

Reproductive Health Survey Georgia 2010



FINAL REPORT



USAID
FROM THE AMERICAN PEOPLE



unicef 
unite for children



შპს "საქართველოს
საზოგადოებრივი
საინფორმაციო
სამსახური"



საქართველოს
საზოგადოებრივი
საინფორმაციო
სამსახური

Reproductive Health Survey Georgia 2010

FINAL REPORT

National Center for Disease Control and Public Health (NCDC)
Ministry of Labor, Health, and Social Affairs (MoLHSA)
National Statistics Office of Georgia
TBILISI, GEORGIA

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

United Nations Population Fund (UNFPA)
United States Agency for International Development (USAID)
The United Nations Children's Fund (UNICEF)

2012

Authors and Contributors:

National Center for Disease Control and Public Health:

M. Butsashvili - RHS Scientific Committee Director

G. Kandelaki

L. Sturua

M. Shakh-Nazarova

N. Mebonia

N. Avaliani

Panel of Experts:

Z. Bokhua

T. Asatiani

Z. Sinauridze

G. Tsuladze

K. Chkhatarashvili

J. Kristesashvili

G. Tsagareishvili

Division of Reproductive Health, Centers for Disease Control and Prevention:

Florina Serbanescu

Vasili Egnatashvili

Alicia Ruiz

Danielle Suchdev

Mary Goodwin

Editor in Chief - John Ross

Cover: Openwork Buckle: Sheuba, 2nd-3rd centuries AD, bronze. (Artwork preserved at the Treasury of the Georgian National Museum) © **Georgian National Museum (GNM)**; www.museum.ge

This report is funded by UNFPA and UNICEF Joint Project “Support to Georgian RH Survey, 2010”

The Preliminary Report of the survey was funded by the United States Agency for International Development (USAID) agreement with the Division of Reproductive Health of the Centers for Disease Control and Prevention and USAID Contract No. HRN-C-00-97-0019-00.

The opinions expressed herein are those of the authors and do not necessarily reflect the views of UNFPA, UNICEF and USAID.

Additional information about this report may be obtained from the National Center for Disease Control and Public Health (NCDC):

9, M. Asatiani str., Tbilisi 0177, Georgia

Tel. : (995 32) 239 89 46

Fax : (995 32) 231 14 85

e-mail: ncdc@ncdc.ge

The report was printed by: Vesta, Ltd (Tbilisi, Georgia)

Preface

This report presents the findings of the 2010 Georgia Reproductive Health Survey (GERHS10). The GERHS10 is the third nationally representative survey to collect comprehensive information on reproductive health status and utilization of reproductive health and maternal and child health care services in the country. The first two surveys took place in 1999 and 2005 and provided a baseline and follow-up for numerous and essential health indicators that can track changes in family planning, maternal and child health, and other reproductive health efforts. Results showing low usage of modern contraception and high rates of unintended pregnancies were instrumental in designing and implementing new health strategies and programs and promoting health care reforms. Since then, maternal and child health services were strengthened, family planning supply efforts have been intensified, the number of sites and physicians providing family planning services has been expanded and reproductive health information, education and communication activities were strengthened.

The efforts to improve the health of women, infants and children are at the core of the health care reforms in Georgia. The National Healthcare Strategy 2011-2015 “Access to Quality Healthcare” targets enhancement of maternal and child health services. For these efforts to be successful, public health professionals have to identify the needs of women and children, to design and implement appropriate interventions, and to monitor and evaluate those interventions. The Ministry of Labor, Health and Social Affairs (MoLHSA) is directly responsible for implementing reproductive health reforms, including: compliancy with international standards and treaties in the health sector; provision and access of high quality healthcare for mothers and children; establishment of an international standard infrastructure for health care services; and maternal and child death reviews to help design the most appropriate evidenced-based preventive measures. The surveys provide the MoLHSA with a much needed ability to track progress in program outcomes, formulate targeted interventions, monitor the national development programs, and report on progress toward the Millennium Development Goals (MDGs).

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



Zurab Tchiaberashvili
Minister of Labor, Health and Social Affairs of Georgia

Acknowledgements

The 2010 Georgian Reproductive Health Survey (GERHS10) was conducted by the Georgian Center for Disease Control and Public Health (NCDC) in collaboration with the Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA) with the support of United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF) and United States Agency for International Development (USAID). The Division of Reproductive Health of the United States Centers for Disease Control and Prevention (CDC/DRH) provided technical assistance on the survey design, questionnaire development, training, data processing and summary report writing. The NCDC and CDC/DRH wish to express their appreciation to those involved in the implementation of the 2010 Georgian Reproductive Health Survey and the preparation of this report.

Particular thanks go to the Ministry of Labor, Health and Social Affairs for its chairmanship of the steering committee and the National Reproductive Health Council, chaired by Ms. Sandra Elisabeth Roelofs, The First Lady of Georgia, for its leadership in reproductive health in the country. Special thanks are extended to Mr. John Ross, Editor-in-Chief of the final report of the survey, and the team of national experts who have contributed to the development of the report.

Our special thanks go to the United States Agency for International Development (USAID) who provided generous financial resources for implementation of the study and developed over the years the NCDC’s capacity to conduct population-based health studies; the technical assistance of DRH/CDC and the preparation of the summary survey report were supported by USAID. We are particularly grateful to Tamara Sirbiladze, Senior Health and Infectious Diseases Advisor, Jeri Dible, Director, Health and Social Development Office, Jonathan Conley, Mission Director, and Nana Chkonia, Programme Assistant, USAID Caucasus, Georgia — for their continuous support of NCDC and DRH/CDC and the catalyst contribution to the study.

We are very grateful for the contribution provided by the United Nations Population Fund (UNFPA) and United Nations Children’s Fund (UNICEF), whose generous funding and technical expertise were essential in survey planning, fieldwork activities, and dissemination of the results. Particularly, we would like to acknowledge the UNFPA staff in Georgia — Tamar Khomasuridze, UNFPA Georgia Assistant Representative, Lela Bakradze, Programme Analyst, and Marina Tsintsadze, Admin/Finance Associate and the UNICEF staff — Roeland Monasch, UNICEF Representative in Georgia and Tinatin Baum, Social Policy Specialist — for their assistance in design, planning and financial management.

Most of all, we would like to thank the households whose participation made it possible to obtain the reliable information collected in the survey and advanced our knowledge of women’s reproductive health in Georgia. We are grateful to our highly skilled interviewers, supervisors, and data entry personnel for their commitment, discipline, and dedication to the project.

This report was prepared by the NCDC with the invaluable guidance and contributions of many individuals, both inside and outside NCDC.

Executive Summary

Georgia is a country with a strong cultural identity. Ethnic Georgians represent 84% of the total population, with Armenians and Azeri the largest ethnic minorities. Women's health in Georgia is strongly influenced by cultural, historical, and socioeconomic factors. The previous Communist regime, notorious for its lack of support for family planning, had a profound impact on women and their reproductive health. Due to a significant decline in socioeconomic conditions in the 1990s, the health of the population deteriorated seriously. In response to the collapse of the publicly-supported hospital-based health system, Georgia initiated an extensive health sector reform in the mid-1990s. The process was designed to address all aspects of the health-care sector and to emphasize quality of care, improved access, efficiency, and rehabilitation of the primary health care system. Decentralization and, since 2007, privatization, have been major components of the reform process. The privatization of hospitals called for full transfer of ownership to the private sector. Primary health care services are also in various stages of privatization. Despite the progress made during the last decade, health care expenditures comprise a decreasing portion of public expenditures, resulting in the underfunding of medical facilities, as well as family planning and reproductive health services.

Over the past several years, the United States Agency for International Development (USAID), the United Nations Population Fund (UNFPA), and other multilateral and bilateral donors have invested resources to improve access to family planning and other reproductive health services in Georgia. Through funds provided by USAID and UNFPA, a series of nationwide Reproductive Health Surveys (RHS) was conducted in 1999, 2005 and 2010. These surveys were developed by the U.S. Centers for Disease Control and Prevention (CDC), in response to the need to obtain detailed reproductive, maternal and child health indicators, with international comparisons. They draw upon CDC's expertise with survey methodologies in the U.S. combined with its international experience, regarding family planning, maternal and child health, and women's health. In many counties, including Georgia, these surveys have been the main source of population-based data for reproductive health policies and planning. The demographic and reproductive health indicators provided by the surveys serve multiple purposes: to examine health trends, set targets for improvement, allocate resources, monitor performance, measure program achievements, prioritize activities, guide research, and allow global comparisons in reproductive health.

A major purpose of the surveys in Georgia was to produce national and sub-national estimates of factors related to pregnancy and fertility, such as sexual activity and contraceptive use; use of abortion and other medical services; maternal and infant health, and women's health. The first RHS was conducted in Georgia in 1999; a new cycle was implemented in 2005, followed by the most recent cycle, implemented in 2010. As with the first two rounds, the Georgian Ministry of Labor, Health and Social Affairs (MoLHSA) conducted the survey in collaboration with the Georgian National Center for Disease Control (NCDC). The CDC provided technical assistance with the survey design, sampling, questionnaire development, training, data processing and analysis to all three surveys through funding from USAID. Local costs were primarily covered by UNFPA and UNICEF.

All three surveys employed large, nationally representative, probability samples and collected information on a wide range of health related topics from women aged 15–44 who were interviewed in their homes. The samples were selected in such a manner as to allow separate urban and rural, as well as regional-level estimates. In the most recent Georgian RHS (GERHS10), 13,363 households were visited and 6,292 women were successfully interviewed, yielding a response rate of 99%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed.

