per 1,000 women aged 15-49 were reported by the Georgian Ministry of Health. In spite of the low level of induced abortion in Georgia compared to other ex-Soviet states, abortion rates in Georgia remain very high compared with those in Western Europe, where in most countries less than 20 abortions per 1,000 women aged 15-44 are reported (Remmenick L, 1991, Henshaw S.K.,1990).

This long tradition of relying on abortion to control fertility, combined with economic difficulties that pressure couples to limit or delay childbearing, 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. However, personal values and reproductive norms could strongly influence abortion and contraceptive behaviors. The respondent's positions on abortion were explored by asking whether "a woman should always have the right to make personal decisions about her pregnancy, including obtaining an abortion" and, for those who disagree that induced abortion should be an option for pregnancy resolution under any circumstance, whether an abortion should be permitted

only under six specified circumstances: if "the woman's life is endangered by the pregnancy," if "the fetus has malformations," if "the pregnancy occurred as a result of rape," if "the woman's health is affected by the pregnancy," if "the woman is not married," and if "the couple has a low income and cannot afford the child."

Overall, the proportion of respondents agreeing that a woman should always have the right to decide about her pregnancy, including resorting to abortion, was 79% (Table 12.4 and Figure 12.4). Only 2% of women opposed pregnancy termination under any circumstance, whereas 19% agreed with the acceptability of abortion being used only for certain reasons. Attitudes toward the right to decide about pregnancy resolution varied by respondents' socio-demographic characteristics, their opinion on the ideal number of children for a couple and previous abortion experience.

Women under the age of 20 (69%) and never married women (71%) were less approving of abortion always being an alternative for pregnancy resolution and more likely to accept abortion only under certain circumstances. Women with the least education were also slightly more likely to disapprove of abortion under all circumstances. The relatively few respondents who believed that a young family in Georgia should have as many children as possible were the sub-group most likely to say that abortion is never acceptable (12%).

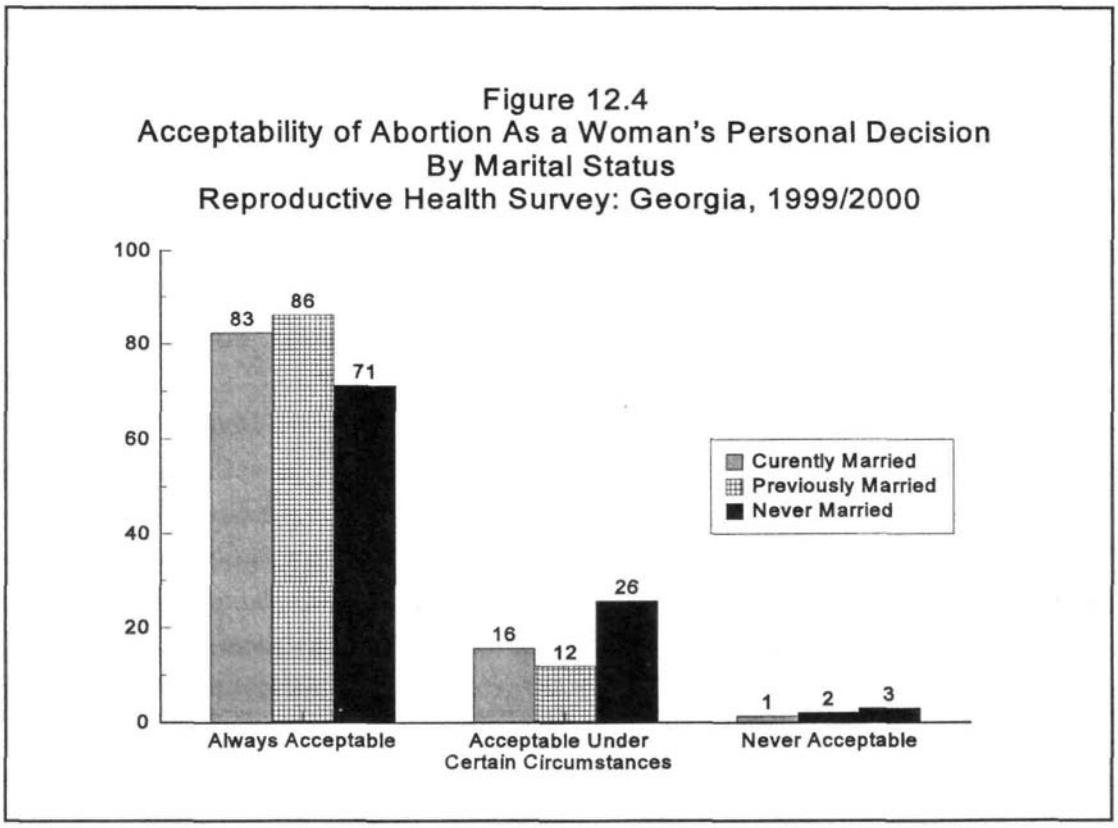


TABLE 12.4.1
Percent Distribution of Women's Opinion on Acceptability of Abortion by Selected Characteristics
Women Aged 15–44
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Always Acceptable	Under Certain Circumstances	Never Acceptable	Total	No. of Cases
Total	**79.2**	**18.8**	**2.0**	**100.0**	**7,797**
Residence					
Tbilisi	76.8	22.2	1.0	100.0	2,029
Other Urban	81.9	15.8	2.2	100.0	2,730
Rural	78.7	18.8	2.5	100.0	3,038
Age Group					
15–19	69.3	27.1	3.5	100.0	1,142
20–24	79.4	19.0	1.6	100.0	1,246
25–29	79.8	17.9	2.3	100.0	1,312
30–34	81.9	16.5	1.6	100.0	1,419
35–39	85.2	13.5	1.4	100.0	1,523
40–44	81.5	17.1	1.4	100.0	1,155
Marital Status					
Currently Married or In Union	82.9	15.7	1.4	100.0	5,176
Previously Married/In Union	86.1	11.9	2.1	100.0	517
Never Married or In Union	71.2	25.7	3.1	100.0	2,104
Education Level					
Secondary Incomplete	70.2	25.3	4.6	100.0	991
Secondary Complete	80.7	18.0	1.4	100.0	2,663
Technicum	84.5	14.2	1.3	100.0	2,058
University	78.2	20.0	1.9	100.0	2,085
Ethnicity					
Georgian	78.6	19.7	1.7	100.0	6,700
Azeri	75.7	18.4	5.9	100.0	588
Armenian	92.2	7.6	0.3	100.0	300
Other	86.7	12.0	1.3	100.0	209
IDP Status					
IDP	80.6	18.4	1.0	100.0	1,828
Non-IDP	79.1	18.8	2.1	100.0	7,797
Ideal No. of Children					
1	79.0	21.0	0.0	100.0	104
1-2	86.6	12.2	1.2	100.0	165
2	81.6	17.2	1.2	100.0	1,754
2-3	83.3	14.3	2.4	100.0	1,469
3	76.8	21.9	1.4	100.0	2,386
More Than Three	76.9	21.2	1.9	100.0	1,625
As Many As Possible	71.7	16.6	11.7	100.0	291

Table 12.4.2 shows the level of approval for abortion under certain circumstances among those who said that abortion is not always acceptable. Overall, respondents demonstrated three levels of acceptance under given circumstances that might motivate a pregnant woman to consider abortion. The highest level of abortion acceptability is when physical or mental health complications are related to continuation of the pregnancy. Eighty percent of these women thought physical deformities of the fetus and life-threatening health problems of the mother were considered acceptable reasons for abortion, while 70% thought abortion was acceptable if the pregnancy would endanger a woman's health. In the middle level of acceptability of abortion, 40% of women in this group thought abortion acceptable when the pregnancy resulted from rape. For women in this group, the lowest level of acceptability of abortion were in cases when the family could not support the child (23%) or the pregnant women was not married (22%).

TABLE 12.4.2
Percent Distribution Women's Agreement or Disagreement With the Acceptability of Abortion Under Selected Circumstances Women Aged 15-44 Who Do Not Believe Abortion Is Always Acceptable Reproductive Health Survey: Georgia, 1999/2000

	Acceptability of Abortion					
Circumstance	Acceptable	Not Acceptable	Depends	Don't Know	Total	Cases
If the Child Might be Born Deformed	80.3	8.5	1.9	9.4	100.0	1,500
If Pregnancy Endangers Woman's Life	79.9	9.7	2.3	8.1	100.0	1,500
If Pregnancy Endangers Woman's Health	70.1	19.0	2.4	8.6	100.0	1,500
If Pregnancy Resulted From Rape	39.8	31.7	13.9	14.6	100.0	1,500
If Family Cannot Afford to Support the Child	23.4	54.7	9.2	12.7	100.0	1,500
If The Woman Is Not Married	22.4	49.3	16.3	12.0	100.0	1,500

Education is the most important determinant of abortion acceptability among women who believe abortion is not acceptable in all circumstances. Generally, women with the least education were less likely to approve of abortion when the fetus is deformed or when a woman's health or life in danger, but, conversely, less educated women were much more likely to agree that abortion is acceptable when a pregnancy results from rape (Table 12.4.3). While almost half

(49%) of women with the least education agree abortion is acceptable in the case of rape, this is true of only 30% of women with a university education. In the case of a pregnant woman being unmarried, the acceptability of abortion is inversely proportional to the level of respondents' education. While one-third of women with less than a secondary education believe abortion is acceptable in such cases, this is true of only 9% of women with a university education.

Also, perhaps because of their previous personal experience with the dangers of war and displacement, internally-displaced women accept abortion to a greater extent when a woman's life or health is in danger.

In addition, almost thirty percent (29%) of currently married (or in union) women agree that not being able to afford a child constitute a reason for abortion, perhaps because of personal experience with family financial problems, compared to about 20% of women formerly or never in union.

All respondents, regardless of their opinion about "a woman's right to decide about her pregnancy, including obtaining an abortion," were asked if a woman who has an unintended pregnancy should keep the baby, give the baby up for adoption, or have an abortion (Table 12.4.4). Though it was seen in Table 12.4.1 that over 80% of women believe abortion to be always acceptable, it is interesting that when presented with these three possibilities in a hypothetical unintended pregnancy, fewer women, 68%, agreed that it should be ended by abortion. Twenty-eight percent thought that a woman who experienced an unintended pregnancy should give birth and keep the baby, while no more that 1% agreed with a third alternative, that of giving the baby up for adoption.

However puzzling, these answers do not contradict each other. Respondents' perceptions that a woman should always have the right to decide about her pregnancy, including abortion, may reflect their desire for personal control over fertility. The right to an abortion may be viewed as a necessary right that should be available on request in the absence of unlimited access to modern birth control methods. Women's opinions about terminating a hypothetical unintended pregnancy by means of abortion elicit more ambivalence, probably reflecting the inherent moral difficulty in deciding between carrying the pregnancy to term or ending it in abortion.

As might be expected, age, marital status and women's number of living children were the most important determinants of women's opinion of what to do in case of an unintended pregnancy. Women with no living children (who are younger and more likely to have never been

TABLE 12.4.3

Percentage of Women Who Disagree That Abortion Is Acceptable for Any Reason by Their Agreement with Certain Circumstances for Abortion

Reproductive Health Survey: Georgia, 1999/2000

	Circumstance						
Characteristic	**Fetus Deformed**	**Woman's Life In Danger**	**Woman's Health In Danger**	**Pregnancy Resulted From Rape**	**Cannot Afford Child**	**Woman Unmarried**	**No. of Cases**
Total	**80.3**	**79.9**	**70.1**	**39.8**	**23.4**	**22.4**	**1,500**
Residence							
Tbilisi	82.0	86.7	76.9	37.6	23.7	18.7	446
Other Urban	79.8	75.5	63.0	38.8	22.4	18.9	469
Rural	79.4	78.1	69.7	41.7	23.8	26.8	585
Age Group							
15–24	79.1	78.3	68.1	44.3	22.2	26.7	582
25–34	78.6	79.9	70.6	33.5	23.0	18.1	502
35–44	84.4	82.8	73.2	38.7	26.2	19.4	416
Marital Status							
Currently Married or In Union	85.1	81.1	71.9	39.8	29.0	24.1	842
Previously Married or In Union	78.9	75.0	62.8	36.9	21.5	13.4	84
Never Married or In Union	75.1	79.0	68.7	40.0	17.5	21.4	585
Education Level							
Secondary Incomplete	71.5	72.1	59.1	48.6	22.8	33.2	268
Secondary Complete	84.4	80.2	72.5	42.6	27.7	27.5	484
Technicum	83.9	82.7	73.6	38.0	25.1	20.4	307
University	80.9	84.6	74.7	30.0	18.0	8.5	441
Ethnicity							
Georgian	81.8	81.5	71.8	39.2	23.3	20.6	1,316
Azeri	67.4	66.9	53.8	38.0	17.9	33.8	132
Armenian	89.1	85.8	92.7	71.4	63.7	42.6	25
Other	83.2	79.7	72.5	50.4	25.8	18.2	27
IDP Status							
IDP	83.1	88.6	81.0	44.9	19.8	22.8	336
Non-IDP	80.1	79.5	69.6	39.5	23.6	22.4	1,164

TABLE 12.4.4
Women's Opinion of What a Woman Should Do If a Pregnancy Is Unintended by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	What A Woman Should Do If A Pregnancy Is Unintended					
Circumstance	Have An Abortion	Give Birth and Keep The Baby	Give Birth And Have Baby Adopted	Don't Know	Total	No. of Cases
Total	**68.1**	**27.5**	**1.4**	**3.0**	**100.0**	**7,798**
Residence						
Tbilisi	63.0	32.7	1.5	2.8	100.0	2,029
Other Urban	72.0	24.0	1.0	3.0	100.0	2,730
Rural	68.6	26.8	1.6	3.1	100.0	3,039
Age Group						
15–24	59.6	34.0	1.3	5.1	100.0	2,388
25–34	71.2	25.0	1.6	2.3	100.0	2,731
35–44	74.9	22.6	1.2	1.3	100.0	2,679
Marital Status						
Currently Married or In Union	75.5	21.5	1.3	1.8	100.0	5,177
Previously Married or In Union	72.5	25.5	0.8	1.1	100.0	517
Never Married or In Union	53.9	38.9	1.7	5.6	100.0	2,104
No. of Living Children						
None	54.5	38.4	1.9	5.2	100.0	2,598
One	71.4	25.2	1.2	2.2	100.0	1,316
Two	79.9	19.1	0.9	1.2	100.0	2,737
Three or More	76.9	20.5	1.2	1.5	100.0	1,147
Education Level						
Secondary Incomplete	57.1	34.4	1.5	7.1	100.0	991
Secondary Complete	71.9	24.8	1.3	2.1	100.0	2,664
Technicum	73.9	23.3	1.3	1.5	100.0	2,058
University	65.2	30.4	1.5	2.9	100.0	2,085
Ethnicity						
Georgian	68.2	27.9	1.5	2.4	100.0	6,700
Azeri	62.9	28.1	0.4	8.7	100.0	589
Armenian	72.9	26.0	0.6	0.6	100.0	300
Other	78.3	16.5	1.4	3.7	100.0	209
IDP Status						
IDP	69.3	25.4	1.9	3.5	100.0	1,828
Non-IDP	68.1	27.6	1.3	3.0	100.0	5,970

in union) are much more likely to believe that a woman should keep the baby in the case of an unintended pregnancy, as 38% of this group had this opinion compared to less than one-fourth of women with children.

12.5 Attitudes and Perceptions about Reproductive Norms and Gender Roles

Adherence to traditional reproductive norms and gender roles for women and men can play a major role in couples' reproductive and contraceptive decisions. Table 12.5 shows the proportion of women who hold conservative views toward four reproductive norms.

Overall, 88% of women believed that "child care is a woman's job," suggesting a low level of desire to share child-care responsibilities in a society where most women (78%) do not work outside the home (see Chapter III). The sub-groups of women who least accepted sharing child-care duties with men were rural women, Azeri women and those in the lowest socio-economic category.

Table 12.5 also shows that 85% of reproductive-age women hold conservative views about sexual experience prior to marriage. Premarital chastity was perceived as most important among rural women (95%), women with less than a university education (about 90%), and those in the lowest socio-economic category (94%). Women of Azeri ethnic background were also more likely than other ethnic groups to value postponement of sexual experience until after marriage.

Overall, more than four of five women (84%) believe "all people should marry". The percentage of women endorsing marriage for all was lower in Tbilisi than in "other urban" and rural areas, as well as among women in the highest education and socio-economic sub-groups. Among various ethnic groups, Azeri women were the most likely to believe that all people should marry (95%).

An important proportion of women have a fatalistic attitude toward fertility. More than half (51%) agreed that "women should have as many children as God gives them." This traditional attitude is more prevalent among women who have ever been in union and those in the lowest education category.

TABLE 12.5

Percentage of Women Aged 15–44 Who Agree With Statements on Reproductive Norms by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Child Care Is A Woman's Job	Woman Must Be A Virgin At Marriage	All People Should Marry	Women Should Have As Many Children As God Gives Them
Total	**88.1**	**85.0**	**83.6**	**51.1**
Residence				
Tbilisi	79.4	64.6	73.5	53.3
Other Urban	89.0	87.7	85.8	45.4
Rural	92.8	95.2	88.2	53.7
Age Group				
15–24	89.8	87.9	84.9	55.2
25–34	86.8	81.0	81.8	50.4
35–44	87.5	85.5	84.0	53.7
Marital Status				
Currently Married or In Union	88.8	86.8	85.6	47.7
Previously Married or In Union	87.5	73.5	76.4	51.4
Never Married or In Union	87.1	83.7	81.3	57.2
No. of Living Children				
None	87.3	83.0	82.3	57.0
One	87.7	78.7	81.3	48.9
Two	88.2	86.0	84.5	44.5
Three or More	90.8	94.6	87.8	51.5
Education Level				
Secondary Incomplete	93.4	93.7	87.1	59.2
Secondary Complete	90.8	90.1	86.3	51.9
Technicum	88.6	87.8	85.1	47.3
University	81.0	70.3	76.8	48.4
Socio-Economic Status				
Low	92.3	93.7	87.3	51.4
Medium	87.3	83.6	83.3	50.6
High	81.4	69.4	76.4	52.2
Ethnicity				
Georgian	87.7	84.2	82.9	50.0
Azeri	95.3	97.6	93.8	57.8
Armenian	87.7	87.0	85.8	62.7
Other	78.1	61.2	67.6	40.9
IDP Status				
IDP	87.7	87.6	82.0	50.2
Non-IDP	88.2	84.8	83.7	51.1

CHAPTER XIII

HEALTH BEHAVIORS

The transition to market economies in many post-communist societies of the former Soviet Union and other former eastern bloc countries in Europe has produced dramatic social, political and economic changes, which in turn have had a profound effect on health. Among the most serious consequences has been a significant drop in life expectancy. A contributing cause of the rising mortality is an increase in health-risk behaviors, especially among men. Old problems, such as alcoholism and tobacco use have increased. Increased mortality from cardiovascular diseases, the leading cause of death in most countries of the region, reflects mainly the effect of such risk factors and the inability of a deteriorating health system to provide adequate prevention services and treatment (e.g., low quality hypertension screening, lack of follow-up, poor emergency care, low access to proper medication).

The prevalence of smoking is increasing most rapidly among young women in many countries of the region and it is widely believed that Georgia has experienced the same trend. According to WHO, smoking kills over 3,000 men per year in Georgia and tobacco-related deaths contribute to 25% of the total mortality among men (Piha T., et al., 1993). Data on morbidity and mortality due to tobacco use are very limited for women. In addition to the association of smoking with lung cancer and cardiovascular diseases, smoking poses specific risks to women. It increases the risk of cervical cancer, greatly modifies the risks associated with taking the contraceptive pill, and affects women's reproductive health by increasing the risk of early menopause, miscarriage, and low birthweight babies. Alcohol use among women has also risen. Women who drink heavily are more likely than men to develop complications such as cirrhosis of the liver.

Cancer is a leading cause of death in women, in both the developed and developing world. Among reproductive system cancers, breast and cervical cancer are the most common. In developing countries most cases are detected at an advanced and incurable stage, due to low perception of risk factors, lack of awareness of the symptoms of the disease, a fatalistic attitude towards cancer generally, lack of information or mistrust about possible treatments, lack of, or inefficient screening services, and a low priority for women's health issues.

13.1 Cigarette Smoking

Tobacco use in Eastern Europe has increased to alarming proportions since 1990, owing mostly to the transition toward a market economy and the arrival of the international tobacco industry whose costly promotional campaigns for their products have thrived in the absence of legislative regulations. Facing increasing restrictions in the U.S. and Western Europe, transnational tobacco companies have been expanding rapidly into Eastern Europe and the Newly Independent States, through local manufacturing and aggressive advertising. Recent population-based surveys of reproductive health conducted in Central and Eastern Europe documented that smoking prevalence among reproductive age women ranges from 7% in Moldova (Serbanescu et al., 1998), to 19% in Ukraine (KIIS and CDC, 2001), 25% in Russia (VCIOM and CDC, 1998), and 30% in the Czech Republic (Goldberg et al., 1995) and Romania; in addition, 54% of men aged 15-49 were currently smoking in Romania (Serbanescu et al., 2001).

Currently, tobacco control policies in Georgia are neither comprehensive nor strongly enforced. Restrictions on tobacco advertising and promotion have recently been imposed, but no systematic efforts have been made toward ensuring prohibition of smoking in public places, preserving smoke-free environments, restricting cigarette sales to children and teenagers, developing health promotion campaigns, and promoting smoking cessation services. Because tobacco is such a profitable commodity, the economic benefits are often given priority over health interests. Gains from tobacco sales, however, are likely to be offset by the impact of cigarette payments on individual budgets and the enormous cost of treating the health consequences of tobacco use.

The 99GERHS included two questions for determining cigarette smoking status: "Have you smoked at least 100 cigarettes in your entire life?" and, for those who ever smoked 100 cigarettes, "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. As shown in Table 13.1.1, only 8% of women reported smoking at least 100 cigarettes during their lifetime (ever smokers), including 5% who have smoked daily during the 30 days preceding the survey (current smokers). In addition, 1% of women reported smoking within the past 30 days but less than every day (data not shown).

Women residing in urban areas were significantly more likely than rural women to have ever smoked (13% vs. 1%) and to be current smokers. The highest percentage of ever and current women smokers reside in Tbilisi (22% and 18%, respectively). Women aged 25 or older reported higher rates of smoking than young adults. Previously married respondents were much more likely than those currently married and those who have never been married to have ever smoked or to smoke

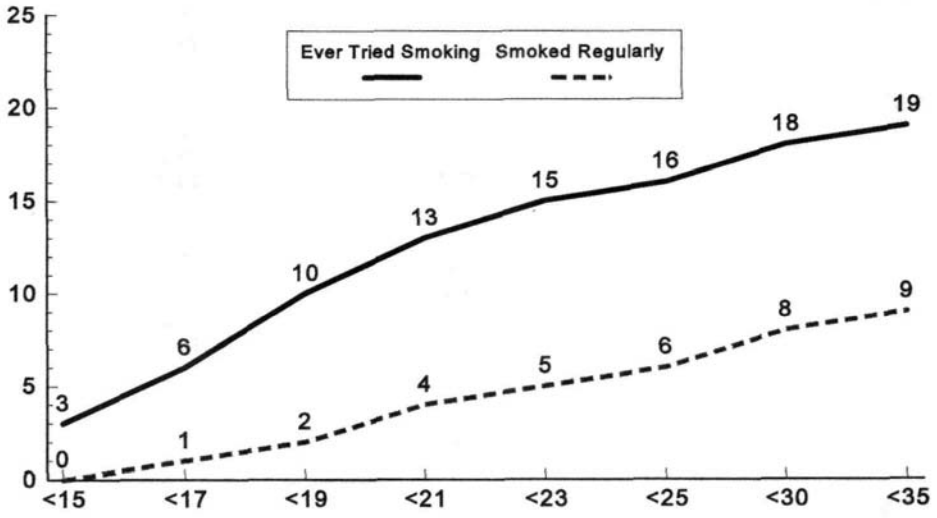
Table 13.1.1
Percentage of Women Aged 15–44 Who Have Ever Smoked and Who Currently Smoke by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Cigarette Use: % Ever Smoked	Cigarette Use: % Currently Smoke	Cigarette Use: Unweighted No. of Cases
Total	**7.5**	**6.0**	**7,798**
Residence			
Urban	12.9	10.4	4,759
Rural	0.7	0.5	3,039
Region			
Tbilisi	21.8	17.7	2,029
Imereti	3.0	2.3	1,590
North-East	2.4	1.9	1,259
South	1.2	0.6	1,017
West	3.1	2.6	1,903
Age Group			
15–24	5.5	4.6	2,388
25–34	9.5	7.1	2,731
35–44	8.0	6.6	2,679
Marital Status			
Currently Married or In Union	6.6	4.8	5,177
Previously Married or In Union	22.1	19.7	517
Never Married or In Union	6.6	5.8	2,104
Education Level			
Secondary Incomplete or Less	1.5	1.3	991
Secondary Complete	5.2	4.4	2,664
Technicum	6.7	5.3	2,058
University	15.2	11.7	2,085
Socio-economic Status			
Low	1.7	1.3	3,276
Middle	8.6	6.7	3,654
High	17.0	14.4	868
Ethnicity			
Georgian	8.1	5.4	6,700
Azeri	0.9	0.0	589
Armenian	5.3	3.6	300
Other	17.3	14.5	209
IDP Status			
IDP	3.3	2.6	1,828
Non-IDP	7.8	6.2	5,970
Employment Status			
Employed	11.9	9.3	1,747
Unemployed	6.3	5.1	6,051

currently (22% and 20%, respectively). Smoking was directly correlated with educational and socioeconomic status (SES). Respondents who were currently employed (presumably older too) were twice as likely as those not employed to have ever smoked and to be current smokers. Azeri women reported the lowest rates of smoking and practically none of them was currently smoking.

Figure 13.1 shows data on ages at which women tried tobacco for the first time and started to smoke regularly. The cumulative life-table probability of initiating habitual smoking by age 15 was less than 1% but 3% of 15 year olds have smoked at least one cigarette by that age. By age 19, 2% of teens reported fairly regularly smoking and 10% had tried to smoke at least once. If smoking was not initiated before age 19, the probabilities of starting to smoke regularly range from 4% by age 21 to 6% by age 25 and 8% to 9% after age 30. Although very few youth became regular smokers by age 25 (6%), it is clear that the most probable period to start smoking is during the young adult years; smoking prevalence doubles between ages 19 and 21 and levels off in the thirties. These findings are particularly alarming since the tobacco industry has identified young women as the key target for advertising and promotion campaigns, frequently associating smoking with modernity, sophistication, and success.

Figure 13.1
Cumulative Percentage of Women Who Have Ever Tried Smoking
And Cumulative Percentage of Women Who Smoked Regularly
Reproductive Health Survey: Georgia 1999/2000



13.2 Alcohol Use

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

Georgia has a long tradition of producing and drinking wine. The economic and political transition has changed both the type of drinks more often used (from wine to beer and strong liquors) and the drinking patterns (from occasional drinks to frequent drinks and binging), especially among young adults. Alcohol consumption is not perceived to be very high in Georgia. Before the break-up of the USSR, Georgia, Armenia and Azerbaijan reported the lowest incidence of alcohol dependence per 100,000 population, less than 20/100,000 (WHO, 1993). However, statistics on alcohol consumption after 1990 are not reliable, since the former system based on data on state-controlled sales has yet to be replaced with other assessment tools.

The 99GERHS included a series of question for assessing alcohol use practices. Alcohol use was measured by asking each respondent how many drinks did they have at any given occasion during the past three months and how often did they drink that amount. Respondents who reported at least one drink per month within the last three months were considered "current drinkers", those who had at least one drink every day or almost every day were defined as "current frequent drinkers", and those who consumed 4 or more drinks in a row at any given time during the three months preceding the survey were defined as "episodic heavy drinkers" or bingers.

Survey results show that 42% of reproductive age women used alcohol during the previous three months, including 28% of women who had at least one drink per month (Table 13.2). Overall, only 3% of women reported consuming alcohol daily or almost daily (current frequent drinkers); 16% had consumed four or more drinks in a row during the three months preceding the interview.

Use of alcohol was slightly higher among women residing in urban areas, including Tbilisi, among women who have never been married, among women of Georgian ethnic group, and among those currently employed (data not shown). Use of alcohol increased with educational attainment and with SES, and was higher among women of Georgian ethnic background. Azeri women, perhaps because of their religious beliefs, reported very low usage of alcohol.

Table 13.2
Percentage of Women Aged 15–44 Who Used Alcohol During the Previous Three Months by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

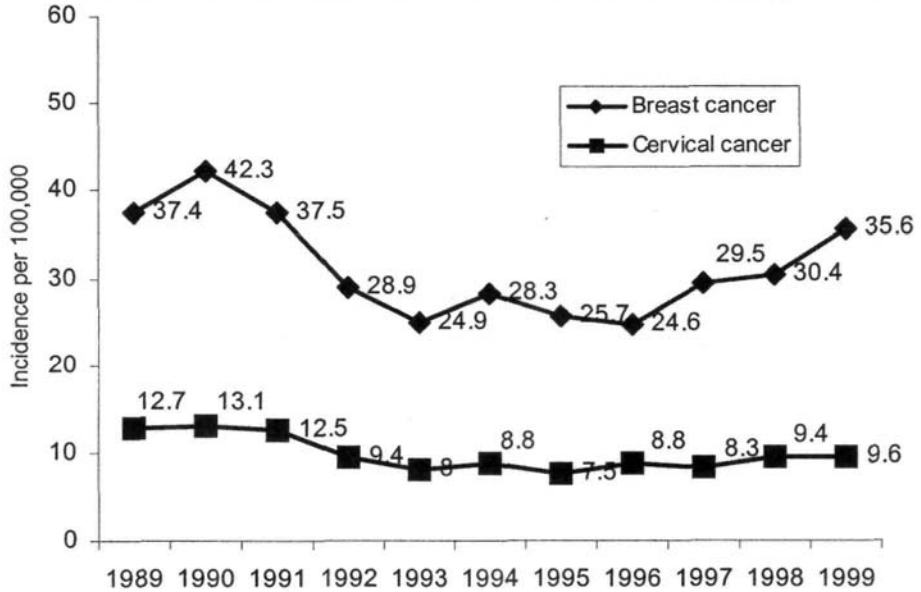
	Alcohol Use During the Past Three Months				
Characteristic	% Ever Drank	% Current Drinkers	% Current Frequent Drinkers	% Current Episodic Heavy Drinkers	Unweighted No. of Cases
Total	**41.8**	**27.6**	**2.7**	**15.7**	**7,798**
Residence					
Urban	46.6	31.4	3.1	17.8	4,759
Rural	35.7	22.8	2.3	12.9	3,039
Region					
Tbilisi	47.3	32.3	4.4	16.5	2,029
Imereti	46.2	32.2	3.2	17.3	1,590
North-East	45.6	28.5	2.8	18.4	1,259
South	24.2	14.6	1.0	7.4	1,017
West	41.5	27.2	1.7	17.2	1,903
Age Group					
15–24	41.8	27.5	2.1	16.9	2,388
25–34	41.9	28.5	3.1	16.8	2,731
35–44	41.7	26.8	3.2	13.2	2,679
Marital Status					
Currently Married or In Union	37.7	24.7	2.7	13.1	5,177
Previously Married or In Union	41.3	28.6	4.7	15.9	517
Never Married or In Union	49.3	32.8	2.4	20.3	2,104
Education Level					
Secondary Incomplete or Less	26.7	15.4	1.6	7.2	991
Secondary Complete	41.4	27.7	2.3	17.8	2,664
Technicum	44.9	29.5	3.4	16.4	2,058
University	49.1	33.6	3.4	17.8	2,085
Socio-economic Status					
Low	34.1	21.5	1.9	12.3	3,276
Middle	45.1	30.6	3.1	17.5	3,654
High	47.4	30.7	3.0	16.7	868
Ethnicity					
Georgian	46.2	30.7	3.0	17.7	6700
Azeri	5.8	2.1	0.8	1.3	589
Armenian	33.6	20.7	2.3	8.6	300
Other	49.8	35.2	2.1	18.4	209
IDP Status					
IDP	41.6	26.6	3.2	17.9	1,828
Non-IDP	41.8	27.7	2.7	15.6	5,970

Overall, about one in six women reported episodic heavy drinking (binging) during the three months prior to the interview. Episodic heavy drinking was less common among rural residents, residents of the South region (where most of the Azeri population lives), women with less education, and women of Azeri or Armenian descent and more common among never married women (20%).

13.3 Prevalence of Routine Gynecologic Visits

Prior to the dissolution of the Soviet Union, Georgia had the lowest all-site cancer incidence rates (for either male or female population) among all 15 Soviet republics, according to incidence data reported through cancer registries (Morabia A. and Levshin V., 1992). Figure 13.3.1 shows recent trends in the incidence of breast and cervical cancers reported to the Ministry of Health. Although still low, the incidence of gynecologic cancers is on the rise: the incidence of breast cancer has increased recently from 24.9/100,000 in 1993 to 35.6/100,000 in 1999; the incidence of cervical cancer, although low, has increased from 8/100,000 to 9.6/100,000 during the same period (CMSI and MOH, 1999). Proportional mortality attributed to genital cancers was 22% in 1999, including 13% due to breast cancer (CMSI and MOH, 1999). Data on gynecologic cancer incidence are thought to be seriously under-reported because most women are registered in cancer registries only in the advanced stages of the disease.

Figure 13.3.1
Breast Cancer and Cervical Cancer Incidence, Georgia 1989-1999
Center for Medical Statistics and Information and Ministry of Health



The 99GERHS included a series of questions that allow us to assess health seeking behaviors among women of reproductive age. Patient attitudes and behaviors regarding health care visits are important determinants of whether they receive routine screening, including cervical and breast cancer screening. Important barriers that can reduce individual utilization of routine health visits include: low perception of being at risk, a fatalistic attitude toward cancer generally, low awareness about benefits of screening, perceived discomfort, and fear of positive results. Lack of knowledge of health-related issues, noncompliance with doctor's recommendations, miscommunication between patient and provider, and socio-economic and geographic factors are also potential barriers to preventive care. Other factors limiting access to preventive health care visits include limited resources within the health system, inadequate and/or maldistribution of health providers, and physician barriers (knowledge, attitudes and beliefs regarding routine screening, lack of time or expertise, and restrictive hours of service availability).

In the US and western Europe it is recommended that women of reproductive age have a routine gynecologic examination every year. The 99GERHS (Table 13.3.1 and Figure 13.4) shows that almost three fourths (72%) of sexually experienced women had ever been examined by a gynecologist during a routine exam but only 30% were examined in the previous 12 months. This low prevalence of routine exams can have a substantial negative impact on screening, counseling, and health education.

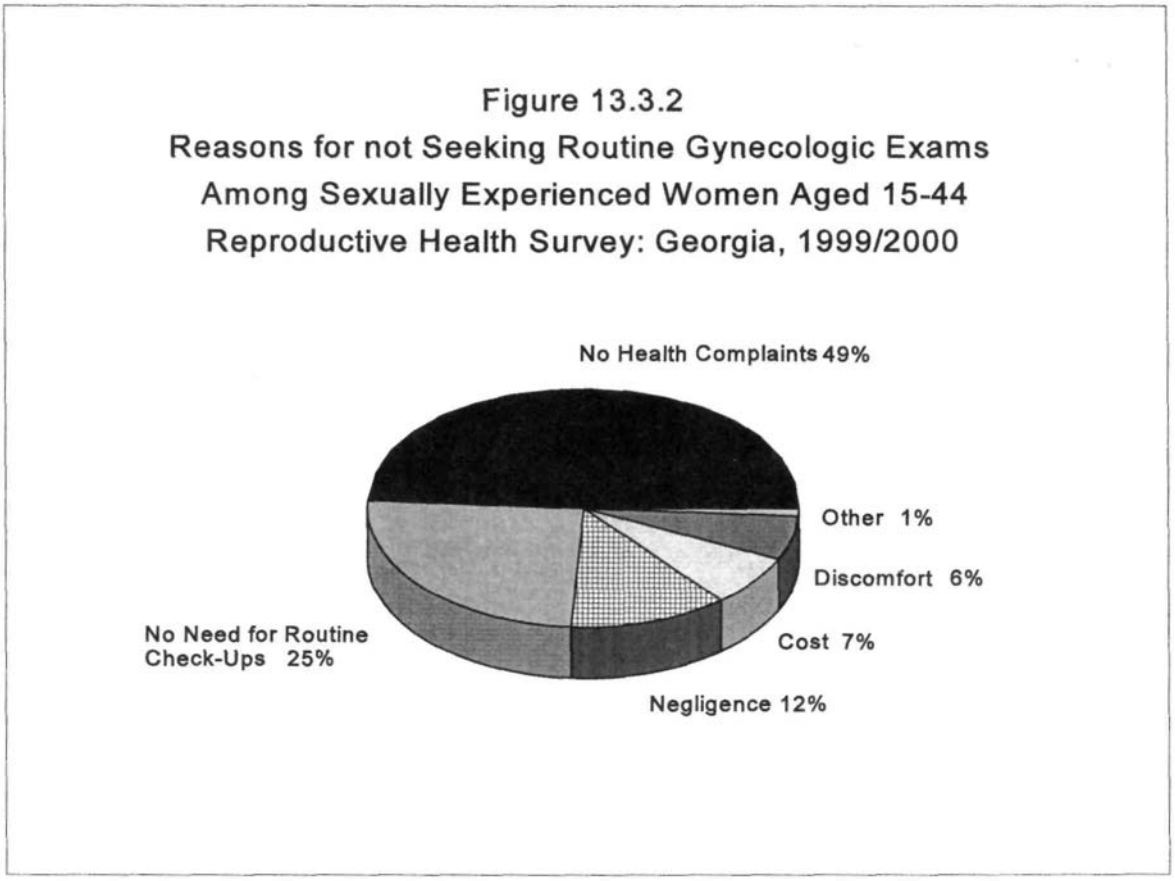
Most of the women who had not undergone an exam within the past year reported an exam within the past three years (23%). Thus, about one of two sexually experienced women had seen a gynecologist within the last three years; 19% reported the last routine examination more than three years ago while 28% have never had a gynecologic exam. Rural residents, women living in the South and West regions, younger women, women with lower levels of education and SES, and those of Azeri ethnicity were more likely to have never received preventive gynecologic exams, as were women who were not using a modern contraceptive method (29%-30%). Even among users of modern contraception, however, one in five women had never had a routine gynecologic exam.

The reasons for not seeking routine gynecologic exams are important to study because they may uncover potential barriers to the use of preventive health services. As shown in Figure 13.3.2, three out of four sexually experienced women who have never had a routine exam believed they did not need one because they have no health complaints (49%) or that it is unnecessary to have routine check-ups (25%). These women probably lacked knowledge of general health issues and were unaware of the screening procedures and/or the health benefits of screening. The second most common reason was lack of time to have a check-up or negligence (12%). Several women claimed that they could not afford such services (7%), suggesting that routine gynecologic exams require out-of-pocket payments. Very few claimed that fear of discomfort, including pain and embarrassment associated with gynecologic check-ups, were preventing them from seeking routine check-ups (6%).

TABLE 13.3

Time of Last Routine Gynecologic Exams by Selected Characteristics
Women 15–44 Years of Age Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000

	Time of Last Routine Gynecologic Exam					
Characteristic	**Within Past Year**	**Within 1-3 Years**	**More Than 3 Years Ago**	**Never Had**	**Total**	**Unweighted No. of Cases**
Total	**29.6**	**23.3**	**19.0**	**28.1**	**100.0**	**5,703**
Residence						
Urban	32.9	24.3	18.9	23.8	100.0	3,362
Rural	25.6	22.2	19.0	33.2	100.0	2,341
Region						
Tbilisi	36.2	24.3	17.8	21.6	100.0	1,387
Imereti	28.7	24.4	18.6	28.2	100.0	1,147
North-East	30.4	21.4	22.1	26.1	100.0	984
South	24.6	24.2	16.6	34.6	100.0	812
West	25.9	22.5	19.5	32.1	100.0	1,373
Age Group						
15–24	42.0	15.4	2.4	40.3	100.0	951
25–34	33.2	26.8	12.7	27.3	100.0	2,300
35–44	21.2	23.6	31.4	23.8	100.0	2,452
Education Level						
Secondary Incomplete or Less	22.1	15.5	16.4	45.9	100.0	485
Secondary Complete	27.8	21.6	20.4	30.3	100.0	2,000
Technicum	28.0	25.1	21.0	25.8	100.0	1,726
University	36.3	26.6	15.9	21.2	1,492.0	1,492
Socio-Economic Status						
Low	22.2	21.8	19.5	36.5	100.0	2,402
Medium	30.9	24.5	19.0	25.7	100.0	2,664
High	42.3	22.8	17.5	17.3	100.0	637
Ethnic Group						
Georgian	30.0	23.7	19.5	26.8	100.0	4,795
Azeri	25.4	19.3	14.8	40.5	100.0	481
Armenian	24.6	28.6	21.8	25.1	100.0	247
Other	40.7	20.9	15.3	23.1	100.0	180
IDP Status						
IDP	34.2	24.3	16.8	24.6	100.0	1,266
Non-IDP	29.3	23.3	19.1	28.3	100.0	4,437
Current Contraceptive Use						
Any Modern Method	35.8	26.3	18.3	19.5	100.0	1,067
Any Traditional Method	25.7	26.8	18.8	28.7	100.0	1,069
No Method	28.9	21.4	19.2	30.4	100.0	3,567



13.4 Breast Self-Exam

Methods for early detection which can reduce breast cancer mortality include breast self-examination (BSE), breast physical exam performed by physicians, and mammography (Last et. al., 1986). In populations where mammography is not readily available or is too expensive (and thus unsuitable to be used for routine screening), BSE and medical exams can reduce breast cancer mortality if they are performed correctly and consistently. 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. Appropriate follow-up by a physician should be available and accessible for women who detect breast changes through self examination.