Several findings of the GERHS10 are highlighted below.

GERHS10 Overview

- Set within the context of overall social and economic development in Georgia, the aim of the 2010 survey was to obtain national and regional estimates of basic demographic and reproductive health indicators and compare them to previous RHS results.
 - In response to the decentralization of health activities, the survey employed a sample design that produced estimates for 11 regions of the country and for rural vs. urban sectors, to enable key stakeholders to assess reproductive health indicators at the subnational level.
 - The survey employed a stratified multistage sampling design, similar to the design used in the 1999 and 2005 cycles.
- Characteristics of Households and Respondents
- While the majority of households had tap water in their residence or yard (76%) there is a great disparity between urban and rural households (96% vs. 55%). Overall, 98% of urban and 88% of rural house-

holds in Georgia use improved sources of drinking water (tap water and water from protected wells).

- Overall, 96% of urban households and 71% of rural households using improved sanitation facilities.
- The distribution of the Georgian population across the wealth quintiles varied greatly by residence; almost three in four (74%) of urban households were classified in the two highest wealth quintiles while only 3% of rural households were in these wealth groups.
- The majority of respondents were of Georgian ethnicity (87%), followed by Azeri (5%) Armenian (5%) and other ethnicities (3%). Respondents belonging to minority ethnic groups were more likely to live in rural areas than in urban areas.
- Eighty two percent of women were Georgian Orthodox and 11% were Muslim.
- Educational attainment is wide-spread in Georgia with 77% of women reporting at least completion of secondary education. Thirty-nine percent of women had gone on to complete university or post-graduate education. Tbilisi residents reported much higher educational attainment than in other regions: 60% of respondents have undergone university training while only 13% did not complete secondary education.
- Boys and girls are equal in the percent entering grade 1 and in the percent transitioning from primary to secondary school.
- Most women (79%) reported not working outside of the house, a situation that was even more pronounced in rural areas (87%) where job availability is very low.

Marriage and Fertility

- Nearly 60% of women in the sample (aged 15-44) were married or in consensual unions, 7% were divorced or separated, and 34% had never been married.
- The TFR (total fertility rate) calculated from the 2010 survey, of 2.0 births per woman (95%CI=1.9–2.1) for the period 2007–2010, is the highest survey-based TFR ever reported for Georgia. It is 25% higher than the TFR of 1.6 births per woman (95%CI=1.4–1.7) observed for 2002–2005.
- Traditionally, Georgian women initiate and complete childbearing at an early age, as reflected in very high age-specific fertility rates for young women. The highest fertility levels were at ages 20-24 and 25-29, accounting for 36% and 29%, respectively, of the TFR. Fertility among adolescent women (39 births per 1,000 women aged 15–19) contributed to only 10% of the TFR. Fertility among women aged 30–34 was the third-highest ASFR, contributing 15% of the TFR.
- Compared to the 2005 survey, age-specific fertility rates increased in all but one age group (ado-

lescent women) suggesting a gradual transition to fertility postponement in Georgia.

- Generally, peak fertility occurred at ages 25–29 among women with the highest educational attainment, whereas at lower educational levels it occurred at ages 20–24. This partially reflects differences in the age at marriage.

Fertility rates of ethnic minorities, particularly among the Azeri group (2.4 children per woman) were higher than those of the Georgians, the major ethnic group (2.0 children per woman), due to much higher ASFRs among Azeri women aged 15–24.

Pregnancy Intention Status

- Most women who have been pregnant in the past 5 years reported the last pregnancy as planned and only 36% said they had an unplanned pregnancy—11% mistimed and 26% unwanted. This compares to the higher levels of 51% of women reporting their last pregnancy as unplanned in 2005 and 59% in 1999. Mistimed pregnancies represented a larger share of unplanned pregnancies in 2010 than in previous surveys, suggesting that more women than in the past want to postpone rather than end childbearing.
- Nearly all women whose last pregnancy ended in induced abortion reported that their conceptions were unplanned (96%).
- Thirty-five percent of women currently married or in consensual union wanted more children, compared to 25% in 1999 (a 40% increase). This trend was consistent regardless of the number of living children. Particularly notable was the relatively high proportion of women with two or more children who said in 2010 that they wanted more children (21% compared to only 12% in 1999).
- The desire to have more children was very high among young women (89% at ages 15-19 and 73% at ages 20–24), dropping to 47% at ages 25-29 and declining further among women aged 30 or older.
- Between 1999 and 2010, there were notable changes in the timing of wanting a(another) child, according to the current age. Among the youngest women, the proportion who wanted a child within two years declined by 29% (from 61% to 44%); the percent saying they wanted no more fell from 14% to 7%. Similar declines occurred in each older age group.
- Among fecund married women who had had two or more children, the majority (68%) were ready to terminate childbearing. This pattern is similar to the one documented in the 1999 and 2005 surveys, but in 2010 fewer women with two or more children said they did not want to have a(another) child.

Induced Abortion

- The survey data allow for calculation of the total induced abortion rate (TIAR), which gives the

number of abortions a woman would have in her lifetime under the current age specific induced abortion rates (ASIARs). Previous RHS surveys showed a steep increase in the TIAR after 1990, when the USSR broke up, with a peak of 3.7 abortions per woman in 1997–1999. The abortion rate declined gradually to 3.1 abortions per woman (95%CI= 2.9–3.4 abortions per woman) in 2002–2005. Between 2005 and 2010, the abortion rate dropped significantly to 1.6 abortions per woman (95%CI= 1.5–1.8 abortions per woman), a 48% decline from 3.1, or 57% from 3.7.

- The estimated TIAR for the period 2007–2010 according to official sources was only 0.9 abortions per woman (44% lower than the rate documented in the survey but an improvement from over 80% under-reporting documented in 1999 and 2005).

- More than one-half of Georgian women obtaining abortions in 2007–2010 were aged 25–29 (102 abortions per 1,000 women) and 30–34 (83 abortions per 1,000 women). The third highest age specific abortion rate, contributing to 25% of the TIAR, occurred among women aged 35–39. The ASIARs were significantly higher than ASFRs only among women aged 30 or older, suggesting that most Georgian women continue to achieve their desired family size before age 30 after which, in the event of having unplanned pregnancies, they are more likely to end them in induced abortions.

- The survey-based estimate of the abortion-to-live-birth ratio changed from to 2.1 induced abortions for each live birth (2.1:1) in 1999, to 1.5:1 in 2005, and to 0.8:1 in 1999. Thus, birth experience surpassed abortion experience for the first time since survey-based reports were collected. This was mainly achieved by a combination of increases in fertility and declines in abortion at ages 20–24, 25–29, and 30–34, which contribute the most to both total fertility and total abortion rates.

- Higher abortion rates among rural women, less educated women, and women of Azeri descent suggest that access to services is unequal and that Georgia's family planning program needs to expand its reach to disadvantaged subgroups.

- The main reasons given for choosing abortion included: desire to stop childbearing (51%), desire to space the next birth (18%), and socioeconomic circumstances that prevent the family from supporting another child (20%).

- Of all abortions reported by survey respondents during the past 5 years, 71% were mini-abortion; this is sharply up from 40% in 1999 and 56% in 2005.

- Most induced abortions occurring in 2005 or later were performed in gynecological wards (56%); 42% were performed in ambulatory clinics, such as women's consultation clinics (WCCs); and 2% were performed outside medical facilities. Regarding fees,

the average abortion payment did not vary by type of medical facility. At the time of the survey, mean charges for an abortion procedure were about US\$29.00, which represents an increase of 65% compared to the average cost in 2005.

- Few family planning services are received around the time of having an abortion. While one in three (33%) respondents with a history of abortion in 2005–2010 reported receiving contraceptive counseling before or/and after the abortion; only 6.6% of women (20% of women who received counseling) received a contraceptive method to prevent future unintended pregnancies; and an additional 7.4% of women received a prescription for contraceptive supplies (22% of all women counseled).

- Receipt of contraceptive information in 2010 was however more than twice the level documented in the 1999 survey (33% vs. 15%). Actual receipt of a contraceptive method or prescription for a method almost tripled, from 5% to 14%, both rather low rates but improving.

Maternal and Child Health Services

- Use of prenatal care was almost universal: 98% of pregnant women received at least one prenatal examination. Initiation of prenatal care in the first trimester was more common in urban areas than in rural areas (93% vs. 86%) and was most widespread in Tbilisi (94%).

- Ninety percent of women received at least 4 prenatal care visits and this was more common among women in urban areas (95%) than in rural areas (86%).

- One in two women received most of their prenatal care from women's consultation clinics (49%) and 44% received their care from regional maternity hospitals. Only 7% of the women received care from primary care clinics or family medicine centers.

- In both 1999 and 2005, about one in twelve births (8%) was delivered at home, the majority without skilled attendance; in 2010 only 2% of births were delivered at home. Home births were slightly higher among Azeri women (5%), but in clear decline compared to the level of 40% home deliveries among this ethnic group in 2005.

- Eighty four percent of newborns received a well-baby checkup but only 23% of women reported receiving postpartum care in 2010. Use of postpartum care was also low in 2005 (23%), indicating that this service is still vastly underutilized in Georgia.

- Virtually all (97%) babies born alive in 2005–2010 were registered, according to the mother; however, registered births ranged from a low of 92% in the region of Kakheti to a high of 99% in the region of Samtskhe-Javakheti. Home births were least likely to be registered (67%).

Breastfeeding

- The majority (87%) of infants born within the five years leading up to the 2010 survey had been breastfed, virtually unchanged compared to 1999 and 2005. Georgian women reported lower rates of breastfeeding than women of other ethnicities.
- Since the 1999 survey, the proportion of babies who were breastfed within the first hour after birth increased by 4 times (from 5% in 1999 to 10% in 2005 and 20% in 2010), while the proportion of those who received breast milk 1–23 hours after birth doubled, from 28% to 55%.
- On average, the duration of any breastfeeding was 12.1 months, 2 months longer from the 10.1 months recorded in the 2005 survey. The duration of full breastfeeding (either exclusive breastfeeding or predominantly breastfeeding) was 4.1 months, longer than the 3.7 months documented in the 1999 and 2005 surveys. Perhaps the most important gain was in the duration of exclusive breastfeeding (only breast milk), which doubled from the level documented in the 1999 survey (from 1.5 to 3 months).

Perinatal & Childhood Mortality

- Of all births that occurred during the five years prior to the survey, 8 per 1,000 were stillbirths. The stillbirth rate was highest among women who did not receive any prenatal care (50 stillbirths per 1,000), women who suffered complications during their pregnancies (34 stillbirths per 1,000), women who had prolonged labor (30 stillbirths per 1,000) and women who delivered after age 35 (11 stillbirths per 1,000).
- The infant mortality rate, the rate at which babies less than one year of age die, has continued to decline steadily, from 41.6 per 1,000 live births in 1995–1999 to 21.1 per 1,000 live births in 2000–2004 and to 14.1 per 1,000 live births in 2005–2009. The neonatal mortality rate (deaths in the first month of life) went down from 25.4 per 1,000 live births in 1995–1999 to 16.8 per 1,000 live births in 2000–2004 and even lower to 9.5 per 1,000 live births in 2005–2009.
- A two-thirds reduction in mortality before age five between 1990 and 2015 is centrally formulated in the Millennium Development Goal 4 (MDG-4). This “under-5 mortality rate” dropped from 45.3 per 1,000 births in 1995–1999 to 25.0 in 2000–2004 and 16.4 in 2005–2009—a nearly 64% decline. Thus, according to the survey estimates, Georgia essentially achieved MDG-4 by 2010.
- Child survival in Georgia improved substantially over the past 15 years, mainly through significant reductions in neonatal and post-neonatal mortality. Given that neonatal deaths continue to account for most of infant mortality and 58% of under-5 deaths in Georgia, further reductions in child mortality will depend heavily on continuing the improvements in sur-

vival during the neonatal period.

Contraceptive Awareness

- Virtually all respondents (96%) had heard of at least one modern method—particularly the condom (94%), IUD (87%), and oral contraceptives (81%). However, only 39% of women had heard of tubal ligation and few (4%) had heard of vasectomy.
- For each contraceptive method, there is a considerable gap between awareness of the method and knowledge of how that procedure or product is used.
- Most women do not have correct knowledge about how effective the modern methods of contraception are; while 30% of women correctly stated that IUDs are very effective in preventing pregnancy, only 16% believed that contraceptive sterilization is very effective. The majority of women incorrectly thought that pills were not very effective.

Contraceptive Use

- Among all women aged 15–44, 32% were currently using a contraceptive method, including 21% who were using supplied methods (condoms, IUDs, oral contraceptives, tubal ligation, and spermicides).
- Among married women aged 15–44 more than half (53%) were currently using contraception, including 35% using modern methods. The use of modern contraceptive methods rose sharply, from 20% in 1999 to 35% in 2010. For the first time, the prevalence of modern methods exceeded the prevalence of traditional methods, which declined. As a result the contraceptive prevalence rate (CPR) for married women increased from 41% in 1999 to 45% in 2005 and 53% in 2010.
- Among all current contraceptive users, 26% were using the condom (14% out of 53%), followed by 25% using the IUD (13% out of 53%), 21% using withdrawal (11% out of 53%), 13% using periodic abstinence (7% out of 53%), 7% using the pill (4% out of 53%), 5% using tubal ligation (2.9% out of 53%), and 3% using spermicides (1.5% out of 53%).
- Between 1999 and 2010, condom use among couples increased 2.5 times (from 6% to 14%) and IUD use increased from 10% to 13%, becoming the first and second most used methods, respectively. Withdrawal and the rhythm method, the leading methods in 1999, became the third and fourth most commonly used methods in 2010. Pill use, still very low, increased from 2% in 1999 to 4% in 2010, and tubal ligation increases from 2% to 3%.
- Health facilities including primarily health care clinics/centers, women’s consultation clinics and city or regional hospitals with gynecology wards were the main sources of modern contraceptive methods,

supplying 50% of users. Commercial sales, specifically through pharmacies, were the second largest source of modern contraceptive supplies (45%). Nearly 5% of users obtained their method from “other” sources, such as their partners, friends and relatives, and the open market.

Potential Demand for Contraception

- Almost two-thirds (65%) of married women have a potential demand for contraception, including 52% who already use a method and 12% whose demand has yet to be satisfied (i.e. have an unmet need for some contraceptive method). The unmet need for contraception among married women in 2010 is half the level documented in 1999 (12% vs. 24%), mostly as a result of increased use of modern methods. Need rises with rural residence, low education, larger families, and poor wealth quintiles. Most need is for limiting rather than spacing, in a 2 to 1 ratio.
- Among current users (52%), 18% use traditional methods, which are subject to high failure rates and consequent abortions. When these are added to the unmet need group (12%) the total need for modern methods is 30%, nearly a third of all married women.
- Among married women, besides the 52% who use a method; 13% are currently pregnant or postpartum, 9% are infecund, 6% are not sexually active, and 8% are seeking to become pregnant, totaling 88%. The other 12% have unmet need as noted, or 30% including traditional method users. (In addition, some who are postpartum will soon be exposed to an unwanted conception.)

Contraceptive Counseling

- Family planning counseling in Georgia is mostly available only through specialized facilities, is mostly offered as part of postpartum or post-abortion care, and seldom includes distribution of supplies or prescription for supplies. Thus, Georgia has a great need for new policies that will expand the scope of contraceptive counseling and allow its integration with other reproductive health services at the primary care level.
- Most family planning services in Georgia are provided by Ob/Gyns and “reproductologists” (physicians who have received extra training related to reproductive issues) who traditionally have little expertise in providing family planning client-oriented counseling. An important component of the newly implemented reproductive health strategy in Georgia is to train health professionals to provide family planning counseling at any point of contact with medical care, including primary health care services.
- Most respondents were advised by a gynecologist or reproductologist to use their current or most

recent modern method (56%). Women who did not receive medical advice started using their last method at the partner’s suggestion (23%), at their own counsel (9%), at the suggestion of friend (5%), or at the suggestion of a relative (4%), bypassing any potential family planning counseling. In only 1% of cases was the choice of the method made at the suggestion of a pharmacist.

- During provider-client interactions, 64% of women received general information about alternative contraceptive methods in 2010, compared to only 32% in 1999; 59% were counseled about the effectiveness of the chosen method in 2010 compared to only 31% in 1999; and 82% reported that the provider explained possible side effects of the method chosen, compared to only 70% in 1999.

Women’s Health

- The majority of respondents (79%) reported having a usual place where they obtain most of their health care. Of those who had a usual place of care, most obtained the care in hospitals (38%) and ambulatory clinics (i.e. polyclinics and women’s consultation clinics) (26%). Only a minority obtained their usual care in primary health care (PHC) facilities (14%).
- More than one in every three women (37%) reported visiting a health care facility in the last year. Among these one half (51%) were seen for acute care, 41% for preventive care including family planning services, and 20% for care of a chronic condition (summing to over 100% due to multiple visits).
- One quarter (25%) of respondents indicated they had to delay getting medical care in the last 12 months (preventive, acute, or chronic care). The overwhelming majority of these women (82%) reported that the cost of health care services was the most important deterrent.
- Only 22% of women had any health insurance at the time of the interview. Given the unequal geographical distribution of the population below the poverty level, insured women in rural areas were much more likely to have government-supported health insurance than urban women and less likely to have private insurance.
- The prevalence of routine gynecological visits remains low in Georgia, since only 24% of women with sexual experience had accessed this preventative service. Since screenings for cervical and breast cancer are generally provided or prescribed during the routine gynecologic visits, the low prevalence of routine gynecologic exams inevitably has an impact on early detection and treatment of the gynecologic cancers. It also has a substantial negative effect on family planning counseling and on dissemination of other health messages.
- Overall, 42% of sexually experienced women

had ever performed BSE (breast self exam), which was higher than in 2005 (29%), but still leaves significant room for improvement. In terms of BSE frequency, 17% of sexually experienced women reported doing one every month, 12% every 2–5 months, 12% every 6–12 months or more, and 58% never.

- BSE is not adequate on its own; consequently, women were also asked about the utilization of CBE (clinical breast exam) and mammography. Less than one in five (18%) of sexually experienced women had ever had a CBE (done by a health professional to detect abnormalities).

- Only 10% of women aged 40–44 have ever had a mammography; the three most important reasons women gave for not having a mammogram were lack of a recommendation from their health provider, saw no need for it, and never heard of it

- The prevalence of cervical cancer screening was also low; only 12% of sexually experienced women reported ever having had a Pap smear test; however, this represents a 3-fold increase from the 4% reported in both 2005 and 1999.