The 99GERHS explored only the level of awareness about BSE and its prevalence, without any indication of proficiency in BSE performance. Overall, less than one of two sexually experienced women of childbearing age (47%) have ever heard about BSE and less than one of four women (23%) have ever performed BSE (Table 13.4). Awareness of BSE was higher among urban

than among rural residents (56% vs. 36%), among women residing in Tbilisi (60%), those aged 35 years or older (55%), and among women with a university education (64%) or high SES (65%). Less than one in ten Azeri women have ever heard of such an exam and only 3% have ever performed BSE. Awareness of BSE was significantly higher among those who underwent routine gynecological exams compared to those who have never had such visits (50% vs. 39%) and among IDP women (55% vs. 47%).

Table 13.4 also shows the frequency of performing BSE among sexually experienced women. Overall less than one of four women practices BSE and only one in eight performs BSE every month. Both prevalence of BSE and monthly practice of the exam were higher among those who underwent routine gynecologic exams, compared with women without routine visits to a gynecologist (25% vs. 16% and 14% vs. 8%). However, the fact that three-fourths of women who had at least one routine gynecological visit did not report routine BSE suggests that this preventive practice is not properly covered by health care providers. Women who never practiced BSE were more likely to live in rural areas than in urban areas (84% vs. 72%), to reside in the South region where Azeri population has the highest concentration (88%), to be young adults (93%), to have less than complete or complete secondary education (94% and 86%, respectively), to have low SES (86%), or to be of Azeri or Armenian descent (97% and 89%, respectively).

Figure 13.4
Frequency of Routine Gynecologic Exams and Breast Self-Exams (BSE)
Among Sexually Experienced Women Aged 15-44
Reproductive Health Survey: Georgia, 1999/2000

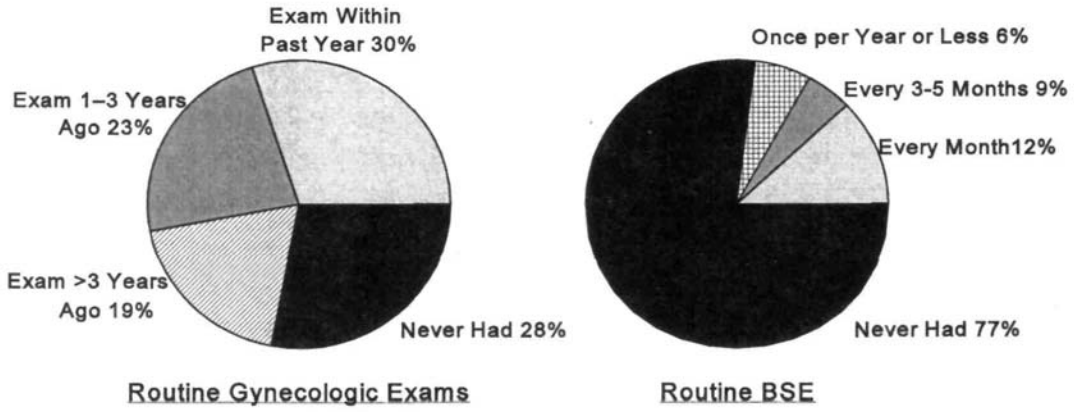


Table 13.4
Awareness of Breast Self-Exams (BSE) and Frequency of BSE by Selected Characteristics
Women 15–44 Years of Age Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000

		Frequency of Breast Self-Exam					
Characteristic	% With Awareness	Every Month	Every 3-5 Months	1-2 Times per Year or Less	Never	Total	No. of Cases
Total	**46.9**	**12.4**	**4.8**	**5.6**	**77.2**	**100.0**	**5,703**
Residence							
Urban	56.4	15.4	6.1	6.9	71.5	100.0	3,362
Rural	35.8	8.8	3.2	4.0	83.9	100.0	2,341
Region							
Tbilisi	59.5	16.3	6.2	10.4	67.1	100.0	1,387
Imereti	51.1	13.3	6.2	4.1	76.4	100.0	1,147
North-East	44.8	12.1	4.9	4.9	78.1	100.0	984
South	27.4	6.0	2.7	3.1	88.2	100.0	812
West	47.2	12.8	3.7	3.8	79.7	100.0	1,373
Age Group							
15–24	27.4	3.8	1.7	1.5	93.0	100.0	951
25–34	47.1	11.2	4.3	5.8	78.7	100.0	2,300
35–44	54.9	17.0	6.4	7.1	69.4	100.0	2,452
Education Level							
Secondary Incomplete or Less	15.9	2.4	1.5	2.5	93.6	100.0	485
Secondary Complete	37.2	7.8	2.8	3.4	85.9	100.0	2,000
Technicum	53.6	14.5	5.8	6.0	73.7	100.0	1,726
University	63.8	19.8	7.3	9.1	63.9	100.0	1,492
Socio-Economic Status							
Low	34.6	8.3	3.3	2.8	85.5	100.0	2,402
Medium	50.1	12.8	5.2	6.1	75.9	100.0	2,664
High	64.5	20.7	6.4	10.7	62.2	100.0	637
Ethnic Group							
Georgian	52.5	14.0	5.5	6.3	74.2	100.0	4,795
Azeri	10.4	1.9	0.7	0.9	96.6	100.0	481
Armenian	31.9	6.3	2.2	2.2	89.3	100.0	247
Other	59.0	18.3	4.7	9.3	67.7	100.0	180
IDP Status							
IDP	54.7	14.0	6.2	4.4	75.4	100.0	1,266
Non-IDP	46.6	12.3	4.7	5.7	77.3	100.0	4,437
Current Contraceptive Use							
Any Modern Method	54.5	15.7	5.5	7.6	71.2	100.0	1,067
Traditional Methods	51.3	14.7	5.5	6.7	73.1	100.0	1,069
None	43.5	10.8	4.4	4.7	80.2	100.0	3,567
Ever Had Gynecologic Exam							
Ever Had	50.1	14.1	4.9	6.5	74.5	100.0	4,158
Never Had	38.8	8.0	4.5	3.3	84.2	100.0	1,545

13.5 Cervical Cancer Screening

Cervical cancer is the second most common cancer of women, with almost 450,000 new cases diagnosed each year worldwide (World Health Organization, 1993). It is the most frequent cancer of women in developing countries, where 80% of cervical cancers are diagnosed (Parkin DM, et al., 1993). Age-adjusted incidence rates range from 5-42 cases per 100,000 women, with high rates in Latin America, Africa, Southeast Asia and lower rates in North America, Western Europe, Australia, and Israel.

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

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

Although the validity of self-reported rates of Pap testing cannot be established without examining medical records, survey results are often used to estimate the extent of cervical screening in the general population. The 99GERHS included a series of questions for female respondents regarding Pap test history: "Have you ever had a cervical smear test (Papanicolaou screening test)?", "When did you have your last cervical smear test?", and, for those who have never had a test, "What is the main reason you have never had a Pap smear?"

Overall, only 4% of sexually experienced women reported that they had ever had a Pap smear (Table 13.5.1) and only 2% had their last test within the past three years. The prevalence of cervical cancer screening was generally very low and does not allow the study of potential determinants of preventive practices. It is worth noting, however, that only 5% of women seeking routine gynecologic exams were screened for cervical cancer. Gynecologic routine visits should be viewed as opportunities to educate patients about healthy lifestyle choices and to promote

TABLE 13.5.1

Cervical Cancer Screening History by Selected Characteristics
Women 15–44 Years of Age Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000

	Cervical Cancer Screening Test					
Characteristic	Within Last Year	2–3 Years Ago	More than 3 Years Ago	Never Had	Total	No. of Cases
Total	**1.2**	**1.0**	**1.5**	**96.3**	**100.0**	**5,703**
Residence						
Urban	1.7	1.2	1.8	95.3	100.0	3,362
Rural	0.7	0.7	1.2	97.4	100.0	2,341
Region						
Tbilisi	2.4	1.5	2.2	93.9	100.0	1,387
Imereti	0.6	0.9	1.4	97.1	100.0	1,147
North-East	0.6	1.0	0.8	97.7	100.0	984
South	0.4	0.3	1.0	98.3	100.0	812
West	1.5	0.9	1.9	95.7	100.0	1,373
Age Group						
15–24	0.5	1.0	0.0	98.5	100.0	951
25–34	1.3	0.8	1.0	97.0	100.0	2,300
35–44	1.4	1.2	2.6	94.8	100.0	2,452
Education Level						
Secondary Incomplete or Less	0.0	0.2	0.0	99.8	100.0	485
Secondary Complete	0.7	0.8	1.3	97.2	100.0	2,000
Technicum	1.4	0.9	1.7	96.0	100.0	1,726
University	2.2	1.6	2.2	94.1	100.0	1,492
Socio-Economic Status						
Low	0.5	0.7	0.8	98.1	100.0	2,402
Medium	1.2	1.0	1.8	96.1	100.0	2,664
High	3.3	1.5	2.3	92.9	100.0	637
Ethnic Group						
Georgian	1.4	1.0	1.6	96.0	100.0	4,795
Azeri	0.3	0.3	0.3	99.0	100.0	481
Armenian	0.7	0.8	1.8	96.7	100.0	247
Other	1.2	2.4	1.7	94.7	100.0	180
IDP Status						
IDP	0.4	1.5	1.6	96.4	100.0	1,266
Non-IDP	1.3	0.9	1.5	96.3	100.0	4,437
Current Contraceptive Use						
Any Modern Method	1.1	1.6	1.1	96.2	100.0	1,067
Traditional Methods	1.0	0.5	0.8	97.7	100.0	1,069
None	1.3	0.9	1.8	95.9	100.0	3,567
Ever Had Gynecologic Exam						
Ever Had	1.7	1.3	2.0	95.0	100.0	4,158
Never Had	0.0	0.2	0.1	99.7	100.0	1,545

appropriate screening for preventable diseases such as cervical cancer.

Table 13.5.2 presents the most important reasons for not having a cervical cancer screening test. For 42% of respondents the most important reason was the lack of a recommendation of the test by a health provider. The second most common reason was lack of knowledge of such a screening test (35%). Almost one in five respondents reported that the most important reason they have not had screening was that they do not need such a test.

TABLE 13.5.2
Most Common Cited Reasons for Never Having a Pap Smear by Age Group
Women Aged 15-44 Years Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000
(Percent Distribution)

				Age Group		
Reason	**Total**	**IDP**	**Non-IDP**	**15-24**	**25-34**	**35-44**
Doctor Never Recommended	**42.4**	45.6	42.2	34.3	43.7	44.7
Never Heard of Cervical Cancer Screening	**34.6**	31.6	34.8	40.3	34.9	31.8
No Need to Have Cervical Cancer Screening	**18.8**	19.5	18.8	22.9	17.9	17.9
Neglected to Have Cervical Cancer Screening	**2.6**	1.9	2.6	1.9	2.3	3.1
Not Currently Sexually Active	**0.2**	0.2	0.2	0.0	0.2	0.3
Other reasons	**1.4**	1.1	1.4	0.7	1.0	2.1
Total	**100.0**	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**5,498**	1,223	4,275	935	2,236	2,327

These findings reiterate the lack of awareness of gynecologic screening procedures among reproductive age women in Georgia and the need for sustained educational campaigns for the public and changes in the practice of health care providers. It is worth noting that only 19% of women seeking routine gynecologic exams within the previous year had also had a pap test and only 23% of women who have ever had gynecologic check-ups were ever screened for cervical cancer (not shown). Gynecologic routine visits should be viewed as opportunities to educate patients about healthy lifestyle choices and to promote appropriate screening for preventable diseases, such as cervical cancer.

13.6 Prevalence of Selected Health Problems

All women were asked "Has a doctor ever told you that you had (selected health problems)?" These problems were: anemia, urinary infection, pelvic inflammatory disease (translated as infections of the tubes or the uterus), high blood pressure, heart disease, hepatitis B, asthma, and diabetes. Table 13.6 shows the percentage of women who have ever been told by a doctor that they had these specific health problems.

Obviously, these results are minimum estimates of the true prevalence of these health problems in the population of women of childbearing age. They probably under-represent the real prevalence since self-reporting of health conditions implies that women had access to health care facilities, had visited these facilities, and had been told by physicians about their health problems. Although Georgia has a high physician-to-population ratio (421 physicians per 100,000 population in 1997), the distribution of personnel and health resources is uneven and communication with health providers are minimal. Thus, the self-reported occurrence of health problems among different subgroups should be interpreted with caution because background characteristics may affect both the access to the health care system and reporting. Furthermore, these are lifetime estimates, do not reflect current health status and cannot be temporally associated with other events. For example, a direct link between anemia and pregnancy cannot be established since is impossible to determine if anemia was a prior condition or had developed during the pregnancy. For all these reasons, the survey data about health problems among women may serve only as proxy estimates in the absence of official statistics based on medical records or hospital discharge data.

Generally, the level of self-reporting of medical conditions was very low. The most common condition reported was a genital tract infection. The prevalence of genital tract infection or pelvic inflammatory disease (PID) was determined by asking women if they had ever been told that they had an infection of the fallopian tubes (salpingitis) or infection of the uterus (endometritis). Overall, 19% of all women reported PID. Those most likely to report PID) were women aged 35-44 years (29%), women with two or more children (28% and 26%, respectively) and women with post-secondary education (24% and 21%, respectively). PID was almost non-existent among virgins and increased with the number of lifetime sexual partners, from 25% among monogamous women to 33% among those with two or more sexual partners.

Other health conditions were reported by various proportions of women: one in ten women reported she had been told by a doctor that she had a heart disease; 9% reported high blood pressure; 7% reported urinary tract infections; 6% reported anemia, 2% had been diagnosed with hepatitis B, and very few women had been told that they have asthma or diabetes (1%).

TABLE 13.6
Percentage of Women Who Have Been Told by a Doctor That They Have Ever Had Selected Health Problems by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Pelvic Inflammatory Disease	Heart Disease	High Blood Pressure	Urinary Infection	Anemia	Hepatitis B	Asthma	Diabetes	No. of Cases
Total	**18.7**	**10.5**	**8.7**	**6.9**	**5.9**	**1.8**	**1.3**	**0.5**	**7,798**
Residence									
Urban	19.5	10.5	9.1	7.8	6.6	1.9	1.8	0.6	4,759
Rural	17.7	10.5	8.1	5.7	5.1	1.6	0.7	0.3	3,039
Region									
Tbilisi	18.2	11.6	9.6	9.0	9.0	2.0	2.1	0.8	2,029
Imereti	20.6	7.9	7.3	7.9	4.4	1.7	1.4	0.3	1,590
North-East	18.3	12.2	9.0	7.3	5.7	1.7	0.8	0.3	1,259
South	16.2	9.0	7.6	4.9	3.8	1.3	0.2	0.2	1,017
West	20.0	10.6	9.1	4.8	5.2	1.9	1.6	0.5	1,903
Age Group									
15–24	7.8	4.6	3.0	2.7	3.5	1.4	1.1	0.2	2,388
25–34	21.1	9.6	7.9	7.4	7.6	1.9	1.1	0.6	2,731
35–44	28.9	18.2	16.0	11.2	7.1	2.0	1.8	0.7	2,679
No. of Living Children									
None	7.7	5.5	3.4	3.5	3.2	1.8	1.4	0.2	2,598
One	22.0	9.1	9.8	8.0	8.7	1.4	1.3	0.5	1,316
Two	28.0	14.7	12.2	10.0	7.9	1.9	1.6	0.8	2,737
Three or More	25.6	16.6	14.4	8.3	6.2	1.8	0.5	0.5	1,147
Education Level									
Secondary or Less	15.1	9.3	6.4	4.7	4.2	1.3	1.1	0.5	3,655
Technicum	24.4	14.0	12.8	9.5	6.6	2.0	1.5	0.6	2,058
University	20.5	9.4	9.3	8.7	8.6	2.5	1.5	0.4	2,085
Socio-Economic Status									
Low	17.0	10.0	7.3	5.4	5.8	1.4	1.0	0.4	3,276
Medium	19.5	11.5	9.6	7.3	5.4	1.9	1.3	0.6	3,654
High	19.6	7.8	8.3	8.5	8.1	1.9	2.1	0.2	868
Ethnic Group									
Georgian	19.5	10.3	8.8	7.2	6.3	2.0	1.5	0.5	6,700
Azeri	12.7	10.4	8.4	4.6	3.6	0.5	0.1	0.3	589
Armenian	17.2	9.2	5.8	3.6	3.9	1.1	0.6	0.8	300
Other	20.1	17.5	10.9	10.5	7.6	0.9	1.4	0.9	209
IDP Status									
IDP	21.3	12.1	11.9	7.5	6.6	1.8	3.3	0.3	1,828
Non-IDP	18.6	10.4	8.5	6.8	5.9	1.8	1.2	0.5	5,970
No. of Lifetime Partners									
Never Had Intercourse	5.1	5.1	3.1	3.0	2.7	1.8	1.4	0.1	2,095
One	25.2	12.8	11.4	8.6	7.3	1.7	1.2	0.6	5,533
Two or More	32.8	23.2	13.5	16.1	13.2	3.5	3.5	2.1	170

CHAPTER XIV

FAMILY LIFE EDUCATION

In recent decades, concerns about teenage sexuality, pregnancy and sexual health have been mounting worldwide. In many countries, due to socio-economic and cultural changes, young people, especially adolescents, are sexually active at earlier ages than they have been in the past. Studies show that they are more likely to have experienced premarital sexual intercourse, have a greater number of sexual partners, a higher incidence of unintended pregnancy and increased exposure to sexually transmitted diseases (STDs). Addressing unintended pregnancy and sexuality is a complex task. Finding appropriate responses to these problems has been made all the more complex by the recent social changes in the last decade. Increasingly, young people live in urban areas, are better educated and are more informed about lifestyle options. However, social attitudes toward sexuality, motherhood and gender roles are still influenced by traditional values. Prevention programs designed to reduce the rate of adolescent pregnancy and STDs require a multifaceted approach and school-based sex education is one important component of a broader effort. A number of studies have demonstrated that quality sex education programs can delay the onset of sexual activity and result in an increased use of contraception (Kirby D et al., 1994; Kirby D, 1999; Dawson DA, 1986).

In many countries sex or family life education in school is mandatory. It is often taught with age-appropriate teaching materials from first to 12th grade as a component of the health and physical education curriculum, and aims to increase knowledge about human biology, sexually transmitted diseases, AIDS prevention, contraception and abstinence.

Currently in Georgia, family life education is not included in the school curriculum on a systematic basis. Prior to 1990, elements of reproductive biology were taught in high school in the biology and human anatomy classes and short lectures about sexually transmitted diseases were sometimes taught by visiting health professionals. Often these extra-curricular lectures were held separately for boys and girls. After 1990, with the continuous support of several international agencies, local non-governmental agencies (NGOs) trained volunteers to lecture in high schools about reproductive health, family planning, and sexually transmitted diseases. These lectures have to be approved by the local school boards and their content varies from one school to another. Thus, sex education has been sporadic and not always standardized, or nonexistent, and the quality and amount of information is variable.

To improve the knowledge of Georgian adolescents it is essential to have high quality family life education curricula in their schools. They may, alternatively, acquire less than accurate information and sometimes misinformation from a variety of sources, including family, peers and the media. An age-appropriate family life education curricula should cover, in addition to reproductive physiology and biology, information on STDs (including AIDS), methods of contraception, and the psychological and social considerations of sex roles and sexual relationships. Only then would myths and misconceptions be addressed, enhancing the likelihood that intimate relationships would be based on caring, affection and awareness of the other person's feelings.

One of the objectives of the 99GERHS was to examine whether reproductive-age women in Georgia favor family life education in schools and to explore their opinions about the best age to start family life education. In addition, the survey was designed to explore young adult women's exposure to family life education in school and discussions about family life education topics at home and their sources of information on sexual matters. Data on exposure to family life education and knowledge of young adults would be useful for the design of school curricula and training of teachers.

14.1 Opinions about Family life Education In School

Table 14.1.1 shows that most Georgian women of reproductive age support family life education in school, regardless of age, residence, marital status, parity, education or socio-economic status. Although not shown in a separate table, among the 15% of women who did not agree that family life education should be taught in school, 84% of this group thought that family life education "may give adolescents the idea to begin sexual activity earlier," 62% thought that family life education should be taught only at home, half of these women thought family life education was contrary to their religious beliefs and 43% thought that those who teach family life education in schools are not qualified. It is important to note that reviews of program evaluators showed that HIV/AIDS and sex education programs do not hasten the onset of sexual activity and do not increase the frequency of sexual encounters among youths. In fact, some programs were associated with a delay in the initiation of intercourse and an increased likelihood of condom use (Grunseit A, 1997; Grunseit A. et al., 1997).

Women who agreed on the need for school-based family life education were also asked their opinion about the best age to start teaching selected topics of family life education. As shown in the left hand panel of Table 14.1.2, more than 80% of women wanted family life education classes on "how pregnancies occur" to be taught before age 16, including 21% of respondents who supported these courses before age 14. Residents of Tbilisi, women formerly in union and women in the

TABLE 14.1.1
Percent of Women Aged 15–44 Who Agree
Family Life Education Should Be Taught in School, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	% Who Agree Family Life Education Should Be Taught in Schools			Unweighted No. of Cases		
Characteristic	**All Women**	**Non-IDP Women**	**IDP Women**	**All Women**	**Non-IDP Women**	**IDP Women**
Total	**84.8**	**84.4**	**91.8**	**7,798**	**5,970**	**1,828**
Residence						
Tbilisi	88.3	88.0	92.7	2,029	1,476	553
Other Urban	90.7	90.5	91.9	2,730	1,685	1,045
Rural	78.6	78.4	90.3	3,039	2,809	230
Age Group						
15–19	81.4	81.0	90.8	1,142	876	266
20–24	86.4	85.9	96.2	1,246	948	298
25–29	88.2	88.0	92.4	1,312	1,030	282
30–34	86.3	85.8	96.4	1,419	1,114	305
35–39	84.7	84.4	92.7	1,523	1,147	376
40–44	81.9	82.0	80.1	1,156	855	301
Marital Status						
Currently Married/In Union	84.5	84.1	92.2	5,177	4,068	1,109
Formerly Married/In Union	84.1	83.9	87.7	517	362	155
Never Married/In Union	85.4	85.0	91.8	2,104	1,540	564
No. of Living Children						
None	85.2	84.8	92.3	2,598	1,934	664
One	88.4	88.0	95.9	1,316	993	323
Two	85.1	84.6	93.2	2,737	2,135	602
Three or more	79.1	79.0	82.2	1,147	908	239
Education Level						
Secondary Incomplete or less	70.0	69.6	85.4	991	846	145
Secondary Complete	84.3	83.7	94.5	2,664	1,968	696
Technicum	87.7	87.4	92.3	2,058	1,516	542
University	82.1	92.3	89.9	2,085	1,640	445
Socio-economic Status						
Low	79.8	78.5	92.1	3,276	1,883	1,393
Medium	86.9	86.7	93.6	3,654	3,257	397
High	88.2	88.4	82.1	868	830	38
Ethnic Group						
Georgian	88.3	88.0	91.7	6,700	4,918	1,782
Azeri	53.9	53.9	**	589	589	0
Armenian	86.2	86.2	**	300	294	6
Other	86.3	86.0	98.6	209	169	40

TABLE 14.1.2
Opinions of Best Age to Begin Teaching School-Based Courses about "How Pregnancies Occur"
Women 15–44 Who Think Schools Should Teach Family Life Education, by Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Opinion of Best Age To Teach "How Pregnancies Occur"				
Characteristic	**≤ 13**	**14–15**	**≥16**	**Total**	**No. of Cases**
Total	**21.3**	**64.3**	**14.4**	**100.0**	**6,843**
Residence					
Tbilisi	28.5	59.4	12.1	100.0	1,829
Other Urban	22.2	63.4	14.5	100.0	2,507
Rural	15.9	68.2	15.9	100.0	2,507
Age Group					
15–19	15.4	69.5	15.1	100.0	967
20–24	23.1	63.4	13.5	100.0	1,108
25–29	21.3	64.9	13.8	100.0	1,186
30–34	25.0	63.0	12.0	100.0	1,262
35–39	20.1	64.5	15.4	100.0	1,326
40–44	24.4	58.6	17.0	100.0	994
Marital Status					
Currently Married or In Union	20.6	64.0	15.4	100.0	4,527
Formerly Married or In Union	29.3	59.1	11.7	100.0	455
Never Married or In Union	21.1	65.7	13.2	100.0	1,861
Education Level					
Secondary Incomplete or less	14.9	65.2	19.9	100.0	733
Secondary Complete	20.0	66.2	13.8	100.0	2,320
Technicum	20.6	64.8	14.6	100.0	1,844
University	26.6	61.1	12.3	100.0	1,946
Socio-economic Status					
Low	20.0	64.2	15.8	100.0	2,815
Medium	21.1	64.8	14.3	100.0	3,247
High	24.8	63.1	12.1	100.0	781
Ethnic Group					
Georgian	21.1	64.2	14.7	100.0	6,034
Azeri	16.6	68.1	15.4	100.0	353
Armenian	21.7	66.8	11.5	100.0	270
Other	37.2	53.0	9.8	100.0	186
IDP Status					
IDP	22.5	65.3	12.2	100.0	1,677
Non-IDP	21.2	64.2	14.6	100.0	5,166

TABLE 14.1.3

Opinions of Best Age to Begin Teaching School-Based Courses about Contraception
Women 15–44 Who Think Schools Should Teach Family Life Education, by Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Opinion of Best Age To Begin Teaching About Contraception				
Characteristic	**≤ 13**	**14–15**	**≥16**	**Total**	**No. of Cases**
Total	**14.2**	**62.5**	**23.3**	**100.0**	**6,383**
Residence					
Tbilisi	21.2	57.8	21.0	100.0	1,760
Other Urban	13.3	62.9	23.8	100.0	2,325
Rural	10.2	65.3	24.5	100.0	2,298
Age Group					
15–19	11.8	63.9	24.3	100.0	897
20–24	15.6	61.3	23.2	100.0	1,044
25–29	14.8	63.2	21.9	100.0	1,105
30–34	16.5	62.4	21.1	100.0	1,186
35–39	12.9	63.1	24.0	100.0	1,231
40–44	14.3	60.4	25.3	100.0	920
Marital Status					
Currently Married or In Union	13.5	61.8	24.7	100.0	4,219
Formerly Married or In Union	21.4	60.8	17.8	100.0	425
Never Married or In Union	14.3	64.0	21.7	100.0	1,739
Education Level					
Secondary Incomplete or less	11.4	60.9	27.7	100.0	656
Secondary Complete	14.1	62.8	23.1	100.0	2,182
Technicum	13.5	61.9	24.6	100.0	1,704
University	16.3	63.4	20.4	100.0	1,841
Socio-economic Status					
Low	13.2	62.1	24.7	100.0	2,576
Medium	14.5	63.1	22.4	100.0	3,057
High	15.4	61.9	23.6	100.0	750
Ethnic Group					
Georgian	13.5	62.5	24.0	100.0	5,848
Azeri	14.8	65.3	19.9	100.0	311
Armenian	17.5	63.9	18.6	100.0	266
Other	28.1	55.2	16.7	100.0	185
IDP Status					
IDP	16.6	63.5	20.0	100.0	1,560
Non-IDP	14.1	62.4	23.5	100.0	4,823

TABLE 14.1.3

Opinions of Best Age to Begin Teaching School-based Courses on Sexually Transmitted Diseases
Women 15–44 Who Think Schools Should Teach Family Life Education, by Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Opinion of Best Age To Begin Teaching on Sexually Transmitted Diseases				
Characteristic	**≤ 13**	**14–15**	**≥16**	**Total**	**No. of Cases**
Total	**14.0**	**60.9**	**25.1**	**100.0**	**6,610**
Residence					
Tbilisi	21.2	56.2	22.6	100.0	1,797
Other Urban	12.9	61.5	25.6	100.0	2,426
Rural	9.9	63.7	26.4	100.0	2,387
Age Group					
15–19	11.1	63.1	25.8	100.0	923
20–24	15.3	60.1	24.6	100.0	1,070
25–29	14.7	61.5	23.8	100.0	1,152
30–34	16.3	60.8	22.9	100.0	1,229
35–39	12.8	60.4	26.8	100.0	1,279
40–44	14.1	59.3	26.7	100.0	957
Marital Status					
Currently Married or In Union	13.3	60.0	26.8	100.0	4,374
Formerly Married or In Union	21.2	58.7	20.2	100.0	438
Never Married or In Union	13.9	63.1	23.0	100.0	1,798
Education Level					
Secondary Incomplete or less	11.1	59.6	29.3	100.0	671
Secondary Complete	13.5	61.3	25.2	100.0	2,251
Technicum	13.8	59.9	26.4	100.0	1,779
University	16.0	62.0	22.0	100.0	1,909
Socio-economic Status					
Low	13.1	60.1	26.8	100.0	2,682
Medium	13.9	61.6	24.4	100.0	3,164
High	16.0	60.0	24.1	100.0	764
Ethnic Group					
Georgian	13.3	60.7	26.0	100.0	6,034
Azeri	14.3	65.3	20.4	100.0	353
Armenian	18.0	62.0	20.0	100.0	270
Other	26.7	56.7	16.4	100.0	186
IDP Status					
IDP	16.0	61.8	22.2	100.0	1,624
Non-IDP	13.9	60.9	25.3	100.0	4,986

highest education and socio-economic categories were more likely to think that classes on "How Pregnancies Occur" should be taught before the age of 14.

Opinions of reproductive-age women on the best age to begin teaching family life education courses covering methods of contraception and STDs are shown in Tables 14.1.3 and 14.1.4. The data are similar in both tables; among respondents who supported school-based education on these topics, there was again a strong preference to start the courses prior to age 16, including 14% who would like to see these courses introduced before age 14. Similarly, respondents who favored the early (before age 14) onset of school-based courses about STDs and contraception were more likely to be residents of Tbilisi and to have been formerly in union. No significant differences were noted according to age, educational level or other characteristics shown in the table.

14.2 Discussions about Family Life Education Topics with Parents

In order to examine the impact of family life education on reproductive health knowledge and sexual and contraceptive behaviors, we explored young women's exposure to family life education topics separately at home and in school. All 15-24-year-olds were asked if, before they reached age 18, they had ever talked to a parent about the menstrual cycle, abstinence before marriage, how pregnancy occurs, contraceptive methods, HIV/AIDS and other STDs. Although they show no significant differences compared with older adolescents and young adults, since the data for 15-17-year-olds is truncated, as they have not yet reached the age of 18, the data for this age group are considered to be minimum estimates only.

Table 14.2.1 shows the percentage of young women who had discussed the above mentioned family life education topics with a parent by selected characteristics. Overall, 61% of young women had talked about at least one family life education topic with a parent. Young women living in urban areas and in higher education and socio-economic groups were slightly much likely to have had such conversations with a parent. Azeri young adults were, by far, the least likely to have discussed any of these topics with a parent. However, these discussions consisted for the most part of talking about the menstrual cycle. Conversations about abstinence before marriage, how pregnancies occur, STDs, HIV/AIDS and contraception were substantially less prevalent, as less than one in seven young women (13%) of young women talked to a parent before age 18 about pregnancy (human reproduction) and less than 5% had discussed methods of birth control, HIV/AIDS or other STDs. Talking to parents about contraception was practically absent among young women.

TABLE 14.2
Percentage of Young Adult Women Aged 15–24
Who Discussed Certain Family Life Education Topics With a Parent Before They Reached Age 18
by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Family Life Education Topic							
Characteristic	Any Topic	Menstrual Cycle	Abstinence Before Marriage	How Pregnancies Occur	HIV/ AIDS	Other Sexually Transmitted Diseases	Contraception	No of Cases
Total	**61.0**	**59.2**	**14.0**	**13.0**	**4.7**	**2.8**	**1.6**	**2,388**
Residence								
Tbilisi	68.1	66.0	16.8	16.4	13.4	7.4	3.6	623
Urban	64.3	63.7	13.0	12.4	2.3	1.6	1.1	821
Rural	54.7	52.3	13.0	11.5	1.4	1.0	0.7	944
Age Group								
15–17	59.4	57.6	13.9	11.8	4.0	2.8	1.0	673
18–19	61.3	59.5	15.3	14.0	6.3	3.1	1.0	469
20–24	62.0	60.3	13.4	13.4	4.5	2.7	2.3	1,246
Marital Status								
Ever Married/In Union	55.8	53.7	10.4	13.7	4.0	1.7	2.0	949
Never Married/In Union	63.5	61.9	15.6	12.6	5.1	3.3	1.4	1,439
Education Level								
Secondary Incomplete	54.3	52.0	13.5	10.3	0.6	2.3	1.1	683
Secondary Complete	62.0	60.7	14.7	15.2	2.5	3.1	1.9	997
Technicum	67.2	64.6	12.1	9.5	5.6	1.9	1.0	291
University	68.5	67.3	14.2	15.7	7.1	3.4	2.0	417
Socio-economic Status								
Low	58.0	55.2	13.2	11.3	2.5	1.1	0.9	1,014
Medium	60.5	59.3	12.9	11.7	3.9	2.5	1.4	1,105
High	70.1	68.4	19.7	21.8	13.0	8.0	4.0	269
Ethnic Group								
Georgian	65.2	63.8	14.3	13.5	5.0	3.1	1.5	2,028
Azeri	32.7	28.8	11.0	7.0	2.5	1.2	0.6	219
Armenian	57.8	54.7	14.6	16.2	1.6	0.0	2.3	91
Other	52.1	52.1	14.8	19.3	11.3	4.8	9.8	50
IDP Status								
IDP	66.9	66.4	12.8	13.4	5.2	2.0	2.1	564
Non-IDP	60.7	58.9	14.0	13.0	4.7	2.8	1.5	1,824

Generally, parent-child conversations on any topic are more often reported by urban than rural young women. Discussions about HIV/AIDS were six times and nine times, respectively, more likely to occur between young adults and their parents in Tbilisi or other urban areas than their counterparts in rural areas. Discussions on all family life education topics were most likely to occur in families with high SES and least likely in Azeri families.

14.3 Family Life Education Instruction in School

Young women were also asked whether, before they reached age 18, they had ever received formal or informal instruction in school about the topics listed in Table 14.3.1. Those who reported exposure to instruction in school were then asked the age at which they first had a class on each specific topic. Similar to the data on discussions with parents, the data for family life education for 15-17-year-olds in schools is truncated, as these respondents have not yet reached age 18. Therefore, the data for this age group are considered to be a minimum estimate only.

Table 14.3.1 shows the percentage of women who reported family life education on specific topics. Overall, about half (49%) of young women had at least one school-based course or class on family life education. However, they were much more likely to have received lectures on female and male reproductive biology, the menstrual cycle, and how pregnancy occurs (45%, 43%, 36%, and 32%, respectively) than lectures on HIV/AIDS, other STDs, and contraceptive methods (5%, 2%, and 1%). As was the case for discussions with parents, those young women with only a primary education were significantly less likely to have taken a family life education course in school. On the other hand, since in some areas these courses may not be offered until secondary school, as a group they had fewer opportunities to take such courses, so the fact that 37% nevertheless have taken a course is important. However, this also points to the need for out-of-school education for those who never entered secondary school. Also, as was the case for discussions of family life education topics with parents, a significantly lower proportion of young women in the lowest socio-economic category and in the Azeri ethnic group had ever taken a school-based course on any family life education topic. Young adults in Tbilisi and other urban areas were more likely to have taken a course, and Tbilisi was the only area where more than 10% received a presentation on HIV/AIDS.

Looking at the proportion of young women who have taken specific courses in school on family life education shows that of those women who have taken a course on female or male reproductive biology, approximately one fourth will have done so by age 15 (Table 14.3.2). However, for "The Menstrual Cycle" and "How Pregnancies Occur" only one in three will have taken courses in these topics by age 16. For contraceptive methods, HIV/AIDS and other STDs, as mentioned above, very few have done so by any age.

TABLE 14.3.1

Percentage of Young Adult Women Aged 15–24 Who Had Family Life Education Topics in School Before They Reached Age 18 According to Specific Family Life Education Topic, by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

	Family Life Education Topics								
Characteristic	Any Topic	Female Reproductive Biology	Male Reproductive Biology	Menstrual Cycle	How Pregnancies Occur	HIV/ AIDS	Other STDs	Contraception	No. of Cases
Total	**49.3**	**44.9**	**42.6**	**36.4**	**32.2**	**5.4**	**2.1**	**1.1**	**2,388**
Residence									
Tbilisi	58.3	46.8	45.6	38.9	36.7	12.2	4.9	2.1	623
Other Urban	52.6	50.2	46.3	43.0	36.2	4.2	1.2	0.7	821
Rural	42.0	40.2	38.3	30.6	27.0	2.3	1.2	0.9	944
Age Group									
15–17	45.0	40.8	39.3	33.5	28.1	5.2	2.4	0.4	673
18–19	52.8	48.1	44.4	41.8	34.9	8.4	1.9	1.8	469
20–24	51.1	46.7	44.3	36.3	34.2	4.2	1.9	1.4	1,246
Marital Status									
Ever Married/In Union	44.5	41.0	39.2	32.6	29.3	3.7	1.2	1.1	949
Never Married/In Union	51.6	46.8	44.2	38.3	33.6	6.2	2.5	1.2	1,439
Education Level									
Secondary Incomplete	36.7	33.6	31.7	26.4	22.5	3.7	1.5	0.4	683
Secondary Complete	54.4	40.2	48.1	40.3	37.5	5.9	2.0	1.4	997
Technicum	51.4	46.4	42.0	36.8	34.2	6.3	2.9	1.6	291
University	62.3	56.9	52.2	48.2	38.4	7.0	3.2	1.6	417
Socio-economic Status									
Low	41.9	39.9	37.9	31.5	28.5	2.7	1.1	0.9	1,014
Medium	51.9	46.8	44.3	37.9	32.8	4.9	1.9	0.9	1,105
High	57.5	49.8	47.8	43.0	39.2	13.5	5.4	2.7	269
Ethnic Group									
Georgian	54.1	49.2	46.5	40.2	35.3	5.8	2.3	1.2	2,028
Azeri	17.8	17.5	16.6	11.1	9.9	2.4	0.6	0.3	219
Armenian	43.1	37.7	37.7	32.3	30.1	3.9	1.6	0.8	91
Other	45.6	39.0	39.0	34.3	35.8	6.4	4.8	3.2	50
IDP Status									
IDP	56.8	48.0	46.5	38.6	34.7	11.1	2.5	2.9	564
Non-IDP	49.0	44.8	42.4	36.3	32.1	5.1	2.1	1.1	1,824

TABLE 14.3.2
Percent of All Young Adult Women 15–24
Who Have Taken Courses in School on Selected Family Life Education Topics by Certain Ages
Reproductive Health Survey: Georgia, 1999/2000

	Percent Who Have Taken Course By Age:						
Family life Education Topic	14	15	16	17	18	19	No. of Cases
Female Reproductive Biology	1.9	23.2	43.6	46.5	46.5	46.6	2,388
Male Reproductive Biology	1.4	21.5	41.3	44.1	44.1	44.2	2,388
The Menstrual Cycle	2.3	19.4	35.5	37.7	37.7	37.8	2,388
How Pregnancies Occur	0.8	15.5	31.7	33.5	33.5	33.6	2,388
HIV/AIDS	0.4	1.9	4.1	5.6	5.8	5.9	2,388
Other Sexually Transmitted Diseases	0.1	0.6	1.4	2.1	2.3	2.4	2388
Contraceptive Methods	0.0	0.4	0.8	1.1	1.2	1.3	2,388

TABLE 14.3.3
Main Source of School-Based Family Life Education Among Young Women Aged 15–24
Who Received Family Life Education in School by Selected Topics
Reproductive Health Survey: Georgia, 1999/2000

	Source of School-Based Family Life Education						
Family Life Education Topic	Teacher	Doctor/ Nurse	Volunteer	Other	Do Not Remember	Total	No. of Cases
Female Reproductive Biology	99.4	0.3	0.0	0.0	0.3	100.0	1,120
Male Reproductive Biology	99.3	0.3	0.0	0.0	0.3	100.0	1,069
Menstrual Cycle	99.1	0.3	0.5	0.0	0.1	100.0	904
How Pregnancies Occur	99.2	0.6	0.1	0.0	0.1	100.0	819
HIV/AIDS	92.0	0.8	1.9	5.3	0.0	100.0	116
Other Sexually Transmitted Diseases	98.3	1.7	0.0	0.0	0.0	100.0	37
Contraceptive Methods	96.9	3.1	0.0	0.0	0.0	100.0	28

Table 14.3.3 shows who young women reported as having taught them the various family life education topics. All courses were taught almost exclusively by the teachers in their school.

In Sections 2 and 3 of this chapter, it is important to note that these are self-reports of the respondents and which give no indication of the quality or depth of discussions with parents or instruction in school.

14.4 Sources of Information on Sexual Matters

Young women aged 15-24 were asked who, in their opinion, has been their most important source of information on topics related to sexual matters. Table 14.4 shows that for most women the most important source for this type of information were their friends and peers (46%). Only one in seven women named the media, one in ten named teachers, and fewer than 9% named their parents as the most important source of information. Similar findings were documented by school-based surveys conducted in several schools in Tbilisi and Rustavi by the Georgian Family Planning Association (FPAG, 2000b).

In Tbilisi, as education increases, and for 15-17-year-olds, the media becomes somewhat more important to young women as a source of information on sexual matters. Also, although relatively few women rely on books, books are more important among women with a university education.

14.5 Impact on Knowledge about Fertility Issues and Contraception

Although 47% of young women were exposed to at least one course or class on family life education before age 18 (see Table 14.3.2) and about one-third had instruction about the menstrual cycle and how pregnancies occur, taking a course does not necessarily translate into correct knowledge and subsequent safer sexual behaviors. To determine whether exposure to formal or parental family life education may have had any impact on respondents' knowledge of human reproduction, all young women were asked to identify the time during the menstrual cycle when conception is most likely to occur (they were read a list of five choices), if breast-feeding increases, decreases or has no effect on a woman's risk of getting pregnant, and if pregnancy can occur at first sexual intercourse.

TABLE 14.4

Opinion on the Most Important Source of Information about Sexual Matters Among Young Adult Women Aged 15–24 by Selected Characteristics Reproductive Health Survey: Georgia, 1999/2000

	Opinion on the Most Important Source of Information About Sexual Matters										
Characteristic	Friends Peers	Media	Teacher	A Parent	Partner/ Husband	Books	Other Relatives	Doctor	Nobody	Total	No. of Cases*
Total	**45.8**	**14.1**	**9.8**	**8.1**	**7.7**	**7.2**	**4.8**	**2.2**	**0.3**	**100.0**	**2,360**
Residence											
Tbilisi	38.8	20.7	11.5	11.1	5.2	8.5	2.0	2.2	0.0	100.0	614
Other Urban	49.6	12.9	13.0	5.5	5.7	6.9	4.2	2.2	0.1	100.0	817
Rural	47.1	11.3	6.7	8.3	10.4	6.7	6.7	2.2	0.6	100.0	929
Age Group											
15–17	34.2	29.8	18.9	6.5	7.1	1.8	0.9	0.3	0.6	100.0	668
18–19	43.5	14.0	13.2	7.4	7.4	6.5	4.9	2.7	0.5	100.0	457
20–24	42.7	14.2	9.6	6.4	11.1	9.1	4.5	2.1	0.4	100.0	1,235
Marital Status											
Ever Married/In Union	40.1	10.2	7.0	6.1	23.5	5.1	4.6	3.0	0.4	100.0	935
Never Married/In	48.5	16.0	11.2	9.1	0.1	8.2	4.8	1.8	0.3	100.0	1,425
Education Level											
Secondary Incomplete	48.8	12.6	6.7	10.1	10.1	3.5	6.0	2.0	0.2	100.0	670
Secondary Complete	45.7	13.1	10.8	7.3	7.0	7.7	5.1	2.8	0.6	100.0	986
Technicum	47.4	13.7	14.9	7.1	5.8	2.4	1.4	2.2	0.0	100.0	290
University	38.4	20.4	10.5	6.7	4.7	14.9	2.8	1.6	0.0	100.0	414
Socio-economic Status											
Low	47.3	12.8	7.3	7.3	10.2	6.4	6.4	1.7	0.6	100.0	997
Medium	45.4	14.3	10.6	8.0	6.7	8.2	4.3	2.3	0.2	100.0	1,097
High	43.7	16.8	13.0	10.3	5.3	5.4	2.6	3.0	0.0	100.0	266
Ethnic Group											
Georgian	47.2	14.7	10.8	8.0	5.1	8.2	4.0	1.9	0.1	100.0	2,015
Azeri	34.1	7.3	3.3	11.1	27.0	0.6	9.6	5.1	1.9	100.0	208
Armenian	57.1	11.2	7.9	4.8	6.3	5.6	7.0	0.0	0.0	100.0	89
Other	26.7	31.4	11.7	3.4	13.3	5.3	4.9	3.3	0.0	100.0	48
IDP Status											
IDP	50.4	11.2	11.6	8.7	6.8	5.5	1.8	3.9	0.0	100.0	562
Non-IDP	45.6	14.3	9.7	8.1	7.7	7.3	4.9	2.1	0.3	100.0	1,798

* = Excludes 28 women who did not respond to this question.

TABLE 14.5.1
Knowledge of Young Adult Women Aged 15–24
About the Most Likely Time to Become Pregnant During the Menstrual Cycle
by Whether or Not Menstrual Cycle Was Discussed with a Parent or Taught in School
Reproductive Health Survey: Georgia, 1999/2000

Most Likely Time to Become Pregnant During Menstrual Cycle	Total	Discussed Menstrual Cycle With Parents		Taught About Menstrual Cycle in School	
		Yes	No	Yes	No
Halfway Between Periods	24.9	26.6	22.3	31.3	21.2
The Week Before, During or Just After the Menstruation	26.2	26.6	25.7	26.2	26.2
Anytime	7.3	6.5	8.6	6.2	8.0
Don't Know	41.6	40.4	43.4	36.4	44.6
Total	100.0	100.0	100.0	100.0	100.0
Number of Cases	2,388	1,465	923	904	1,484

Knowledge of the most fertile time in a woman's menstrual cycle is an important measure of a couple's ability to assess the risk of pregnancy occurrence during unprotected intercourse, and thereby an indicator of the potential to prevent unintended pregnancies. Table 14.5.1 shows the percent distribution of young women according to their answers to the question on identifying the time during the menstrual cycle when conception is most likely to occur, by whether they had ever discussed the menstrual cycle with their parents or taken a related school-based family life education course or class.

Overall, only one in four young women were able to correctly identify the most fertile time (halfway between periods) during a woman's menstrual cycle. Discussions with parent(s) about the menstrual cycle had little effect on young women' knowledge, but family life education in school had a positive influence on the proportion of young adults with correct answers. The proportion of women who knew the correct time during the menstrual cycle when the risk of pregnancy was greatest among those who took a school based course versus those who did not report formal instruction (31% vs. 21%). Thus, though widespread exposure to this topic increases knowledge of the correct information, the fact still remains that most young adults who acknowledged education

TABLE 14.5.2
Knowledge of Young Adult Women Aged 15–24
About the Risk of Getting Pregnant While Breastfeeding and the Possibility of Getting Pregnant at the Time of First Sexual Intercourse
by Whether or Not "How Pregnancies Occur" Was Discussed With a Parent or Taught in School
Reproductive Health Survey: Georgia, 1999/2000

		Discussed "How Pregnancies Occur" With Parents		Taught About "How Pregnancies Occur" In School	
	Total	Yes	No	Yes	No
Risk of Getting Pregnant While Breastfeeding					
Lower Risk	40.0	50.7	38.4	44.7	37.8
Same Risk as if not Breastfeeding	15.4	19.7	14.7	18.3	14.0
Higher Risk	1.6	1.1	1.7	2.2	1.3
Do not Know	43.0	28.5	45.2	34.9	46.9
Total	100.0	100.0	100.0	100.0	100.0
Possibility of Getting Pregnant at First Intercourse					
Possible	76.4	86.8	74.8	82.2	73.6
Not Possible	3.4	4.6	3.2	2.1	4.0
Do not Know	20.3	8.6	22.0	15.8	22.4
Total	100.0	100.0	100.0	100.0	100.0
Number of Cases	2,388	302	2,086	819	1,569

on the menstrual cycle either in school or at home gave the wrong answer or did not know how to respond to the question.

Overall, 40% of women correctly responded that breast-feeding decreases the risk of pregnancy and this proportion was significantly higher if young women reported home-base or school-based discussions on "How Pregnancies Occur" (Table 14.5.2, upper panel). Almost half (43%) of young women did not know how to respond to this question.

More than three fourths of young women agreed that a woman can get pregnant at first

intercourse (Table 14.5.2, lower panel). Of the remaining women, most do not know how to answer this question. Greater proportions of women who had either home or school-based discussions correctly agreed that a woman can get pregnant at first intercourse, demonstrating that education can have an association with correct knowledge on this issue. The survey included a series of questions in which respondents were asked whether they knew how to use any of 10 methods of contraception listed (see Chapter VII). It had been planned that the data analysis include a table showing the percentages of young adult women who knew how particular contraceptive methods are used cross-tabulated with the proportion who had discussions with their parents or who had been taught in school about "contraceptive methods". However, as seen in Tables 14.2.1 and 14.3.1, less than two percent of young women had ever had parental discussions or had been taught in school about contraception, so these data would not have statistical validity. As a result, this analysis was not done.

CHAPTER XV

SEXUAL AND CONTRACEPTIVE EXPERIENCE OF YOUNG ADULTS

The Young Adult module of the 99GERHS included questions on attitudes toward condom use, age and partner at first sexual intercourse, and use of contraceptive methods as well as current and past sexual partners and sexual behaviors.

15.1 First Sexual Intercourse

Life table estimates shown in Table 15.1.1 demonstrate differentials in initiating sexual intercourse by the ages of 16, 18 and 20. The proportion of all young adults who have had their first sexual experience by age 16 is low (2%) and by age 20, less than one-third have initiated sexual intercourse (32%). The table shows that the likelihood of initiating sexual intercourse increases with age among all education, residential and socioeconomic levels. In comparing young women in rural and urban areas, a greater proportion of women in rural areas have began sexual intercourse by age 16, 18 and 20- most likely due to the earlier age at marriage in rural areas.

The role of education also demonstrates an effect on a bivariate basis as the likelihood of initiating sexual intercourse decreases as women reach higher educational levels. Smaller proportions of women at each age who have completed secondary school or attended technical school or university have initiated sexual intercourse compared with women who did not complete secondary school; however, there is probably a strong multivariate relationship between lower education, rural residence and earlier age at marriage. By age 20, only 21% of university- level women report having had sexual intercourse. An inverse relationship by socioeconomic status is also demonstrated with slightly more than a quarter of the women in the middle (28%) and higher (28%) socioeconomic levels who have initiated sex by the time they reach 20 years old compared to more than one-third of the women in the lower socioeconomic level (39%) who have initiated intercourse by that age. In comparing regional differences, almost half of young women in the South region have their first sexual experience by the age of 20 (49%). In contrast, only about two out of ten women in the Imereti region have had their first sexual intercourse by the same age (22%). Lastly, internally displaced status is compared among the respondents. A young woman with internally displaced (IDP) status and a young woman without IDP status have almost an equal likelihood, 29% and 32%, respectively, of initiating sexual intercourse by the age of 20.

TABLE 15.1.1
Life Table Estimates of Age at First Sexual Experience Among Women Aged 15–24 Years by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Age At First Intercourse <16	<18	<20	No. of Cases
Total	**2.3**	**13.9**	**31.5**	**2388**
Residence				
Urban	1.2	9.6	25.6	1444
Rural	3.7	19.5	39.6	944
Education Level				
Secondary Incomplete	4.2	24.4	48.1	683
Secondary Complete	2.1	12.6	31.0	997
Technical School	0.8	8.8	26.5	291
University	0.0	5.3	20.8	417
Socio-Economic Status				
Low	3	17.3	38.9	1014
Middle	2.1	12.7	28.3	1105
High	1.5	10.6	28.0	269
Region				
Northeast	4.3	19.2	40.0	384
South	3.7	24.3	48.5	337
Tbilisi	1.0	9.2	24.5	623
Imereti	1.5	10.2	21.8	472
West	1.7	10.0	28.2	572
IDP Status				
Yes	2.0	6.9	28.5	564
No	2.4	14.3	31.7	1824

Young women were asked for the date (month and year) of their first sexual intercourse as well as their age at the time. As Table 15.1.2 demonstrates, women aged 15-24 remain virgins throughout most of their young adulthood. Of the 2388 young adult respondents, two-thirds (67%) report that they have not had sexual intercourse. This table also shows that virtually all sexually experienced women had their first sexual experience after marriage (96%). Only within the 22-24 age group do more than half of women report sexual experience, with 95 % reporting their first

TABLE 15.1.2
Reported Sexual Experience of Young Women Aged 15–24 Years by Marital Status at Time of First Sexual Experience by Current Age Group Reproductive Health Survey: Georgia, 1999/2000

	Reported Sexual Experience			Marital Status at First Intercourse		
Current Age Group (years)	No Sexual Experience	Sexual Experience	Total	After Marriage	Before Marriage	No. of Cases
Total (15-24)	**67.4**	**32.7**	**100.0**	**31.3**	**1.3**	**2,388**
15-17	90.2	9.8	100.0	9.5	0.3	673
18-19	73.5	26.5	100.0	25.9	0.5	469
20-21	59.8	40.2	100.0	38.6	1.6	479
22-24	38.3	61.7	100.0	58.7	3.1	767

sexual encounter after marriage. The prevalence of premarital sex is extremely low; approximately 1% report sexual intercourse before marriage. This is in stark contrast to neighboring Eastern European countries. The comparison between countries will be discussed at the end of this chapter.

As shown in Table 15.1.3, the proportion of women reporting sexual experience is slightly lower among urban residents than rural residents (28% and 39% respectively), reflecting the earlier age at marriage in rural areas since almost all reported sexual experience is marital. As in most countries, younger women in rural areas may be more inclined to marry at younger ages for various social and economic reasons. In addition, the increased opportunity for young women in urban areas to continue their education may delay the age at marriage and subsequently, in this society, the age at first sex.

The marital status of young women at first sexual experience by current age group and education is described in Table 15.1.4. A greater proportion of young women aged 15-24 who have completed their secondary education reported sexual intercourse (36%-42%) compared to those who have not completed their secondary education (23%). Cross-sectional data for women aged 15-24 is not comparable to life table estimates to age 20 (shown in Table 15.1.1). The life table estimates show an inverse relationship between age at first sex and educational attainment, and if one controls for age group and compares only 20-24-year-old women in the Table 15.1.4, we find a similar inverse relationship with educational attainment.

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 1999/2000

Current Age & Residence	Reported Sexual Experience: No Sexual Experience	After Marriage	Before Marriage	Total	Unweighted No. of Cases
All Women					
15–19	84.2	15.4	0.4	100.0	1,142
20–24	47.3	50.3	2.4	100.0	1,246
Total	**67.4**	**31.3**	**1.3**	**100.0**	**2,388**
Urban					
15–19	87.5	12.1	0.4	100.0	666
20–24	56.4	40.9	2.7	100.0	778
Total	**72.1**	**26.3**	**1.5**	**100.0**	**1,444**
Rural					
15–19	80.7	18.9	0.4	100.0	476
20–24	33.5	64.4	2.1	100.0	468
Total	**61.4**	**37.6**	**1.1**	**100.0**	**944**

Married and unmarried respondents who were sexually experienced were asked if they or their partner used any contraceptive method during their first sexual experience (data not shown). Only four respondents out of 951 sexually experienced young women reported that they or their partner used any contraception at that time. The remainder of respondents were asked for their reasons for not using contraception at first intercourse. Their responses are given in Table 15.1.5. Among all sexually experienced women who did not use contraception at their first sexual intercourse, the majority did not use contraception because they wanted to get pregnant (75%). The second most cited reason for not using contraception was "did not think about it" (13%). These reasons were the two most common reasons cited among women in union, 76% and 13%, respectively. Despite the small sample size of sexually experienced women not in union who did not use contraception at first sex, the main reason for non-use was the desire to become pregnant (68%) followed by unexpected intercourse (18%). Over 60% of unmarried women who wanted to become pregnant at first intercourse dated their partner for more than one year (data not shown). The desire for pregnancy appears to be a major concern for many women in this age group independent

of marital status. Given that most young women in Georgia have their first sexual experience after marriage and have a strong desire to have children once they are married, demand for family planning among young married women is minimal until they have their first child. Programs can concentrate on spacing of future children to improve maternal and infant health and should provide appropriate counseling on contraceptive use at prenatal care.

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, 1999/2000

	Reported Sexual Experience				
Current Age & Education	No Sexual Experience	After Marriage	Before Marriage	Total	Unweighted No. of Cases
All Women					
15–19	84.2	15.4	0.4	100.0	1,142
20–24	47.3	50.3	2.4	100.0	1,246
Total	**67.4**	**31.3**	**1.3**	**100.0**	**2,388**
Secondary Incomplete					
15–19	86.3	13.1	0.6	100.0	558
20–24	19.4	77.6	3.0	100.0	128
Total	**76.8**	**22.2**	**0.9**	**100.0**	**683**
Secondary Complete					
15–19	81.2	18.6	0.2	100.0	472
20–24	46.0	51.9	2.2	100.0	525
Total	**64.4**	**34.5**	**1.1**	**100.0**	**997**
Technical School					
15–19	75.6	24.4	0.0	100.0	64
20–24	52.5	44.4	3.0	100.0	227
Total	**58.2**	**39.5**	**2.3**	**100.0**	**291**
University					
15–19	96.1	3.9	0.0	100.0	48
20–24	55.8	42.0	2.3	100.0	369
Total	**60.9**	**37.2**	**2.0**	**100.0**	**417**

TABLE 15.1.5
Most Commonly Cited Reasons for Not Using Contraception at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24 Years by Marital Status at First Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status at First Intercourse	
Main Reason for Not Using Contraception	**Total**	**Married&In Union**	**Not Married**
She Wanted to Get Pregnant	75.4	75.7	67.9
She Did Not Think About Using a Method	12.7	12.9	8.7
She Did Not Know About Contraception	5.3	5.4	2.8
Sexual Intercourse Was Unexpected	3.2	2.6	17.5
She Did Not Want to Use Contraception	2.8	2.8	3.1
Other	0.3	0.3	0.0
Don't Remember	0.3	0.3	0.0
Total	100.0	100.0	100.0
Unweighted No. of Cases	945	916	29

TABLE 15.1.6
Age Difference Between Married Partners at First Sexual Intercourse by Age at First Sexual Intercourse
Reproductive Health Survey: Georgia, 1999/2000

Age at First Sexual Experience	**≤ 5 Years**	**5 Years or More**	**Total**	**Unweighted No. of Cases**
Total	**45.0**	**55.0**	**100.0**	**928**
12-14	56.0	44.0	100.0	59
15	49.3	50.7	100.0	128
16	54.3	45.7	100.0	149
17	39.5	60.5	100.0	182
18	45.1	54.9	100.0	165
19	28.7	71.3	100.0	82
20-24	35.9	64.1	100.0	163

As seen in Table 15.1.6, over half of partners (55%) at first marriage are at least five years older than the woman. Among women marrying at 19-24 years of age, about two-thirds of their partners are five years or older.

15.2 Current Sexual Activity

Table 15.2.1 shows the current sexual activity status of women aged 15-24. Sexually experienced respondents were asked when they last had intercourse. As mentioned in the previous section, most young adult women (67%) have never had sex. The majority of the remaining 33% of women who have had sexual intercourse have had sex in the last month (62%), followed by women who were identified as currently pregnant or postpartum at the time of the interview (29%). Thirty percent of women currently married or in union and 14% of women previously married, were identified as pregnant or postpartum. Conversely, among women who were never married, almost 100% reported never having sexual intercourse. By age group, 6 out of 7 women aged 15-19 have never had sexual intercourse (84%). However, among women aged 20-24 about one-half of women have had a sexual experience (53%). About one out of three women have had intercourse in the last month (35%).

TABLE 15.2.1
Current Sexual Activity Status Among Young Adult Women Aged 15–24 Years by Current Marital Status and by Age Group
Reproductive Health Survey: Georgia, 1999/2000

	Total	Marital Status			Age Group	
Sexual Activity Status		Married/ In Union	Previously Married	Unmarried	15-19	20-24
Never Had Intercourse	**67.4**	0.0	0.0	99.8	84.2	47.3
Ever Had Intercourse	**32.8**	100.0	100.0	0.2	15.8	52.7
• Within the Last Month	**20.4**	66.3	1.9	0.1	8.6	34.5
• 1-3 Months Ago	**0.9**	2.1	11.2	0.0	0.4	1.4
• Over 3 Month Ago but Within Last Year	**0.8**	1.0	24.0	0.0	0.1	1.6
• One Year or Longer	**1.1**	0.5	49.2	0.0	0.2	2.1
• One Month or Longer-Unknown Interval	**0.1**	0.1	0.0	0.1	0.0	0.2
Currently Pregnant or Postpartum	**9.5**	30.0	13.8	0.0	6.5	12.9
Total	**100.0**	100.0	100.0	100.0	100.0	100.0
No. of Cases	**2,388**	900	49	1,439	1,142	1,246

The majority of all sexually experienced women did not use contraception at their most recent sexual intercourse (73%). The proportions are shown in Table 15.2.2 by current marital status. The likelihood of not using contraception is higher among those young women who are not currently married (98%) compared to those who are currently married (72%). Among the 27% of sexually experienced women who are using contraception, modern methods are more common than traditional methods, 16% and 11%, respectively. IUD is the most common modern method (7%) and withdrawal is the most common traditional method (8%).

TABLE 15.2.2
Use of Contraception at Most Recent Sexual Intercourse by Current Marital Status Among Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status	
Use of Contraception	**Total**	**Currently Married&In Union**	**Not Currently Married**
Currently Using	**26.8**	**28.4**	**1.8**
Modern Methods	16.1	17.1	1.8
IUD	7.1	7.4	1.8
Condom	5.2	5.5	0.0
Pills	2.0	2.1	0.0
Emergency Contraception	1.7	1.8	0.0
Female Sterilization	0.2	0.2	0.0
Traditional Methods	10.7	11.4	0.0
Withdrawal	7.9	8.4	0.0
Calendar (Rhythm Met.)	2.9	3.0	0.0
Not Currently Using	73.2	71.6	98.2
Total	100.0	100.0	100.0
No. of Cases	951	900	51

TABLE 15.2.3
Most Commonly Cited Reasons for Not Using Contraception at Most Recent Sexual Intercourse Among Women Aged 15–24 Years Who Have Had Sexual Intercourse in Last 3 Months by Current Marital Status
Reproductive Health Survey: Georgia, 1999/2000

		Current Marital Status	
Main Reason for Not Using Contraception	**Total**	**Married&In Union**	**Not Married**
Currently pregnant	**20.4**	22.2	0.0
Wanted to Get Pregnant	**26.4**	28.2	5.9
Currently postpartum or breastfeeding	**18.9**	19.4	13.2
Did not think about it/negligence	**10.0**	10.8	1.9
Not Sexually Active	**8.8**	2.7	79.0
Female infertility/subfecundity	**3.3**	3.6	0.0
Dislike	**2.9**	3.1	0.0
Cost/Lack of Access	**2.2**	2.4	0.0
Don't Know	**1.6**	1.7	0.0
Fear of Side Effects	**1.5**	1.6	0.0
Lack of Knowledge of FP use	**1.4**	1.6	0.0
Pelvic Inflammatory Disease	**1.0**	1.1	0.0
Doubt She can get Pregnant	**0.7**	0.8	0.0
Other Reason	**0.6**	0.7	0.0
Male Infecundity	**0.1**	0.2	0.0
Total	**100.0**	100.0	100.0
Unweighted No. of Cases	**686**	636	50

The reasons cited for not using contraception among women having intercourse in the last three months or among currently pregnant or postpartum women by marital status is described in Table 15.2.3. The desire to get pregnant was the most commonly cited reason for not using contraception (28%) among women in union. The second reason is being currently pregnant or postpartum (22% and 19% respectively). However, among women who are not married, not having a partner, or not being sexually active, was the most common reason for not using contraception

(79%). Sexually experienced respondents were asked to recall the number of sexual partners that they had in the past three months. These figures are shown in Table 15.2.4; 90% of sexually experienced women report having had only one partner, while less than one percent have had two or more partners. Among women who are married, 95% report having one partner in the past three months. Among women who are previously married, 67% have had no partners and 33% have had one partner in the past three months. Subsequently, these respondents were also asked to recall the number of sexual partners that they have had in their lifetime. 98% of all women report one sexual partner in their lifetime. This proportion is essentially the same among married and previously married women (99% and 98% respectively).

TABLE 15.2.4
Number of Sexual Partners Reported in Last 3 Months and in Lifetime by Current Marital Status Among Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Georgia, 1999/2000

		Marital Status		
Use of Contraception	**Total**	**Currently Married&In Union**	**Previously Married**	**Never Married**
Three Months				
None	9.5	4.5	66.7	*
One	90.4	95.4	33.3	*
Two or more	0.1	0.1	0.0	*
Total	100.0	100.0	100.0	*
Lifetime				
One	98.2	99.1	98.0	*
Two or more	1.0	0.9	2.0	*
Refused to Answer	0.2	0.0	0.0	*
Total	100.0	100.0	100.0	*
No. of Cases	951	900	49	2

* Less than 25 cases in this category.

15.3 Opinions and Attitudes About Condoms and Condom Use

Table 15.3.1 shows sexually experienced women's beliefs about condoms and condom use categorized by women who are ever users and never users. First, many more users of condoms than non-users either agreed or disagreed with the statements and very few were uncertain. Among non users, the proportion of women with an uncertain response ("Don't Know") was 40% or higher for each statement. This is probably due to their lack of exposure to using condoms or discussing topics related to condom use. Most users of condoms agree that using a condom with your partner is a good idea (85%) Almost two thirds believe that women should ask their partners to use condoms (61%). Most condom users disagree with the notion that condoms can be used more than once (97%). A high proportion of condom users also disagree with the belief that people who use condoms sleep around a lot (91%) and that it is embarrassing to ask for condoms in FP clinics or pharmacies (88%). This suggests that women who have used condoms with their partners disagree with societal myths that may act as barriers in using condoms. Less than half of non users of condoms agreed that using condoms with partners is a good idea (48%). Fewer non-users than users agreed that women should ask their partners to use condoms (16% versus 61%) and that it is easy to discuss condoms with a partner (8% versus 33%). A high proportion of both women who use condoms (48%) and women who do not use condoms (40%) agreed that condoms are not necessary if you know your partner. This finding should encourage programs to promote the acceptability of condoms even among married couples.

TABLE 15.3.1
Beliefs About Condoms and Condom Use by Condom Experience
Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Georgia, 1999/2001

	Ever Users (N=118)			Never Users (N=833)		
	Agree	Disagree	Don't know	Agree	Disagree	Don't Know
Using Condoms with your Partner is Smart Idea	85.0	3.2	11.8	47.9	6.4	45.7
Condoms are not necessary if you know your partner	48.0	41.1	10.8	40.3	15.2	44.4
Women should Ask Their Partners to Use Condoms	61.2	28.4	10.5	16.1	35.6	48.4
It is Easy to Discuss Condom Use with a Prospective Partner	32.6	45.0	22.4	8.2	39.2	52.7
Condoms Diminish Sexual Enjoyment	43.8	53.5	2.7	8.9	5.7	85.5
Same Condoms Can be used more than Once	1.6	96.6	1.7	1.3	56.0	42.7
People Who Use Condoms Sleep Around Alot	2.5	90.8	6.7	5.7	50.0	44.3
It Is Embarrassing to Ask for Condoms in FP Clinics or pharmacies	8.4	88.3	3.4	17.7	40.9	41.5

Table 15.3.2 shows the percentage of sexually experienced young women who have ever talked to a partner about using condoms by condom experience. Only about one-quarter of all sexually experienced women (25%) have talked to a partner about using condoms. Ninety-four percent of women who have ever used condoms have spoken with their partner about using condoms whereas only fifteen percent of women who have never used condoms have spoken to their partner. This suggests that the partners' ability to discuss condom use is associated with use. Among all sexually experienced women, women who have discussed condom use with their partner tend to be urban, aged 20-24, had first intercourse after marriage and attended technical school or university. Thirty-six percent of urban women have ever talked to their partner, while only 15% of rural women have talked with their partner.

TABLE 15.3.2
Percent of Women Who Have Ever Talked to A Partner About His Using Condoms by Condom Experience
Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Georgia, 1999/2000

Characteristics	All Sexually Experienced Women		Women Who Have Ever Used Condoms		Women Who Have Never Used Condoms	
	%	N	%	N	%	*N
Total	**24.9**	**932**	**94.3**	**118**	**14.5**	**814**
Residence						
Urban	36.3	491	93.5	90	21.1	401
Rural	14.5	441	96.6	28	9.4	413
Age Group						
15–19	10.0	224	†	13	6.0	211
20–24	30.3	708	95.4	105	17.9	603
Marital Status at First Intercourse						
Married	25.3	900	94.2	116	14.5	784
Not Married	16.7	32	†	2	14.0	30
Education Level						
Secondary Complete or less	20.5	618	95.1	58	12.2	560
Technical School/University	34.2	314	93.4	60	19.8	254
IDP Status						
Yes	39.4	193	100.0	25	25.9	168
No	24.2	739	93.9	93	13.9	646

* Excludes respondents that did not answer the question correctly or could not remember whether talked to partner
† Fewer than 25 observations in this category

TABLE 15.3.3
Agreement With Specific Statements Regarding Interpersonal Impact of Condom Use
Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Georgia, 1999/2000

	"If Your Partner Would Want to Use Condoms with You, Would You Feel..."							
Characteristic	Embarrassed	Angry	Safe from Getting Pregnant	Safe from Getting HIV/AIDS	Worried You Have Done Something Wrong	Safe from Getting Other STDs	Suspicious of Partner's Behavior	No. of Cases
Total	**22.1**	**12.9**	**62.8**	**53.2**	**10.5**	**51.5**	**14.1**	**951**
Residence								
Urban	19.7	12.1	75.3	67.8	10.3	68.0	16	500
Rural	24.2	13.5	51.5	40.1	10.8	36.6	12.3	451
Region								
Tbilisi	15.9	10.6	74.2	66.6	11.7	64.0	10.6	201
Imereti	32.8	17.7	69.6	59.5	8.9	63.5	17.7	166
Northeast	23.5	13.2	62.1	53.6	5.7	47.6	13.2	189
South	18.8	9.4	42.5	30.8	10.8	29.8	9.4	180
West	23.7	15.5	69.8	59.6	15.6	58.9	15.5	215
Age Group								
15–19	19.9	10.0	47.1	38.1	9.4	36.1	7.3	229
20–24	22.9	13.9	68.4	58.6	10.9	57.0	16.4	722
Marital Status at First Intercourse								
Married	21.4	12.4	62.3	52.5	10.4	51.1	13.6	918
Not Married	37.5	24.2	73.9	70.7	12.9	60.9	23.8	33
Education Level								
Secondary Incomplete	24.7	13.1	38.1	28.1	15.1	27.7	9.8	202
Secondary Complete	24.7	14.9	66.4	53.8	9.4	50.1	16.8	429
Technical School	18.1	11.4	75.5	65.8	9.8	68.0	12.9	143
University	15.6	8.9	76.4	74.9	7.8	73.1	13.8	177
Talked About Condom								
Ever Talked	11.5	8.7	92.7	75.6	8.9	73.3	11.7	232
Never Talked	25.5	14.2	53.1	45.9	11.0	44.4	14.8	719
Know How Condom								
Yes	20.8	12.8	79.8	68.2	9.2	65.4	14.6	634
No	24.5	13.0	31.9	26.0	12.9	26.3	13	317
Ever Used Condom								
Yes	3.3	4.1	95.1	79.2	3.4	77.1	4.2	118
No	24.9	14.1	58.0	49.4	11.6	47.7	15.5	833

Table 15.3.3 shows the percentage of sexually experienced young women who would agree with specific reactions if their partner wanted to use a condom. Almost two-thirds of women agreed with the statement that they would feel safe from getting pregnant if their partner asked to use a condom with them (63%). These positive feelings were more common among women who lived in urban areas (75%), attended university (76%) or technical school (76%), have talked to their partner about condoms (93%), know how to use a condom (80%) or have ever used a condom (95%). About half of women agreed that they would feel safe from HIV/AIDS (53%) and safe from getting other STDs (52%). Almost one out of seven women agreed that she would be suspicious of her partner's behavior (14%) if her partner wanted to use condoms with her. About one-fifth (22%) of women would feel embarrassed and 13% would feel angry.

15.4 Regional Comparisons

Table 15.4 shows the differences in reported premarital sexual experience and use of contraception at first premarital sex among young women age 15-24 in Eastern Europe. Available data from similar Reproductive Health Surveys conducted in the Czech Republic, Moldova, Russia, Romania, Ukraine and Georgia are compared. Czechs have the highest level of reported premarital sexual experience in both the 15-19 and 20-24 age groups. Over 90% of 20-24-year-old women have had premarital sex in the Czech Republic. Russia has the next highest proportion of young women initiating sexual intercourse before marriage. Almost 90% of 20-24-year-olds in the Russia survey have had premarital sex followed by 73% in Ukraine. The lowest proportion of women reporting premarital sexual intercourse in either age group, is Georgia. Among 15-19-year-olds, reported premarital sex is less than 1%, and among 20-24-year-olds, premarital sex is only 2%. Given the proportions of reported premarital sex in all other Eastern European countries that range from 14% to 49% among 15-19-year-olds and range from 40% to 93% among 20-24-year-olds, Georgia's proportions are outliers and evidently represent a very conservative society. In a school-based survey of high school students in Imereti and Samtskhe-Javakheti Regions only 18% and 4% of students, respectively, said "that premarital sexual contacts are acceptable" (FPAG, 2000c).

The use of contraceptives in these countries also demonstrates marked differences between Georgia and neighboring countries. Romania, Czech Republic and Russia have the highest proportions of young women aged 15-24 using contraceptives at first sexual intercourse (none more than one-half). Except for Ukraine and Russia where modern methods are more common, traditional methods and modern methods are relatively equal in Romania and the Czech Republic. In contrast, Georgian women report a contraceptive use rate of only 3% at first sexual intercourse before marriage.

Since the fall of the Soviet Union and Soviet Bloc in Eastern Europe, economic, political and social changes have resulted in societies that are less isolated and more exposed to Western culture and mass media. These changes have affected cultural norms that relate to reproductive health, sexual behaviors and family values. Although an increase in premarital sexual experience has been documented in all other countries listed in Table 15.4, it is plausible to suggest that the effect of institutional changes on cultural norms have not yet occurred in Georgia or in such a conservative culture, young women will not be candid about their sexual behavior.

TABLE 15.4
Percentage of Young Women Aged 15–24 Years Reporting Premarital Sexual Experience and Contraceptive Use at First Premarital Sexual Experience
Reproductive Health Surveys, Eastern Europe: 1993-1999

		% Reporting Premarital Sexual Experience			% Aged 15–24 Years Using Contraception at First Sexual Experience	
Country	Year of RHS	15–19	20–24	Total	Modern Methods	Traditional Methods
Czech Republic	1993	36	93	57	28	29
Moldova	1997	14	40	33	14	19
Russia	1999	49	87	51	40	10
Romania	1999	22	58	58	28	30
Ukraine	1999	30	73	47	32	15
Georgia	1999-2000	†	2	3	3	0

* Three oblasts: Ivanovo, Ekaterinburg and Perm
† Less than 1%

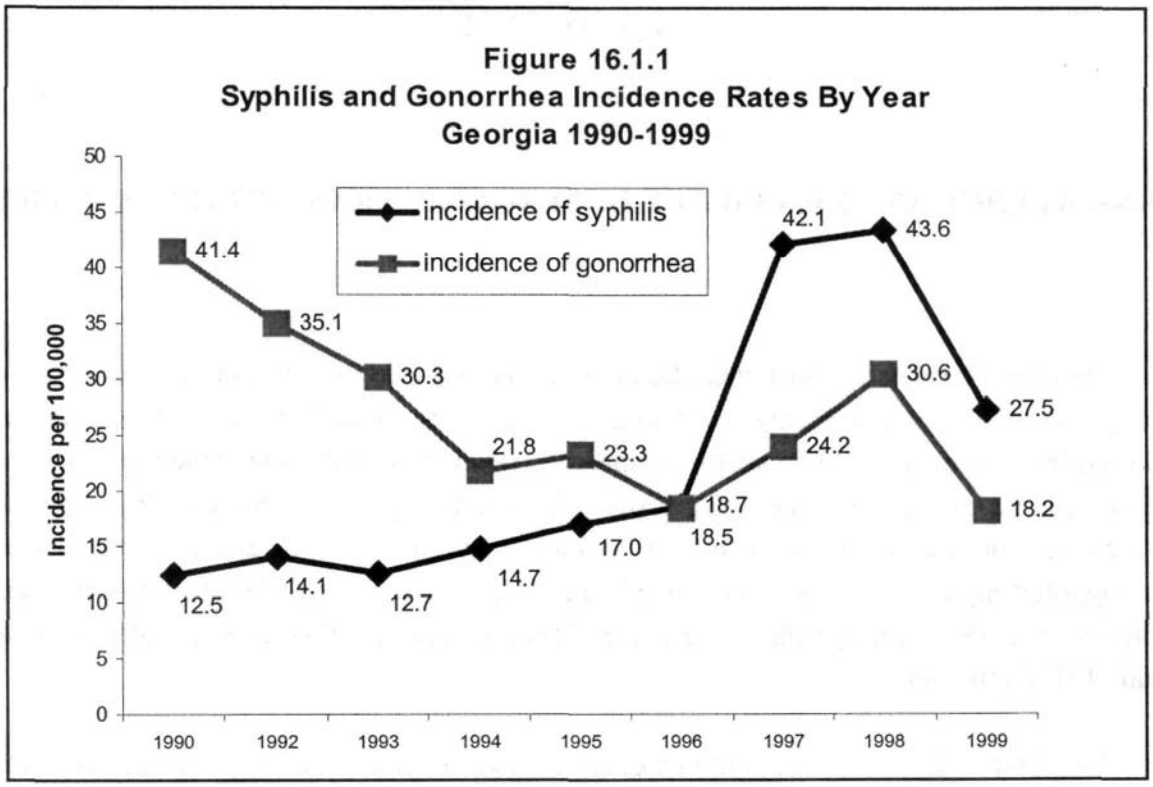
CHAPTER XVI

KNOWLEDGE AND EXPERIENCE OF SEXUALLY TRANSMITTED DISEASES

Worldwide, sexually transmitted diseases (STDs) continue to be a major and growing public health problem with both immediate and long term health, social and economic consequences for millions of people. From a public health perspective, several rationales make the prevention, early diagnosis and treatment of STDs a high priority: STDs particularly affect the well-being of women and men of reproductive age and their offsprings; they can result in acute illness, disability, including infertility and other long term complications, and increased risk for premature delivery for infected women who are pregnant; and several STDs have been identified to potentially facilitate the spread of HIV infection.

Recently, many former communist countries have experienced major epidemics of STDs, particularly of syphilis. Case notifications for syphilis appear to be more reliable than for other STDs (excepting HIV/AIDS); it is unclear what the magnitude of the other STDs may be. While in Western Europe, syphilis incidence rates have dropped to under 2/100,000, in several former Soviet Union countries—Russia, Belarus, Kazakhstan, Kyrgystan, Moldova, and Ukraine—the reported incidence of new cases of syphilis increased 15-30 times during 1990-1996, from under ten cases per 100,000 to levels as high as 263 new cases per 100,000 in 1996 in Russia (Thiconova L, et al., 1997, Renton AM. et. al., 1998). Although the magnitude of the STD epidemic in Georgia is much lower than in these countries, the recent increase in STDs, especially primary and secondary syphilis, is a matter of great concern. As shown in Figure 16.1.1, between 1993 and 1998, the syphilis incidence rate increased by almost 4 times, from 12.7/100,000 population to 43.6/100,000 population (Ministry of Health and the National Research Institute of Dermato-Venerology, 1999) while the incidence of gonorrhea has gradually declined (from 41.4 new cases/100,000 in 1990 to 18.2/100,000 in 1999). For the first time, an alarming number of babies born with congenital syphilis was reported in 1997-1998 (29 and 27 cases, respectively, corresponding to an incidence rate of 55-54/100,000 live births), reflecting an increase in the prevalence of untreated syphilis among pregnant women. 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.