- For the first time, the 2010 survey explored the level of awareness and use of the HPV vaccine in Georgia. Only a fifth (21%) of all women aged 15–44 had ever heard of HPV; 18% had heard of the vaccine, and once told about the vaccine's effectiveness in preventing cervical cancer, 29% expressed an interest in receiving it.

- Almost all women surveyed (95%) were aware of tuberculosis (TB), and two-thirds (67%) correctly indicated that it is transmitted through the air when coughing. A substantial proportion of women had been exposed to TB either from a family member who has had TB (9%) or from frequent contact with someone else who has had TB (12%).

- Only three-quarters (75%) of women were aware that TB can be completely cured. When asked the most appropriate treatment for TB-infected people, the vast majority (82%) said they should be hospitalized, 14% said they should be hospitalized initially and then treated at home, and 2% said they should be treated entirely at home.

- Across all age groups, reports of ever, current, and past smoking were low with only 8% of women having ever smoked, 6% being current smokers and 2% past smokers. These figures were higher in urban areas than in rural areas. For example, 9% of urban women reported being current smokers (13% of Tbilisi women), compared to only 2% of rural women.

- Although the majority of women surveyed did not smoke, one in two reported high levels of current (in the past 30 days) secondhand smoke (SHS), both at home and at work. The level of SHS in the home was high, reported by 52% of all women aged 15–44 and by 50% of non-smokers. Among women

working indoors, 44% were exposed to SHS, including 40% of non-smokers.

- On average, 31% of women have ever drunk alcohol and 17% were current drinkers, but only 2% were current frequent drinkers. Eight percent of women reported binge drinking (5 or more drinks on one occasion) in the three months preceding the survey.

Young Adult Behaviors

- Nearly a third of young women (aged 15–24 years) in Georgia reported sexual experience (32%); of those, the overwhelming majority (31%) reported sexual initiation after marriage.

- One of the most noticeable differences in age at first intercourse is across education levels; over half of women who had secondary education or less had engaged in sexual activity prior to age 22, whereas only 39% of young women with university or technical education had done so. Age at marriage helps explain this.

- Among young women who had their first sexual intercourse before age of 18, more than half had partners who were 5 or more years older.

- Contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status. The primary reasons given for not using a contraceptive method at first intercourse were wanting to get pregnant (67%) and not thinking about using a method (24%).

Domestic Violence

- There are new legal regulations and increased efforts to raise awareness on domestic violence. In 2010 women's reports of violence by an intimate partner were quite low: few women reported experience of physical and sexual abuse, either during the last 12 months (2%) or during lifetime (7%). These percentages remained relatively unchanged since 1999. Moreover, the patterns of formal reports of abuse to the authorities did not change significantly.

- Physical abuse by an intimate partner occurred in all subgroups regardless of socioeconomic and educational backgrounds, and was the highest (23%) among previously married women. Higher prevalence of recent physical violence was reported by young women aged 15 to 19 years compared to older women.

- Domestic violence has consequences for children too. On average, 8% of all respondents reported having heard or seen abuse between their parents, and 8% reported that they had experienced parental physical abuse. Witnessing or experiencing domestic abuse as a child increases the likelihood of becoming a victim of intimate partner violence as an adult: among women who had experienced parental abuse, the

prevalence of recent psychological abuse was three times as high and prevalence of physical abuse twice as high as among those who had not experienced parental abuse.

- Living in households with low gender equity was associated with a higher risk of any type of domestic violence.
- Among women who had ever experienced physical abuse, about one in three (29%) had not disclosed their experience to anyone. Those who disclosed the abuse had primarily discussed it with a

family member or friend; only 5% reported the abuse to the police; 3% sought medical help; and 2% sought legal counsel.

- Overall, almost 20% of ever-married women agreed with at least one circumstance in which they consider wife-beating justifiable. This percentage was greater among women who reported lifetime physical or sexual abuse compared to those who had never been abused, suggesting that lack of empowerment may leave women more vulnerable to physical or sexual intimate partner violence.

TABLE OF CONTENT

PREFACE	<i>iii</i>
ACKNOWLEDGEMENTS	<i>v</i>
EXECUTIVE SUMMURY	<i>vii</i>
CHAPTER 1. INTRODUCTION	1
1.1 Background	1
1.2 Objectives	3
CHAPTER 2. METHODOLOGY	5
2.1 Sampling Design	6
2.2 Questionnaire Content	7
2.3 Data Collection	7
2.4 Response Rates	8
2.5 Quality Control Measures	8
2.6 Sampling Weight	9
2.7 Comparison with Official Statistics	9
CHAPTER 3. CHARACTERISTICS OF THE SAMPLE	11
3.1 Household Characteristics	12
3.2 Characteristics of the Respondents	17
3.3 School Entries and Attendance Ratios	19
CHAPTER 4. FERTILITY AND PREGNANCY EXPERIENCE	37
4.1 Fertility Levels and Trends	37
4.2 Fertility Differentials	40
4.3 Nuptiality	41
4.4 Age at First Intercourse, Union and Birth	43
4.5 Recent Sexual Activity	45
4.6 Planning Status of the Last Pregnancy	45
4.7 Future Fertility Preferences	47
4.8 Infertility Problems	49
CHAPTER 5. INDUCED ABORTION	61
5.1 Abortion Levels and Trends	62
5.2 Induced Abortion Differentials.....	66

5.3 Abortion Services	67
5.4 Abortion Complications	72
5.5 Reasons for Abortion	73
CHAPTER 6. MATERNAL AND CHILD HEALTH	87
6.1 Maternal Mortality Statistics	87
6.2 Prenatal Care	88
6.3 Intrapartum Care	95
6.4 Postpartum Care	97
6.5 Smoking and Drinking During Pregnancy	99
6.6 Pregnancy and Postpartum Complications	100
6.7 Poor Birth Outcomes	100
6.8 Breastfeeding	101
6.9 Infant and Child Mortality	102
CHAPTER 7. CONTRACEPTIVE KNOWLEDGE	125
7.1 Contraceptive Awareness and Knowledge of Use	125
7.2 Most Important Source of Information about Contraception	129
7.3 Knowledge about Contraceptive Effectiveness	130
CHAPTER 8. CONTRACEPTIVE USE	139
8.1 Ever Use of Contraceptives	139
8.2 Current Use of Contraceptives	141
8.3 Source of Contraception	146
8.4 Desire to Use a Different Contraceptive Method	148
8.5 Users of Traditional Methods	148
8.6 Reasons for not Using Contraception	150
8.7 Intention to Use Contraceptives Among Non-users	150
CHAPTER 9. NEED FOR CONTRACEPTIVE SERVICES	169
9.1 Potential Demand and Unmet Need for Contraception	170
9.2 Potential Demand for Family Planning by Fertility Preferences	170
CHAPTER 10. CONTRACEPTIVE COUNSELING	177
10.1 Client-Provider Communications Regarding Family Planning	177
10.2 Satisfaction with Counseling Services	180
10.3 Postabortion and Postpartum Counseling	181

CHAPTER 11. OPINIONS ABOUT CONTRACEPTION	187
11.1 Opinions on Method Effectiveness	187
11.2 Opinions on Advantages and Disadvantages of the Bill and the IUD	189
11.3 Opinions on the Risks of Contraceptive Use	190
11.4 Desire for More Information on Contraceptive Methods	191
 CHAPTER 12. REPRODUCTIVE HEALTH KNOWLEDGE AND OPINIONS	 205
12.1 Ideal Family Size	205
12.2 Knowledge of the Menstrual Cycle	206
12.3 Knowledge of the Contraceptive Effect of Breastfeeding	207
12.4 Opinions on the Acceptability of Abortion	207
12.5 Attitudes and Opinions toward Family and Reproductive Roles	209
 CHAPTER 13. HEALTH BEHAVIOR	 219
13.1 Utilization of Health Care Services	219
13.2 Prevalence of Routine Gynecologic Visits	221
13.3 Breast Cancer Screening	221
13.4 Cervical Cancer Screening and HPV Awareness	223
13.5 Tuberculosis Awareness and Exposure	225
13.6 Cigarette Smoking	226
13.7 Alcohol Use	227
13.8 Prevalence of Selected Health Problems	227
 CHAPTER 14. FAMILY LIFE EDUCATION	 247
14.1 Opinions about Family Life Education at Schools	247
14.2 Discussions about Sex Education. Topics with Parents	249
14.3 Family Life Education at Schools	249
14.4 Sources of Information on Sexual Matters	250
14.5 Impact on Knowledge about Fertility Issues from Exposure at School or with Parents	251
 CHAPTER 15. YOUNG ADULTS SEXUAL AND CONTRACEPTIVE EXPERIENCE	 259
15.1 Sexual Experience	259
15.2 Partner at First Intercourse	260
15.3 Contraceptive Use at First Intercourse, Current Sexual Activity and Contraceptive Use	261
15.4 Opinions and Attitudes about Condoms and Condom Use	262
 CHAPTER 16. SEXUALLY TRANSMITTED INFECTIONS OTHER THAN HIV/AIDS	 273
16.1 STIs in Georgia and Former Soviet Countries	273
16.2 Awareness of STIs	274

16.3 Awareness of Symptoms Associated with STIs	274
16.4 Self-Perceived Risk of Contracting an STI	275
16.5 Self-Reported STI Testing	275
16.6 Self-Reported STI Symptoms	276
16.7 Primary Sources of Information on STIs	278
 CHAPTER 17. HIV/AIDS	 289
17.1 HIV/AIDS in Georgia	289
17.2 Awareness and Correct Knowledge of HIV/AIDS	289
17.3 HIV testing	291
17.4 Sources of Information on HIV/AIDS	293
17.5 Knowledge of HIV transmission	293
17.6 Knowledge of HIV prevention	294
17.7 Self-perceived of HIV/AIDS	295
 CHAPTER 18. DOMESTIC VIOLENCE	 309
18.1 History of Witnessing or Experiencing Parental Physical Abuse	311
18.2 Prevalence of Intimate Partner Violence	312
18.3 Seeking Help for Intimate Partner Violence	312
18.4 Aspects of Intimate Partner Relationships and Gender Norms	313
 ANNEX A: INSTITUTIONAL PARTICIPATION	 322
 ANNEX B: FIELD AND DATA ENTRY PERSONNEL	 324
 REFERENCES	 325

1 CHAPTER

INTRODUCTION

1.1 Background

The status of women's health in Georgia is strongly influenced by cultural, historical, and socioeconomic factors. The old health system placed emphasis on curative rather than preventive services, relied on specialized care and did not maintain adequate primary health care services. Subsequently, family planning services received little support as well.