Much of what is known about STDs in Georgia has been learned from data reported to the



STD surveillance system. The HIV/AIDS surveillance system is separate from that of other STDs, with diagnostics, reporting and treatment centered around the Georgian Center for AIDS and Immunological Research (see also Chapter XVII). At the break-up of the Soviet Union, Georgia, along with all newly independent states, have inherited a centrally controlled STD surveillance system based on case-finding and screening among both low risk-groups (clinical patients, pregnant women, blood donors, occupational groups) and high-risk populations (STD patients, prison inmates, commercial sex workers, injecting drug users, contacts of STD infected individuals). The system is centered around 58 raional dermato-venerology cabinets, 29 regional venereal disease (VD) clinics and 15 venereal disease hospitals (each has one of the VD clinics), and a national research institute. The National Institute of Skin and Venereal Diseases is primarily responsible for all aspects of diagnosis, treatment, data-collection and reporting of STDs. Patients seen in other clinics or maternities requiring diagnosis, treatment, or follow-up are referred to the VD network. 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 are required to be confirmed by laboratory means or other means prior to treatment and reporting: syphilis requires serologic testing, gonorrhea requires bacteriologic testing, trichomonas and chlamydia diagnostics are made based on microscopic examination, mycoplasma by culture and genital herpes by clinical examination. However, because of limited laboratory resources, very few VD clinics have the ability to provide a wide array of laboratory testing and treatment. Therefore, reporting is believed to be

seriously affected by the general lack of resources that have plagued health care services during the transition period.

Even with adequate laboratory resources, the statistics reported by STD surveillance reflect only patients who seek medical care and under-report those with asymptomatic STDs, those who get treatment from alternative providers, those who use self-treatment or no treatment, and those with limited access to medical care. Since STDs are frequently asymptomatic or their symptoms are often non-specific and episodic, infected individuals may be unaware of their infections and may not seek diagnostics and treatment; thus, surveillance systems based solely on case-notification reports are substantially underestimating the real magnitude of the STDs in a population.

As a response to growing concern about the spread of STDs, a new government program, offering free STD diagnostic services and sometimes treatment throughout the dermato-venerology system and in gynecologic wards, was launched in 1997. Most of the increase in syphilis and gonorrhea rates occurred in 1997-1998 and coincided with the implementation of this program. Under the new STD program, case ascertainment has remained basically unchanged but mass-screening and active case finding have increased, suggesting that the increase in syphilis and gonorrhea rates shown in 1997-1998 in Figure 16.1 may be the result of better reporting. Currently, the entire program is challenged by financial constraints, lack of equipment and supplies, and lack of or inadequate training for laboratory personnel. The recent decline in incidence (from 43.6 to 27.5/100,000 for syphilis and from 30.6 to 18.2/100,000 for gonorrhea) coincides with substantial funding cuts and discontinuation of the mass-screening in 1999.

In the wake of the rapid increase in STD cases in recent years, the national program on STD prevention should make more programmatic effort in educating the general public about the threat of STDs, including HIV/AIDS, including dissemination of information on means of transmission, promotion of safer sex and risk reduction practices. However, it is also critical that information does not convey needless threats to those having a very low risk of becoming infected. In order to effectively target these educational efforts, it is important to periodically examine STD knowledge among various population groups and define population subgroups in greater need of primary prevention messages, to identify factors that influence correct knowledge, and to better understand misconceptions surrounding HIV transmission and prevention. The 99GERHS included a module designed to assess respondents' level of awareness of most common STDs, their history of STD testing and treatment, main source of information about STDs, exposure to media campaigns about STDs transmission and/or prevention, self perceived risk of STDs, and knowledge about HIV transmission and prevention (see also Chapter XVII).

16.1 Awareness of AIDS and Other STDs

All reproductive-age women were asked if they had ever heard of eight specific STDs (see Table 16.1); those who have heard of specific STDs were asked if they have ever been tested; women who have been tested were asked if they have been told they have tested positive and those with positive testing if and where they received treatment.

The 99GERHS showed that awareness of HIV/AIDS among women of reproductive age was almost universal (93%) but awareness of other STDs was less widespread. Most women were aware of syphilis (82%) and yeast infection (80%), but fewer have heard of other common STDs. Respondents demonstrated moderate levels of awareness of gonorrhea (60%) and trichomonas (57%) and low levels of knowledge about the names of several other diseases which are transmitted through sexual contact; only 16% of women have heard of chlamydia, 15% have recognized that genital warts are transmitted sexually, and 11% have heard of genital herpes.

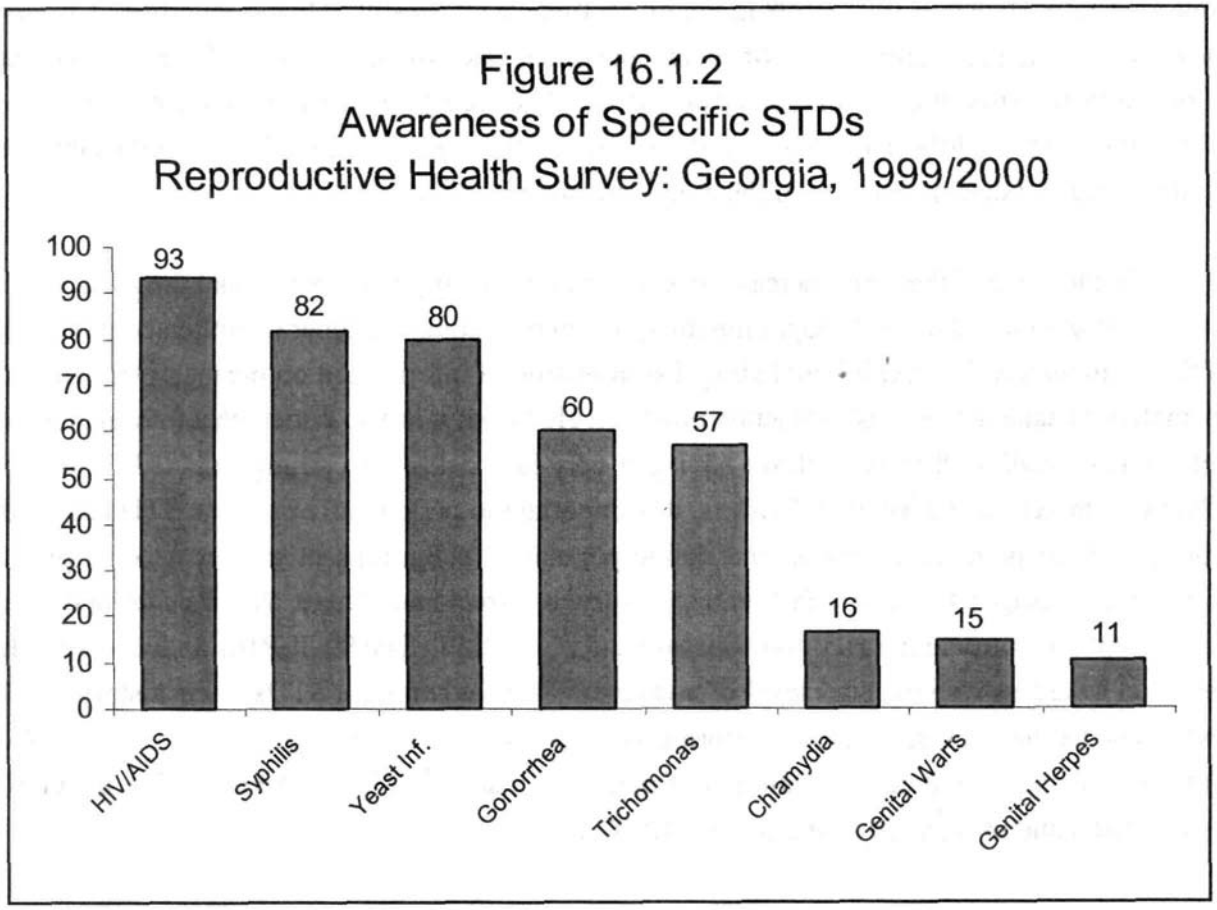


TABLE 16.1.1
Percent of Women Aged 15–44 Who Have Heard of Specified Sexually Transmitted Diseases by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	HIV/ AIDS	Syphilis	Yeast Infection	Gonorrhea	Tricho-monas	Chlamydia	Genital Warts	Genital Herpes	No. of Cases
Total	**93.4**	**81.5**	**79.8**	**60.0**	**56.8**	**16.2**	**14.7**	**10.5**	**7,798**
Residence									
Urban	98.5	89.9	86.6	70.1	67.9	23.0	18.9	15.4	4,759
Rural	86.8	70.8	71.1	47.0	42.6	7.5	9.4	4.3	3,039
Region									
Tbilisi	99.2	91.3	86.8	74.8	74.4	32.1	22.6	21.3	2,029
Imereti	98.0	87.0	87.4	66.4	59.8	12.9	16.6	8.0	1,590
North-East	91.8	79.3	79.6	56.1	54.9	10.8	11.5	5.6	1,259
South	77.9	64.8	53.2	40.6	37.3	6.8	7.7	4.8	1,017
West	95.5	79.9	85.2	55.2	49.8	11.3	12.0	7.9	1,903
Age Group									
15–24	90.0	64.3	69.5	38.4	34.9	9.5	11.0	7.5	2,388
25–34	95.7	90.8	86.6	70.4	67.8	19.3	17.0	12.6	2,731
35–44	95.0	92.2	85.1	74.7	71.3	20.9	16.9	11.8	2,679
Marital Status									
Currently Married/In Union	94.1	88.6	83.7	68.8	66.8	18.4	14.9	10.1	5,177
Previously Married	91.3	89.8	84.8	72.5	70.2	21.9	19.9	14.5	517
Never Married	92.5	67.1	71.8	41.7	36.2	11.1	13.5	10.4	2,104
Education Level									
Secondary Incomplete or Less	76.0	45.9	51.1	22.1	18.5	3.0	3.0	1.2	991
Secondary Complete	93.2	78.8	76.2	50.3	48.2	9.1	10.9	6.0	2,664
Technicum	98.9	94.3	91.2	76.4	72.2	18.2	19.3	11.5	2,058
University/Postgraduate	99.8	96.1	92.5	81.6	78.2	31.9	23.0	21.1	2,085
Ethnic Group									
Georgian	97.6	85.1	85.9	63.7	61.0	17.4	16.3	11.6	6,700
Azeri	57.8	45.9	31.8	22.9	18.6	2.2	1.8	1.0	589
Armenian	91.5	83.6	67.0	58.7	52.3	13.2	11.1	5.9	300
Other	96.8	94.5	87.4	81.9	73.4	34.8	19.7	19.2	209
IDP Status									
IDP	97.8	88.7	86.1	68.5	60.6	17.7	17.9	13.2	1,828
Non-IDP	93.2	81.1	79.5	59.5	56.6	16.1	14.6	10.3	5,970
No. of Lifetime Partners									
Never Had Intercourse	92.5	66.9	71.7	41.6	36.0	11.1	13.5	10.4	2,095
1	93.7	88.4	83.6	68.6	66.6	18.3	15.1	10.2	5,533
2+	97.4	96.8	92.2	83.1	82.9	31.8	23.6	19.5	170

The level of awareness about AIDS and syphilis was virtually universal across various population subgroups. However, for other STDs, the level of awareness varied substantially by some respondent characteristics. Generally, urban residence, older age, higher educational attainment, and sexual experience were associated with higher levels of awareness of specific STDs. Awareness was also much higher in Tbilisi than in any other areas of the country. Lower levels of awareness was notable among residents of the southern region and Azeri women.

The survey also explored respondents' opinions about the best source of information about STDs, according to their own experience (Table 16.1.2). Mass media has played the most important role in increasing women's awareness of STDs, probably because media coverage of the AIDS epidemic has been very extensive in Georgia. Almost three fourths of respondents mentioned mass media as the most important source of information, and there is little variation by background characteristics in respondents' opinion of the media's role in distributing information on STDs. Friends and peers were the second most important source of information (10%). Women of Azeri descent were more likely to value information on STDs from friends and peers. Only 3% of respondents believed that a doctor was an important source of information about STDs, presumably because STD counseling is very limited in Georgia. Only 3% of women think that teachers were their best source of information about STDs, since sex education in schools is very limited (see also Chapter XIV).

The survey included additional questions about recent mass-media exposure (within the six months prior to the interview) to messages related to HIV/AIDS and other STDs. As shown in Tables 16.1.3 and 16.1.4, most respondents mentioned that the messages on STDs distributed through audio-visual media are about HIV/AIDS; 47% of women have seen or heard such messages recently compared to only 7% of women who received information about other STDs through audio-visual media. Irrespective of the STD message, rural residents, residents of the South region, young adults, those with who did not complete secondary education, and those of Azeri ethnic background, were more likely to say they have not recently seen or heard programs about HIV/AIDS or other STDs. Generally, most respondents have seen such messages on TV and very few have heard radio messages on HIV/AIDS or other STDs.

TABLE 16.1.2

Women's Opinion About Best Source of Information Received on Sexually Transmitted Diseases
Women Aged 15–44 Who Have Heard of At Least One STD
by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Mass Media	Friends	Books	Doctor	Teacher	Parent or Relative	Partner	Other	Do Not Know	Total	No of Cases
Total	**72.6**	**10.0**	**6.2**	**2.7**	**2.6**	**1.8**	**1.5**	**1.1**	**1.6**	**100.0**	**7,523**
Residence											
Urban	74.2	8.8	7.4	1.8	2.6	2.6	1.0	0.8	0.9	100.0	4,716
Rural	70.3	11.6	4.4	4.0	2.6	0.8	2.2	1.5	2.6	100.0	2,807
Region											
Tbilisi	72.0	7.7	8.9	2.4	3.2	3.4	1.1	0.8	0.5	100.0	2,022
Imereti	74.1	12.2	5.8	2.5	2.1	1.0	0.7	0.4	1.1	100.0	1,577
North-East	72.9	10.5	4.8	2.6	3.3	1.5	1.5	1.0	1.9	100.0	1,198
South	69.0	12.5	3.3	4.1	2.3	0.4	2.7	1.8	3.8	100.0	861
West	73.9	9.1	6.0	2.4	1.9	1.7	1.8	1.5	1.6	100.0	1,865
Age Group											
15–24	69.8	12.5	4.3	4.0	1.7	3.7	1.2	1.2	1.7	100.0	2,233
25–34	73.8	8.1	7.7	1.6	3.3	1.1	1.9	0.9	1.6	100.0	2,670
35–44	74.5	9.0	6.7	2.4	2.9	0.5	1.5	1.1	1.4	100.0	2,620
Marital Status											
Currently Married/In Union	73.9	9.2	5.8	1.8	3.6	0.8	2.4	1.0	1.5	100.0	5,016
Previously Married	70.5	11.8	6.8	3.1	2.8	0.4	0.5	1.6	2.5	100.0	499
Never Married	70.5	11.0	6.8	4.4	0.7	3.9	0.0	1.2	1.6	100.0	2,008
Education Level											
Secondary Incompl. or Less	68.4	11.8	1.3	6.6	1.9	1.2	1.8	3.1	3.8	100.0	821
Secondary Complete	72.9	12.9	3.1	3.1	1.9	1.5	2.1	0.7	1.9	100.0	2,565
Technicum	74.9	8.5	7.1	1.0	2.7	2.4	1.4	1.2	0.8	100.0	2,054
University/Postgraduate	72.3	6.8	11.6	1.7	3.7	2.0	0.8	0.3	0.8	100.0	2,083
Ethnic Group											
Georgian	73.5	9.7	6.4	2.5	2.6	2.0	1.3	0.8	1.2	100.0	6,633
Azeri	56.2	15.7	1.9	7.1	2.7	0.8	4.7	3.5	7.3	100.0	398
Armenian	75.7	10.5	6.2	1.7	1.2	0.3	0.6	2.4	1.5	100.0	287
Other	78.0	4.0	7.7	0.9	4.3	2.4	0.9	1.3	0.5	100.0	205
IDP Status											
IDP	71.8	10.1	8.7	2.3	2.2	2.3	1.0	1.2	0.3	100.0	1805
Non-IDP	72.6	9.9	6.0	2.7	2.6	1.8	1.5	1.2	1.7	100.0	5718
No. of Lifetime Partners											
Never Had Intercourse	70.4	11.0	6.8	4.4	0.7	3.9	0.0	1.2	1.6	100.0	1,999
1	73.5	9.4	5.9	1.8	3.6	0.8	2.3	1.1	1.6	100.0	5,356
2+	78.4	9.4	4.8	3.9	1.8	0.0	0.0	0.6	1.1	100.0	168

TABLE 16.1.3
Recent Exposure to Mass Media Messages About HIV/AIDS Among Women Aged 15–44 by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Women Aged 15-44					
	TV	Radio	Radio and TV	Neither Radio nor TV	Total	No of Cases*
Total	**45.2**	**1.2**	**1.2**	**52.5**	**100.0**	**7,584**
Residence						
Urban	54.8	1.4	1.9	41.9	100.0	4,646
Rural	32.8	0.9	0.3	66.0	100.0	2,938
Region						
Tbilisi	55.3	2.0	3.5	39.3	100.0	1,983
Imereti	48.1	1.4	0.8	49.7	100.0	1,562
North-East	35.6	1.5	0.7	62.2	100.0	1,228
South	30.4	0.2	0.2	69.2	100.0	975
West	49.5	0.4	0.1	50.0	100.0	1,836
Age Group						
15-24	41.7	1.5	1.5	55.3	100.0	2,316
25-34	49.1	1.1	1.2	48.6	100.0	2,653
35-44	45.2	0.8	0.9	53.0	100.0	2,615
Marital Status						
Currently Married/In Union	45.0	0.8	0.9	53.3	100.0	5,043
Previously Married	42.6	0.8	3.0	53.5	100.0	501
Never Married	45.9	1.8	1.5	50.7	100.0	2,040
Education Level						
Secondary Incompl. or Less	29.3	1.4	0.8	68.5	100.0	943
Secondary Complete	40.3	1.1	1.0	57.6	100.0	2,583
Technicum	49.3	1.3	1.0	48.5	100.0	2,014
University/Postgraduate	57.3	1.0	2.0	39.6	100.0	2,044
Ethnic Group						
Georgian	49.2	1.3	1.3	48.2	100.0	6,540
Azeri	14.0	0.3	0.1	85.6	100.0	552
Armenian	36.4	0.9	0.6	62.1	100.0	291
Other	45.0	1.0	3.9	50.1	100.0	201
IDP Status						
IDP	55.2	0.8	0.8	43.3	100.0	1,790
Non-IDP	44.6	1.2	1.2	52.9	100.0	5,794
No. of Lifetime Partners						
Never Had Intercourse	45.8	1.8	1.6	50.8	100.0	2,031
1	44.7	0.8	0.9	53.6	100.0	5,388
2+	48.6	2.5	6.0	42.9	100.0	165

* Exclude 214 women who did not remember if they have seen or heard an HIV/AIDS message on TV or Radio within the past six months.

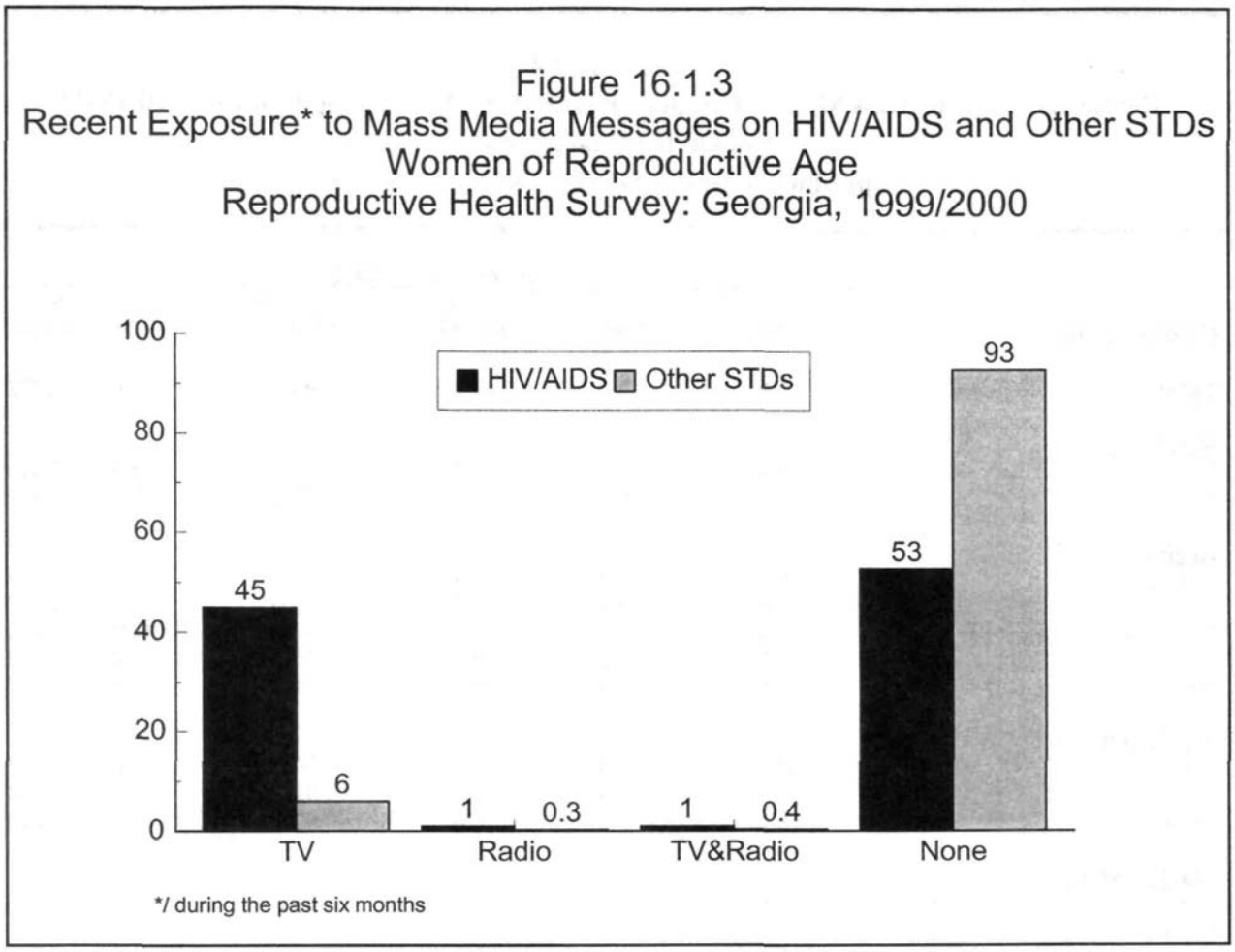
TABLE 16.1.4

Recent Exposure to Mass Media Messages About Other STDs Among Women Aged 15–44 by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

	Women Aged 15-44					
Characteristic	**TV**	**Radio**	**Radio and TV**	**Neither Radio nor TV**	**Total**	**No of Cases***
Total	**6.0**	**0.3**	**0.4**	**93.2**	**100.0**	**7,572**
Residence						
Urban	7.3	0.4	0.5	91.8	100.0	4,623
Rural	4.4	0.2	0.2	95.1	100.0	2,949
Region						
Tbilisi	8.2	0.7	0.9	90.3	100.0	1,975
Imereti	6.4	0.4	0.1	93.0	100.0	1,560
North-East	5.6	0.2	0.6	93.6	100.0	1,222
South	3.3	0.2	0.1	96.5	100.0	978
West	5.5	0.2	0.1	94.3	100.0	1,837
Age Group						
15–24	4.7	0.4	0.3	94.6	100.0	2,308
25–34	7.2	0.3	0.3	92.2	100.0	2,648
35–44	6.4	0.4	0.6	92.7	100.0	2,616
Marital Status						
Currently Married/In Union	6.4	0.3	0.2	93.0	100.0	5,035
Previously Married	5.8	0.2	1.8	92.2	100.0	505
Never Married	5.4	0.4	0.4	93.8	100.0	2,032
Education Level						
Secondary Incompl. or Less	1.7	0.5	0.0	97.8	100.0	939
Secondary Complete	4.4	0.3	0.3	95.1	100.0	2,600
Technicum	7.5	0.3	0.4	91.8	100.0	2,002
University/Postgraduate	9.5	0.4	0.7	89.4	100.0	2,031
Ethnic Group						
Georgian	6.7	0.4	0.4	92.6	100.0	6,523
Azeri	1.0	0.0	0.0	99.0	100.0	552
Armenian	4.0	0.3	0.0	95.8	100.0	293
Other	7.6	0.5	2.9	89.0	100.0	204
IDP Status						
IDP	8.3	1.3	0.0	90.3	100.0	1,777
Non-IDP	5.9	0.3	0.4	93.4	100.0	5,795
No. of Lifetime Partners						
Never Had Intercourse	5.3	0.4	0.4	93.8	100.0	2,023
1	6.3	0.2	0.2	93.2	100.0	5,381
2+	7.0	2.3	5.2	85.5	100.0	168

* Excludes 226 women who did not remember if they have seen or heard an STD message on TV or Radio within the past six months.



16.2 Self-Reported STD Testing and Diagnosis

Population-based surveys represent an important addition to traditional STD surveillance data because they help produce estimates that represent the general population; however, they may have the disadvantage of under-reporting related to self-reporting (e.g., recall bias, under-reporting of sensitive information). In addition, surveys produce prevalence estimates but are less useful in examining incidence levels. Despite their limitations, surveys complement surveillance data because they allow examination of the STD experience by respondents characteristics and correlates of STDs with reproductive-related information and health risk behaviors.

Tables 16.2.1 and 16.2.2 show the reported levels of testing and diagnosis for the eight most common STDs in Georgia. Respondents were not asked about HIV diagnosis and treatment. In interpreting these results it should be kept in mind that laboratory testing resources in Georgia are

quite limited and, for most STDs, without testing there is no diagnosis. Furthermore, the differences in awareness of specific STDs (that are influenced by background characteristics) may affect the level of reporting of both testing and confirmed diagnosis. Some STDs are better known than others and may be reported more accurately. Also, some STDs require mandatory notifications to the dermato-venerology network (e.g., syphilis, gonorrhea) and respondents may be reluctant to acknowledge such infections, despite the assured confidentiality of the interviews.

As shown in Table 16.2.1, the most often diagnosed STDs were yeast infection and trichomoniasis. Overall, 8% and 7% of all respondents, respectively, report having had a yeast infection and trichomonas infection. The prevalence of ever having such infections was higher among urban residents (11% and 9%, respectively), women living in Tbilisi (16% and 13%), and women with a postgraduate education (16% and 11%), probably reflecting differences in health seeking behaviors and access to health services. Yeast infection and trichomoniasis were much more common among currently and previously married than never married women and among women 25 and older compared with younger women. The lifetime prevalence of yeast infection increased from 11% among women who have had only one lifetime partner to 25% among those with two or more lifetime partners. Similarly, reports of trichomoniasis were almost three times as likely among women with two or more partners than among monogamous women (24% vs 9%). A history of other STDs was very seldom reported: only 0.4% of women have been diagnosed with chlamydia, 0.2% with gonorrhea, and 0.1% with syphilis.

Prevalence data on STDs are not available in many countries, including Georgia. For designing effective public health interventions, countries need accurate data on both incidence and prevalence of the most common STDs. In a recent paper, WHO published estimated prevalence and incidence of syphilis, gonorrhea, chlamydia, and trichomoniasis in 1995 (Gerbase A.C. et all., 1998). The prevalence figures were based on WHO country files and an extensive review of epidemiologic studies conducted in low risk populations, such as pregnant women, blood donors, and women attending family planning clinics. In the Eastern Europe and Central Asia region, the estimated prevalence for syphilis, gonorrhea, chlamydia, and trichomoniasis among 15-49 year old women were 0.08%, 0.5%, 3.7%, and 7.4%, respectively. With the exception of chlamydia infection, these estimates are very similar with lifetime prevalence data reported in the survey. Prevalence of chlamydia infection was much lower in the survey compared to the WHO estimates (0.6% vs. 3.7%), presumably because limited access to proper laboratory testing and a very low level of awareness of this disease in general population.

TABLE 16.2.1
Percent of Women Aged 15–44 Who Have Been Diagnosed with Specified Sexually Transmitted Diseases by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Yeast Infection	Trichomonas	Chlamydia	Gonorrhea	Genital Warts	Syphilis	Genital Herpes	No. of Cases
Total	**7.9**	**6.5**	**0.4**	**0.2**	**0.2**	**0.1**	**0.1**	**7,798**
Residence								
Urban	10.8	9.0	0.6	0.3	0.3	0.1	0.1	4,759
Rural	4.1	3.4	0.1	0.2	0.1	0.0	0.0	3,039
Region								
Tbilisi	15.8	12.7	0.8	0.4	0.4	0.0	0.2	2,029
Imereti	5.8	5.1	0.1	0.6	0.4	0.1	0.0	1,590
North-East	6.1	5.5	0.5	0.2	0.0	0.2	0.1	1,259
South	4.4	4.0	0.2	0.0	0.0	0.1	0.0	1,017
West	4.2	3.2	0.1	0.0	0.2	0.0	0.1	1,903
Age Group								
15–24	3.4	2.1	0.1	0.0	0.1	0.1	0.0	2,388
25–34	11.2	9.0	0.8	0.3	0.2	0.1	0.2	2,731
35–44	9.8	9.3	0.3	0.4	0.3	0.1	0.1	2,679
Marital Status								
Currently Married/In Union	11.2	9.7	0.6	0.3	0.3	0.1	0.1	5,177
Previously Married	12.9	8.1	0.6	0.8	0.0	0.2	0.0	517
Never Married	0.8	0.6	0.0	0.0	0.0	0.0	0.0	2,104
Education Level								
Secondary Incompl. or Less	1.7	1.4	0.1	0.1	0.1	0.1	0.0	991
Secondary Complete	4.7	4.5	0.2	0.1	0.2	0.1	0.0	2,664
Technicum	8.3	7.7	0.2	0.5	0.2	0.2	0.1	2,058
University/Postgraduate	15.5	11.3	1.0	0.3	0.3	0.0	0.2	2,085
Ethnic Group								
Georgian	8.5	7.2	0.4	0.3	0.2	0.1	0.1	6,700
Azeri	2.3	1.7	0.0	0.0	0.0	0.0	0.0	589
Armenian	4.5	4.2	0.3	0.0	0.0	0.0	0.0	300
Other	14.1	9.4	0.9	1.0	0.9	0.0	0.5	209
IDP Status								
IDP	5.6	4.6	0.9	0.7	0.1	0.1	0.3	1,828
Non-IDP	8.0	6.6	0.4	0.2	0.2	0.1	0.1	5,970
No. of Lifetime Partners								
Never Had Intercourse	0.8	0.5	0.0	0.0	0.0	0.0	0.0	2,095
1	10.9	9.0	0.5	0.4	0.3	0.1	0.1	5,533
2+	24.7	24.2	1.7	0.6	1.1	0.0	0.6	170

TABLE 16.2.2
Level of Awareness, Testing, Diagnosis, and Treatment for STDs Among Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse by Specified Sexually Transmitted Diseases
Reproductive Health Survey: Georgia, 1999/2000

Specific STDs	% with Awareness of STD	% Who Have Been Tested for STD	% Diagnosed with STD	% Treated for STD	Unweighted Number of Cases
HIV/AIDS	93.8	6.5	*	*	5,703
Syphilis	88.7	9.5	0.1	0.1	5,703
Yeast Infection	83.9	22.5	11.4	11.1	5,703
Gonorrhea	69.1	6.4	0.4	0.4	5,703
Trichomonas	67.1	17.9	9.5	9.4	5,703
Chlamydia	18.7	2.8	0.6	0.5	5,703
Genital Warts	15.4	0.4	0.3	0.3	5,703
Genital Herpes	10.5	0.3	0.1	0.1	5,703
Any STD	**96.0**	**30.2**	**16.0**	**15.7**	5,703

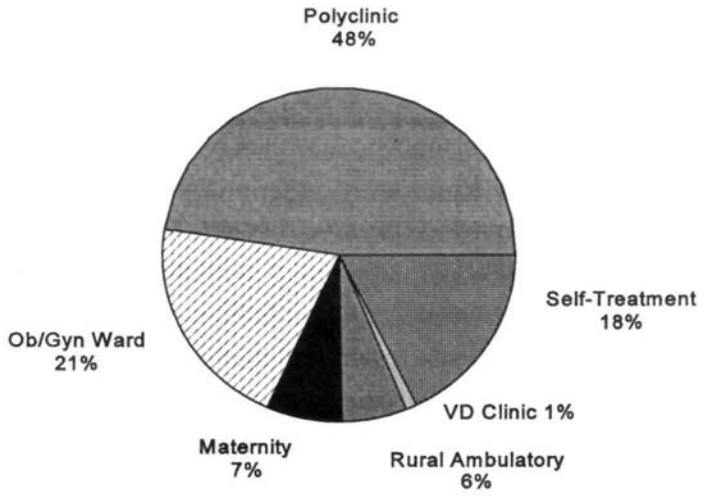
* Respondents were not asked about the results of HIV testing

Table 16.2.2 shows the levels of awareness, testing, and diagnosis for the most common STDs among sexually experienced women. Overall, almost one in three women (30%) have ever been tested for STDs. Almost 10% of sexually experienced women aged 15-44 have reported being tested for syphilis and one percent of those tested had been diagnosed with the disease, yielding a prevalence of 0.1%. The most frequently tested and reported STDs among sexually experienced women were yeast infection and trichomoniasis. About one in five women has been tested for these conditions. For both infections, the positivity rate was about 50% among those tested. The

prevalence among sexually experienced women was 12% and 10%, respectively. Chlamydia and gonorrhea were reported by 0.6% and 0.4% of women, respectively. The positivity rates for chlamydia and gonorrhea testing were lower, 11% and 6%, respectively. Viral STDs like genital warts and genital herpes are very seldom tested in Georgia (0.3% and 0.1%, respectively) because diagnosis is usually established based on clinical examination. Presumably, testing is performed only when suggestive clinical pathology occurs, since most of those tested were confirmed as having the disease.

The vast majority of those who have tested positive for STDs have received medical treatment for these infections. As shown in Figure 16.2, the main source of treatment for women with a STD diagnosis was the polyclinic (48%), followed by an Ob/Gyn hospital or ward (21%) or maternity (7%). Only 1% of women were treated in a VD cabinet or clinic. However, the majority of women who reported STD treatment suffered from yeast infection or trichomoniasis, conditions who can be treated outside the dermato-venerology network. Depending on the condition, between 11-30% of women who tested positive have been treated outside the health system (18%, on average). Self-treatment includes respondents who have been told by a pharmacist (12%), a friend (3%) or by no one (2%) how to treat their infections, presumably because they chose not to mention their STD experience to a doctor.

Figure 16.2
Main Source for STD Treatment
Among Women Who Have Ever Been Treated for a STD
Reproductive Health Survey: Georgia, 1999/2000



16.3 Self-Reported STD Symptoms

In an attempt to assess the prevalence of STD symptoms among the general population, the survey included a series of questions about recent history of vaginal discharge and the presence or absence of any genital sores or ulcers. Table 16.3 shows the reported prevalence of vaginal discharge and genital sores/ulcers among sexually experienced women aged 15-44 during the 12 months prior to the interview. This information will help the national STD program to help decide if a syndromic approach for the case management of STDs among female population is warranted. Syndromic case reports do not require laboratory diagnostic tests and are based on the identification of a combination of symptoms and signs (syndromes) suggestive of selected STDs. Syndromic case management combines the identified syndromes with knowledge about the most common causative organisms and their antibiotic susceptibility. However, several important limitations make the syndromic approach not suitable for assessment of STD incidence and prevalence or to measure the impact of STD prevention programs. First, a high proportion of vaginal discharge cases are not caused by STDs; genital ulcers are often an indication of recurrent HSV infection which may have been acquired years before. Second, a high proportion of STDs in women are asymptomatic. Third, syndromic case definitions are not pathogen-specific (WHO, 1999). Finally, treatment based on syndromic case definitions leads inevitably to over-treatment, promotion of antimicrobial resistance, and social costs related to mislabeling individuals as infected with a STDs. These drawbacks should be carefully balanced against the costs associated with STD complications, continued transmission and potential increased transmission of HIV infection, and medical costs such as laboratory testing and clinician diagnosis (Johannes van Dam et al., 1998).

As shown in Table 16.3, almost one in four sexually experienced women reported abnormal vaginal discharge and 5% reported "sores, warts, or ulcers in the genital area". Reports were slightly higher among the same subgroups of women who showed higher levels of awareness, suggesting that STD syndrome reporting is probably correlated with STD awareness. Similarly, reports of STD signs and symptoms were higher among women who have ever been tested for or diagnosed with a STD. Among women who have recently experienced vaginal discharge, 59% reported also low abdominal pain, 31% reported dyspareunia (pain during sexual intercourse), 26% reported vaginal itching, and 16% reported painful urination (dysuria).

16.4 Self Perceived Risk of STDs

The rate of spread of STDs in a population is basically determined by three factors: a) exposure to infection, b) the probability of acquiring the infection; and c) the duration of time in which infected individuals can spread the infection (Eng TR and Butler WT, 1997). As a result of poor knowledge and awareness of STDs, Georgians greatly underestimate their risk of infection, especially for STDs other than HIV/AIDS. As shown in Table 16.5, the 99GERHS found that only

TABLE 16.3
Percent of Sexually Experienced Women Who Have Had Vaginal Discharge During the Past Year and Percent Who Reported Other Symptoms Associated with Vaginal Discharge by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Vaginal Discharge or Genital Ulcer			Symptoms Associated with Vaginal Discharge				
	Vaginal Discharge	Genital Ulcer/Sores	N	Abdominal Pains	Pain During Intercourse	Vaginal Itching	Dysuria	N
Total	**24.1**	**4.7**	**5,703**	**59.4**	**30.6**	**26.1**	**16.1**	**1,407**
Residence								
Urban	25.2	4.8	3,362	55.5	29.1	26.9	16.3	889
Rural	22.7	4.5	2,341	64.6	32.7	25.0	15.7	518
Region								
Tbilisi	29.2	4.0	1,387	51.3	29.5	28.3	15.8	422
Imereti	23.2	5.8	1,147	59.8	31.1	24.7	19.4	276
North-East	26.5	5.5	984	62.9	31.3	23.7	14.3	247
South	18.6	4.5	812	68.7	31.8	27.9	14.8	153
West	21.1	4.2	1,373	61.5	30.6	25.2	16.8	309
Age Group								
15–24	23.2	5.4	951	51.8	37.4	26.7	14.6	243
25–34	26.3	4.7	2,300	58.3	31.1	26.4	14.7	618
35–44	22.4	4.4	2,452	63.9	27.3	25.6	18.2	546
Education Level								
Secondary or Less	22.4	4.3	2,485	65.1	32.9	22.6	15.4	589
Technicum	24.9	5.5	1,726	62.8	28.3	29.1	20.4	428
University/Postgraduate	25.9	4.5	1,492	47.9	29.9	28.1	12.5	390
Ethnic Group								
Georgian	25.5	5.1	4,795	58.6	30.0	26.9	16.2	1,238
Azeri	14.7	2.0	481	70.2	38.3	23.3	25.6	72
Armenian	20.4	2.9	247	59.8	21.7	18.3	7.5	49
Other	26.4	6.3	180	58.2	42.2	22.7	4.7	48
IDP Status								
IDP	29.2	5.1	1,266	58.0	35.1	21.9	15.7	342
Non-IDP	23.8	4.7	4,437	59.5	30.4	26.4	16.1	1,065
No. of Lifetime Partners								
1	24.0	4.8	5,533	59.7	30.7	26.3	16.1	1,363
2+	26.8	1.7	170	52.8	28.0	21.6	16.7	44
STD Testing								
Never Tested	19.0	3.5	4,051	62.0	26.3	19.2	14.6	796
Ever Tested	35.9	7.6	1,652	56.3	36.0	34.5	17.9	611
STD Diagnosis								
Negative	20.1	3.8	4,847	59.8	26.8	20.1	14.5	1,006
Positive	44.7	9.4	856	58.4	39.7	40.4	19.7	401

10% of women thought they had any risk of acquiring an STD, including 1% of women who believed that their risk was medium or high. Concerns about exposure to the risk of HIV/AIDS were significantly higher than concerns of acquiring other STDs—32% of women said they believed they had some risk of getting HIV/AIDS—probably because of the intensive HIV/AIDS media coverage in the recent years (see also Chapter XVII). The differences in perception about the risk of getting infected with an STD other than HIV/AIDS were small. Lack of awareness of any STD risk was slightly more common in rural areas and in the South, among young adults, never married women, those with less than complete secondary education, among Azeri women, and those with no sexual experience.

In conclusion, Georgian women have a high level of awareness for HIV/AIDS and syphilis but lower awareness for other common STDs, including gonorrhea. With the exception of yeast infection and trichomonas (23% and 18%, respectively), the level of STD testing among sexually experienced women was very low: less than one in ten women have been tested for syphilis, 7% for HIV, 6% for gonorrhea, and less than 3% for other STDs. Conversely, one in four women had experienced vaginal discharge and 5% reported genital ulcers or sores during the year preceding the survey. Most women who have tested positive for STDs have been treated but very few have received treatment in the VD network and presumably have not been reported to the STD surveillance network.

Only one in ten women perceive that they have any risk for getting infected with a STD other than HIV, three times less than those who believe they may contract HIV/AIDS; studies in USA have shown that the risk of acquiring a sexually transmitted disease during a single unprotected intercourse ranges from 50% for gonorrhea, 40% for chlamydia, 30% for genital herpes, and 1% for HIV/AIDS (Harlap S. Et. Al., 1991). The disproportionate high level of self-perceived HIV risk among Georgian women implies that their awareness of risky sexual behaviors (which would have had a similar impact on self perceived risk of any STDs) does not play an important role in their perception of risk. Rather, alarming media messages that point toward the health care system as a potential source of HIV infection, are likely to play a major role in the HIV risk perceptions but no role at all in self-perceptions of risk for other STDs (since audio-visual media seldom mentions other STDs).

The survey found that mass-media is almost unanimously considered the most important source of information about STDs but most media messages contain information (and possible misinformation) about HIV/AIDS whereas the other STDs are seldom mentioned. There is compelling evidence in the literature that behavioral changes can be positively influenced by well designed media-campaigns. The STD governmental program should actively involve mass-media in implementing behavioral interventions aimed at decreasing exposure to and transmission of STDs. However, public health efforts to educate the public have first to offset the negative image projected by media about the risk of HIV from health care utilization.

TABLE 16.5
Percentage Distribution of Women Who Heard About STDs by Self Perceived Risk of Contracting a STD, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

	Self Perceived Risk of Contracting STDs Other Than HIV/AIDS						
Characteristic	**High Risk**	**Some Risk**	**Little Risk**	**No Risk**	**Do Not Know**	**Total**	**No. of Cases**
Total	**0.2**	**1.0**	**8.8**	**85.6**	**4.4**	**100.0**	**7,390**
Residence							
Urban	0.3	1.2	10.9	84.4	3.2	100.0	4,688
Rural	0.1	0.8	5.8	87.3	6.0	100.0	2,702
Region							
Tbilisi	0.5	1.3	14.6	80.0	3.5	100.0	2,016
Imereti	0.1	1.3	5.6	91.2	1.8	100.0	1,563
North-East	0.2	1.3	7.1	87.2	4.2	100.0	1,172
South	0.1	0.5	7.1	82.0	10.3	100.0	817
West	0.1	0.6	6.5	88.7	4.0	100.0	1,822
Age Group							
15–24	0.1	0.9	5.1	87.6	6.3	100.0	2,181
25–34	0.4	1.5	11.5	83.1	3.4	100.0	2,633
35–44	0.2	0.7	10.1	85.8	3.2	100.0	2,576
Marital Status							
Married/In Union	0.3	1.2	11.8	82.9	3.7	100.0	4,923
Previously Married	0.7	0.7	7.9	88.3	2.4	100.0	487
Never Married	0.1	0.7	3.3	90.0	5.9	100.0	1,980
Education Level							
Secondary Incompl. or Less	0.2	0.6	2.3	85.9	11.0	100.0	767
Secondary Complete	0.3	0.8	6.8	87.9	4.2	100.0	2,500
Technicum	0.2	1.4	9.5	86.0	2.9	100.0	2,042
University/Postgraduate	0.2	1.2	13.7	82.3	2.7	100.0	2,081
Socio-Economic Index							
Low	0.1	0.7	5.9	86.9	6.4	100.0	2,995
Medium	0.2	1.2	8.5	86.6	3.5	100.0	3,537
High	0.4	1.1	15.9	78.9	3.7	100.0	858
Ethnic Group							
Georgian	0.2	1.1	8.6	86.5	3.6	100.0	6,563
Azeri	0.2	0.2	3.4	79.9	16.3	100.0	352
Armenian	0.0	0.6	7.7	85.7	6.0	100.0	275
Other	0.0	1.4	26.9	70.3	1.4	100.0	200
IDP Status							
IDP	0.3	0.8	8.1	88.5	2.4	100.0	1,784
Non-IDP	0.2	1.1	8.8	85.4	4.5	100.0	5,606
Lifetime Partners							
Never Had Intercourse	0.1	0.7	3.3	90.0	5.9	100.0	1,971
1	0.2	1.2	10.9	84.1	3.7	100.0	5,254
2+	2.4	2.9	28.5	63.5	2.7	100.0	165

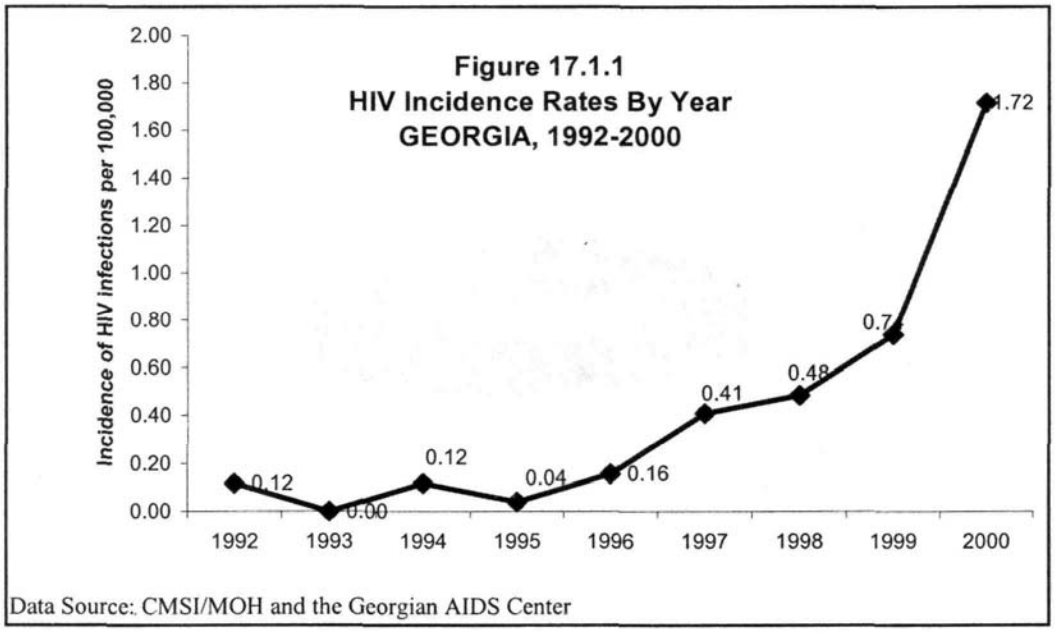
CHAPTER XVII

KNOWLEDGE OF HIV/AIDS TRANSMISSION AND PREVENTION

The HIV/AIDS epidemic has infected more than 36 million people worldwide. Almost half of the infected adults, over 16 million cases, are women. During the year 2000 alone, AIDS claimed the lives of an estimated 1.3 million women and 500,000 children under the age of 15. The infection poses a serious risk to women's reproductive health globally.

Eastern Europe is one of the last regions of the world to be challenged by an HIV/ AIDS epidemic. Up until mid 1995, eastern Europe, and the former Soviet Union did not seem threatened by a substantial HIV epidemic. Of the 450 million residents in the region, HIV infections were estimated at less than 30,000 cases. However, between 1995 and 1997, the estimated number of cases of HIV increased more than fivefold in this region. UNAIDS and WHO estimated that two thirds of these infections had occurred in the last 12 months of this time period (Dehne, K., 1999).

Current statistics suggest a startling trend in the incidence of HIV infection in Georgia, which has quadrupled between 1997 and 2000 (Figure 17.1.1). The actual number of cases seems quite low



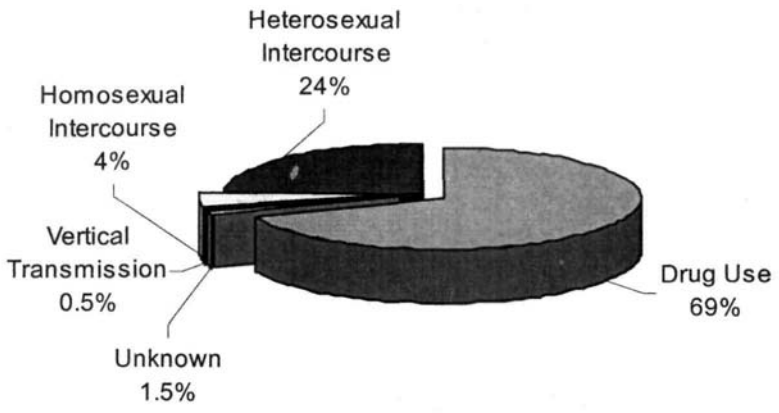
in comparison to other countries. However, this sudden increase in new cases may be the beginning of a larger epidemic yet to come (Nutsubidze N., 1999).

Georgia was one of the first countries in eastern Europe to address the HIV/AIDS epidemic. HIV surveillance in Georgia is conducted through the AIDS Prevention and Control Program of the MOH. Started in 1994, the program is supervised by the National AIDS committee and includes the Georgian AIDS Center, 60 diagnostic laboratory facilities, and the AIDS Research Department of the Tbilisi State Medical Institute. As part of recent health care reforms in Georgia, HIV testing is only mandatory for blood donors and tests are provided by the Safety of Blood and Blood Products Program. However, HIV testing is also available at no cost to individuals in high risk groups (Nutsubidze, N., 1999).

HIV case reporting in the 15 successor states of the Soviet Union entails two stages: the recording of the screening test and the referral to a health care institution for an epidemiologic history. The second stage is particularly important because that is where patients are classified by transmission and source of infection (Dehne, K., 1999).

Figure 17.1.2 distinguishes HIV infections in Georgia by the source of transmission. The largest proportion of HIV infections (69%) are among injecting drug users. More than one fourth

Figure 17.1. 2
Sources of HIV Infection in Georgia
Georgian Center for AIDS and Immunological Research



(28%) of the HIV infections are due to sexual intercourse (either heterosexual or homosexual intercourse). Vertical transmission from pregnant mother to baby represents 0.5% of the cases and for 1.5% of the cases the source of infection is unknown.

Overall, infection rates in Georgia may be under reported and the significant epidemic among injecting drug users may be an initial outbreak with serious potential of spreading to the general population via sexual transmission. Future infections may depend on this link between injecting drug users and the rest of the population. Effective prevention efforts initiated at these beginning stages of the epidemic may confine the extent of the disease. However, this window of opportunity for public health prevention efforts will be limited and focusing these efforts on specific subgroups is vital and necessary and requires population based-surveillance data, as featured in this chapter, to better target prevention programs.

17.1 Knowledge of HIV/AIDS

Respondents were asked if they have ever heard of HIV/AIDS (Table 17.1). A high percentage (93%) of Georgian women have heard of HIV/AIDS. This awareness varied slightly by characteristics. Rural and young adult women, and women with less education were less likely to have heard of HIV/AIDS. Azeri respondents (58%) had the lowest level of awareness of HIV/AIDS. However, awareness of HIV/AIDS did not necessarily mean that the respondents had detailed information about the disease.

All of the 7,390 individuals who had heard of HIV/AIDS were asked whether they believed a person could be infected with the HIV virus and be asymptomatic. Only slightly more than one half (56%) of the women who had heard of HIV knew that the disease could be present with no symptoms. This fact is particularly important because the women who do not know the virus could be present without symptoms, could put themselves at risk if they have sexual intercourse with an apparently healthy HIV-infected individual.

The respondents' knowledge of asymptomatic HIV varied by respondent characteristics. Women of rural residence (45%), incomplete secondary education (36%), and low socioeconomic level (44%) had less knowledge of asymptomatic HIV than women of urban residence (63%), post secondary education (72%) and high socioeconomic level (71%). Ethnic Azeri women (24%) had the lowest level of knowledge of asymptomatic potential. Sexual experience and marital status had little or no effect on knowledge.

In both questions, urban settings, higher education, and higher socioeconomic level had an

TABLE 17.1
Percent of Women Aged 15–44 Who Have Heard of HIV/AIDS, Percent Who Believe HIV/AIDS Infection Can Be Asymptomatic, and Percent Who Know Where HIV Testing Can be Provided by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Have Heard of HIV/AIDS		Believe That HIV/AIDS Infection Can Be Asymptomatic		Know Where HIV Tests are Provided	
	%	N	%	N	%	N
Total	**93.4**	**7,798**	**55.8**	**7,390**	**23.5**	**7,798**
Residence						
Urban	98.5	4,759	63.4	4,688	30.1	4,759
Rural	86.8	3,039	44.9	2,702	15.1	3,039
Region						
Tbilisi	99.2	2,029	66.5	2,016	38.7	2,029
Imereti	98.0	1,590	58.2	1,563	21.3	1,590
North-East	91.8	1,259	52.2	1,172	18.2	1,259
South	77.9	1,017	40.3	817	12.0	1,017
West	95.5	1,903	53.0	1,822	20.2	1,903
Age Group						
15–24	90.0	2,388	51.4	2,181	15.5	2,388
25–34	95.7	2,731	58.8	2,633	29.3	2,731
35–44	95.0	2,679	57.7	2,576	27.1	2,679
Marital Status						
Currently Married/In Union	94.1	5,177	55.6	4,923	25.8	5,177
Previously Married	91.3	517	56.0	487	25.0	517
Never Married	92.5	2,104	56.1	1,980	19.0	2,104
Education Level						
Secondary Incomplete or Less	76.0	991	35.7	767	6.2	991
Secondary Complete	93.2	2,664	46.8	2,500	16.5	2,664
Technicum	98.9	2,058	60.5	2,042	28.2	2,058
University/Postgraduate	99.8	2,085	72.1	2,081	39.3	2,085
Socio-Economic Status						
Low	87.0	3,276	43.9	2,995	13.1	3,276
Medium	96.0	3,654	58.5	3,537	25.8	3,654
High	98.6	868	70.6	858	39.6	868
Ethnic Group						
Georgian	97.6	6,700	58.4	6,563	25.7	6,700
Azeri	57.8	589	23.7	352	5.3	589
Armenian	91.5	300	41.5	275	17.6	300
Other	96.8	209	67.5	200	33.3	209
IDP Status						
IDP	97.8	1,828	61.1	1,784	21.6	1,828
Non-IDP	93.2	5,970	55.5	5,606	23.6	5,970
No. of Lifetime Partners						
Never Had Intercourse	92.5	2,095	56.1	1,971	19.0	2,095
1	93.7	5,533	55.5	5,254	25.3	5,533
2+	97.4	170	61.2	165	41.0	170

effect on increased knowledge that HIV/AIDS exists and that it can be asymptomatic. Health education programs may be most beneficial to those women in rural settings and from lower education and socioeconomic levels. Information should stress the risk potential in having sexual relations with asymptomatic HIV-positive individuals. Only one fourth (24%) of respondents said that they know where HIV tests are provided, including 5% who have been tested for HIV/AIDS. The proportion of women who know where to get a HIV test is significantly lower among rural women, women outside Tbilisi, young adults, women with lower education or lower SES, and Azeri women.

17.2 Knowledge of HIV/AIDS Transmission

To assess knowledge of HIV/AIDS transmission, respondents were asked to agree or disagree with 14 statements. Respondents were classified as lacking knowledge of a particular mechanism of transmission if they answered "No" or "Don't Know," when the method of transmission was a known route for HIV infection. A "Yes" answer on an incorrect mechanism of transmission was classified as having misinformation. If a respondent answered "No" or "Don't Know" to an incorrect mechanism of transmission, they were grouped together and not knowing an incorrect mechanism of HIV transmission was considered a correct answer.

Table 17.2.1 identifies the percentage of women who heard of HIV, but did not know the correct mechanisms of HIV transmission. The transmission route that was least known by respondents was vertical transmission from a pregnant or nursing mother to baby (28%). Homosexual intercourse (9%), blood transfusion (9%) and non-sterile needles (8%) followed, with heterosexual intercourse (3%) being the most known form of HIV transmission. Overall, correct knowledge of HIV transmission among women who were aware of HIV/AIDS varied between having no knowledge (3%) and knowing all five main routes of transmission (81%), with a mean of 4.6 known ways of transmission (data not shown).

Azeri, rural residents, and women with lower educational and socioeconomic levels, were less likely to have knowledge of HIV transmission. Women who had never been married or were not sexually experienced were also less likely to have knowledge on HIV transmission in comparison with women who were married and sexually experienced. Similarly, these women were the most likely to not be able to identify any correct means of HIV transmission.

Table 17.2.2 highlights the percentage of women with misinformation about HIV/AIDS transmission. None of the behaviors noted in this table have been identified scientifically as a source of HIV transmission. The percentage of women who believed that these were possible ways for

TABLE 17.2.1

Percentage of Women Aged 15–44 Who Did Not Know the Most Important Ways of HIV/AIDS Transmission, by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Heterosexual Intercourse	Non-Sterile Needles	Homosexual Intercourse	Blood Transfusion	Mother to Baby	Number of Cases
Total	**3.4**	**7.7**	**9.1**	**9.3**	**27.5**	**7,390**
Residence						
Urban	1.8	4.1	6.0	5.6	27.3	4,688
Rural	5.8	13.0	13.7	14.7	27.8	2,702
Region						
Tbilisi	0.8	2.8	4.2	3.9	34.4	2,016
Imereti	2.6	5.7	10.8	7.3	20.4	1,563
North-East	3.6	8.5	8.0	10.5	27.3	1,172
South	10.2	19.5	18.4	20.1	34.3	817
West	3.1	7.6	9.4	10.2	21.0	1,822
Age Group						
15–24	4.8	10.4	11.7	12.8	30.8	2,181
25–34	2.2	5.9	7.4	6.9	26.4	2,633
35–44	3.1	6.5	8.2	7.9	25.2	2,576
Marital Status						
Currently Married/In Union	2.9	7.4	8.4	8.9	25.3	4,923
Previously Married	2.2	4.9	5.8	5.8	27.2	487
Never Married	3.1	8.7	11.2	10.7	31.7	1,980
Education Level						
Secondary Incompl. or Less	10.0	21.0	19.7	24.9	38.9	767
Secondary Complete	4.0	9.5	9.7	10.9	27.6	2,500
Technicum	1.9	4.7	7.7	6.2	21.8	2,042
University/Postgraduate	0.9	1.8	4.5	2.6	27.1	2,081
Socio-Economic Status						
Low	6.1	12.7	13.3	15.5	28.8	2,995
Medium	2.5	6.3	7.9	7.4	26.4	3,537
High	1.4	2.6	5.3	3.7	29.3	858
Ethnic Group						
Georgian	2.4	5.4	7.8	7.3	25.6	6,563
Azeri	16.6	35.0	28.9	31.5	45.7	352
Armenian	7.2	15.9	10.8	19.2	33.9	275
Other	0.9	6.1	4.4	8.2	36.8	200
IDP Status						
IDP	1.5	3.8	5.7	6.2	22.8	1,784
Non-IDP	3.5	7.9	9.3	9.5	27.8	5,606
No. of Lifetime Partners						
Never Had Intercourse	4.7	8.7	11.2	10.8	31.8	1,971
1	2.8	7.3	8.3	8.7	25.2	5,254
2+	2.4	3.6	3.5	4.7	32.5	165

TABLE 17.2.2

Percentage of Women Aged 15–44 With Misconceptions about HIV/AIDS Transmission, by Alleged Ways of Transmission by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Shaking Hands	Using Public Toilets	Kissing	Sharing Objects with an Infected Person	Mosquito Bites	Donating Blood	Surgical or Dental Treatment	No. of Cases
Total	**9.5**	**28.2**	**36.9**	**41.3**	**47.6**	**73.0**	**82.4**	**7,390**
Residence								
Urban	6.1	24.3	33.1	35.3	47.3	75.6	87.6	4,688
Rural	14.3	33.7	42.2	49.9	48.1	69.2	74.8	2,702
Region								
Tbilisi	3.1	17.6	24.4	25.4	44.7	77.5	88.6	2,016
Imereti	7.9	30.0	40.5	47.7	47.9	72.1	84.5	1,563
North-East	11.5	34.6	41.6	46.9	48.3	76.2	79.7	1,172
South	14.9	31.8	39.2	43.7	44.9	65.0	70.3	817
West	13.5	32.3	43.8	49.6	51.9	70.3	82.5	1,822
Age Group								
15–24	9.3	30.5	39.7	43.8	43.2	69.9	75.7	2,181
25–34	8.2	25.9	35.5	39.5	49.1	75.1	85.0	2,633
35–44	10.8	27.9	35.1	40.4	51.0	74.3	87.1	2,576
Marital Status								
Currently Married/In Union	10.4	29.0	37.1	41.0	49.0	74.0	83.5	4,923
Previously Married/In Union	10.0	27.0	41.3	41.2	53.6	78.5	85.9	487
Never Married/In Union	7.7	26.8	35.6	41.8	44.0	70.1	79.6	1,980
Education Level								
Secondary Incompl. or Less	14.1	32.2	38.6	45.4	39.1	59.7	62.1	767
Secondary Complete	11.7	32.7	43.0	47.8	49.3	72.6	79.4	2,500
Technicum	10.4	31.8	41.9	45.1	53.6	77.6	86.2	2,042
University/Postgraduate	3.7	17.6	24.2	28.0	44.4	75.7	92.3	2,081
Socio-Economic Status								
Low	12.8	30.8	40.6	47.4	45.5	68.0	74.5	2,995
Medium	8.7	28.5	37.5	41.4	49.1	74.9	84.8	3,537
High	5.3	21.3	26.8	28.3	46.3	76.3	89.8	858
Ethnic Group								
Georgian	8.5	28.2	36.5	41.5	48.4	74.5	84.8	6,563
Azeri	20.6	32.3	40.5	42.0	39.4	52.0	55.4	352
Armenian	12.4	27.5	40.3	44.2	45.5	75.6	71.4	275
Other	10.3	21.5	34.9	29.2	43.9	69.1	83.2	200
IDP Status								
IDP	7.7	27.5	36.3	41.0	54.1	79.4	87.1	1,784
Non-IDP	9.6	28.2	36.9	41.3	47.3	72.6	82.1	5,606
No. of Lifetime Partners								
Never Had Intercourse	7.6	26.8	35.6	41.8	44.0	70.0	79.6	1,971
1	10.4	29.2	37.7	41.4	49.5	74.6	83.6	5,254
2+	10.3	20.3	29.8	30.0	46.8	69.6	88.3	165

contracting HIV are classified by their characteristics. Surgical or dental treatment (82%) and donating blood (73%) were the most common misconceptions about HIV transmission. The other misconceptions ranked as follows: mosquito bites (48%), sharing forks, plates and other objects with infected persons (41%), kissing (37%), using public bathrooms (28%), and shaking hands (10%). About one in five women who has heard of HIV/AIDS (21%) was not able to correctly identify any misconceptions about HIV transmission. One in two women (50%), however, could correctly identify three or more HIV/AIDS misconceptions (data not shown).

Except for misconceptions about donating blood and surgical/dental treatment as potential ways of HIV transmission, the level of misconceptions was higher in rural areas, among women with lower educational and socioeconomic levels, and among Azeri women. Marital status, previous sexual experience, and IDP status had little or no effect on misconceptions about HIV/ADS transmission. Donating blood and surgical/dental treatment were more likely to be identified as potential ways of HIV transmission by women with high education and high SES. For example, when asked whether donating blood could transmit the HIV virus, women with technical college (78%), university education (76%), and high socioeconomic level (76%) had a higher level of incorrect responses than women with low education levels (60%) or low SES (68%). Almost all (92%) of women in the highest education level believed that surgical or dental treatment could lead to HIV transmission.

There are several possible explanations for the higher percentage of women (particularly better educated and higher socioeconomic status) who believed that they could contract HIV by simply donating their own blood or receiving surgical or dental treatment. HIV transmission is often associated with sharp objects, particularly needles. As will be discussed later in the chapter, a large percentage of Georgian women have a high level of mistrust in the health care system and view health care services as a significant source of risk for contracting HIV. Surgical or dental treatment and donating ones own blood does not pose a risk for contracting HIV. However, receiving HIV infected blood products would be a risk for HIV infection. The large percentage of older, and more educated woman who believed that donating blood or medical treatment was a possible route of HIV transmission, leads to the assumption that this is a broad misconception among the population, one that may take significant public health education to overcome.

This broad misconception among the higher educated respondents was also noted in their opinions about beauty salons (data not shown). A large proportion of the women believed that manicures or pedicures carried the potential of HIV transmission (74%). Again, these misconceptions likely stem from the thought that HIV is transmitted through the use of sharp objects. Respondents who answered this way were more often older, highly educated, from a higher socioeconomic level, and resided in urban settings.

The high level of misconceptions pertaining to HIV transmission illustrates the need for public health education programs. Although mosquitos and other vectors have not been known to transmit the HIV virus, a large number of women found that to be of concern. HIV cannot be found in large amounts in saliva, however, one out of three respondents thought it carried some risk. Shaking hands or sharing objects with an infected person does not pose a risk for HIV transmission, yet over half of the respondents thought otherwise. Educational programs on the routes of HIV transmission should target women of rural residence, and those with lower educational and socioeconomic levels. Misconceptions on possible HIV transmission through blood donation, dental treatment, and beauty parlors are not limited by characteristic. Women of all educational and socioeconomic levels require education on verifiable transmission sources, particularly those relating to blood donation and use of blood products.

17.3 Knowledge of HIV/AIDS Prevention

A two-part question was used to identify women's knowledge of HIV prevention. Respondents were asked what a person can do to reduce their risk of HIV. Those individuals that spontaneously answered a correct prevention mechanism were coded ('Spontaneously'). In part two, the women were asked about the mechanisms that they did not answer spontaneously ('Probed'). Spontaneous answers that were not already precoded into the survey questionnaire were also recorded (the "other" category consisted mainly in "abstaining from sex", having "good hygiene" receiving "information about HIV/AIDS" and "isolating" HIV/AIDS patients).

Almost two-thirds of the female respondents spontaneously mentioned that limiting the number of sexual partners and knowing your partner—"being monogamous" (27%) or "avoiding sex with unknown partners"or "avoiding sex with prostitutes" (36%)—are protective against the HIV/AIDS transmission. Only one in four women (25%) noted the use of condoms as a possible preventive behavior but this percentage increases to 81% after probing. Only one in five women (19%) spontaneously mentioned "using clean needles" as a way to avoid HIV infection. Similarly, the majority of women correctly identify this preventive behavior after probing (92%). Less than 5% of the women identified the use of HIV testing as a form of prevention. Yet, after probing, 86% recognized testing as a prevention mechanism.

Overall, more than one in three women (38%) could not correctly state any main way of avoiding HIV infection and only 12% could name three or more preventive behaviors. On average, Georgian women could only name one main way of preventing HIV transmission (data not shown). Lack of any preventive knowledge is higher among rural residents (41%), residents outside Tbilisi, young adults (40%), respondents with less than complete high school education (56%), women with a low SES (42%) and Azeri women (54%).

TABLE 17.3.1
Percent Distribution of Women Who Have Heard about HIV/AIDS Who Mentioned Possible Means of Preventing HIV/AIDS Transmission Spontaneously and After Probing Reproductive Health Survey: Georgia, 1999/2000

	Mentioned			
Possible Means	Spontaneously	Probed	Did Not Mention	Total
Avoiding Sex with Casual Partners*	35.7	57.6	6.7	100.0
Being Monogamous	27.3	67.0	5.7	100.0
Using Condoms	24.7	56.3	19.0	100.0
Using Sterile Needles	18.7	73.4	7.9	100.0
Avoiding Injections	7.8	81.2	11.0	100.0
Asking Partner to be Tested for HIV	4.7	81.1	14.2	100.0
Avoiding Bisexual Relations	2.9	79.7	17.4	100.0
Others	1.4	0.2	98.4	100.0

* Include having sex with unknown partners and with prostitutes

Table 17.3.2 shows the proportion of women who spontaneously mentioned possible means of preventing HIV without probing. As mentioned above, avoiding sex with unknown partners or prostitutes (36%), being monogamous (27%), and using condoms (25%) were the highest spontaneous responses. Rural respondents had a similar level of prevention knowledge to urban women with the exception of condom use and needle transmission. Women with lower educational and socioeconomic levels, no sexual experience, and Azeri women were less likely to be able to spontaneously mention prevention mechanisms. These subgroups should serve as the target populations for prevention education programs.

Table 17.3.3 identifies the proportion of women who did not know the means of preventing HIV even after probing from the interviewer. Remarkably, a large number of respondents did not recognize condom use (19%) as a mechanism of preventing HIV transmission. A large number of women also lacked knowledge of avoiding relations with bisexuals (17%) and asking a partner to be tested for HIV (14%) as prevention mechanisms. Having a lack of knowledge in HIV prevention mechanisms was associated with rural residents, lower educational level, lower socioeconomic level, no sexual experience, and Azeri women. Younger women and women who had never been married were also less likely to have prevention knowledge.

TABLE 17.3.2

Percentage of Women Who Heard of HIV/AIDS, Who Spontaneously Mentioned Possible Means of Preventing HIV/AIDS Transmission, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Avoiding Casual Sexual Partners	Being Monogamous	Using Condoms	Using Sterile Needles	Avoiding Injections	Asking Partner to Be Tested for HIV	Avoiding Bisexual Relations	No. of Cases
Total	**35.7**	**27.3**	**24.7**	**18.7**	**7.8**	**4.7**	**2.9**	**7,390**
Residence								
Urban	36.8	27.6	31.8	21.2	9.2	5.3	3.2	4,688
Rural	34.0	26.8	14.4	15.1	5.7	3.7	2.5	2,702
Region								
Tbilisi	34.7	27.7	39.0	21.5	11.9	5.3	4.4	2,016
Imereti	39.8	25.8	22.4	21.4	7.0	5.2	1.6	1,563
North-East	36.9	27.7	17.2	17.8	6.5	4.1	1.9	1,172
South	34.0	26.8	17.0	14.2	5.0	3.1	2.5	817
West	33.9	27.9	19.9	16.7	6.1	4.9	3.1	1,822
Age Group								
15–24	29.9	21.0	24.2	16.0	6.3	4.3	2.5	2,181
25–34	38.3	30.3	27.6	20.4	8.1	4.9	3.3	2,633
35–44	39.3	31.2	22.4	19.9	9.0	4.9	3.0	2,576
Marital Status								
Currently Married/In Union	38.5	31.0	23.9	19.1	7.8	4.4	3.1	4,923
Previously Married/In Union	39.0	28.5	28.9	17.9	10.6	4.8	3.2	487
Never Married/In Union	29.8	20.1	25.5	18.1	7.3	5.2	2.5	1,980
Education Level								
Secondary Incompl. or Less	22.7	16.9	11.7	10.5	4.9	2.8	1.0	767
Secondary Complete	35.8	26.4	23.0	17.2	7.2	4.9	3.9	2,500
Technicum	38.2	30.5	23.1	18.6	6.9	4.7	2.8	2,042
University/Postgraduate	39.6	30.6	34.6	24.6	10.6	5.3	2.8	2,081
Socio-Economic Status								
Low	30.8	24.1	15.5	14.9	5.4	3.4	2.2	2,995
Medium	38.3	28.3	25.5	19.3	7.6	5.0	2.9	3,537
High	35.9	30.2	41.0	24.2	13.2	6.2	4.5	858
Ethnic Group								
Georgian	36.6	27.6	25.7	19.8	8.2	5.0	3.0	6,563
Azeri	28.5	21.2	8.9	6.8	2.9	1.6	0.9	352
Armenian	27.0	27.5	22.3	13.9	6.7	3.7	3.7	275
Other	35.9	28.8	32.8	18.3	8.0	3.9	3.4	200
IDP Status								
IDP	35.7	27.2	27.7	15.8	6.0	5.5	2.3	1,784
Non-IDP	35.7	27.3	24.6	18.9	7.9	4.6	2.9	5,606
Lifetime Partners								
Never Had Intercourse	29.7	20.0	25.6	18.1	7.3	5.2	2.5	1,971
1	38.6	30.9	24.0	19.1	7.9	4.5	3.1	5,254
2+	39.3	29.1	33.9	15.4	12.4	3.5	3.0	165

TABLE 17.3.3

Percentage of Women Who Heard of HIV/AIDS, Who Did Not Know Possible Means of Preventing HIV/AIDS Transmission After Probing, by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Using Condoms	Avoiding Bisexual Relations	Asking Partner to Be Tested for HIV	Avoiding Injections	Using Sterile Needles	Avoiding Casual Sexual Partners	Being Monogamous	Total No. of Cases
Total	**19.0**	**17.4**	**14.2**	**11.1**	**7.9**	**6.7**	**5.7**	**7,390**
Residence								
Urban	12.8	11.9	10.3	8.5	4.6	4.4	3.8	4,688
Rural	28.0	25.2	19.9	14.8	12.6	10.1	8.4	2,702
Region								
Tbilisi	11.1	8.5	12.3	10.1	3.5	4.1	3.6	2,016
Imereti	17.6	19.3	9.9	8.1	7.2	5.6	5.0	1,563
North-East	20.4	18.4	14.7	11.1	9.2	7.3	6.2	1,172
South	31.9	25.7	24.9	19.9	17.6	14.0	11.8	817
West	20.9	20.9	13.2	9.3	7.1	6.1	4.7	1,822
Age Group								
15–24	24.7	20.3	17.7	14.0	10.9	9.8	8.7	2,181
25–34	14.3	15.4	11.7	8.8	6.1	4.8	4.0	2,633
35–44	17.4	16.1	12.8	10.1	6.4	5.4	4.1	2,576
Marital Status								
Currently Married/In Union	16.8	16.8	13.7	7.3	10.3	5.8	4.7	4,923
Previously Married/In Union	16.7	12.7	10.9	4.8	8.4	4.2	3.5	487
Never Married/In Union	23.5	19.2	15.7	9.6	12.9	9.0	7.9	1,980
Education Level								
Secondary Incompl. or Less	40.0	35.4	30.1	20.5	24.4	18.3	16.0	767
Secondary Complete	21.5	17.7	16.2	8.8	11.9	7.6	6.5	2,500
Technicum	15.3	16.2	10.4	5.9	8.6	4.1	3.4	2,042
University/Postgraduate	9.0	9.3	7.6	2.5	5.9	2.6	1.8	2,081
Socio-Economic Status								
Low	27.5	23.6	19.6	14.7	12.4	9.7	8.8	2,995
Medium	16.4	15.7	11.9	9.7	6.5	5.7	4.2	3,537
High	11.1	10.4	11.7	8.5	3.9	4.6	4.8	858
Ethnic Group								
Georgian	16.7	15.7	12.2	9.3	6.0	5.5	4.6	6,563
Azeri	53.8	41.5	39.9	32.6	30.5	23.4	20.4	352
Armenian	19.5	18.8	19.9	16.5	13.5	9.0	8.1	275
Other	14.3	14.6	12.2	9.1	7.6	7.2	4.9	200
IDP Status								
IDP	12.9	14.9	9.1	7.7	6.4	4.9	4.9	1,784
Non-IDP	19.3	17.5	14.5	11.2	8.0	6.8	5.7	5,606
Lifetime Partners								
Never Had Intercourse	23.4	19.1	15.8	12.8	9.5	9.0	7.9	1,971
1	16.7	16.7	13.5	10.1	7.2	5.7	4.6	5,254
2+	20.9	11.6	11.4	13.6	5.9	5.3	3.6	165

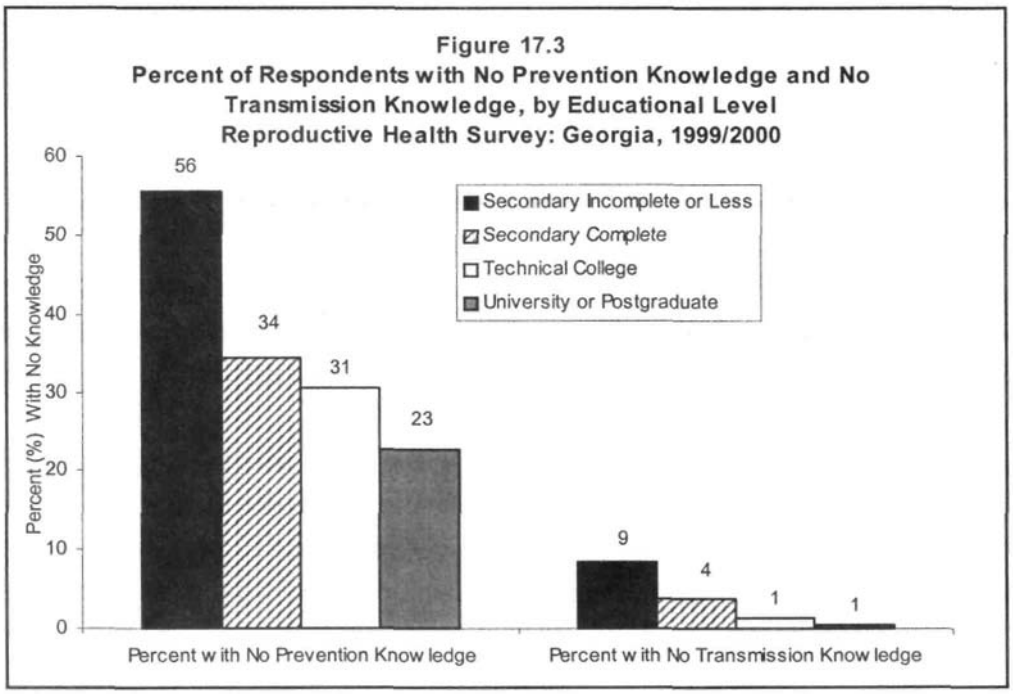


Figure 17.3 examines the relationship between no HIV prevention knowledge and no HIV transmission knowledge by educational level. Respondents who did not correctly identify any of the HIV prevention or transmission mechanisms were classified as having either 'No Prevention Knowledge' or 'No Transmission Knowledge'. Over half of the individuals in the lowest educational level had no knowledge on HIV prevention. This is in comparison to individuals in the highest educational category, where only one out of four had no knowledge on HIV prevention. In all educational categories, there were a larger percent of respondents lacking prevention knowledge than HIV transmission knowledge.

As demonstrated in Figure 17.3, women were more likely to have knowledge on HIV transmission, but did not have an understanding on how to prevent the disease. Despite women's higher level of knowledge on HIV transmission, they also had a large number of misconceptions (misinformation) about HIV transmission. Prevention information and education on the proper mechanisms of HIV transmission could be the focus for public health education programs.

Educational messages should target young women and emphasize mechanisms to protect oneself against HIV transmission, particularly the use of condoms, HIV testing, and abstinence. Messages should stress that HIV can be transmitted through casual, unprotected sexual relations with heterosexual or bisexual individuals. Focusing on young women who are inexperienced sexually could prevent future behavior that may lead to HIV infection. Due to Georgia's high rate of HIV infection among intravenous drug users, further emphasis should be made on unclean needle use as

a form of HIV transmission and on having unprotected sexual relations with a drug user. Drug prevention efforts should target younger, lower educated women, and women from the lower socioeconomic level.

17.4 Beliefs About the Risk of HIV/AIDS and Self-Perceived Risk of HIV/AIDS

Current scientific knowledge of the HIV virus and its transmission has placed individuals who partake in risky behavior at higher risk of contracting the disease. The risky behaviors include unsafe sex, numerous sexual partners, trading sex for money, and intravenous drug use.

Table 17.4.1 identifies women's responses when asked about their perception of risk of 'selected groups'. A large number of women correctly identified prostitutes (92%) and drug users (89%) as having a high risk of contracting HIV. Homosexual men (82.8%) were also attributed as having a high level of risk. Women classified unmarried men and women with sexual experience as having a higher risk of contracting HIV compared with married men and women.

Female respondents were asked to rate their own personal risk of getting HIV/AIDS (on a scale of 'high risk', 'moderate risk', 'low risk', or 'no risk'). Table 17.4.2 represents the proportion of women who believed they had some level of risk of contracting HIV. Information on groups who believe they are at higher risk of HIV is useful in targeting resources that may assist in preventing individuals in engaging in risky behavior.