With the end of the centralized USSR administration and the following economic decline, the costly hospital-based curative system became impossible to maintain. Most hospitals lacked minimal equipment, drugs, and supplies, and could not afford maintenance costs.

In response to the collapse of the publicly-supported hospital-based health system, Georgia's health sector went through several transformation stages. Since 2007 the Government has initiated bold health care reforms to develop an insurance-based health care financing system targeted at the poor population, while increasing the share of public resources allocated to public health interventions.

The 2011-2015 national healthcare strategy "Access to Quality Healthcare" outlined a new plan for healthcare development. The complete replacement of the obsolete hospital infrastructure by modern district healthcare centers that combine primary, pre-hospital, and hospital care services will be fully complete by 2013.

Significant improvements in family planning (FP) and reproductive health (RH) service provision have marked the last few years in Georgia. The Government with the support of international and local non-governmental communities is increasingly supporting staff retraining, education, and infrastructure development to increase access to quality FP and RH services. Public health interventions and government financed services currently include TB, HIV/AIDS, immunization, mother and child health including universal access to antenatal care, and breast and cervical cancer screening services. However challenges still exist to integrate family planning and other reproductive health services in the health insurance schemes.

Family planning activities are currently supported by several donor initiatives, primarily from the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA).

USAID, UNFPA, and other bilateral and multilateral donors have supported the efforts of the Georgian gov-

ernment and local non-governmental organizations to increase access to reproductive health and family planning services. Since the early 1990s, most of the efforts have focused on designing client-centered family planning and reproductive health policies and programs, training physicians and other medical professionals, organizing public information campaigns, and developing a nationwide system for delivery of contraceptive supplies.

USAID has funded several reproductive health initiatives, including the Healthy Women in Georgia (HWG) project (concluded). The HWG project, implemented by the John Snow Research and Training Institute (JSI), primarily focused on evidence-based, women-friendly, and client-focused family planning and reproductive health services. More emphasis was placed on maternity and newborn care by introducing effective perinatal care in 16 maternities. Family planning services were expanded to several hundred service delivery points. The program also supported breast and cervical cancer screening, quality of care in reproductive health, family life education courses, and other initiatives. In 2008-2009, MoLHSA in collaboration with CDC and HWG conducted the first mortality study among women of reproductive age (RAMOS) with USAID support.

Since then, USAID has funded two additional RH programs, also implemented by JSI: SURVIVE (breast and cervical cancer prevention), conducted in 2009–2010, and SUSTAIN, which is currently in progress. SUSTAIN continues to provide FP training for primary health care and family doctors, pediatricians, and OB/Gyns, and supports the implementation of EPC principles through EPC training for multidisciplinary teams.

UNFPA has provided Georgia with reproductive health commodities and supplies since 1993, including supplies of modern FP methods, for all regions of Georgia. Building on the results achieved during the previous years, UNFPA's second Country Program, for 2011-15, supports implementation of the ICPD Program of Action and the Georgia National Health Strategy 2011-15, and includes large portfolios of RH activities in three main areas: strengthening RH policies, enhancing the legislative environment, and improving quality of services according to internationally recognized standards. UNFPA also supports the National RH Council (NRHC), initiated and chaired by the First Lady of Georgia since 2006, and in partnership with MoLHSA helps to develop and implement clinical practice guidelines for RH, including EmOC, FP, cervical and breast cancer screening, etc.

UNFPA also supports the integration of RH services at the PHC level through training for PHC providers on

relevant RH services, such as antenatal care, postpartum care, FP, and breast and cervical cancer screening, including practical training on Pap-test methodology.

MOLHSA and the Reproductive Health Council also collaborate with UNICEF and the Sheba Medical Centre of Israel, to strengthen the perinatal/neonatal system in the country. In addition, MOLHSA and the Ministry of Justice in collaboration with UNICEF collaborated to introduce a Parent-Baby Book (Personal Record for Child Health and Development) in 2011. The book provides parents of all newborns in the country with essential knowledge of child health and development in the first six years.

The partnership of UNFPA/Georgia and Municipality of Tbilisi for reproductive tract cancer prevention and early diagnoses, initiated in 2006, was chosen for a "Pearl of Wisdom" award at the European Parliament Cervical Cancer Prevention Summit in 2009. From 2008 to 2012, in Tbilisi, more than 57,000 women benefited from breast cancer screening (clinical examination or mammography) and more than 59,000 women benefited from cervical cancer screening services. The program was subsequently expanded by the MOLHSA/NCDC to all regions of Georgia.

UNFPA has also supported youth reproductive health initiatives, including the introduction of youth-friendly reproductive health services, youth awareness rising on SRH&R through peer education.

Through the government's efforts and the support provided by international donor organizations, Georgia has increased women's access to modern contraceptives and other reproductive health services. However, many challenges remain, particularly to further improve access and quality of services. To help policymakers and program managers assess and respond to current needs, nationwide surveys on reproductive health were conducted in Georgia in 1999, 2005 and 2010. Two major international agencies have primarily supported these surveys: USAID, which funded technical assistance from the US Centers for Disease Control and Prevention's Division of Reproductive Health (CDC/DRH), and UNFPA, which covered costs related to field work, translation, and dissemination seminars. Technical assistance and funding for the 2010 survey was also contributed by the United Nations Children Fund (UNICEF). For all three surveys, CDC/DRH provided technical assistance to the National Centers for Disease Control and Public Health (NCDC) the main implementing agency.

The 1999 Georgia Reproductive Health Survey (GERHS) was the first national representative household survey ever conducted in Georgia and it document-

ed low levels of contraceptive use and high levels of abortion. The second round of GERHS was carried out during the first part of 2005. Similarly, the 2010 GERHS continues to document RH efforts, as well as the trends in the main RH indicators. The 2010 questionnaire incorporated certain indicators from UNICEF's Multiple Indicator Cluster Survey (MICS), specifically related to children's education, water, sanitation, and hygiene issues. The 1999 survey included a supplemental sample of internally displaced women living in nonresidential housing, which was not replicated in the later rounds.

All three surveys used nationally representative samples of women aged 15–44 and were similar in scope, design and content, with multistage probability samples. The selection of primary sampling units in 2005 and 2010 was based on the 2002 Census and allowed for independent regional estimates for the most important reproductive health indicators. However the sampling design in 1999, based on the sampling frame of MICS 1999, did not permit independent estimates for all regions.

The availability of high-quality RHS data has revealed levels of contraceptive use and induced abortion in Georgia with more accuracy than was previously possible. Survey estimates of contraceptive prevalence are more accurate than estimates based on service statistics, which count only women attending facilities that provide family planning services. Survey-based estimates of the number of abortions in Georgia are also higher than official values; however in recent years the official estimates are coming closer to the survey figures, indicating improved reporting.

Two other surveys have augmented the information available for this report. One is the MICS (Multiple Indicator Cluster Survey) of 2010–11, used to add information to Chapter 3. The other is the special survey on domestic violence of 2009 (Chitashvili et al., 2010), used especially in chapter 18.

1.2 Objectives

Periodic household-based probability surveys are the best and most timely way to collect data on a wide assortment of health topics that are essential to determining the health needs of Georgian families and the types of services they should receive. Set within the context of overall social and economic development in Georgia, the aim of the 2010 survey was to obtain national and regional estimates of basic demographic and reproductive health indicators, in order to set targets for improvements, allocate resources, and monitor performance of family planning and maternal and child health programs. The survey interviewed a

sample of 6,292 women aged 15–44 years between October 2010 and February 2011. It was similar in design and content to the 1999 and 2005 surveys as noted above, as well as with surveys conducted in other Eastern European and Central Asian countries.

The GERHS10 was specifically designed to meet the following objectives:

- to assess the current situation in Georgia concerning fertility, abortion, contraception and various other reproductive health issues;
- to enable policy makers, program managers, and researchers to evaluate and improve existing programs and to develop new strategies;
- to document the socio-economic characteristics of households in Georgia and their patterns of access to and utilization of health care services;
- to measure changes in fertility and contraceptive prevalence rates and study factors that affect these changes, such as geographic and socio-demographic factors, breast-feeding patterns, use of induced abortion, and availability of family planning;
- to provide data needed to estimate global development indicators related to education, maternal and child survival, gender equality, and reduction of HIV and other disease transmission;
- to obtain data on knowledge, attitudes, and behavior of young adults 15–24 years of age and assess their exposure to sex education and health promotion programs;
- to identify topics of special interest regarding reproductive health among high risk groups.