TABLE 17.4.1
Perception of Women on the Risk of Contracting HIV/AIDS Among Selected Groups
(Percent Distribution)
Reproductive Health Survey: Georgia, 1999/2000

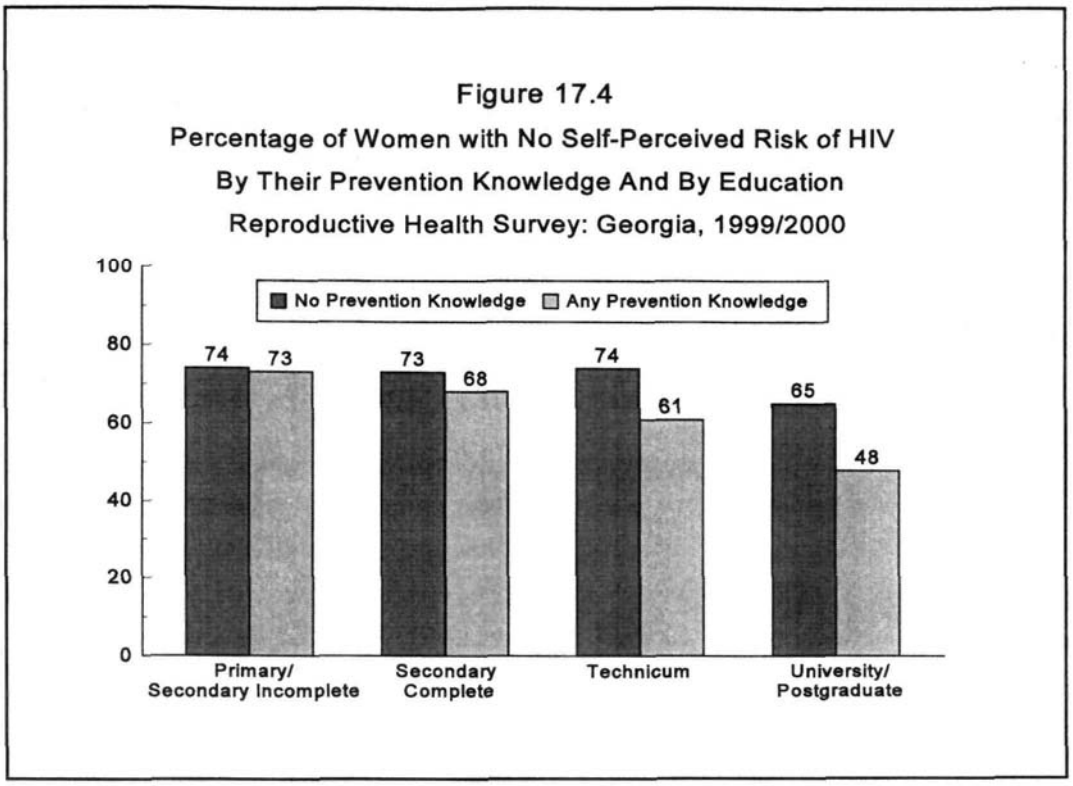
Selected Group	High Risk	Some Risk	Little Risk	No Risk	Do Not Know	Total	Unweighted Number of Cases
Prostitutes	91.9	2.2	0.5	0.2	5.2	100.0	7,390
Drug Users	89.0	2.2	0.7	0.3	7.8	100.0	7,390
Homosexual Men	82.8	3.2	1.6	0.3	12.1	100.0	7,390
Unmarried men with sexual experience	64.4	19.7	6.3	0.5	9.1	100.0	7,390
Unmarried women with sexual experience	63.1	20.0	7.3	0.6	9.0	100.0	7,390
Married men	9.7	46.1	32.0	4.6	7.6	100.0	7,390
Married women	7.1	46.2	32.9	5.9	7.9	100.0	7,390

TABLE 17.4.2

Percentage Distribution of Women Who Heard About HIV/AIDS by Self Perceived Risk of Contracting HIV/AIDS, by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

	Self Perceived Risk of Contracting HIV/AIDS						
Characteristic	**High Risk**	**Some Risk**	**Little Risk**	**No Risk**	**Do Not Know**	**Total**	**No. of Cases**
Total	**0.8**	**3.0**	**28.1**	**64.0**	**4.1**	**100.0**	**7,390**
Residence							
Urban	1.0	3.5	33.6	59.3	2.6	100.0	4,688
Rural	0.5	2.3	20.1	70.9	6.2	100.0	2,702
Region							
Tbilisi	0.8	3.2	39.7	54.5	1.8	100.0	2,016
Imereti	0.6	4.6	23.3	69.7	1.9	100.0	1,563
North-East	0.8	2.5	23.6	69.0	4.1	100.0	1,172
South	0.2	2.9	20.1	66.2	10.6	100.0	817
West	1.2	2.1	26.0	65.9	4.8	100.0	1,822
Age Group							
15–24	0.3	2.5	22.3	68.7	6.2	100.0	2,181
25–34	1.4	3.7	31.4	60.7	2.8	100.0	2,633
35–44	0.7	2.9	31.2	62.1	3.1	100.0	2,576
Marital Status							
Currently Married/In Union	0.9	2.6	29.4	63.9	3.3	100.0	4,923
Previously Married/In Union	0.5	5.3	27.4	63.7	3.0	100.0	487
Never Married/In Union	0.7	3.4	25.9	64.3	5.8	100.0	1,980
Education Level							
Secondary Incompl. or Less	0.2	1.4	14.6	73.5	10.4	100.0	767
Secondary Complete	0.9	2.2	22.6	69.7	4.6	100.0	2,500
Technicum	0.7	3.1	28.3	65.0	2.9	100.0	2,042
University/Postgraduate	1.0	4.6	41.1	51.6	1.6	100.0	2,081
Socio-Economic Status							
Low	0.6	2.4	20.0	70.1	6.9	100.0	2,995
Medium	0.8	3.2	29.1	63.8	3.2	100.0	3,537
High	1.2	3.4	41.4	52.2	1.8	100.0	858
Ethnic Group							
Georgian	0.8	3.0	29.2	63.9	3.1	100.0	6,563
Azeri	0.2	1.8	9.9	71.1	17.1	100.0	352
Armenian	0.3	2.5	23.5	67.1	6.6	100.0	275
Other	0.9	5.8	42.1	48.8	2.3	100.0	200
IDP Status							
IDP	1.7	1.9	29.7	64.6	2.1	100.0	1,784
Non-IDP	0.7	3.1	28.0	64.0	4.2	100.0	5,606
Lifetime Partners							
Never Had Intercourse	0.7	3.4	25.8	64.4	5.8	100.0	1,971
1	0.8	2.7	28.8	64.3	3.3	100.0	5,254
2+	1.2	4.8	41.5	50.8	1.8	100.0	165



Less than one percent of women believed that they were at high risk of contracting HIV and one third of the respondents believed they had some or little level of risk of contracting HIV. Almost two out of three women believed they were at no risk of HIV infection. Individuals who responded that they had high risk or some risk of HIV were more often urban residents. Marital status and sexual experience had little or no effect on self-perception of risk.

A larger proportion of younger, lower educated, lower socioeconomic, and Azeri women, perceived themselves as having no risk (69%, 74%, 70%, and 71% respectively). These were also the same subgroups that had the lowest level of knowledge of HIV transmission and prevention. Lack of knowledge of HIV transmission and prevention may affect a woman's ability to correctly assess her own risk of contracting the disease. The relationship between self-perception of HIV-risk and knowledge of prevention was examined among these subgroups. Figure 17.4 displays the percent of women with no self-perceived HIV risk by their prevention knowledge and education. The graph shows that, for women with lower levels of education, prevention knowledge has no impact on their self-perceived risk of getting HIV/AIDS; however, these women were more likely to not be able to assess their HIV risk than women with higher education levels. Among women with postsecondary education, perception of HIV risk increases with the increase in knowledge of HIV prevention.

In conclusion, the subgroups of younger women, lower educated women, rural residents, and Azeri all had a high percentage of individuals with no prevention or transmission knowledge (see also Figure 17.3) and were the subgroups with the highest perception that they do not have any HIV risk. It is unlikely that these subgroups, who lacked HIV prevention and transmission knowledge throughout the survey, could correctly assess their own risk of HIV. Compared to their older, better educated, urban counterparts, these women are less aware of the ways of HIV-transmission and how one can protect herself from getting infected. These groups require a greater emphasis by public health providers to educate individuals on HIV transmission and prevention facts. Educational programs should be targeted at these individuals to help prevent them from taking part in risky behavior that may lead to contracting HIV.

The one out of three women who believed that they had some level of risk (answering 'high', 'some', or 'little' risk) (32%) were asked why they considered themselves to be at risk. Table 17.4.3 identifies women's opinions on risk factors of contracting HIV. The overwhelming majority (88%) believed that they were at risk of HIV due to utilization of health care services. With the addition of blood transfusions, more than 90% of women who perceived they have some risk of infection believed that they had a risk of contracting HIV due to the health care system. Less than 5% of women believed that they are at risk of HIV due to their own behavior, due to either distrusting her partner (4%) or having multiple partners or unprotected sexual intercourse (0.4%). Reasons for self-perceived risk in all categories (besides 'Other') were similar across demographic characteristics and subgroups. None of the respondents cited past intravenous drug use as a possible source for contracting HIV.

Women's opinions concerning other potential risk factors were also recorded on the survey. These responses are grouped with the 'Other' category. Two percent of women believe that they are at risk of getting infected by HIV because they utilize beauty parlors (manicure, pedicure, or haircut). These concerns may come from the fear of sharp objects being associated with possible HIV infection and transmission. Fear of contracting HIV by using beautician's services was more often found in younger, unmarried, lower educated women. These respondents were often not sexually experienced and often from urban areas.

There are several reasons why a high percentage of women may believe that the health care system carries a possible risk for HIV transmission. First, the economic crisis in Georgia had a deep impact on the health infrastructure and utilization of health services (that often lack electricity, heat, and running water). State health expenditures represent less than 1% of GDP (0.7% in 1998 and 0.6% in 1999); the clinic caseload has dropped 33%-90%; health seeking behaviors are generally low (see also Chapter XIII), partly because a widespread mistrust in the quality of the health care system. Second, the Russian television that is broadcast in Georgia, particularly Channel 1 and

TABLE 17.4.3

Opinions about the Risk Factors of Contracting HIV/AIDS Among Women Aged 15–44 Who Heard About HIV/AIDS and Believed That They Had a Risk of Contracting HIV/AIDS by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Utilization of Health Services	Distrust in Partner	Blood Transfusions	Unsafe Sex	Other	Do Not Know	Total	Total No. of Cases
Total	**88.3**	**3.8**	**3.4**	**0.4**	**3.0**	**1.0**	**100.0**	**2,364**
Residence								
Urban	89.1	3.4	2.6	0.3	3.7	0.8	100.0	1,737
Rural	86.5	4.7	5.2	0.7	1.3	1.5	100.0	627
Region								
Tbilisi	88.9	3.7	2.5	0.2	4.4	0.2	100.0	875
Imereti	88.2	3.3	4.4	0.3	2.2	1.7	100.0	456
North-East	87.0	3.3	6.0	0.6	1.7	1.4	100.0	316
South	87.1	4.0	2.2	1.7	4.5	0.4	100.0	196
West	88.9	4.6	2.9	0.2	1.6	1.8	100.0	521
Age Group								
15–24	88.1	2.5	3.2	0.0	5.1	1.1	100.0	569
25–34	86.7	4.7	4.2	0.7	2.6	1.1	100.0	930
35–44	90.2	4.0	2.7	0.5	1.9	0.8	100.0	865
Marital Status								
Currently Married/In Union	87.6	5.9	3.4	1.7	0.9	0.5	100.0	1,605
Previously Married/In Union	91.4	0.7	2.2	3.0	2.0	0.7	100.0	152
Never Married/In Union	89.2	0.1	3.6	5.8	1.0	0.3	100.0	607
Education Level								
Secondary Incomplete or Less	80.9	6.3	3.3	8.7	0.7	0.0	100.0	130
Secondary Complete	86.4	3.4	4.5	3.1	2.0	0.7	100.0	630
Technicum	88.5	5.4	3.4	1.8	0.9	0.0	100.0	645
University/Postgraduate	90.7	2.8	2.7	2.8	0.4	0.6	100.0	959
Socio-Economic Status								
Low	85.4	4.8	5.9	0.4	1.4	2.2	100.0	776
Medium	89.5	3.3	3.3	0.3	3.0	0.7	100.0	1,193
High	88.3	4.3	1.2	0.8	4.9	0.6	100.0	395
Ethnic Group								
Georgian	88.5	3.6	3.4	0.4	3.2	0.9	100.0	2,145
Azeri	75.6	11.4	3.7	3.7	1.9	3.7	100.0	46
Armenian	85.9	5.8	5.8	0.0	1.3	1.2	100.0	75
Other	94.2	3.0	0.9	0.0	1.0	1.0	100.0	98
IDP Status								
IDP	86.1	4.1	5.5	0.1	3.9	0.3	100.0	570
Non-IDP	88.5	3.8	3.3	0.4	3.0	1.0	100.0	1,794
No. of Lifetime Partners								
Never Had Intercourse	89.4	0.0	3.6	0.3	5.8	1.0	100.0	602
1	88.0	5.5	3.3	0.5	1.7	1.1	100.0	1,680
2+	85.4	6.3	2.2	1.2	4.8	0.0	100.0	82

TABLE 17.4.4

Opinions about Factors that Protect from the Risk of Contracting HIV/AIDS Women Aged 15–44 Who Heard About HIV/AIDS and Believed That They Had No Risk of Contracting HIV/AIDS by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Trust worthy Partner	Sexual Abstinence	Only One or Faithful Partner	Use Condoms	Other	Do Not Know	Total	No. of Cases
Total	**45.8**	**36.5**	**13.4**	**0.3**	**0.8**	**3.2**	**100.0**	**4,776**
Residence								
Urban	43.0	41.1	12.3	0.2	1.2	2.2	100.0	2,838
Rural	49.2	30.9	14.8	0.3	0.4	4.5	100.0	1,938
Region								
Tbilisi	41.5	42.0	11.9	0.4	2.2	2.0	100.0	1,107
Imereti	45.3	39.5	12.1	0.1	0.0	3.1	100.0	1,077
North-East	50.3	30.7	14.2	0.2	1.4	3.2	100.0	814
South	49.1	29.8	15.1	0.8	0.0	5.2	100.0	543
West	44.8	37.3	14.2	0.1	0.2	3.3	100.0	1,235
Age Group								
15–24	23.6	63.7	5.8	0.3	1.2	5.5	100.0	1,502
25–34	58.3	21.7	17.7	0.2	0.6	1.4	100.0	1,638
35–44	60.5	17.8	18.5	0.3	0.6	2.2	100.0	1,636
Marital Status								
Currently Married/In Union	74.1	1.0	21.8	2.3	0.4	0.4	100.0	3,169
Previously Married/In Union	3.8	90.1	1.1	2.4	1.9	0.7	100.0	325
Never Married/In Union	1.0	92.5	0.1	5.0	1.4	0.0	100.0	1,282
Education Level								
Secondary Incompl. or Less	24.2	59.3	5.7	9.8	1.1	0.0	100.0	560
Secondary Complete	47.8	35.3	13.3	2.9	0.3	0.4	100.0	1,779
Technicum	54.3	27.1	16.5	1.2	0.6	0.2	100.0	1,343
University/Postgraduate	47.9	33.1	15.5	1.4	1.8	0.3	100.0	1,094
Socio-Economic Status								
Low	45.9	34.4	14.1	0.1	0.7	4.8	100.0	2,081
Medium	46.4	37.0	13.2	0.4	0.8	2.3	100.0	2,245
High	42.8	39.9	12.6	0.5	1.4	2.7	100.0	450
Ethnic Group								
Georgian	45.4	37.7	13.0	0.2	1.0	2.7	100.0	4,246
Azeri	43.7	23.3	20.8	1.2	0.3	10.7	100.0	249
Armenian	54.6	32.8	10.4	0.4	0.0	1.8	100.0	183
Other	47.8	34.5	12.9	0.0	0.0	4.8	100.0	98
IDP Status								
IDP	47.6	37.6	12.5	0.1	0.1	2.1	100.0	1,173
Non-IDP	45.7	36.4	13.5	0.3	0.9	3.3	100.0	3,603
No. of Lifetime Partners								
Never Had Intercourse	1.0	92.4	0.1	0.0	1.4	5.0	100.0	1,278
1	68.5	8.3	19.9	0.4	0.5	2.3	100.0	3,419
2+	44.0	29.3	20.8	1.2	2.3	2.4	100.0	79

messages within the programs that may imply a risk of HIV from health care utilization. Similar misconceptions about the risk of HIV transmission through using the health care system have been noted in other population-based studies in Russia (Amirkhanian, 2001), Romania (Serbanescu et. al., 2001), and Moldova (Serbanescu et. al. 1998). Media imagery poses a constant and difficult challenge for public health care initiatives to offset. Women's personal behavior is the primary reason for contracting and transmitting HIV. The misconception that health care services put an individual at higher risk of contracting HIV may cause women to put less emphasis on their own behavior in preventing the disease. Public health efforts to educate women may demand the use of mass media campaigns targeted at countering the television programming that is causing these misconceptions. Although such efforts are often too costly for public health organizations, media networks should be advised of their negative impact on public health and the Georgian health care industry. Proper education of the population requires collaboration between public health organizations, NGOs, and media organizations.

The two out of three women (65%) who believed that they did not have any risk of contracting HIV/AIDS were asked why they thought they had no risk of the disease (Table 17.4.4). Over half of the women responded that they had trust in their partner. A third of the women responded that they were not sexually active and 14% responded that they were monogamous. Only 0.2% of the respondents claimed using condoms lowered their risk of infection. Abstinence was more common in younger and unmarried women, while monogamy and a trustworthy partner were more often reported by older, married women. These values did not vary across residence, socioeconomic levels, or ethnicity.

In conclusion, this study reveals that particular subgroups of Georgian women are less educated about HIV/AIDS transmission, and possible forms of prevention. Younger women, rural residents, women from lower educational and socioeconomic levels, sexually inexperienced women, and Azeri women were less informed about HIV infection. These groups of women are particularly important to target. Younger and sexually inexperienced women should be educated about the potential of HIV infection, possibly preventing them from 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 obtain HIV/AIDS related materials and education. Women in lower socioeconomic situations may not have immediate access to health care providers and may require a specific targeted educational campaign. Educational programs targeted to Azeri women should involve members of the ethnic community to reinforce the importance of HIV-related education.

Georgian women require education on the potential risk of HIV infection due to their own or their partner's behavior, and increased education that utilization of health care services would not put an individual at risk of HIV infection. Misconceptions on HIV risk due to health care utilization

need to be corrected by accentuating the usefulness of the health care system in preventing and controlling infectious diseases. Georgia has precautions in place to prevent HIV contaminated blood from being used in health care settings. The public's fears of HIV risk from blood products or health care services could be alleviated by public awareness campaigns identifying the safety features in these services.

Georgia's high percentage of HIV infections among drug users requires additional attention to be made on drug prevention efforts in the country. Younger women in urban settings would likely benefit from drug prevention education and resources. Specific education on transmission and prevention of HIV should emphasize the use of HIV testing and condom usage. Early prevention programs could limit the potential of an epidemic and avert a possible shift in the HIV transmission, from injecting drugs to transmission by sexual intercourse.

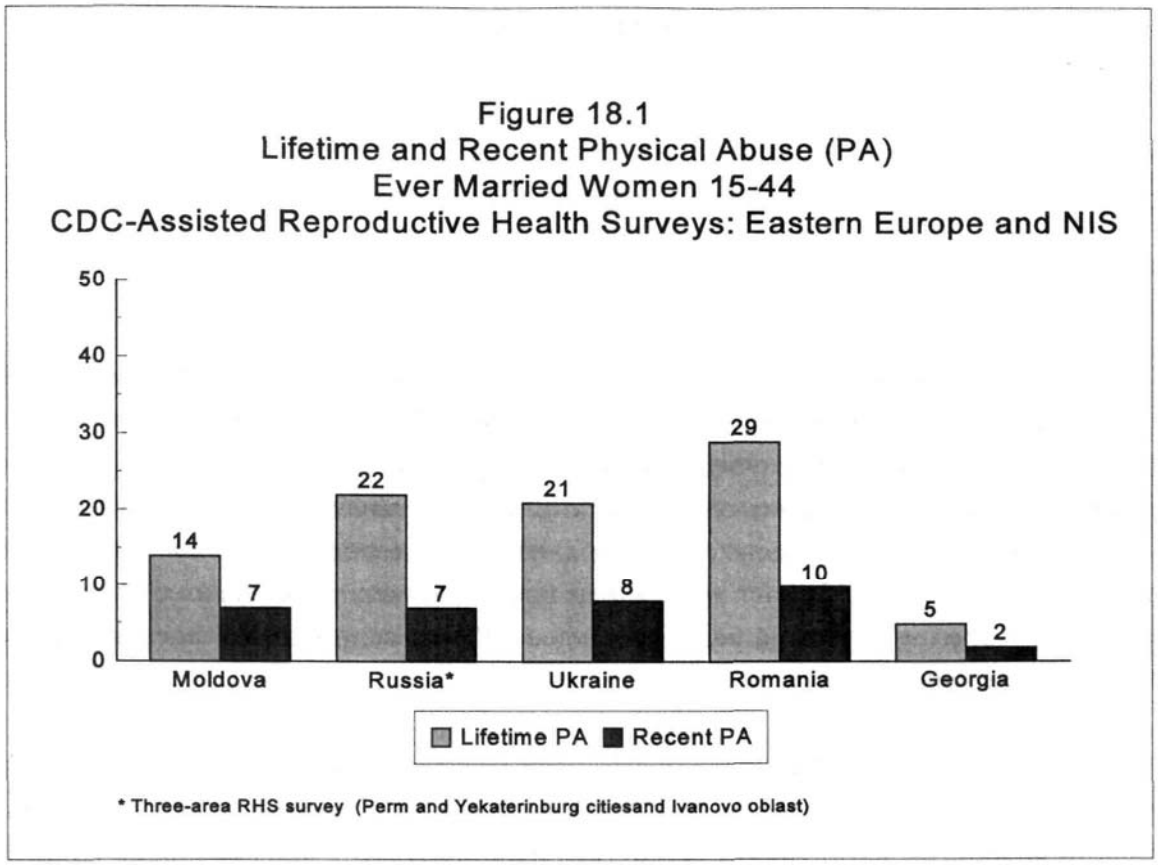
CHAPTER XVIII

PHYSICAL AND SEXUAL ABUSE

In recent years, violence against women has come to be recognized as a significant public health problem with serious consequences for women's health and for society. According to the United Nations, violence against women is defined as "any act of ...physical, sexual, or psychological harm...including threats of such acts, coercion or arbitrary deprivations of liberty, wether occurring in public or private life " (UN General Assembly, 1993). One of the most common acts of violence against women is perpetrated by men against their female partners. Often referred to as "domestic violence" or "battering", intimate partner violence (IPV) encompasses all ages and all socio-economic and educational backgrounds.

The questions included in the 99GERHS focus principally on two types of violence against women: 1) intimate partner violence and 2) sexual coercion (at any point in a woman's life). Violence by an intimate partner was explored using a modified (eight items) Conflict Tactic Scale. It was defined as verbal, physical, and sexual abuse among ever married (legally or consensually) women. Female respondents were asked a series of questions related to past and present (within the past year) abuse. Verbal abuse includes insults, curses, and verbal threats, and gestures with the intent of physical harm ("threaten to hit you or throw something at you"). Physical violence, further classified into moderate and severe violence (O'Campo P. et al., 1994), includes pushing, shoving, and slapping (moderate violence) and kicking, hitting with the fist or an object, being beaten up, and threats with a knife or other weapon (severe violence). Women who experienced recent physical abuse were further asked about the severity of physical injuries and if they sought help from law enforcement agencies, family, friends, or health care providers. Sexual abuse by an intimate partner was defined by asking whether "a partner ever physically forced [the woman] to have sex against her will." In order to examine reporting of domestic violence from the male perspective, similar questions regarding types of abuse perpetrated by males against their female partners were included in the male questionnaire.

In addition, all respondents were asked about their history of witnessing physical abuse between parents or experience of abuse as a child or adolescent; all female respondents, irrespective of their marital experience, were asked about their lifetime exposure to sexual coercion defined as "being forced by a man to have sexual intercourse against [the woman's] will." Furthermore,



questions about age at first forced intercourse and relationship with the perpetrator at first forced intercourse were also included.

18.1 Comparative Findings on Domestic Violence in Eastern Europe

The questions included in the 99GERHS are similar in scope to those asked in other CDC-assisted reproductive health surveys conducted in Eastern Europe and Former Soviet Union countries (Figure 18.1.1). In all these countries, with the exception of Russia, the survey data produced the first population-based information on violence against women available at the national level. These surveys provide the opportunity to study characteristics of battered women and linkages with reproductive health. In addition to documenting violence against women 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 policies, and ultimately to develop laws and interventions to protect and benefit the battered women. Most countries of the region share similarities with regard to legal status of women and gender roles; they all experienced in the past the same Communist efforts to promote gender equality only to see them

replaced by recent political and social changes aimed at relegating women to traditional roles. None of these countries have yet established laws and mechanisms to protect women from spousal abuse. The absence of any government capacity to respond to domestic violence triggered, in many countries, the founding of local NGOs and women's coalitions with a strong support from the international community.

The estimates presented here are likely to underestimate the true population prevalence because, for both psychological and practical reasons, some women may have understated or not reported their abuse history, despite assurances of maintaining confidentiality. Moreover, cross-cultural data on spousal abuse can be difficult to interpret because cultural definitions or perceptions of abuse may differ from one country to another. Reported lifetime experience with spousal physical abuse varied between 5% in Georgia and 29% in Romania while physical abuse during the past 12 months ranged from 2% in Georgia to 10% in Romania. Georgian women reported much lower levels of spousal abuse than any other country, findings which may be attributed to differences in reporting, cultural definitions and perceptions, or a particularly strong role of the extended family and friends in the life of Georgian women.

18.2 History of Witnessing or Experiencing Parental Physical Abuse

History of witnessing physical abuse between parents or the experience of parental abuse as a child or adolescent have been identified as important risk factors for emotional and behavioral problems during childhood and adolescence (Edleson JL, 1999, Kolbo JR and Blakely EH, 1996). Data from the literature suggests that children who experienced both risk factors are the most likely to develop serious behavioral problems. Several studies have linked childhood exposure to violence with child and adolescent violent behaviors (Song LY et al., 1998) and to physical abuse during adulthood (Hotaling GT and Sugarman DB., 1986). In the 99GERHS, all respondents were asked if, when they were growing up, they ever heard or saw their parents physically abuse each other and if their parents physically abused them.

As shown in Table 18.2, overall, 7% of respondents reported having heard or seen abuse between their parents, ranging from 7% to 22%. Between 16% and 26% of women reported that they have experienced parental physical abuse, with an overall average of 21%. Women who experienced parental abuse as children were more likely to grow up in Tbilisi, to be 15-24 years of age, to not have completed secondary education, and to grow up in households with low socioeconomic status (SES), and in families of Azeri or other ethnic group background. Experience of abuse was not significantly influenced by respondents' background characteristics, with the exception of educational attainment. The highest prevalence of parental abuse (26%) was reported

TABLE 18.2
Percentage of Women Aged 15–44 Who Witnessed or Experienced Parental Abuse by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000

Characteristic	Witnessed Abuse	Experienced Abuse	No. of Cases*
Total	**6.9**	**20.8**	**7,764**
Residence			
Tbilisi	10.2	18.9	2,019
Other Urban	4.9	23.5	2,716
Rural	6.2	20.1	3,029
Age Group			
15–24	8.5	24.6	2,376
25–34	6.5	19.0	2,716
35–44	5.4	18.2	2,672
Education Level			
Secondary Incomplete	11.1	26.4	983
Secondary Complete	6.5	21.3	2,655
Technicum	6.1	21.4	2,050
University	5.3	16.1	2,076
Socio-economic Status			
Low	8.9	22.9	2,364
Medium	5.9	19.9	3,060
High	5.9	19.2	1,426
Ethnicity			
Georgian	5.6	21.2	5,977
Azeri	13.0	19.7	437
Armenian	8.4	14.1	341
Other	21.7	24.4	95
Any Physical Abuse from a Partner			
Yes	22.4	35.9	282
No	5.7	18.0	5,406

* Excludes 34 women who reported that they did not grow up with their parents

by women with less than complete secondary education (who are also the youngest women in the sample) whereas the lowest occurrence of parental abuse (16%) was reported by women with postgraduate education. Georgian women were less likely to witness parental abuse compared to other ethnic groups. Respondents who reported having experienced physical abuse by a partner when they were growing up were significantly more likely than those who did not report physical abuse to have witnessed physical violence between parents (22% vs. 6%) and to have been exposed to parental abuse (36% vs. 18%).

18.3 Verbal, Physical and Sexual Abuse by a Partner or Ex-Partner

In order to measure the lifetime prevalence of intimate partner violence (IPV), women who ever had a partner were asked if they had ever been verbally, physically, or sexually abused by a partner or ex-partner. The terms "partner" and "ex-partner" include a current or former spouse (legal or common-law) or other partner with whom the respondent may have cohabitated for any length of time.

Figure 18.3.1 and Table 18.3.1 show that only one in five (19%) women reported having been verbally abused, 5% have been physically abused and 3% have been sexually abused by a partner or ex-partner at some time in their life. Among women who reported verbal abuse, all of them (19%) reported they were insulted by their partners and 4% said that they were also threatened to be beaten (data not shown). Not surprisingly, there is a considerable overlap between the three types of abuse; almost all women (94%) who have been subjected to physical violence said that the physical abuse was accompanied by verbal abuse (not shown). Similarly, sexual abuse is frequently associated with other acts of physical harm: 66% of women who have been sexually abused had also reported other acts of physical violence (data not shown).

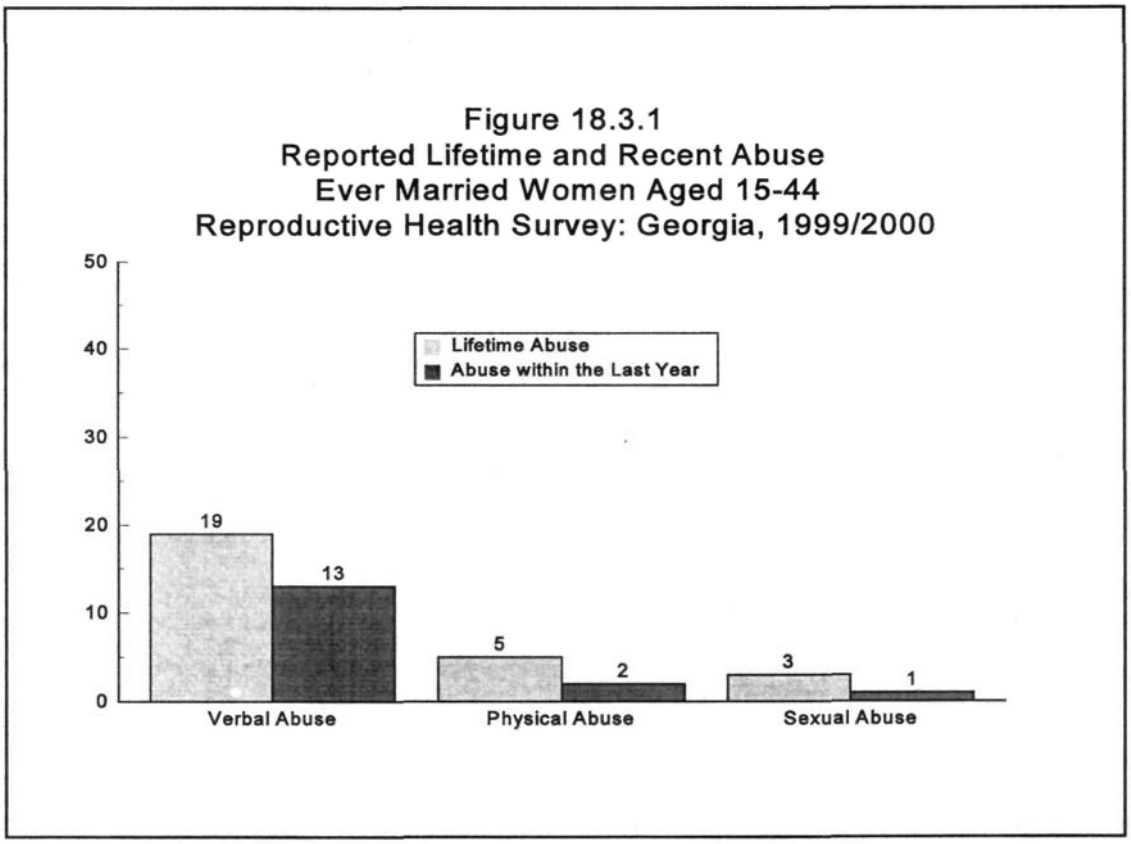
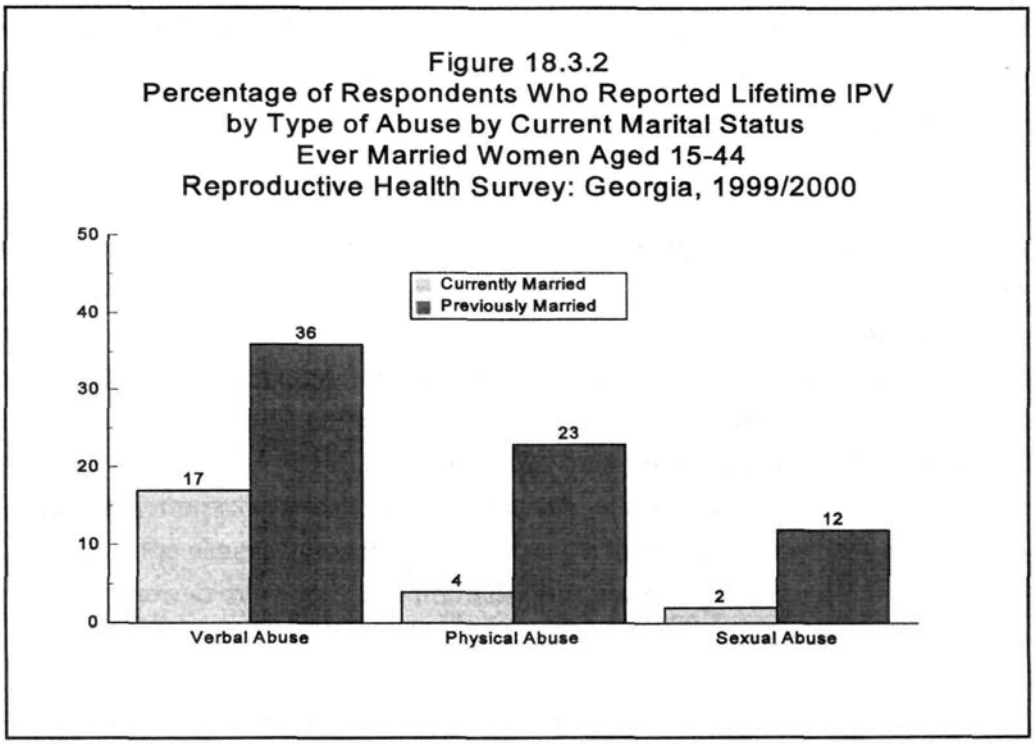


TABLE 18.3.1
Percentage of Women Who Reported Intimate Partner Violence (IPV) in Their Lifetime and Percentage Who Reported Intimate Partner Violence in the Last Year by Type of Abuse by Selected Characteristics
Ever Married Women Aged 15–44
Reproductive Health Survey: Georgia, 1999/2000

	Lifetime IPV				IPV During the Last Year			
Characteristic	Verbal Abuse	Physical Abuse	Sexual Abuse	No. of Cases	Verbal Abuse	Physical Abuse	Sexual Abuse	No. of Cases
Total	**18.7**	**5.3**	**2.5**	**5,694**	**13.2**	**1.7**	**0.8**	**5,694**
Residence								
Tbilisi	23.5	9.8	4.4	1,386	13.7	3.1	1.0	1,386
Other Urban	16.3	3.7	1.7	1,968	11.6	0.8	0.5	1,968
Rural	17.7	3.8	1.9	2,340	14.0	1.5	0.9	2,340
Age Group								
15–24	15.9	4.2	1.8	949	12.3	1.9	0.7	949
25–34	18.9	5.9	2.5	2,294	13.5	2.1	0.5	2,294
35–44	19.8	5.2	2.7	2,451	13.4	1.3	1.1	2,451
Marital Status								
Currently Married/In Union	17.0	3.6	1.5	5,177	14.2	1.7	0.8	5,177
Previously Married	36.4	22.6	12.1	517	3.7	2.1	1.0	517
No. of Living Children								
None	14.3	5.3	2.8	496	7.1	1.9	0.7	496
One	20.1	7.5	3.0	1,314	11.2	1.9	0.3	1,314
Two	18.1	4.8	2.3	2,737	13.8	1.8	0.9	2,737
Three or More	20.7	4.0	2.1	1,147	16.8	1.3	1.1	1,147
Education Level								
Secondary Incomplete	19.8	6.6	3.0	484	14.1	2.4	0.4	484
Secondary Complete	19.9	5.1	2.7	1,997	14.6	1.7	1.2	1,997
Technicum	19.0	5.8	2.5	1,723	13.2	2.0	0.8	1,723
University	16.7	4.6	1.9	1,490	11.2	1.1	0.6	1,490
Socioeconomic Status								
Low	20.1	5.7	2.5	2,396	14.8	2.0	0.9	2,396
Medium	18.8	5.1	2.3	2,662	13.1	1.7	0.9	2,662
High	15.2	4.6	3.0	636	9.9	1.0	0.6	636
Ethnicity								
Georgian	17.7	4.6	2.2	4,787	12.8	1.4	0.9	4,787
Azeri	21.4	6.6	2.5	481	14.8	2.7	0.3	481
Armenian	19.1	4.5	2.6	247	12.6	1.1	0.4	247
Other	34.7	19.3	8.6	179	19.0	6.4	0.6	179
IDP Status								
IDP	15.1	2.5	1.6	1,264	12.6	1.3	0.8	1,264
Non-IDP	18.9	5.4	2.5	4,430	13.3	1.7	0.8	4,430



To document some of the risk factors for abuse, the prevalence of different types of abuse was analyzed by selected characteristics of the respondents. Significant differences were found between abuse reported by respondents residing in Tbilisi and those living in other urban or rural areas, the former reporting lifetime prevalence of verbal and physical abuse of 24% and 10%, respectively. The prevalence of verbal and physical abuse were directly correlated with age but age differences in reports of lifetime events are likely to be confounded by the length of exposure (older women having had a longer time exposed to the risk of abuse). For this reason, the association between age and IPV is better reflected in the study of present abuse (see the right panel of Table 18.3.1).

When physical abuse by a partner or ex-partner was analyzed by the respondent's current marital status, women categorized as previously in formal or consensual marriages had significantly higher prevalence of past verbal and physical abuse, compared with currently married (or in union) women (see also Figure 18.3.2). Whereas 23% of those previously married or in union reported past physical abuse, only 4% of women currently married or in union reported having been abused (a ratio of almost 6:1). Similarly, previously married women reported, on average, six times more sexual abuse compared with currently married women. Although the survey did not ask if IPV contributed to a woman's decision to separate from her partner, these data suggest that women who were divorced and separated may have been exposed to more domestic abuse, contributing to their decision to split up with an abusive partner.

Prevalence of all types of abuse was not significantly influenced by education but was slightly higher among women with low and medium SES. Levels of IPV were the lowest among respondents of Georgian ethnic background.

As shown in the right panel of Table 18.3.1, 13% of all women interviewed reported having been verbally abused by a partner or ex-partner during the last 12 months. Current physical and sexual abuse was reported by only 2% and 1% of women, respectively. Some characteristics of the women who experienced higher levels of recent abuse were similar with those for women who reported lifetime abuse but, for such low levels of physical abuse, the differences were not significant. Abuse during the past 12 months was higher among Tbilisi women, was inversely correlated with educational attainment and socio-economic status, and was much higher among women of other ethnic groups. Opposed to lifetime abuse, currently married women experience higher levels of current verbal abuse than previously married women presumably because episodes of abuse may have contributed to the later group's marital dissolution and they were currently less exposed to verbal violence than the married women.

As shown in Table 18.3.2, the acts of violence most often mentioned were slaps, pushing and thrown objects (4%) that constitute moderate acts of violence. Between 1-3% suffered one form of severe physical violence (3% were kicked or hit with the fists or objects, 2% suffered severe beating and 1% were threatened with a knife or other weapon). Severity of abuse was more prominent among women living in Tbilisi, previously married women, and women of other ethnic background, who reported higher rates of any type of abuse.

18.4 Reports of Physical Abuse

As can be seen in Table 18.4, women are generally reluctant to disclose their history of current abuse to health care providers or law enforcement authorities. Although between 60% and 70% of women who have been abused during the past year had talked to a family member or a friend about it, only 10% have reported the episodes of domestic violence to the police and 8% have talked to a medical care provider. Only 8% have sought legal counsel for recent domestic abuse.

Urban women, including residents of Tbilisi, were more likely to report recent abuse than rural women. Older women were more likely to talk to the police or other legal authority and to seek medical advice whereas young adults were more likely to report abuse to a family member. Women who were divorced or separated, were more likely to talk to a family member or a friend, to report the abuse to the police, and to seek legal or medical counsel, probably because of the severity of the abuse and their intention to end an abusive relationship. The best educated women and those with

TABLE 18.3.2

Percentage of Respondents Who Reported Lifetime Physical Abuse and Recent Abuse by Severity of Abuse by Selected Characteristics

Ever Married Women Aged 15–44

Reproductive Health Survey: Georgia, 1999/2000

	Lifetime Abuse					Abuse During the Last Year					
	Moderate		Severe			Moderate		Severe			
Characteristic	Slapped	Pushed, Shoved	Hit with Fist	Was Beaten Up	Threatened With A Weapon	Slapped	Pushed, Shoved	Hit with Fist	Was Beaten Up	Threatened With A Weapon	No. of Cases
Total	**4.4**	**4.3**	**2.8**	**1.5**	**1.3**	**1.3**	**1.3**	**0.8**	**0.5**	**0.3**	**5,694**
Residence											
Tbilisi	7.9	7.7	5.0	3.3	2.8	2.5	2.2	1.5	1.0	0.6	1,386
Other Urban	3.5	3.6	2.2	0.7	1.2	0.7	0.8	0.3	0.1	0.2	1,968
Rural	3.1	2.9	2.0	1.0	0.5	1.1	1.0	0.6	0.6	0.2	2,340
Age Group											
15–24	3.7	3.6	2.6	1.2	0.8	1.7	1.5	1.1	0.5	0.4	949
25–34	5.1	4.6	3.0	1.7	1.5	1.6	1.4	0.9	0.7	0.3	2,294
35–44	4.1	4.3	2.7	1.5	1.3	1.0	0.9	0.5	0.4	0.3	2,451
Marital Status											
Currently In Union	2.9	2.7	1.7	0.9	0.6	1.3	1.2	0.7	0.5	0.3	5,177
Previously In Union	19.9	20.9	14.3	8.0	8.4	1.9	1.9	1.1	0.7	0.7	517
No. of Living Children											
None	4.7	4.7	2.7	0.7	1.0	1.9	1.5	0.8	0.4	0.2	496
One	6.1	6.6	3.8	2.3	2.3	1.3	1.4	0.9	0.4	0.5	1,314
Two	4.0	3.7	2.8	1.6	1.2	1.3	1.3	1.0	0.7	0.3	2,737
Three or More	3.5	3.1	1.8	0.9	0.5	1.1	0.9	0.2	0.3	0.2	1,147
Education Level											
Secondary Incomplete	5.3	5.4	4.3	2.2	0.9	1.3	1.9	1.1	1.3	0.0	484
Secondary Complete	4.4	4.2	2.7	1.3	1.4	1.3	1.2	0.9	0.5	0.3	1,997
Technicum	4.9	4.5	3.1	1.6	1.2	1.6	1.4	0.5	0.5	0.3	1,723
University	3.6	3.7	2.0	1.4	1.3	1.0	1.0	0.6	0.4	0.4	1,490
Socio-Economic Status											
Low	4.7	4.9	3.1	1.7	1.1	1.5	1.7	1.0	0.8	0.4	2,396
Medium	4.4	4.1	2.7	1.5	1.1	1.3	1.2	0.6	0.4	0.2	2,662
High	4.1	3.5	2.5	1.3	2.3	1.0	0.7	0.6	0.3	0.4	636
Ethnicity											
Georgian	4.0	3.7	2.8	1.3	1.2	1.2	1.0	0.6	0.5	0.3	4,787
Azeri	4.9	5.4	3.9	1.5	0.5	1.2	2.0	1.2	1.0	0.0	481
Armenian	4.1	3.7	1.9	1.5	1.1	1.1	0.7	0.4	0.0	0.0	247
Other	12.9	15.1	11.2	6.3	5.7	4.1	5.3	3.5	1.7	2.3	179

TABLE 18.4

Percentage of Women Who Were Physically Abused by an Intimate Partner During the Past Year Who Discussed the Abuse With Family, Friends, Health Providers, Police, or Lawyers by Selected Characteristics

Reproductive Health Survey: Georgia, 1999/2000

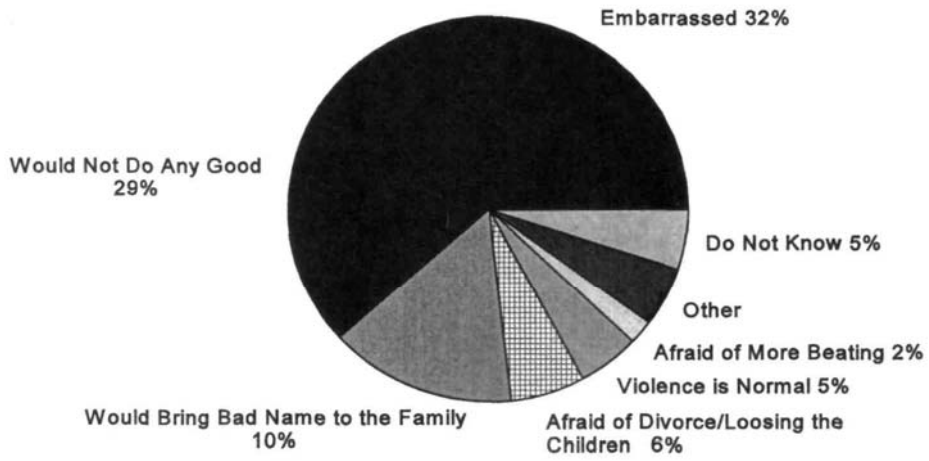
Characteristic	Family	Friends	Police	Lawyer	Health Provider	No. of Cases
Total	**70.0**	**59.8**	**9.9**	**8.4**	**8.1**	**323**
Residence						
Tbilisi	69.7	62.3	10.9	11.0	8.1	141
Other Urban	83.2	67.2	10.0	9.9	9.6	80
Rural	62.8	52.2	8.7	4.2	7.4	102
Age Group						
15–24	86.4	61.9	6.7	6.5	5.5	42
25–34	67.8	62.5	6.6	3.3	4.8	142
35–44	66.9	56.7	13.9	13.4	11.2	139
Marital Status						
Currently Married/In Union	62.0	53.9	7.8	3.8	5.8	208
Previously Married	84.5	70.4	13.8	16.6	12.4	115
No. of Living Children						
None	81.2	68.2	0.0	0.0	0.3	35
One	77.3	66.5	12.5	11.4	7.4	90
Two	67.9	57.3	10.4	11.1	11.0	145
Three or More	57.4	50.4	10.4	1.6	6.7	53
Education Level						
Secondary Incomplete	78.4	66.7	7.3	4.9	5.1	35
Secondary Complete	71.1	58.3	10.1	5.9	4.9	109
Technicum	74.5	54.9	13.0	14.2	12.9	101
University	57.6	64.5	7.1	5.8	7.9	78
Socioeconomic Status						
Low	75.9	56.4	9.6	5.3	9.1	139
Medium	68.2	60.1	11.3	9.4	7.6	148
High	60.6	68.5	5.2	13.1	7.9	36
Ethnicity						
Georgian	70.8	61.8	10.3	9.8	9.5	236
Azeri	67.3	41.4	8.8	0.0	0.0	37
Other	69.3	67.4	9.6	9.6	9.6	50

a high SES were least likely to report IPV to the police.

Given that very few women reported disclosure of IPV to a medical health provider and only about one in five of those who had injuries sought medical help, the medical community has to adopt active measures to detect abused women and prevent future episodes. Health care providers have to be aware of the relatively high prevalence of IPV and the reluctance of victims to seek treatment and should initiate inquiries about domestic violence experience during routine health visits. Such screening could effectively reduce the frequency and severity of intimate violence and could provide early interventions for domestically abused victims.

The most common reasons for a battered woman to not report acts of domestic violence to the law enforcement agencies or health providers are shown in Figure 18.4. The most often cited reasons were that it would be too embarrassing to report domestic abuse (32%) or it would bring the family a bad reputation (10%), followed by a widespread belief that no charges will be brought forth (29%), and fear of divorce and losing the children (6%); about 5% of beaten women thought that domestic violence is "normal" and 2% cited fear of more beating.

Figure 18.4
Reasons for Not Seeking Medical or Legal Help for IPV
Ever Married Women Who Were Physically Abused During the Past Year
Reproductive Health Survey: Georgia, 1999/2000



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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 1999/2000 GERHS 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 Georgia 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 99GERHS did not employ a simple random sample but included clusters of elements in the second stage of the sample selection.

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

Sample Size	Estimated Proportions (Pi)					
	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

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 99GERHS 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%; 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%.

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.

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

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

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November 17, 1999

1999 GEORGIA REPRODUCTIVE HEALTH SURVEY
HOUSEHOLD QUESTIONNAIRE

STRATA ____ PSU ___ ___ ___ **ID NUMBER** __ __ __ __ __

REGION_____ ____

DISTRICT(RAION) ____ ____ SECTOR ___ ___

ENUMERATION AREA ____ ____ CENSUS UNIT (RURAL AREAS ONLY) ___

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**

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, THEY 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. Is any of the people living in this household displaced from Abkhasia or Tskhinvali region?

1. YES
2. NO------>**GO TO Q3**

2B. How many people living in this dwelling are displaced from Abkhasia or Tskhinvali region ? ___ ___ people

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
1	_____	__ __	__	__
2	_____	__ __	__	__
3	_____	__ __	__	__
4	_____	__ __	__	__
5	_____	__ __	__	__
6	_____	__ __	__	__

Marital Status
1 Married
2 Unregistered Marriage
3 Separated
4 Divorced
5 Widowed
6 Never Married
9 UNKNOWN

Education:
0. No formal education
1. Primary education (1-4 yrs)
2. Basic Secondary (5-9 yrs.)
3. Incomplete Secondary (10 yrs of school)
4. Complete Secondary (11yrs of school)
5. Basic secondary + vocational education
6. Complete secondary + technical education
7. Incomplete postsecondary
8. Complete postsecondary (Diploma)
9. Postgraduate Education
88. UNKNOWN

GO TO THE RANDOMIZATION TABLE

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:_____

1999 GEORGIA REPRODUCTIVE HEALTH SURVEY
INDIVIDUAL QUESTIONNAIRE

Hello. I'm_____ from the Georgian Center for Disease Control. We are doing a national survey about the health of women and children in Georgia. The purpose of the survey is to collect information that will help the government to plan health services.

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 45-50 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 ___ ___ 99 DON'T KNOW
YEAR 19 ___ ___

101. How old are you (at last birthday)? ___ ___ YEARS OLD 99 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. INTERNAL 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
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 city, in a town, or in a village?

1 CITY
2 TOWN
3 VILLAGE

106. In what month and year did you start to live continuously at this current place of residence?

___ ___ MONTH ___ ___YEAR

22 ALWAYS, SINCE BIRTH
33 DON'T REMEMBER
34

IF Q106_YEAR="90" OR LESS, GO TO Q111; OTHERWISE (1991 OR LATER) CONTINUE

107. Before 1991, did you live in either Abkhazia or Tskhinvali Region?

1. YES - ABKHAZIA
2. YES-TSKHINVALI REGION-----> **GO TO Q109**
3. NO ----------> **GO TO Q111**

108. What district did you live in?

1. GAGRA
2. GALI
3. GUDAUTA
4. GULIRIPSHI
5. OCHAMCHIRE
6. SOKHUMI CITY
7. SOKHUMI DISTRICT
8. TKVARCHELI
9. OTHER_____

GO TO Q109A

109. What district did you live in?

1. JAVA
2. TSKHINVALI CITY
3. ZNAURI

109A What was the most important reason of your moving?

1. RELOCATION DUE TO POLITICAL UNREST
2. GOT MARRIED ----------> **GO TO Q111**
3. TO ATTEND SCHOOL ----------> **GO TO Q111**
4. JOB RELATED ----------> **GO TO Q111**
7. OTHER_____----------> **GO TO Q111**

110. Do you have an IDP card?

1. YES
2. NO

110A. During the past 12 months, did you or your family receive any humanitarian aid?

1. YES
2. NO----**>GO TO Q110C**
8. DK----**>GO TO Q110C**

110B. From whom did you receive humanitarian aid (**CIRCLE ALL MENTIONED**)?

	MENTIONED	NOT MENTIONED
1. STATE ORGANIZATION	1	2
2. UNHCR	1	2
3. OTHER INTERNATIONAL RELIEF ORGANIZATION	1	2
4. LOCAL NGO	1	2

110C Are you willing to return to your former place of residence?

1. YES----**>GO TO Q111**
2. NO
8. DK----**>GO TO Q111**

110D Why Not (**CIRCLE ALL MENTIONED**)?

	MENTIONED	NOT MENTIONED
1. HAVE ALREADY SETTLED AT THE PRESENT PLACE	1	2
2. NO SOURCE OF INCOME IF SHE RETURNS	1	2
3. HOUSE SHE LEFT BEHIND IS RUINED/DESTROYED	1	2
4. NO MEANS FOR RETURN	1	2
5. MOST OF THE RELATIVES WERE RELOCATED ELSEWHERE	1	2
6. WILL NOT FEEL SAFE/GENERAL SENSE OF THREAT	1	2
7. CHILDREN WILL NOT BE ABLE TO GO TO SCHOOL	1	2
8. LACK OF ADEQUATE HEALTH CARE	1	2
9. PAINFUL EXPERIENCE OF THE PAST	1	2
20. OTHER_____	1	2

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

1 MARRIED --> **GO TO Q113**
2 NOT MARRIED BUT LIVING WITH A PARTNER --> **GO TO Q113**
3 SEPARATED \-->**GO TO Q113**
4 DIVORCED /
5 WIDOWED /
6 NEVER MARRIED

112. Have you ever lived with a boyfriend or partner ? **(LIVING TOGETHER MEANS HAVING A SEXUAL RELATIONSHIP WHILE SHARING THE SAME USUAL ADDRESS.)**

1 YES
2 NO--->**GO TO Q122**

113. How many **times** have you been married or lived with a man as husband and wife?

___ TIMES 9. REFUSAL--------->**GO TO Q120**

TIMES	**114.** In what month and year did you begin living with your... (first, second, third, or fourth) husband/partner?	**115.** How old was your I, II, III, IV husband/ partner when you started to live together?	**116**. What was the highest grade in school that your I,II,III,IV husband/ partner completed when you got married/started to live together ?	**117.** 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?	**118.** In what month and year did your union with your I,II,III,IV, .husband/partner end?	**119 IF:**
I	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0. NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=1- >120 ELSE CONTINUE**
II	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=2- >120 ELSE CONTINUE**
III	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=3- >120 ELSE CONTINUE**
IV	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=4- >120 ELSE CONTINUE**
V	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=5- >120 ELSE CONTINUE**
VI	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**Q113=6- >120 ELSE CONTINUE**
VII	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRIMARY/B.SEC (1-9) 2. SECONDARY (10-12) 3. VOCATIONAL 4. TECHNICAL SCH. 5. UNIVERSITY 8. UNKNOWN	1 Married--->**Q119** 2 Living with partner->**Q119** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR 19 __ __ 22 DON'T KNOW/REF	**CONTINUE WITH Q120**

120. When you first got married/living together as husband and wife did you wish to have any children?

1 YES
2 NO---------->**GO TO Q122**
3 NOT SURE----->**GO TO Q122**

121. How many children did you wish to have when you first got married?

1. 1
2. 1-2
3. 2
4. 2-3
5. 3
6. 3-4
7. 4 OR MORE
8. AS MANY AS GOD GIVES
20. OTHER: _____
88. NOT SURE/DON'T REMEMBER

122. More or less how many hours a day do you listen to the radio?

HOURS A DAY __ __

00 NEVER----------**>GO TO Q127**
55. DOES NOT HAVE ACCESS TO RADIO -------**>GO TO Q127**
77. NOT EVERY DAY
88. DON'T KNOW

123. What stations do you most often listen to? **(PROBE FOR MORE THAN ONE STATION, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
RADIO 21	2	
I ARKHI (PIRVELI RADIO)	1	2
RADIO 105	1	2
AUDIENCIA	1	2
AMERIKIS KHMA (VOICE OF AMERICA)	1	2
FORTUNA	1	2
MSTVANE TALGA	1	2
SAKARTVELAS KHMA (VOICE OF GEORGIA)	1	2
RADIO 106	1	2
EVRIKA 1	2	
MAIAK	1	2
OTHER_____	1	2

124. What types of programs do you most often listen to? **(PROBE FOR MORE THAN ONE PROGRAM, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
NEWS	1	2
PERSONAL ANNOUNCEMENTS	1	2
COMMERCIALS	1	2
SPORTS	1	2
MUSIC	1	2
PLAYS/DRAMAS	1	2
CHURCH/RELIGIOUS PROGS	1	2
WOMEN'S PROGRAMS	1	2
HEALTH PROGRAMS	1	2
POLITICAL EVENTS	1	2
BUSINESS PROGRAMS	1	2
OTHER (SPECIFY)_____	1	2

125. What times do you most often listen to the radio? **(PROBE FOR MORE THAN ONE STATION, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
6-8 AM	1	2
8-10 AM	1	2
10AM-NOON	1	2
NOON-2 PM	1	2
2-4 PM	1	2
4-6 PM	1	2
6-8 PM	1	2
8-10 PM 1	2	
AFTER 10 PM	1	2
NO REGULAR TIMES	1	2

126. Within the past 6 months, have you listened to any program or ad on radio about modern contraceptives such as the pill, IUD or condom?

1. YES
2. NO
8. NOT SURE

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

HOURS A DAY ___ ___

00 NEVER----------**>GO TO Q133**
55. DOES NOT HAVE ACCESS TO TV----------**>GO TO Q133**
66. WHEN THE HOUSEHOLD HAS ELECTRICITY
77. NOT EVERY DAY
88. DON'T KNOW

128. What channels do you most often watch? **(PROBE FOR MORE THAN ONE CHANNEL, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
ARKHI I (CHANNEL I)	1	2
ARKHI II (CHANNEL II)	1	2
RUSTAVI 2	1	2
IBERIA	1	2
RUSSIAN CHANNELS (PTP, OPT)	1	2
ARKHI MESHVIDE (CHANNEL VII)	1	2
OTHER LOCAL CHANNEL (KUTHAISI, ALGHETI, DIDGORI)	1	2
SHAKARTVELOS KHMA	1	2
KAVKASIA	1	2
OTHER_____	1	2

129. What types of programs do you most often watch? **(PROBE FOR MORE THAN ONE PROGRAM , DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
NEWS	1	2
ENTERTAINMENT PROGRAMS	1	2
SERIALS/MOVIES	1	2
SPORTS	1	2
CHILDREN'S PROGRAMS	1	2
PLAYS/DRAMAS	1	2
CHURCH/RELIGIOUS PROGS	1	2
WOMEN'S PROGRAMS	1	2
HEALTH PROGRAMS	1	2
POLITICAL EVENTS	1	2
BUSINESS PROGRAMS	1	2
MUSIC PROGRAMS, VIDEO CLIPS	1	2
OTHER (SPECIFY)_____	1	2

130. What times do you most often watch television on weekdays? (**CIRCLE ALL MENTIONED, DO NOT READ LIST**)

	MENTIONED	NOT MENTIONED
6-8 AM	1	2
8-10 AM	1	2
10AM-NOON	1	2
NOON-2 PM	1	2
2-4 PM	1	2
4-6 PM	1	2
6-8 PM	1	2
8-10 PM	1	2
AFTER 10 PM	1	2
NO REGULAR TIMES	1	2

131. What times do you most often watch television on weekends? (**CIRCLE ALL MENTIONED**, **DO NOT READ LIST**)

	MENTIONED	NOT MENTIONED
6-8 AM	1	2
8-10 AM	1	2
10AM-NOON	1	2
NOON-2 PM	1	2
2-4 PM	1	2
4-6 PM	1	2
6-8 PM	1	2
8-10 PM	1	2
AFTER 10 PM	1	2
NO REGULAR TIMES	1	2

132. Within the past 6 months have you seen anything on television about modern contraceptives such as the pill, IUD, or condom?

1 YES
2 NO
8 NOT SURE

133. Do you think information about contraception should be broadcast on radio or television?

1. YES
2. NO
8. NOT SURE

134. How often do you read a daily 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----------**>GO TO MODULE II**

135. Which newspaper(s) do you read most often? (**CIRCLE ALL MENTIONED, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
1 ALIA	1	2
2 RESONANSI	1	2
3 AKHALI TAOBA	1	2
4 KVIRIS POLITRA	1	2
5 SAKARTVELOS REPUBLIKA	1	2
6. ASAVAL DASAVALI	1	2
7. SARBIELI	1	2
8. KALTA GAZETI	1	2
9. AKHALI TALGA	1	2
10. 7 DGE	1	2
20 OTHER_____	1	2

II. SEX EDUCATION

The next set of questions are about sex education.

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

1. YES
2. NO --> **GO TO 203**
8. DK
9. REFUSED --> **GO TO 203**

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

A. Human Reproduction?	___ ___	77. SHOULD NOT BE TAUGHT IN SCHOOL.
B. Contraception?	___ ___	88. DK
C. STD's	___ ___	99. NR

GO TO BOX 2-I

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

BOX 2-I

IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO SECTION III

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 Diseases?.....	1	2	8	9

READ EACH QUESTION 205-207 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...?	**207.** Who taught you at school about...?
A. Menstrual Cycle	1 YES -->**GO TO Q206** 2 NO --> **GO TO Q205B** 8 DK --> **GO TO Q205B** 9 NR --> **GO TO Q205B**	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
B. Female Reproductive System	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205C** 8 DR --> **GO TO Q205C** 9 NR --> **GO TO Q205C**	___ ___	1 TEACHER 2 DOCTOR/ NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
C. Male Reproductive System	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205D** 8 DR --> **GO TO Q205D** 9 NR --> **GO TO Q205D**	___ ___	1 TEACHER 2 DOCTOR/ NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
D. How Pregnancy Occurs	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205E** 8 DR --> **GO TO Q205E** 9 NR --> **GO TO Q205E**	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
E. Contraceptive Methods	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205F** 8 DR --> **GO TO Q205F** 9 NR --> **GO TO Q205F**	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
F. HIV/AIDS	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q205G** 8 DR --> **GO TO Q205G** 9 NR --> **GO TO Q205G**	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
G. Other Sexually Transmitted Diseases	1 YES --> **GO TO Q206** 2 NO --> **GO TO Q208** 8 DR --> **GO TO Q208** 9 NR --> **GO TO Q208**	___ ___	1 TEACHER 2 DOCTOR/ NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER

208. In your opinion, 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

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**
3 NOT SURE

304. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

1 YES **---->GO TO PREGNANCY HISTORY, PAGE 11**
2 NO------>**GO TO MODULE IV, PAGE 21**

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 21**

306. Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

1. YES----->**GO TO PREGNANCY HISTORY, PAGE 11**
2. NO------>**GO TO MODULE IV, PAGE 21**

307. Have you ever had any live-born children?

1. YES
2. NO------> **GO TO PREGNANCY HISTORY, PAGE 11**

308. How many living children do you have, including those who do not live with you?

_____ _____ CHILDREN

309. Have you ever had a child born alive who later died or died right after birth?

1. YES
2. NO --> **GO TO PREGNANCY HISTORY, PAGE 11**

310. How many children died? ___ ___ CHILDREN

311. So altogether you had a total of **___ ___ (Q308+Q310)** live births?

1. YES
2. NO**----->CHECK Q308 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 Q313B < 94 --->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?	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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES-**>Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES-**>Q318** 2. NO	1._ _WKS. OR 2._ _MTHS OR 3._ _ YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES-**>Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES-**>Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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

#	312	313	314	315	316	317	318 IF Q313B < 94 --->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?	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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1._ _WKS. OR 2._ _MTHS OR 3._ _ YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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

#	312	313	314	315	316	317	318 IF Q313B < 92 --->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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR	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

#	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?
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR

#	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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO NEXT LINE**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO THE NEXT PG.** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR
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	A.__ __ MTH B.__ __ YEAR 22. DK 33. NR	1__ __ WEEKS OR 2__ __ MONTHS 888. DK 998. NR **IF Q312>3** **GO TO BOX 3-I**	1. BOY 2. GIRL 3. BOTH	1. YES->**GO TO BOX 3-I** 2. NO	1_ _WEEKS OR 2_ __MTHS OR 3._ __YRS.. 888. DK 998. NR

319. HOW MANY INDUCED ABORTIONS AND/OR MINIABORTIONS DID THE RESPONDENT HAVE BETWEEN JANUARY 1994 AND THE PRESENT (SEE PAGE 11)

1. INDUCED ABORTIONS __ __
2. MINIABORTIONS __ __ (IF NO INDUCED ABORTION OR MINIABORTION, GO TO Q338)

BOX 3-I

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

319A. **COPY LINE #.** **FROM PG. TABLE PAGE 11**	**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 (ANY) CHILDREN 5. PARTNER DID NOT WANT (ANY) CHILDREN 6. DID NOT HAVE A PARTNER 7. OTHER_______________	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANY) CHILDREN 5. PARTNER DID NOT WANT (ANY) CHILDREN 6. DID NOT HAVE A PARTNER 7. OTHER_______________	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANY) CHILDREN 5. PARTNER DID NOT WANT (ANY) CHILDREN 6. DID NOT HAVE A PARTNER 7. OTHER_______________	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANY) CHILDREN 5. PARTNER DID NOT WANT (ANY) CHILDREN 6. DID NOT HAVE A PARTNER 7. OTHER_______________
321. Before the abortion, have you been tersted by ultrasound or pregnancy test to confirm the pregnancy?	1. YES, ULTRASOUND 2. YES PREGNANCY TEST 3. YES BOTH 4. NO 8. DK/DR	1. YES, ULTRASOUND 2. YES PREGNANCY TEST 3. YES BOTH 4. NO 8. DK/DR	1. YES, ULTRASOUND 2. YES PREGNANCY TEST 3. YES BOTH 4. NO 8. DK/DR	1. YES, ULTRASOUND 2. YES PREGNANCY TEST 3. YES BOTH 4. NO 8. DK/DR
321A Before the abortion, have you been lab tested for any infection?	1. YES 2. NO ------->**GO TO Q 323** 8. DK/ DR-------->**GO TO Q323**	1. YES 2. NO ------->**GO TO Q323** 8. DK/ DR-------->**GO TO Q323**	1. YES 2. NO ------->**GO TO Q323** 8. DK/ DR-------->**GO TO Q323**	1. YES 2. NO ------->**GO TO Q323** 8. DK/ DR-------->**GO TO Q323**
322. Did you have a blood exam, vaginal bacteriologic exam or both?	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/ DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/ DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/ DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/ DR
323. Where was that abortion performed?	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE \ 4. AT HOME \ 5. AT HOME AND HOSP.---- >**GO** 7. OTHER____________ **/ TO Q326**	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE \ 4. AT HOME \ 5. AT HOME AND HOSP.---- >**GO** 7. OTHER____________ **/ TO Q326**	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE \ 4. AT HOME \ 5. AT HOME AND HOSP.---- >**GO** 7. OTHER____________ **/ TO Q326**	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULTATION 3. PRIVATE CLINIC/OFFICE \ 4. AT HOME \ 5. AT HOME AND HOSP.---- >**GO** 7. OTHER____________ **/ TO Q326**
324. Have you been registered in the hospital/clinic abortion registry?	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER
325. Did you received a receipt for the abortion payment?	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER
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. DRUG ABORTION (RU 486) 4. EMPIRICAL MET__________ 7. OTHER___________________ 8 DON'T KNOW/ DR	1. D&C 2. VACUUM ASPIRATION 3. DRUG ABORTION (RU 486) 4. EMPIRICAL MET__________ 7. OTHER___________________ 8 DON'T KNOW/ DR	1. D&C 2. VACUUM ASPIRATION 3. DRUG ABORTION (RU 486) 4. EMPIRICAL MET__________ 7. OTHER___________________ 8 DON'T KNOW/ DR	1. D&C 2. VACUUM ASPIRATION 3. DRUG ABORTION (RU 486) 4. EMPIRICAL MET__________ 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?	__ __ __ LARI 000 NO CHARGE 555 OTHER CURRENCY 777 ONLY GIFTS 888 DK	__ __ __ LARI 000 NO CHARGE 555 OTHER CURRENCY 777 ONLY GIFTS 888 DK	__ __ __ LARI 000 NO CHARGE 555 OTHER CURRENCY 777 ONLY GIFTS 888 DK	__ __ __ LARI 000 NO CHARGE 555 OTHER CURRENCY 777 ONLY GIFTS 888 DK
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 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER
331. Within 30 days after that abortion did you have any health problems?	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 1-7)**	YES NO 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever >38 ºC 1 2 4. Infection 1 2 5. Pelvic Pain 1 2 7. Other_________ 1 2	YES NO 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever >38 ºC 1 2 4. Infection 1 2 5. Pelvic Pain 1 2 7. Other_________ 1 2	YES NO 1.Perforation 1 2 2. Severe Bleeding 1 2 3. Fever >38 ºC 1 2 4. Infection 1 2 5. Pelvic Pain 1 2 7. Other_________ 1 2	YES NO 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever >38 ºC 1 2 4. Infection 1 2 5. Pelvic Pain 1 2 7. 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?	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. PELVIC PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_______________	1. PELVIC PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_______________	1. PELVIC PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_______________	1. PELVIC 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?	1. GOT A METHOD 2. GOT PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. GOT A METHOD 2. GOT PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. GOT A METHOD 2. GOT PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. GOT A METHOD 2. GOT PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER
337A. After that abortion, did a doctor or nurse refer you to a Family Planning cabinet?	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 BIRTHS HAS THE RESPONDENT HAD BETWEEN JANUARY 1994 AND PRESENT (SEE PG. 11-15)**

1. LIVE BIRTHS __ __
2. STILLBIRTHS __ __ **(IF NO LIVE BIRTH OR STILLBIRTH GO TO MODULE IV PAGE 21)**

339. COPY LINE #. FROM PREGNANCY TABLE PAGE 11	**LAST BIRTH** ___ ___	**NEXT TO LAST BIRTH** ___ ___	**SECOND TO LAST BIRTH** ___ ___
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 + (LESS THAN A PACK OR MORE) 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 + (LESS THAN A PACK OR MORE) 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 + (LESS THAN A PACK OR MORE) 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 + (LESS THAN A PACK OR MORE) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (LESS THAN A PACK OR MORE) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (LESS THAN A PACK OR MORE) 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. 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
344. During that pregnancy, did you have any prenatal care visits?	1. YES 2 NO--->**GO TO Q352** 8. DON'T REMEMBER->**GO TO Q352**	1. YES 2 NO--->**GO TO Q352** 8. DON'T REMEMBER->**GO TO Q352**	1. YES 2 NO--->**GO TO Q352** 8. DON'T REMEMBER->**GO TO Q352**
345. 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
346 How many prenatal visits did you have during that pregnancy?	___ ___ VISITS 88. DK 98. REF	___ ___ VISITS 88. DK 98. REF	___ ___ VISITS 88. DK 98. REF
347. Where did you go for most of the prenatal care visits?	1. RURAL AMBULATORY 2. MEDICAL CIRCUMSCRIPTION 3. WOMEN'S CONSULTATION CLINIC 4. PRIVATE OFFICE/CLINIC/HOSP 5. MATERNITY/HOSPITAL 6. HOME 7. OTHER__________	1. RURAL AMBULATORY 2. MEDICAL CIRCUMSCRIPTION 3. WOMEN'S CONSULTATION CLINIC 4. PRIVATE OFFICE/CLINIC/HOSP 5. MATERNITY/HOSPITAL 6. HOME 7. OTHER__________	1. RURAL AMBULATORY 2. MEDICAL CIRCUMSCRIPTION 3. WOMEN'S CONSULTATION CLINIC 4. PRIVATE OFFICE/CLINIC/HOSP 5. MATERNITY/HOSPITAL 6. HOME 7. OTHER__________
348. 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
349. During any of those visits did you have blood drawn for lab tests?	1. YES 2. NO 8. DK/DR	1. YES 2. NO 8. DK/DR	1. YES 2. NO 8. DK/DR
350. During those visits, did you have your blood pressure measured?	1. YES 2. NO------>**GO Q352** 8. DON'T REMEMBER-->**GO TOQ352**	1. YES 2. NO------>**GOQ352** 8. DON'T REMEMBER--->**GO TOQ352**	1. YES 2. NO------>**GOQ352** 8. DON'T REMEMBER-->**GO TOQ352**
351. 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
352. Did you have an ultrasound (US) exam during that pregnancy?	1. YES 2. NO------>**GO TO Q354** 8. DON'T REMEMBER->**GO TOQ354**	1. YES 2. NO------>**GO TOQ354** 8. DON'T REMEMBER->**GO TOQ354**	1. YES 2. NO------>**GO TOQ354** 8. DON'T REMEMBER->**GO TOQ354**

	LAST BIRTH	**NEXT TO LAST BIRTH**	**SECOND TO LAST BIRTH**
353. 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
354. During that pregnancy, did you have **a**ny complications that required medical attention?	1. YES 2. NO------>**GO TO Q358** 8. DON'T REMEMBER-->**GO TO Q358**	1. YES 2. NO------>**GO TO Q358** 8. DON'T REMEMBER---->**GO TO Q358**	1. YES 2. NO------>**GO TO Q358** 8. DON'T REMEMBER---->**GO TO Q358**
355. What complications did you have? Did you have: **(READ EACH CONDITION A-L)**	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 H. Anemia Related to Preg. 1 2 I. Urinary Tract Infection 1 2 J. Risk of Preterm Delivery 1 2 K. Rh Isoimmunization 1 2 L. Other__________________ 1 2	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 H. Anemia Related to Preg. 1 2 I. Urinary Tract Infection 1 2 J. Risk of Preterm Delivery 1 2 K. Rh Isoimmunization 1 2 L. Other__________________ 1 2	YES NO A. Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 H. Anemia Related to Preg. 1 2 I. Urinary Tract Infection 1 2 J. Risk of Preterm Delivery 1 2 K. Rh Isoimmunization 1 2 L. Other__________________ 1 2
356. Not Including the delivery, how many times were you hospitalized for pregnancy complications?	00 NEVER HOSP. ____ ____ TIMES 88 DK/DR **IF "00" GO TO Q358**	00 NEVER HOSP. ____ ____ TIMES 88 DK/DR **IF "00" GO TO Q358**	00 NEVER HOSP. ____ ____ TIMES 88 DK/DR **IF "00" GO TO Q358**
357. Altogether, how many total 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
358. Where did you give birth to this baby?	1. HOSPITAL, MATERNITY 2. PRIVATE CLINIC 3 RURAL AMBULATORY 4. HOME-----> **Q363** 5. ON THE WAY TO HOSP.----> **Q363**	1. HOSPITAL, MATERNITY 2. PRIVATE CLINIC 3 RURAL AMBULATORY 4. HOME-----> **Q363** 5. ON THE WAY TO HOSP.----> **Q363**	1. HOSPITAL, MATERNITY 2. PRIVATE CLINIC 3 RURAL AMBULATORY 4. HOME-----> **Q363** 5. ON THE WAY TO HOSP.----> **Q363**
359. How many hours before delivery were you admitted to the place where you gave birth?	___ ___ HOURS 85. 85+ HOURS 88. DK/DR	___ ___ HOURS 85. 85+ HOURS 88. DK/DR	___ ___ HOURS 85. 85+ HOURS 88. DK/DR
360. How many nights were you in that place after you delivered?	___ ___ NIGHTS 85. 85+ NIGHTS 88 DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88 DK/DR	___ ___ NIGHTS 85. 85+ NIGHTS 88 DK/DR
361. Was that baby born by vaginal delivery, forceps, or C-section?	1. VAGINAL DELIVERY-->**GO TO Q363** 2. FORCEPS ->**GO TO Q363** 3. VACUUM EXTRACTION--->**Q363** 4. CESAREAN SECTION	1. VAGINAL DELIVERY-->**GO TO Q363** 2. FORCEPS ->**GO TO Q363** 3. VACUUM EXTRACTION--->**Q363** 4. CESAREAN SECTION	1. VAGINAL DELIVERY-->**GO TO Q363** 2. FORCEPS ->**GO TO Q363** 3. VACUUM EXTRACTION---->**Q363** 4. CESAREAN SECTION
362. Do you know what was the reason or reason s you had to deliver by cesarean section ? **(CIRCLE ALL REASONS GIVEN BY THE RESPONDENT)**	YES NO 1. BABY TOO BIG (CPD) 1 2 2. MALPRESENTATION 1 2 3. BABY STARTED TO SUFFER 1 2 4. PROLONGED LABOR/FAILED INDUCTION 1 2 5. OBSTETRIC HEMORRHAGE 1 2 6. PREVIOUS CESAREAN SECTION 1 2 7. ON REQUEST 1 2 88. DON'T KNOW 1 2 20. OTHER________________ 1 2	YES NO 1. BABY TOO BIG (CPD) 1 2 2. MALPRESENTATION 1 2 3. BABY STARTED TO SUFFER 1 2 4. PROLONGED LABOR/FAILED INDUCTION 1 2 5. OBSTETRIC HEMORRHAGE 1 2 6. PREVIOUS C- SECTION 1 2 7. ON REQUEST 1 2 88. DON'T KNOW 1 2 20. OTHER________________ 1 2	YES NO 1. BABY TOO BIG (CPD) 1 2 2. MALPRESENTATION 1 2 3. BABY STARTED TO SUFFER 1 2 4. PROLONGED LABOR/FAILED INDUCTION 1 2 5. OBSTETRIC HEMORRHAGE 1 2 6. PREVIOUS C- SECTION 1 2 7. ON REQUEST 1 2 88. DON'T KNOW 1 2 20. OTHER________________ 1 2
363. How long had you been in labor with that pregnancy (regular contractions 5' apart)	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR
364. Who attended the delivery of that child?	1. PHYSICIAN 2. NURSE/MIDWIFE 3. OTHER__________ 4. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. OTHER__________ 4. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. OTHER__________ 4. UNATTENDED
365. How much did the baby weigh at birth?	___ ___ ___ ___ GRAMS---->**GO TO Q367** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS--->**GO TO Q367** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS---->**GO TO Q367** 8888 DON'T KNOW

366. 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 3. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 3. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 3. DK/DR

	LAST BIRTH	**NEXT TO LAST BIRTH**	**SECOND TO LAST BIRTH**
367. 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. Dysuria 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. Dysuria 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. Dysuria 1 2 G. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_______________
368. For how many months after birth <u>did you not</u> have a period?	___ ___ MONTHS 88. DK/DR 77. NOT YET	___ ___ MONTHS 88. DK/DR	___ ___ MONTHS 88. DK/DR
369. 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
	IF STILLBIRTH --> GO TO THE NEXT BIRTH	**IF STILLBIRTH --> GO TO THE NEXT BIRTH**	**IF STILLBIRTH GO TO MODULE IV**
370. During the first 6 wks after birth, did you have any postnatal visit?	1. YES 2. NO ----->**GO TO Q372** 8. DON'T REMEMBER -->**GO TO Q372**	1. YES 2. NO ----->**GO TO Q372** 8. DON'T REMEMBER -->**GO TO Q372**	1. YES 2. NO ----->**GO TO Q372** 8. DON'T REMEMBER -->**GO TO Q372**
371. During those visits 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
372. Did you breastfeed?	1. YES 2. NO------->**GO TO Q376** 3. NO, INFANT DIED--->**NEXT BIRTH**	1. YES 2. NO ----->**GO TO Q376** 3. NO, INFANT DIED--->**NEXT BIRTH**	1. YES 2. NO----------->**GO TO Q376** 3. NO, INFANT DIED--->**NEXT BIRTH**
373. 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.
374. Are you still breastfeeding?	1. YES ----->**GO TO Q 376** 2. NO 3. NO, INFANT DIED--->**NEXT BIRTH**		
375. 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
376. How old was the baby when you gave him/her water or other liquids?	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
377. How old was the baby when you started feeding with formula or other milk?	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
378. How old was the baby when you started feeding with solid or semi-solid food?	77. NOT YET __ __ MTHS 88. DK/DR **IF STILL BREASTFEEDING-->GO TO THE NEXT BIRTH**	77. NOT YET __ __ MTHS 88. DK/DR	77. NOT YET __ __ MTHS 88. DK/DR
379. Why did you Stop breastfeeding? **FOR WOMEN WHO DID NOT BREASTFEED (Q372=2) ASK:**	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED

Why did you not breastfeed?	8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR	8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR	8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR

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. How did you hear about it? **(SEE CODES BELOW)**
A. The Pill (Oral Contraceptives)	1 Yes-->Q401 2 No--->B	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
B. IUD (*Spirali*)	1 Yes-->Q401 2 No--->C	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
C. Condoms	1 Yes-->Q401 2 No--->D	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
D. Foam/Jelly/ Cream/ Foamy Tablets	1 Yes-->Q401 2 No--->E	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
E. Tubal Ligation (Female Sterilization)	1 Yes-->Q401 2 No--->F	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
F. Vasectomy (Male Sterilization)	1 Yes-->Q401 2 No--->G	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
G. Injectables (e.g. Depo-Provera)	1 Yes-->Q401 2 No--->H	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q403	1 Yes \ 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 \ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
I. Rhythm/Calendar Method	1 Yes-->Q401 2 No--->J	1 Yes-->Q402 2 No-->Q402	1 Yes \ 2 No / Q404		__ __
J. Withdrawal (Coitus Interruptus)	1 Yes-->Q401 2 No--->Q405	1 Yes-->Q402 2 No--->Q402	1 Yes \ 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
11. TEACHER
12. PHARMACIST
13. BOOKS
14 NEWSPAPERS, MAGAZINES, BROCHURE, FLYERS
15. RADIO
16. 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
3. Condom
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----------**>GO TO BOX 4-I**
88. DON'T KNOW/NOT SURE -------**>GO TO BOX 4-I**

406. If each of these methods (on **CARD A)**, please tell me how sure can a woman be that she would not get pregnant if she uses the method correctly. Will she be very sure, almost sure, sure, not very sure, or not at all sure that she will not get pregnant?