By making available appropriate country- and region-specific data on reproductive health and related health services and enhancing the ability of national organizations to collect, analyze, and disseminate such information, the survey has fostered collaboration between the Georgian government, international donors, and other partners. Survey data will be used to monitor RH and maternal and child health programs within the context of Georgian health sector reforms and poverty reduction strategies. The survey will also help to identify linkages among health needs, health services, and health sector reforms. International bilateral and multilateral donors (e.g., USAID, UN agencies, World Bank, and EU) and various government partners, particularly MoLHSA, the Ministry of Economic Development, and Ministry of Finance, can use these data for developing new health strategies and health sector reforms under 'Strategic "10-Point Plan" of the Government of Georgia for Modernization and Employment' and 'National health care strategy - Access to Quality Health Care', as well as for monitoring and evaluating progress toward achieving the UN Millennium Development Goals.

CHAPTER 2

METHODOLOGY

Worldwide, population-based surveys are widely used to complement the routine health information systems. They have the advantage of providing information on a large number of health issues and can track progress of health programs and evaluate their impact for the population as a whole or for specific risk groups. The Reproductive Health Surveys (RHS) were developed by Centers for Disease Control and Prevention (CDC) in response to the need to collect detailed reproductive, maternal, and child health indicators in international settings (Morris, 2000). These surveys draw upon the CDC expertise in family planning and women's health survey methodologies in the United States, combined with its international experience. Beginning in the mid-1990s, several RHS surveys were conducted in Eastern Europe with CDC technical assistance, including three surveys in Georgia.

A major purpose of the RHS is to produce national and sub-national estimates of factors related to pregnancy and fertility, such as sexual activity and contraceptive use, use of abortion and other medical services, and maternal and infant health. The first RHS was conducted in Georgia in 1999; a new cycle was implemented in March-July 2005, followed by the third Georgian RHS (GERHS10), implemented in 2010. As was the case with the first two rounds, the Georgian Ministry of Labor, Health and Social Affairs (MoLHSA) conducted the survey in collaboration with the Georgian National Center for Disease Control. CDC provided technical assistance with the survey design, sampling, questionnaire development, training, data processing, and analysis to all rounds of the RHS in Georgia through funding from the United States Agency for International Development (USAID). All local costs of GERHS10, including the dissemination activities, were supported by the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF).

All RHS in Georgia employed nationally representative, probability samples and collected information on a wide range of health related topics from women of reproductive age. A major function of successive cycles of the survey is to produce comparable time trend data. Thus, the 2005 survey was modeled after the 1999 RHS and the 2010 drew from the experience of the previous rounds and added some new content. The content of all surveys was reviewed by Georgian national experts, government representatives, and researchers from inside and outside governmental organizations, as well as donor agencies. The panel of experts who reviewed the questionnaire and the main findings of GERHS10 is attached.

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

2.1 Sampling Design

Similar to the 1999 and 2005 RHS surveys, the GERHS10 is based on a large representative probability sample (13,363 households) and consists of face-to-face interviews with women of reproductive age at their homes. The population from which the respondents were selected included all females between the ages of 15 and 44 years, regardless of marital status, who were living in households in Georgia during the survey period (excluding the separatist regions of Abkhazia and South Ossetia).

This sample was selected in such a manner as to allow separate urban and rural, as well as regional-level estimates for key population and health indicators, such as fertility, abortion, contraceptive prevalence, maternal and child health, and infant mortality for children under five.

The number of households included in the sample was set to yield approximately 6,000 interviews with women aged 15–44. As in the 2005 RHS, the survey employed a stratified multistage sampling design that used the 2002 Georgia census as the sampling frame (State Department for Statistics, 2003). To better monitor the health issues at a sub-national level and assist

key stakeholders in assessing decentralization efforts, the sample was designed to produce estimates for 11 regions of the country. Census sectors were grouped into 11 strata, corresponding to Georgia's administrative regions; three small regions, Racha-Lechkhumi, Kvemo Svaneti, and Zemo Svaneti were included in one stratum, identified as the Racha-Svaneti stratum. Figure 2.1 compares the distribution of households in the 2002 census with the distribution of households that resulted in the sample.

The first stage involved selection of a sample of primary sampling units (PSUs), which were the same census sectors selected in the 2005 survey. The first stage selection was done with probability of selection proportional to the number of households in each of the 11 regional sectors. A systematic sampling process with a random starting point in each stratum was applied. During the first stage, 310 census sectors were selected as primary sampling units (PSUs), as shown in Table 2.1.

Therefore the overall sample consisted of 310 PSUs, and the target number of completed interviews was an average of 20 completed interviews per PSU. The minimum acceptable number of interviews per stratum was set at 400, so that the minimum number of PSUs per stratum was set at 20. With these criteria, 20 PSUs were allocated to each stratum, which accounted for 220 of the available PSUs. Another 80 PSUs were distributed in the largest regions in order to obtain a distribution of PSUs approximately proportional to the distribution of households in the 2002 census. An additional 10 PSUs were added to the smallest stratum, Racha-Svaneti, to compensate for the considerable sparseness of women of reproductive age in this stratum.

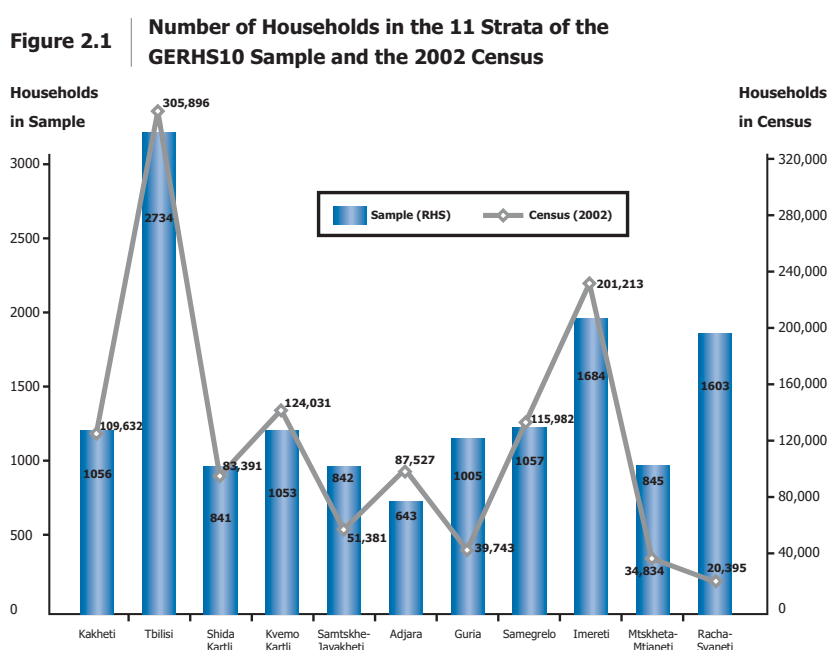


Table 2.1 also compares the distribution of households in the sample with the distribution of households in the 2002 Census by the 11 strata. The sampling fraction ranges from 1 in 13 households in the Racha-Svaneti stratum (the least populated stratum) to 1 in 136 in Adjara. As shown in Table 2.1, if the ratio of households in the census to households in the sample is above 100.0, the region has been under-sampled, whereas if the ratio is less than 100.0, the region has been over-sampled.

In the second stage of sampling, clusters of households were randomly selected from each census sector chosen in the first stage. A listing of each of the selected PSUs had been carried out in preparation for the 2005 survey. The 2010 survey selected households from the updated household listing in each PSU. Determination of cluster size was based on the number of households required to obtain an average of 20 completed interviews per cluster. The total number of households in each cluster took into account estimates of unoccupied households, the average number of women aged 15–44 per household, the rule of interviewing only one respondent per household, and an estimated response rate of 98%. In the case of households with more than one woman between the ages of 15 and 44, one woman was selected at random to be interviewed.

2.2. Questionnaire Content

Similar to the 1999 and 2005 RHS, GERHS10 used two questionnaires to collect information from the households and from eligible respondents: the household questionnaire and the women's questionnaire. Both questionnaires produced in both the Georgian and Russian languages.

The household questionnaire included details on the household's composition, questions about the education attainment of the household members and school readiness and attendance among children and youth, socio-economic characteristics of the household, and questions about the availability and type of social assistance received by household members. These questions were adapted for Georgia's needs using the RHS model household questionnaire and the fourth round of the Multiple Indicator Cluster Surveys (MICS) developed by UNICEF.

As in the previous surveys, the women's questionnaire for GERHS10 was designed to collect information on the following:

- Demographic characteristics
- Fertility and child mortality
- Family planning and reproductive preferences
- Use of reproductive and child health care services

- Range and quality of maternity care services
- Use of preventive and curative health care services
- Reproductive health care expenditures
- Perceptions of health service quality
- Risky health behaviors (smoking and alcohol use)
- Young adult health education and behaviors
- Intimate partner violence
- HIV/AIDS and other STDs

Additionally, a series of questions was asked to assess the awareness and occurrence of tuberculosis and other chronic illnesses, the use of breast cancer screening, and awareness and use of the HPV vaccine. Finally, women were asked a number of questions aimed at assessing their access to preventive and curative health services, their health insurance status, and affordability and costs of health services.