	VERY SURE	ALMOST SURE	SURE	NOT VERY SURE	NOT SURE	DON’T KNOW
1. THE PILL	1	2	3	4	5	8
2. IUD	1	2	3	4	5	8
3. CONDOM	1	2	3	4	5	8
6. LOCAL SPERMICIDES	1	2	3	4	5	8
7. TUBAL LIGATION	1	2	3	4	5	8
8. EMERGENCY HORMONAL CONTRACEPTION/MAP	1	2	3	4	5	8
9. INJECTABLES (DEPO-PROVERA)	1	2	3	4	5	8
10. VASECTOMY	1	2	3	4	5	8
11. CALENDAR	1	2	3	4	5	8
12. WITHDRAWAL	1	2	3	4	5	8

BOX 4-I

IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO Q420 PAGE 24

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?)**

A.___ ___ MONTH B.___ ___ YEAR

20. NEVER HAD INTERCOURSE----**>GO TO Q601, PG 36**
22. DON'T REMEMBER
33. REFUSE TO ANSWER

411. How old were you at that time? ____ _____ YEARS 88. DON'T REMEMBER

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
8. RELATIVE
9. RAPE/INCEST**----------->GO TO Q421**
20. OTHER(SPECIFY) _____
88. DO NOT REMEMBER/REF

413. How old was your first partner? ___ ___ YEARS 88. DK/DR

414. 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_____

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

1. You
2. Your partner
3. Both you and your partner
8. DON'T REMEMBER

GO TO 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 COULD NOT FIND A CONTRACEPTIVE METHOD/UNAVAILABLE/DIFFICULT TO GET
4 RESPONDENT WAS AGAINST IT
5 PARTNER WAS AGAINST IT
6 DID NOT KNOW ABOUT CONTRACEPTION
7 WANTED TO GET PREGNANT
8 DID NOT WANT TO USE A METHOD
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 many times 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 19__ __ YEAR

22. DK
33. NR

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/INCEST**------->GO TO Q429**
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 Q429**
9. DK/REF --->**GO TO Q429**

428. Which contraceptive method did you or your partner use at the last intercourse?

1. THE PILL
2. 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
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS_____
88. NOT SURE

429. Counting all the men you had sexual intercourse with, even only once, how many partners have you had sexual intercourse with <u>in your life</u>?

___ ___ 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)

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 28**
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 28**

504. What method are you currently using?

1. THE PILL
2. 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. 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

IF Q504=1,2,7, 9, 10, OR 11 GO TO Q507

506. In the last 30 days how often did you/your partner use this method (**READ 1-3**) ?

1. Always, at each sexual intercourse,
2. almost always,
3. Sometimes,
4. Only once
9. REF

507. What was the most important reason for choosing this method?

1. DOCTOR RECOMMENDED
2. COST
3. VERY EFFECTIVE
4. VERY SAFE (FEW 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
20. OTHER_____
88. DK

BOX 5-I

IF Q504 = 1-10, OR 88 GO TO Q510; IF SHE USES NATURAL METHODS (Q504 =11-20), CONTINUE

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. Other person 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 the IUD? **(READ 1-3)**

1 Current method more effective
2 About equally effective
3 Current method less effective
8 DON'T KNOW/NOT SURE

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. SIDE EFFECTS
2. HEALTH CONCERNS
3. ACCESS/AVAILABILITY
4. COST
5. SOMETIMES FORGET TO USE
6. SOMETIMES DIFFICULT/INCONVENIENT TO USE
7. HUSBAND/PARTNER DISAPPROVES
8. LESS EFFECTIVE METHOD/GOT PREGNANT WHILE USING IT
9. DEEPLY UNSATISFIED WITH THE METHOD
0. 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 BOX 5-II**

513. What method would you prefer to use (**OTHER THAN THE METHOD SPECIFIED IN Q504**) ?

1. THE PILL
2. 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
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, TL, NORPLANT)
20 OTHER_____
88 DON'T KNOW

BOX 5II

GO TO Q521 PAGE 29

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. DIDN'T THINK ABOUT IT/ NEGLECTED
11. CANNOT AFFORD BIRTH CONTROL (COSTS TOO MUCH)
12. BIRTH CONTROL IS THE PARTNER'S RESPONSIBILITY
13. BIRTH CONTROL IS NOT (VERY) EFFECTIVE
14. RESPONDENT DOES NOT WANT 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. DOES NOT KNOW HOW TO USE BIRTH CONTROL METHODS
19. RESPONDENT DOES NOT THINK SHE CAN GET PREGNANT
20. OTHER (SPECIFY) _____
88. DK/REF

516. Do you think that you will use a contraceptive method during the next 12 months?

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. 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**
20. OTHER_____----------**>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 OR MORE
99= NOT SURE/DON'T KNOW

520. Where would you want to get your contraceptive method?

1. RURAL AMBULATORY ("FAP")
2. POLICLINIC
3. WOMEN'S CONSULTATION CLINIC
4. GOV HOSPITAL-GYN WARD
5. GOV HOSPITAL-MATERNITY WARD
6. PRIVATE CLINIC OR OFFICE
7. NGO
8. PHARMACY
9. OPEN MARKET, BAZAAR
10. STORE/ KIOSK
11. TERAPEUT
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 approve or disapprove with the use of contraceptive methods?

1. APPROVE
2. DISAPPROVE
3. NEITHER APPROVES NOR DISAPPROVES
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 with a partner only for birth control, only to prevent diseases, or have you used them for both reasons?

1. BIRTH CONTROL ONLY---------->**GO TO BOX 5-III**
2. DISEASE PREVENTION ONLY---->**GO TO BOX 5-III**
3. BOTH---------->**GO TO BOX 5-III**
4. NEVER USED CONDOM
5. OUT OF CURIOSITY
8. OTHER _____

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

BOX 5-III

- **IF RESPONDENT HAS USED ANY CONTRACEPTIVE METHOD SINCE JANUARY 1994, FILL IN ALL FOUR COLUMNS OF THE CONTRACEPTIVE CALENDAR**

- **IF NO METHOD HAS BEEN USED SINCE JANUARY 1994, FILL IN ONLY COLUMN 1 (SEE ALSO PREGNANCY HISTORY) AND COLUMN 4 (SEE ALSO MARITAL STATUS AT PAGE 3) AND WRITE "0" AT THE BEGINNING AND THE END OF THE 2ND COLUMN THEN GO TO Q554, PAGE 34**

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. IUD
3. CONDOM
4. CONDOM+SPERMICIDES
5. CONDOM+CAL./WITHDRAWAL
6. SPERMICIDES
7. TUBAL LIGATION
8. EMERGENCY HORM. CONTRACEPTION
9. DEPO-PROVERA
10. OTHER MODERN MET._____
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. SHE NEGLECTED TO USE
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
1994					1997				
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				
1995					1998				
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				
1996					1999				
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				
					2000				
					1 Jan				
					2 Feb				
					3 Mar				
					4 Apr				

IF SHE DID NOT USE A METHOD IN JANUARY 1994 (COLUMN 2_IAN 1994=0) GO TO Q527

526. You said that in January of 1994 you were using ____ (**WRITE CODE # FOR THE MET. USED IN COLUMN 2_JAN 1994**). When did you start using that method?

A. MONTH __ __B. YEAR 19__ __ 22. DK/REF

527. LAST CONTRACEPTIVE METHOD USED (COPY THE METHOD FROM THE CONTRACEPTIVE CALENDAR):

1. THE PILL
2. 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 ("FAP")
2. POLICLINIC
3. WOMEN'S CONSULTATION CLINIC
4. GOV HOSPITAL-GYN WARD
5. GOV HOSPITAL-MATERNITY WARD
6. PRIVATE CLINIC OR OFFICE
7. NGO
8. PHARMACY
9. OPEN MARKET, BAZAAR
10. STORE/ KIOSK
11. TERAPEUT
12. PARTNER/HUSBAND
13. FRIEND
14. RELATIVE
20. OTHER (SPECIFY): _____
88. DON'T KNOW

529 Do (Did) you pay for this method?

1 YES
2 NO———>**GO TO Q531**
3 PARTNER GETS THE METHOD———>**GO TO Q531**

530. How much did you pay? ___ ___ LARI

85 85 LARI OR MORE
90 PAID IN RUBLES OR COUPONS
99= 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
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

535. Overall, would you say you have been very satisfied, satisfied, somewhat satisfied, not satisfied or not at all satisfied with the family planning services you have received?

1. Very satisfied
2. Satisfied
3. Somewhat satisfied
4. Not satisfied
8. DO NOT KNOW

536. OBSERVE THE CALENDAR AND RECORD IF RESPONDENT HAS USED PILLS OR IUD AT ANY TIME DURING THE PAST FIVE YEARS:

1. ONLY PILLS
2. PILL AND IUD
3. ONLY IUD----------->GO TO Q545
4. NEITHER PILL NOR IUD (OTHER MODERN OR TRAD. METHODS)--->GO TO BOX 5-IV, PG. 34

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 22. 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. ANTEOVIN	9. LOESTRIN 30	17. MINULET	25. STEDIRIL
2. BISECURIN	10. LO-OVRAL	18. NON-OVLON	26. TRINORINYL
3. CILEST	11. LO-FEMENAL	19. NORETHYSTERON	27. TRINOVUM
4. DEMULEN	12. LYNDIOL	20. OVIDON	28. TRISISTON
5. DIANE-35	13. MARVELON	21. OVOSTAT	29. TRIQUILAR
6. EXLUTON	14. MERCILON	22. OVYSMEN	30. TRI-REGOL
7. FEMODEN	15. MICROGYNON	23. POSTINOR	77. OTHER_____
8. GRAVISTAT	16. MINISISTON	24. RIGEVIDON	88. DO NOT KNOW

539. When you started taking pills, how long did your physician tell you that you could take them? **(Q539 REFERS TO THE LAST INTERVAL OF USE, INCLUDING CURRENT USE)**

__ __ MONTHS
00. NEVER TALKED TO A DOCTOR ABOUT IT
44. THREE OR MORE YEARS (36 MONTHS OR MORE)
55. AS LONG AS RESPONDENT WANTED/INDEFINITELY
66. DID NOT SAY HOW LONG
77. OTHER (SPECIFY)_____
88. DON'T REMEMBER

540. At any time during the last usage of pills have you had any health problems or side effects that you think are related to using pills?

1 YES
2 NO--->**GO TO Q543**

541. What kind of problem or side effect have you had? **(IF MORE THAN ONE PROBLEM, CIRCLE MORE THAN ONE ANSWER)**

	YES	NO
A. HEADACHES OR DIZZINESS	1	2
B. BLURRED VISION, SEEING FLASHING LIGHTS	1	2
C. WEIGHT GAIN	1	2
D. NAUSEA	1	2
E. BREAST TENDERNESS	1	2
F. BLEEDING/SPOTTING BETWEEN MENSTRUAL PERIODS	1	2
G. MOOD CHANGES (LESS INTEREST IN SEX, DEPRESSION)	1	2
H. OTHER (SPECIFY)_____	1	2

542. Was this problem serious enough that you went to a doctor or clinic about it?

1 YES
2 NO

543. What should a woman do if she realized that she had forgotten to take **one pill** (24 HOURS OR LESS) ?

1 NOTHING (CONTINUE TAKING PILLS AS USUAL)
2 TAKE THE MISSED PILL AT ONCE AND THE REST AS USUAL
3 TAKE THE MISSED PILL AND THE REST AS USUAL AND USE OTHER METHOD
4 TAKE THE MISSED PILL AND THE REST AS USUAL AND AVOID SEX
5 STOP TAKING THE PILL AND RESTART WHEN THE PERIOD BEGINS
7 OTHER (SPECIFY)_____
8 DON'T KNOW

544. What should a woman do if she realized that she had forgotten to take **two pills** ?

1 NOTHING (CONTINUE TAKING PILLS AS USUAL)
2 TAKE THE MISSED PILL AT ONCE AND THE REST AS USUAL
3 TAKE THE MISSED PILL AND THE REST AS USUAL AND USE OTHER METHOD
4 TAKE THE MISSED PILL AND THE REST AS USUAL AND AVOID SEX
5 STOP TAKING THE PILL AND RESTART WHEN THE PERIOD BEGINS
7 OTHER (SPECIFY)_____
8 DON'T KNOW

IF RESPONDENT HAS USED ONLY PILLS (Q536=1) THEN GO TO BOX 5-IV PAGE 34; ELSE CONTINUE

545. 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 22. DO NOT REMEMBER

546. Now, I want you to think back at the time when you had inserted your (last) IUD. Was that IUD inserted immediately after an abortion?

1. YES
2. NO

547. After the 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

548. When the IUD was inserted, did the physician tell you how to check that the IUD is in place?

1. YES
2. NO
8. DON'T REMEMBER

550. Did the physician tell you how long could the IUD be left in place?

1. YES
2. NO
8. DON'T REMEMBER

551. Thinking back at the first year after you had this IUD inserted, did you have any health problems or side effects that you think are related to your IUD?

1 YES
2 NO--->**GO TO BOX 5-IV**

552. What kind of problem or side effect did you have? **(CODE MORE THAN ONE IF NECESSARY)**

	YES	**NO**
A. ABDOMINAL CRAMPING	1	2
B. HEAVY BLEEDING 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

553. Did you see a doctor for this(these) problem(s)?

1. YES
2. NO

IF ANY CONTRACEPTIVE METHOD WAS USED IN THE LAST MONTH (LAST CELL IN COLUMN 2 >"0") THEN GO TO Q556; ELSE CONTINUE

554. Do you think you are physically able to get pregnant at the present time?

1 YES--->**GO TO Q556**
2 NO
3 NOT SURE
4 CURRENTLY PREGNANT--->**GO TO Q557**

555. 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 INFLAMMATORY DISEASE (PID)
4. ENDOCRINE DYSFUNCTION OR OTHER SYSTEMIC DISEASES
5. HYSTERECTOMY (SURGICAL REMOVAL OF UTERUS)---------->**GO TO Q601 PAGE 36**
6. PREMENOPAUSE/ MENOPAUSE---------->**GO TO Q601 PAGE 36**
7. OVARIAN CYSTS/ OVARIAN DYSFUNCTION---------->**GO TO Q601 PAGE 36**
8. RESPONDENT HAD BOTH TUBES REMOVED OR OBSTRUCTED---------->**GO TO Q601 PAGE 36**
9. HAS TRIED TO GET PREGNANT IN THE PAST 2 YEARS AND DID NOT SUCCEED--->**GO TO Q601 PAGE 36**
10. PARTNER HAD A MEDICAL OPERATION AND CANNOT HAVE CHILDREN---------->**GO TO Q601 PAGE 36**
11. PARTNER IS INFERTILE---------->**GO TO Q601 PAGE 36**
12. CURRENTLY USES A METHOD **(GO BACK TO Q504 AND CORRECT IT)**
20. OTHER (SPECIFY) _____
88. DO NOT KNOW
99. REFUSE TO ANSWER

556. Looking to the future, do you yourself intend to have (a/another) baby at some time?

1. WANTS A BABY ---**>GO TO Q558**
2. DOES NOT WANT A BABY ---**>GO TO Q559**
3. RESPONDENT WANTS A BABY BUT PARTNER DISAGREES ---> **GO TO Q558**
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS ---> **GO TO Q559**
8. DK ----**>GO TO Q559**

557. Looking to the future, do you yourself intend to have another baby after this pregnancy?

1. YES
2. NO ---> **GO TO Q559**
3. RESPONDENT WANT A BABY BUT PARTNER DISAGREES ---> **GO TO Q559**
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS ---> **GO TO Q559**
8. DK ---> **GO TO Q559**

558. When do you, yourself, actually want to get pregnant (again)**...(READ 1-5)**

1. Right away, (**DO NOT READ IF THE WOMAN IS ALREADY PREGNANT**)
2. Within the next 12 months,
3. In 1-2 years,
4. In 3-5 years,
5. or after 5 years?
6. AFTER SHE MARRIES
7. WHEN GOD WANTS
8. DK

559. (After having all the children you want **READ ONLY IF Q556 OR Q557=1,3, OR 8**) Do you think you would be interested in having an operation to prevent you from having any more children?

1 YES----------**>GO TO MODULE VI**
2 NO
3 ALREADY STERILIZED----------**>GO TO MODULE VI**
8. NOT SURE

560. 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

VI. WOMEN'S HEALTH

Now I would like to ask you some questions about your health.

601. Have you ever had a gynecologic exam?

1. YES ----**>GO TO Q603**
2. NO
9. NR

602. What is the most important reason that you have not had a routine gynecologic exam?

1. DOES NOT NEED TO GO TO GYNECOLOGIC EXAM
2. SHE IS HEALTHY AND HAS NOT GYNECOLOGIC PROBLEMS
3. THERE IS NOT TIME TO GO FOR EXAM
4. SHE FORGETS ABOUT IT
5. SHE DOES NOT LIKE GYNECOLOGIC EXAM
6. IT IS DIFFICULT TO GET APPOINTMENT
7. DOES NOT LIKE PLACE/FACILITY
8. DOES NOT LIKE THE STAFF
9. WAITING TIME IS TOO LONG
10. DOCTOR DID NOT RECOMMEND
11. SHE IS EMBARRASSED TO HAVE GYNECOLOGIC EXAM
12. NEVER THOUGHT ABOUT IT
13. NOT SEXUALLY ACTIVE
14. NEVER HAD SEXUAL INTERCOURSE (VIRGIN)
20. OTHER _____
88. DK
99. NR

GO TO Q604

603. When was your last routine gynecologic exam (not pregnancy related) ? **(READ 1-4)**

1. Last year (1-11 MTH)
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

604. Have you ever had a Pap smear? (PROBE: A pap smear is a test that takes a sample of cells from the cervix, or opening to the uterus, to detect cancer)

1. YES ----**>GO TO Q606**
2. NO
8. DK
9. REF

605. 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. SHE HAD NO PARTNER/ NOT SEXUALLY ACTIVE
20. OTHER (SPECIFY):_____
88. DON'T KNOW
99. REFUSE TO ANSWER

GO TO Q607

606. When did you have your last Pap smear? Was it...**(READ 1-4)**

1. within the last year, (O 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

607. Have you heard about breast self-examinations?

1 YES
2 NO----------**GO TO Q610**

608. Do you ever do breast self-examinations?

1 YES
2 NO----------**GO TO Q610**

609. 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

610. Have you ever tried cigarette smoking, even one or two puffs?

1. YES
2. NO---> **GO TO 617**

611. How old were you when you smoked a cigarette for the first time?

__ __ YEARS 88. DK
99.NR

612. Have you smoked at least 100 cigarettes in your entire life? (PROBE: 100 cigarettes is about 5 packs)

1. YES
2. NO---> **GO TO 617**
8. DK---> **GO TO 617**
9. REF---**GO TO 617**

613. How old were you when you first started smoking fairly regularly?

___ ___ YEARS 00. NEVER SMOKED REGULARLY
99. DO NOT REMEMBER

614. 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 Q616**
9. REF----------**GO TO Q616**

615. 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 Q617

616. In what month and year did you last smoke cigarettes at all? **(PROBE FOR SEASON IF MONTH IS UNKNOWN)**

___ ___ MONTH___ ___ YEAR 22. DK
33. REF

617. Now, I will ask you about some medical conditions that you may have had? Has a doctor ever told you that you have...(**READ A-H**)

	YES	NO	DK	REF
A. Diabetes?	1	2	8	9
B. High blood pressure?	1	2	8	9
C. Anemia?	1	2	8	9
D. Heart Disease?	1	2	8	9
E. PID (salpingitis or endometritis)	1	2	8	9
F. Urinary infection?	1	2	8	9
G. Asthma	1	2	8	9
H. Hepatitis B	1	2	8	9

618. In the past 12 months have you had any vaginal discharge that was not menstrual?

1 YES
2 NO **----->GO TO Q622**
8 NOT SURE **----->GO TO Q622**
9 REFUSAL**------->GO TO Q622**

619. Along with the discharge, did you have any:

	YES	NO	NOT SURE
A. Itching	1	2	8
B. Painful urination	1	2	8
C. Painful intercourse	1	2	8
D. Lower abdominal pain	1	2	8

620. Did you have any treatment for this(these) condition(s)?

1 YES
2 NO----> **GO TO Q622**
8 NOT SURE **---> GO TO Q622**

621. Where have you been treated?

1. RURAL AMBULATORY
2. STD DISPENSARY
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. HOSPITAL-MATERNITY WARD
6. HOSPITAL-GYN WARD
7. HOSPITAL-STD
8. PRIVATE CLINIC OR OFFICE
9. TREATMENT RECOMMENDED BY PHARMACIST
10. TREATMENT RECOMMENDED BY A FRIEND/RELATIVE
11. SELF-TREATMENT
12. UNOFFICIAL PRESCRIPTION
20. OTHER_____
99. DR/REF.

622. In the past 12 months have you had any sores, warts, or ulcers in the genital area?

1. YES
2. NO **----->GO TO Q625**
8. NOT SURE **----->GO TO Q625**
9. REFUSAL**------->GO TO Q625**

623. Did you have any treatment for this(these) condition(s)?

1 YES
2 NO ---> **GO TO Q625**
8 NOT SURE ---> **GO TO Q625**

624. Where have you been treated?

1. RURAL AMBULATORY
2. STD DISPENSARY
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. HOSPITAL-MATERNITY WARD
6. HOSPITAL-GYN WARD
7. HOSPITAL-STD
8. PRIVATE CLINIC OR OFFICE
9. TREATMENT RECOMMENDED BY PHARMACIST
10. TREATMENT RECOMMENDED BY A FRIEND/RELATIVE
11. SELF-TREATMENT
12. UNOFFICIAL PRESCRIPTION
20. OTHER_____
99. DR/REF.

625. In the past 3 months, have you had a drink containing alcohol, that is a beer, a glass of wine, a cocktail, a shot of liqueur, vodka, or whiskey?

1. YES
3. NO----> **GO TO MODULE VII**
8. DO NOT REMEMBER/REF ---> **GO TO MODULE VII**

626. 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. DK-----> **GO TO MODULE VII**
99. REF --> **GO TO MODULE VII**

627. How often did you drink that amount during the past 3 months? (PROBE: How many times a week, a 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

628. In the past 3 months, have there been days when you had more than usual **(# FROM Q626**) drinks?

1. YES
2. NO ---> **GO TO MODULE VII**
8. DK ---> **GO TO MODULE VII**
9. REF --> **GO TO MODULE VII**

629. In the past 3 months, how many drinks did you have on the days that you drank more than usual **(# FROM Q626**)? **(CHECK IF # FROM Q629>># FROM Q626)**

_____ _____ # OF DRINKS

88. DK --> **GO TO MODULE VII**
99. REF --> **GO TO MODULE VII**

630. How often did you drink that amount?

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

VII REPRODUCTIVE HEALTH KNOWLEDGE/ATTITUDES

700. What do you think is the ideal number of children for a young family in Georgia?

0. 0 CHILDREN
1. 1 CHILD
2. 1-2 CHILDREN
3. 2 CHILDREN
4. 2-3 CHILDREN
5. 3 CHILDREN
6. 3-4 CHILDREN
7. 4 CHILDREN
8. 5 OR MORE
9. AS MANY AS GOD GIVES
77. AS MANY AS POSSIBLE
88. DON'T KNOW

701. When is it most likely for a woman to become pregnant **(READ 1-5)**?

1 Just before menstruation starts
2 During menstruation
3 Right after menstruation ends
4 Halfway between her periods
5 It doesn't matter, all times alike
7 OTHER (SPECIFY)_____
8 DON'T KNOW

702. Do you think that breastfeeding increases, decreases or has no effect on a woman's risk to get pregnant?

1. INCREASES THE RISK
2. DECREASES THE RISK
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 child	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-J)**:

	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

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	MEDIUM	HIGH	
1. Pill	1	2	3	8
2. IUD	1	2	3	8
3. Condom	1	2	3	8
4. Tubal Ligation	1	2	3	8
5. Injectables (e.g., Depo-Provera)	1	2	3	8
6. Emergency Hormonal Contraception	1	2	3	8
7. Abortion on Request	1	2	3	8

BOX 7-I

IF Q400_A=2 ON PAGE 21 (NEVER HEARD OF PILLS), GO TO BOX 7-II BELOW

710. Please tell me if you agree or disagree with the following statements about birth control pills **(READ A-J)**:

	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
E. Pills allow spontaneity of sexual intercourse	1	2	8
F. Pills protect against some gynecologic cancers	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
J. Pills decrease menstrual cramps and pain	1	2	8
K. Pills are bad for blood circulation	1	2	8

BOX 7-II

IF Q400_B=2 ON PAGE 21 (NEVER HEARD ABOUT IUD), GO TO Q712

711. Please tell me if you agree or disagree with the following statements about IUDs **(READ A-H)**:

	AGREE	DISAGREE	DK
A. IUD is easy to use	1	2	8
B. IUD increases sexual enjoyment because removes worries about pregnancy	1	2	8
C. IUD increases the risk of pelvic inflammatory disease	1	2	8
D. IUD is a relatively inexpensive contraceptive method	1	2	8
E. IUD may cause spotting between periods	1	2	8
F. IUD may increase the blood loss during menses	1	2	8
G. IUD increases menstrual pains	1	2	8
H. IUD decreases the risk of ectopic pregnancy	1	2	8

712. As far as you know, is there anything that a woman can do to prevent pregnancy in the next few days after unprotected sexual intercourse?

1. YES, THERE IS SOMETHING
2. NO, THERE IS NOT ANYTHING-----**>GO TO Q715**
8. NOT SURE **----->GO TO Q715**

713. What can she do to prevent pregnancy?

1. TAKE COMBINED PILLS OR "MORNING AFTER PILL"
2. TAKE POSTINOR
3. HAVE AN IUD INSERTED (WITHIN 5 DAYS)**--->GO TO Q715**
7. OTHER_____**---------->GO TO Q715**
8. DK/NOT SURE **---------->GO TO Q715**

714. How soon after sexual intercourse should emergency hormonal contraception be taken **(READ 1 TO 5)**:

1. right away,
2. within 12 hours,
3. within 24 hours,
4. within 3 days, or
5. within a week?
8. DO NOT KNOW

715. Do you want to have more information about contraceptive methods?

1. YES
2. NO **----------> GO TO BOX 7-IV**
8. DON'T KNOW **---> GO TO BOX 7-IV**

716. 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
16. TV
20. OTHER (SPECIFY): _____
88. DON'T REMEMBER

BOX 7-IV

IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO SECTION VIII

717. 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 1-4)**

1. Very Effective
2. Somewhat effective
3. Not very effective
4. Not at all effective
8. DON'T KNOW

718. 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

719. Have you ever asked a partner to use a condom?

1. YES
2. NO --> **GO TO Q721**
8. DON'T REMEMBER --> **GO TO Q721**

720. 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

721. If your partner/husband would want to use a condom when having sex with you, would you feel: **(READ A-G)**

	AGREE	DISAGREE	DK
A. Embarrassed?	1	2	8
B. Angry?	1	2	8
C. Safe from getting pregnant?	1	2	8
D. Safe from getting HIV?	1	2	8
E. Like you had done something wrong?	1	2	8
F. Safe from getting STD?	1	2	8
G. Suspicious that he may sleep around?	1	2	8

722. Please indicate whether you agree or disagree with the following statements about condoms:

	AGREE	DISAGREE	DK
A. Using condoms with a new partner is a smart idea	1	2	8
B. Using condoms is not necessary if you know your partner	1	2	8
C. Women should ask their partners to use condoms	1	2	8
D. It is easy to discuss using a condom with a prospective partner	1	2	8
E. Condoms diminish sexual enjoyment	1	2	8
F. Same condoms can be used more than once	1	2	8
G. People who use condoms sleep around a lot	1	2	8
H. It is embarrassing to ask for condoms in FP clinics or pharmacies	1	2	8

VIII. SOCIOECONOMIC CHARACTERISTICS

800. Please tell me whether this household or any member of it has the following items: **(READ A-J):**

	YES	NO
A. Flush Toilet	1	2
B. Heating System	1	2
C. Refrigerator	1	2
D. TV	1	2
E. Automobile	1	2
F. VCR	1	2
G. Household phone 1	2	
H. Cellular phone	1	2
I. Vacation home (villa)	1	2
J. Vegetable garden/orchid/vineyard	1	2

801. Which of the following describes your living arrangements. Do you live: (**READ 1-4**)

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_____

802. How many rooms are occupied by you and your family (not including bathrooms and kitchen):

____ ____ ROOMS

803. How many hours per day do you have electricity? ___ ___ HOURS

804. 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

805. What language does your family speak at home most of the time?

1. GEORGIAN
2. RUSSIAN
3. AZERI
4. ARMENIAN
5. OSSETIAN
7. OTHER (SPECIFY):_____

806. 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
20. OTHER (SPECIFY):_____
77. NO RESPONSE ——————>**GO TO Q900**
99. UNDECLARED——>**GO TO Q900**

807. About how often do you usually attend religious services? **(READ 1-5)**

1 At least once a week
2 At least once a month, but less than once a week
3 Less than once a month
4 Only on holidays
5 Never

IX-A. AIDS/STDs

The next set of questions are about sexually transmitted diseases and AIDS. For each of the following conditions please tell me if:

CONDITION	**900.** Have you ever heard of it?	**901.** Have you ever been tested for...?	**902.** Have you ever been told that you have...?	**903.** Did you take any treatment for...?	**904.** Where did you get treatment for ...? **(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. YES 2. NO--->**B** 8. DK/DR-->**B**	_____
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. YES 2. NO--->**C** 8. DK/DR-->**C**	_____
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. YES 2. NO--->**D** 8. DK/DR-->**D**	_____
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. YES 2. NO--->**E** 8. DK/DR-->**E**	_____
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. YES 2. NO--->**F** 8. DK/DR-->**F**	_____
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. YES 2. NO--->**G** 8. DK/DR-->**G**	_____
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. YES 2. NO--->**H** 8. DK/DR-->**H**	_____
H. HIV/AIDS	1. YES 2. NO	1. YES->**Q905** 2. NO->**Q904A** 8. DK->**Q904A**			

CODES FOR Q904:

1. RURAL AMBULATORY
2. STD DISPENSARY
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. HOSPITAL-MATERNITY WARD
6. HOSPITAL-GYN WARD
7. HOSPITAL-STD
8. PRIVATE CLINIC OR OFFICE
9. TREATMENT RECOMMENDED BY PHARMACIST
10. TREATMENT RECOMMENDED BY A FRIEND/RELATIVE
11. SELF-TREATMENT
12. UNOFFICIAL PRESCRIPTION

20. OTHER_____

99. DR/REF.

904A Do you know a place where you could get an HIV/AIDS test?

1. YES
2. NO

905. In general, what has been your most important source of information about STDs including AIDS? (Where or from whom have you learned the most about STDs?)

1. MOTHER
2. FATHER
3. OTHER RELATIVE
4. BOYFRIEND
5. HUSBAND, PARTNER
6. SOMEBODY WHO HAD STDs
7. FRIENDS COLLEAGUES, PEERS
8. FAMILY PLANNING OFFICE
9. DOCTOR, DERMATOLOGY
10. DOCTOR, GYNECOLOGY
11. FAMILY DOCTOR
12. NURSE, MIDWIFE
13. TEACHER
14. PHARMACIST
15. SPECIALITY BOOKS
16. NEWSPAPERS, MAGAZINES, BROCHURES, FLYERS
17. RADIO
18. TV
20. OTHER (SPECIFY):_____
77. NEVER HEARD OF ANY STDs **(Q900_A--Q900_H=2)**
99. DR/REF.

906. In the past 6 months, have you seen or heard any public announcements or ads about AIDS on television or radio?

1. YES, ON TV
2. YES, ON RADIO
3. YES, ON BOTH
4. NO
8. DK/DR

907. In the past 6 months, have you seen or heard any public announcements or ads about OTHER STDs on television or radio?

1. YES, ON TV
2. YES, ON RADIO
3. YES, ON BOTH
4. NO
8. DK/DR

IF Q900 H =2 (NEVER HEARD OF HIV/AIDS) GO TO Q914; ELSE CONTINUE

908. 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

909. Please tell me whether you think that the AIDS virus can be transmitted in the following ways? **(READ A-N)**

	YES	NO	DK
A. By receiving a blood transfusion	1	2	8
B. Using public toilets	1	2	8
C. Through Kissing on mouth	1	2	8
D. Through sexual intercourse between a man and a woman	1	2	8
E. Through sexual intercourse between men	1	2	8
F. By Shaking hands	1	2	8
G. By Donating blood	1	2	8
H. Using non-sterile syringes or needles	1	2	8
I. Through mosquito bites	1	2	8
J. Sharing plates, forks, or glasses with someone who has HIV/AIDS	1	2	8
K. From a woman who has the AIDS virus to her baby during pregnancy/delivery	1	2	8
L. From a mother to her child through breast milk	1	2	8
M. Getting a manicure, pedicure or haircut	1	2	8
N. Having dental treatment	1	2	8

910. Do you think the following persons generally have no risk, a low risk, or a high risk of getting AIDS? (**READ A-G**)

	NO RISK	LOW RISK	HIGH RISK	DEPENDS	DK
A. Married women	1	2	3	4	8
B. Married men	1	2	3	4	8
C. Men who have sex with men	1	2	3	4	8
D. Prostitutes	1	2	3	4	8
E. Intravenous drug users	1	2	3	4	8
F. Unmarried sexually active women	1	2	3	4	8
G. Unmarried sexually active men	1	2	3	4	8

911. What can a person do to reduce the risk of getting AIDS?

	SPONTANEOUS	PROBED		
	YES	YES	NO	DK
A. USE CONDOMS	1	3	4	8
B. AVOID RELATIONS WITH PROSTITUTES	1	3	4	8
C. AVOID INJECTIONS	1	3	4	8
D. HAVE ONLY ONE SEXUAL PARTNER	1	3	4	8
E. ASK PARTNER TO HAVE BLOOD TESTED FOR AIDS	1	3	4	8
F. DO NOT HAVE CASUAL SEXUAL RELATIONS	1	3	4	8
G. STERILIZE NEEDLES	1	3	4	8
H. AVOID RELATIONS WITH BISEXUALS	1	3	4	8
I. OTHER_____	1	3	4	8

912. How much of a risk do you think you personally have of getting HIV/AIDS? Would you say you are at:

1 Great risk,
2. Moderate Risk,
3. Little risk, or
4. No risk at all **---------->GO TO Q913A**
8 DON'T KNOW**----->GO TO Q913B**

913. Why do you think you have any risk of getting AIDS?

1. HAVE RECEIVED MANY BLOOD TRANSFUSIONS/BLOOD PRODUCTS
2. SHE MAY GET INFECTED WHILE RECEIVING MEDICAL OR DENTAL TREATMENT
3. MANY SEXUAL PARTNERS, TRADE SEX FOR MONEY
4. UNPROTECTED INTERCOURSE WITH CASUAL PARTNER(S)
5. USED IV DRUGS
6. DOES NOT TRUST HER PARTNER, HE MAY HAVE INTERCOURSE WITH OTHER WOMEN
7. SHE MAY GET INFECTED GETTING A MANICURE, PEDICURE, OR HAIRCUT
8. OTHER_____
9. DK/REF

GO TO Q913B

913A Why do you think you have no risk of getting AIDS?

1. MONOGAMOUS RELATIONSHIP
2. NOT SEXUALLY ACTIVE
3. USES CONDOMS
4. TRUSTS HER PARTNER
7. OTHER_____
9. DK/REF

913B How about your risk of getting other STDs. Would you say you are at **(READ 1-4)**:

1 Great risk,
2. Moderate Risk,
3. Little risk, or
4. No risk at all
9 DON'T KNOW/REF

IX-B VIOLENCE

914. 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 Q916**
8 DR/REF

915. 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

916. THE INTERVIEWER SHOULD GO BACK TO PAGE 3 AND RECORD HOW MANY TIMES THE RESPONDENT LIVED WITH A MEN AS HUSBAND AND WIFE (SEE Q113):

___ TIMES

IF Q916=0 GO TO Q928; IF Q916>0 CONTINUE

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.

918. Please tell me if any of your partners or ex-partners ever **(READ A-H):**		**919.** When was the **last time** when **(A-H)** happened to you?	**920.** During the last year, **how many times** did **(A-H)** happen to you?
A. Insulted you, or swore at you?	1. YES---> **Q919** 2. NO----> **Q918_B** 8. DK----> **Q918_B** 9. REF---> **Q918_B**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_B** 3. 4-5 YEARS AGO--------> **Q918_B** 4. 5 YEARS AGO OR MORE-->**Q918_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---> **Q919** 2. NO----> **Q918_C** 8. DK----> **Q918_C** 9. REF---> **Q918_C**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_C** 3. 4-5 YEARS AGO--------> **Q918_C** 4. 5 YEARS AGO OR MORE-->**Q918_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---> **Q919** 2. NO----> **Q918_D** 8. DK----> **Q918_D** 9. REF---> **Q918_D**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_D** 3. 4-5 YEARS AGO--------> **Q918_D** 4. 5 YEARS AGO OR MORE-->**Q918_D**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
D. Slapped you or twisted your arm?	1. YES---> **Q919** 2. NO----> **Q918_E** 8. DK----> **Q918_E** 9. REF---> **Q918_E**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_E** 3. 4-5 YEARS AGO--------> **Q918_E** 4. 5 YEARS AGO OR MORE-->**Q918_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---> **Q919** 2. NO----> **Q918_F** 8. DK----> **Q918_F** 9. REF---> **Q918_F**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_F** 3. 4-5 YEARS AGO--------> **Q918_F** 4. 5 YEARS AGO OR MORE-->**Q918_F**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
F. Threatened you with a knife or other weapon?	1. YES---> **Q919** 2. NO----> **Q918_G** 8. DK----> **Q918_G** 9. REF---> **Q918_G**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_G** 3. 4-5 YEARS AGO--------> **Q918_G** 4. 5 YEARS AGO OR MORE-->**Q918_G**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
G. Kicked you, choke you or beat you up?	1. YES---> **Q919** 2. NO----> **Q918_H** 8. DK----> **Q918_H** 9. REF---> **Q918_H**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO--------> **Q918_H** 3. 4-5 YEARS AGO--------> **Q918_H** 4. 5 YEARS AGO OR MORE-->**Q918_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---> **Q919** 2. NO---->**BOX 9-I** 8. DK---->**BOX 9-I** 9. REF--->**BOX 9-I**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO-------->**BOX 9-I** 3. 4-5 YEARS AGO-------->**BOX9-I** 4. 5 YEARS AGO OR MORE->**BOX 9-I**	__ __ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES

BOX 9-I

IF ALL Q918_A--Q918_H >1 (NEVER EXPERIENCED ANY TYPE OR ABUSE) GO TO Q928; ELSE CONTINUE

921. You told me before that you lived with a man as husband and wife _____ times **(RECORD THE NUMBER OF TIMES FROM Q916). During which of these periods** has that partner physically abused you as you have just mentioned? **MARK THE INTERVAL(S) NUMBER FROM THE UNION TABLE AT PAGE 2 (ALLOW FOR MULTIPLE RESPONSES):**

I. ___ **V. ___**
II. ___ **VI. ___**
III. ___ **VII. ___**
IV. ___

BOX 9-II

- **IF ANY OF THE INCIDENTS OF PHYSICAL VIOLENCE TOOK PLACE DURING THE LAST YEAR (ANY Q919_C--Q919_H=1), CONTINUE;**
- **IF ANY OF THE INCIDENTS OF PHYSICAL VIOLENCE TOOK PLACE MORE THAN ONE YEAR AGO (ANY Q919_C--Q919_H>1) GO TO Q925;**
- **IF R. SUFFERED ONLY VERBAL VIOLENCE (Q918 C--Q918 H>1) THEN GO TO Q928**

922. 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 Q925**
8. DON'T REMEMBER -----**GO TO Q925**

923**.** Did you see a doctor, or other medical care provider for medical treatment of these injuries?

1. YES
2. NO----------**GO TO Q925**
8. DON'T REMEMBER -----**GO TO Q925**

924. Did this(these) injury(injuries) require hospitalization?

1. YES
2. NO
8. DON'T REMEMBER

925. Did you talk about this(these) incidents with **(READ A-F)?**

	YES	**NO**
A. A Family member	1	2
B. A Friend	1	2
C. A Doctor/Medical Personnel	1	2
D. Police	1	2
E. Legal Adviser	1	2
F. Other (Specify)_____	1	2

926. What is the main reason you have never sought any legal or medical 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
20. OTHER
88. DK/REF

927. 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)**

NOTE: IF SHE REPORTED MORE THAN ONE PARTNER THIS QUESTION REFERS TO THE LAST PARTNER WHO USED VIOLENCE

	MENTIONED	NOT MENTIONED
A. WHEN DRUNK	1	2
B. WHEN THE FAMILY HAS MONEY TROUBLES	1	2
C. WHEN HE HAS DIFFICULTIES AT WORK	1	2
D. WHEN HE IS UNEMPLOYED	1	2
E. FAMILY PROBLEMS	1	2
F. JEALOUSY	1	2
G. WHEN SHE IS PREGNANT	1	2
H. WHEN HE CANNOT GET ALCOHOL	1	2
I. WHEN THEY DO NOT HAVE FOOD AT HOME	1	2
J. OTHER_____	1	2

928. 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----------->**END OF INTERVIEW, GO TO Q 931**
8. DON'T REMEMBER--->**END OF INTERVIEW, GO TO Q 931**

929. 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

930. 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

END OF INTERVIEW

931. TIME INTERVIEW ENDED __ __ : __ __