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

2.3 Data Collection

The interviews were performed by 40 female interviewers trained in interview techniques, survey procedures, and questionnaire content. Interviewer training took place at the NCDC headquarters just before data collection began. Interviewer training was conducted mostly in Georgian by a team of trainers. The training team consisted of three consultants from CDC and staff from NCDC. At the end of the training period, eight teams were selected, each consisting of five female interviewers, one supervisor, and two drivers. All interviewers were bilingual (Georgian and Russian). Fieldwork was managed by staff of NCDC, with technical assistance from CDC, and lasted from October 2010 through February 2011. Each team was assigned several primary sampling units and traveled by car throughout the country on planned itineraries. The majority of interviews were conducted in Georgian while approximately 20% were conducted in Russian. Azeri-speaking health professionals facilitated interviews with monolingual Azeri respondents. Completed questionnaires were first reviewed in the field by team supervisors and then taken by the fieldwork coordinators to the NCDC for data processing.

The field unit for GERHS10 consisted of two coordinators who divided the fieldwork assignments among the eight teams of interviewers and supervisors. The field work coordinators and supervisors prepared interviewer assignments and were responsible for monitoring the progress of each interviewer, performing

field observations, conducting in-person verifications of the interviewers' work, and conducting refusal conversion efforts. Field supervisors were also responsible for analyzing each interviewer's weekly production and quality of work, reviewing errors, and serving as the point of contact for the data entry supervisors.

2.4 Response Rates

Of the 13,363 households selected in the household sample, 6,356 included at least one eligible woman (aged 15–44 years). Of these identified respondents, 6,292 women were successfully interviewed, yielding a response rate of 99%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed and were very cooperative. The refusal rates for the household questionnaire and the women's questionnaire were very low (0.2%). Response rates did not vary significantly by geographical location (Table 2.2).

2.5 Quality Control Measures

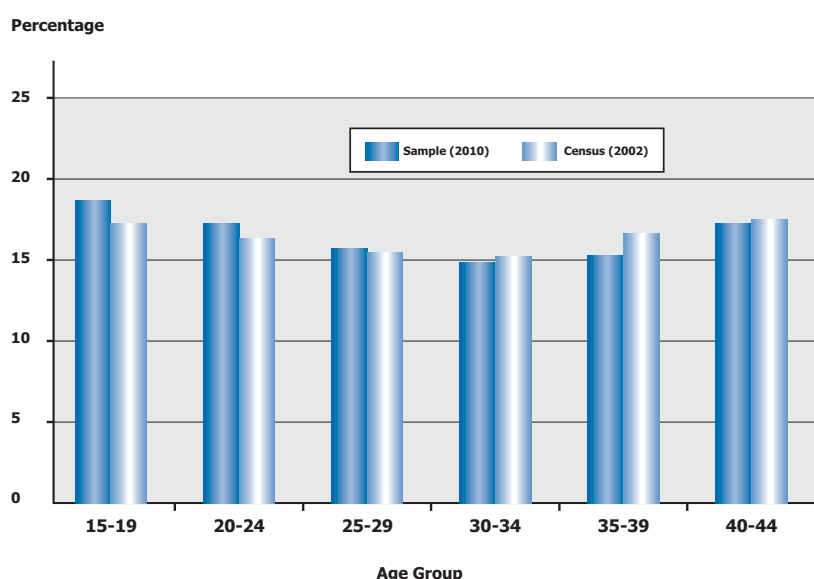
A number of measures were taken to ensure that the data were of the highest possible quality. First, the questionnaire, already refined during the previous RHS rounds in Georgia, was revised carefully and reviewed by a panel of Georgian experts. As a result, the content of the questionnaire was expanded substantially and made more relevant for programmatic needs. The questionnaire was tested extensively, both before and during the pretest and prior to beginning the field work. Testing included practice field interviews and simulated interviews conducted by both CDC and NCDC staff. The questionnaire was translated into Georgian and Russian and back-translated into English.

The training team selected 40 interviewers and 8 supervisors after one week classroom training and another week in the field. The training was very competitive and allowed for selection of the most highly qualified staff from an original pool of 75 trainees. Supervisors were trained to review and edit the questionnaires immediately after each interview; thus, if they noticed errors or omissions the interviewers or the respondents had made, the interviewers could make immediate corrections during short follow-up visits. These edits reduced the item nonresponse rate for most questions to less than 2%. Supervisors and field work coordinators spot-checked the quality of each interviewer's work often and carefully. This process of verifying fieldwork was a critical component of the overall quality control system.

The inclusion of life histories (marital history and pregnancy history) and the five-year month-by-month calendar of pregnancy, contraceptive use, and union status helped respondents accurately recall the dates of one event in relation to the dates of others they had already recorded. Consistency checks between life events were programmed into the data entry software, so that data entry supervisors would notice errors or inconsistencies and could send problematic interviews back to the field for follow-up visits.

The CDC team followed the progress of fieldwork by receiving approximately every two weeks a standard set of quality control tables generated from the most recently collected data. In addition, the team spent four weeks in the field and accompanied all teams for visits in several PSUs. Along with the NCDC team members, the CDC staff observed fieldwork, reviewed progress, and checked the quality of fieldwork.

Figure 2.2 Age Distribution of Women Aged 15–44, 2010 RHS and 2002 Census



2.6 Sampling Weights

The purpose of the RHS is to produce statistical estimates that are nationally representative. National estimates are produced by devising a “sampling weight” for each respondent that adjusts for her probability of selection in the sample. The weights for the RHS were calculated as follows: First, the weight was adjusted to reflect the selection of only one eligible woman from each household containing women of reproductive age. In cases where households included more than one eligible female respondent, the woman who was selected for interview received an additional weight. Second, the weight was adjusted to reflect that women residing in the regions with sparser populations were selected at higher rates (i.e., were over-sampled) relative to those residing in regions with high population density, who were under-sampled. Because the overall response rate (99%) was so high, no weighting was needed to adjust for the survey staff’s inability to locate some eligible women or for nonresponse among those who were located. After the weighted survey population distribution was broken down by five-year age groups and by residence and was compared with the Census estimates, poststratification weights were not deemed to be necessary (see Section 2.7).

Except for Table 2.2, all tables in this report present weighted results, but the unweighted number of cases, used for variance estimation, is shown in each ta-

ble. Generally, tables where percent distributions are shown should add up to 100%, but due to rounding they may add up to either 99.9% or 100.1%.

2.7 Comparison with Official Statistics

The weighted percentage distribution of women selected in the 2010 survey sample by 5-year age groups differs only slightly from the 2009 mid-year official estimates, based on the official census projections (Table 2.3). For the overall distribution by age, the differences were not statistically significant after confidence intervals are taken into account. Unfortunately, the urban/rural distribution of the sample cannot be compared with current official estimates because the official statistics do not project population figures separately for the urban and rural areas. Compared to 2002, both the total and the urban/rural distribution of the sample include fewer women aged 35–39 and 40–44 (Figure 2.2). However, the age composition had changed significantly since 2002 so comparisons need to be made with projected population figures. The official age projections for 2009 for the percentages of women in these age groups are similar to the figures documented by GERHS10 and there was no great variation in age distribution among these women when stratified by urban or rural residence. These findings suggest that the sample distribution of women aged 35–39 and 39–44 by residence would be close to the official projections, if such projections were available.

Table 2.1 Number of Households (HH) in the GERHS10 Sample and the 2002 Census and the Ratio of the Number of Households in the Census to the Number of Households in the Sample, by Region, Reproductive Health Survey: Georgia, 2010

Strata (Regions)	No. of HH in Census	No. of PSUs in Sample	No. of HH Sampled	Ratio of HH-Census to the HH in Sample	No. of Completed Women's Interviews
Kakheti	109,632	25	1056	103.8	498
Tbilisi	305,896	65	2734	111.9	1,426
Shida Kartli	83,391	20	841	99.2	392
Kvemo Kartli	124,031	25	1053	117.8	546
Samtskhe-Javakheti	51,381	20	842	61.0	481
Adjara	87,527	20	643	136.1	419
Guria	39,743	20	1005	39.5	401
Samegrelo	115,982	25	1057	109.7	477
Imereti	201,213	40	1684	119.5	805
Mtskheta-Mtianeti	34,484	20	845	40.8	393
Racha-Svaneti [†]	20,395	30	1603	12.7	454
Total	1,173,675	310	13,363	87.8	6,292

*Source: SDS, 2002 Census Population

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

HH = households; PSU = primary sampling unit

Table 2.2 Results of Household Visits and Interview Status of Eligible Women, by Residence Reproductive Health Survey: Georgia 2010

Households Visits	Total	Residence			Region											
		Tbilisi	Other Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti	
identified eligible woman No eligible women Resident(s) not at home household refusal Unoccupied house Other Total	47.6	52.7	49.5	44.9	47.4	52.7	47.0	52.0	57.5	65.6	40.8	45.5	48.1	47.7	28.7	
	49.0	43.7	48.0	51.4	49.5	43.7	50.2	44.8	40.1	30.9	59.0	53.8	48.9	49.5	62.2	
	0.1	0.5	0.0	0.1	0.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	
	0.2	0.9	0.1	0.1	0.0	0.9	0.0	0.4	0.2	0.0	0.0	0.0	0.0	0.1	0.1	
	3.0	1.9	2.4	3.6	2.8	1.9	2.9	2.8	2.0	3.4	0.2	0.7	3.0	2.4	9.0	
	0.1	0.3	0.1	0.0	0.0	0.3	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0	
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
	13,363	2,734	3,152	7,477	1,056	2,734	841	1,053	842	643	1,005	1,057	1,684	845	1,603	
No. of Households Visited																
	Eligible Women															
		Completed interviews	98.9	99.4	98.9	99.4	98.9	99.2	99.6	99.4	99.3	97.8	99.2	99.4	97.5	98.7
		Selected respondents not at home	0.1	0.3	0.1	0.1	0.0	0.3	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.0
		Selected respondent refused	0.2	0.3	0.1	0.1	0.6	0.3	0.0	0.0	0.0	0.2	0.2	0.0	0.2	0.0
		Selected respondent is not competent	0.7	0.4	0.5	0.9	0.0	0.4	0.4	0.6	0.7	1.2	0.6	0.6	2.2	1.3
		incomplete interview	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Eligible Women Identified	6,356	1,442	1,559	3,355	501	1,442	395	548	484	422	410	481	810	403	460	
No. of Completed interviews	6,292	1,426	1,549	3,317	498	1,426	392	546	481	419	401	477	805	393	454	

Table 2.3 Women with Complete Interviews Compared with Official Estimates by Residence, by Age Group. Reproductive Health Survey: Georgia 2010

Age Group	GERHS10 ($\pm 95\%$ Confidence Interval)			2009 Official Estimates (mid-year) [*]		2002 Official Estimates [†]		
	Total	Urban	Rural	Total		Total	Urban	Rural
15–19	17.9 (1.3)	17.4 (1.3)	18.6 (1.3)	17.2		17.6	16.7	18.8
20–24	18.9 (1.4)	19.7 (1.4)	18.0 (1.3)	18.1		16.4	16.2	16.7
25–29	16.6 (1.3)	16.3 (1.3)	17.0 (1.3)	17.0		15.8	15.9	15.8
30–34	16.3 (1.3)	16.7 (1.3)	15.9 (1.3)	16.1		15.5	15.6	15.3
35–39	15.8 (1.3)	15.6 (1.3)	16.1 (1.3)	15.8		17.0	17.4	16.6
40–44	14.4 (1.4)	14.3 (1.3)	14.5 (1.4)	15.8		17.7	18.3	16.8
Total	100.0	100.0	100.0	100.0		100.0	100.0	100.0

* SDS, 2011: Mid-year population according to age and sex groups, Georgia, 2008 – 2009

† SDS, 2003: Population of Georgia in 2002.

3 CHAPTER

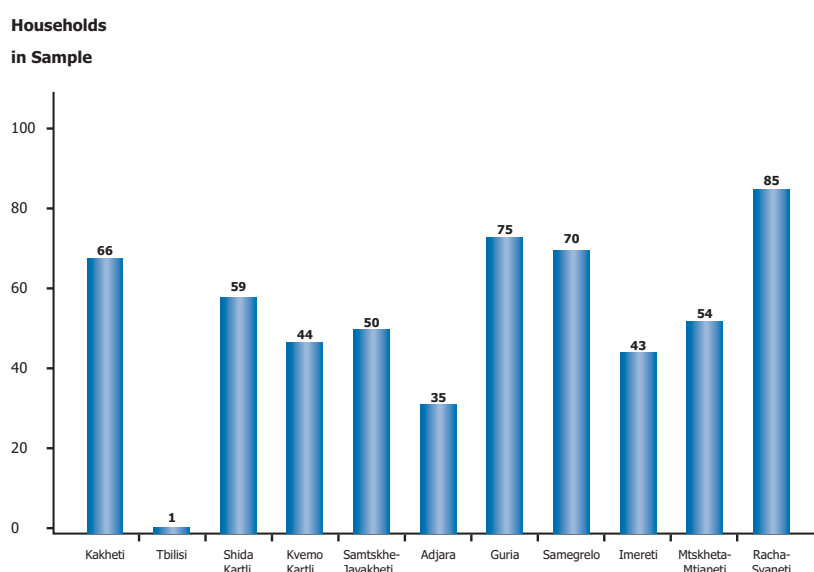
CHARACTERISTICS OF THE SAMPLE

The survey documents a wide array of key reproductive health outcomes and their determinants for women of reproductive age. To better understand these outcomes, Chapter 3 presents the main characteristics of the survey respondents that will be used throughout the report. Geographic key variables are area of residence, meaning either urban and rural or else Tbilisi, other urban area, and rural area; as well as region of residence (11 regions). Key demographic variables are the age at the time of the interview, which is grouped by five years (or by ten years in some tables in other chapters), and current marital/union relationship status. The latter consists of 4 types: two formal union relationships (legal marriage and common-law union), one previous union relationship (widowed, divorced and separated women), and women who have never been married.

Socioeconomic variables include education and the wealth status of the household. Education is categorized into secondary incomplete or less (roughly corresponding to 0–10 years of education), secondary complete (11–12 years of education), postsecondary technical education (high vocational education), and postsecondary academic education. The wealth status is based on household assets, including durable goods (refrigerator, television, car, computer, etc.) and dwelling characteristics (type of source for drinking water, toilet facilities, fuel used for cooking and heating, main roof material, and the household's crowdedness). To construct the index, each household asset was assigned a weight or a factor score generated through principal component analysis. The resulting asset scores were standardized to have a standard normal distribution with a mean of zero and a standard deviation of one (Gwatkin et al., 2000). Each household was assigned a standardized score reflecting its existing set of assets and possessions; overall scores were generated by summing the standardized asset-specific scores. Next, the sample of households was divided into five equal-sized groups or quintiles based on a weighted frequency distribution of households by the resulting asset score. The households with the lowest 20% of the total asset scores are classified as quintile 1, the lowest wealth quintile, and the next 20% are classified as quintile 2 or the second wealth quintile, etc. Each respondent was ranked according to the wealth quintile of the household in which she resided.

Thus, the wealth index measures the standard of living of a household relative to other households, indicating that respondents living in households with a higher wealth quintile have a better socioeconomic

Figure 3.1.1 Percentage of Households in the Lowest Two Wealth Quintiles by Region



status (SES) than those with a lower wealth quintile. Table 3.1.1 shows the distribution of the Georgian population by wealth quintiles, according to urban-rural residence and region. The distribution indicates the degree to which wealth is distributed in geographic areas. Almost three in four (74%) urban households were classified in the two highest wealth quintiles while only 3% of rural households were in those wealth groups. Looking at regional variation, Tbilisi has the largest proportion of households in the two highest wealth quintiles (91%). In Figure 3.1.1 Racha-Svaneti, Guria, and Samegrelo have the largest proportions of households in the two lowest wealth quintiles (85%, 75%, and 70%, respectively).

It is also worth mentioning that previous RHS surveys in Georgia did not use the wealth index to characterize the SES of the households. Previous surveys used a socioeconomic index based on equal values assigned for possession of household amenities and goods. The resulting scores ranged from 0–9 or 0–10, where 0 represented the lower end (i.e. no score-related amenities or goods in the household) and 9 or 10 represented the higher end (all items present in the household). The score was further divided into terciles to create three levels of the SES of the household. To facilitate comparisons of reproductive health indicators by the SES of the respondents interviewed in the 2010 survey with the results collected in previous surveys, the wealth index created in GERHS10 is also used to create a distribution of households by terciles. The wealth terciles are based on the principal component analysis and classify the households in the sample as being in the lowest 33% of the total asset score, the middle 33%, and the highest 33%. Thus, the trend comparison of indicators by socioeconomic status should be interpreted with caution, since a slightly

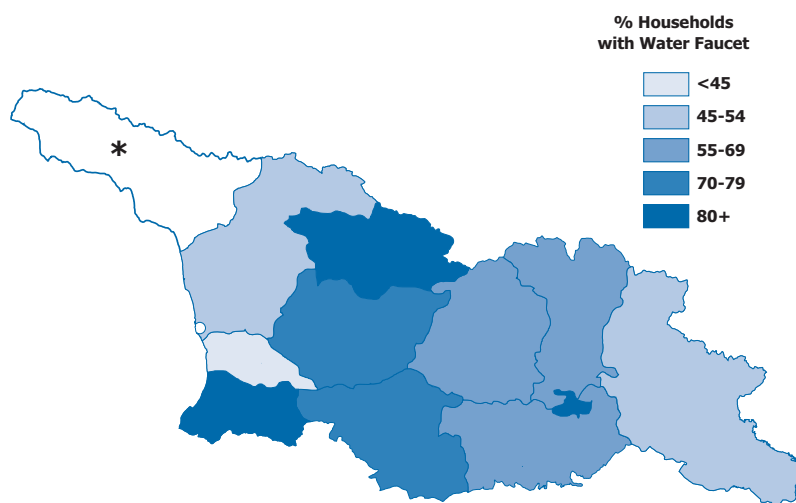
different methodology for assessing the SES was employed in the analyses of the 2010 survey.

3.1 Household Characteristics

Socio-economic well-being is an important determinant of reproductive health status. In order to assess the socio-economic conditions of respondents GERHS10 collected information on the availability of basic services (such as electricity supply, source of drinking water, type of toilet facilities, energy used for cooking, type of heating system, and roof material) and various goods and amenities (e.g. T.V., telephone, refrigerator, working automobile, satellite dish, computer, VCR/DVD, etc.) in respondents' households.

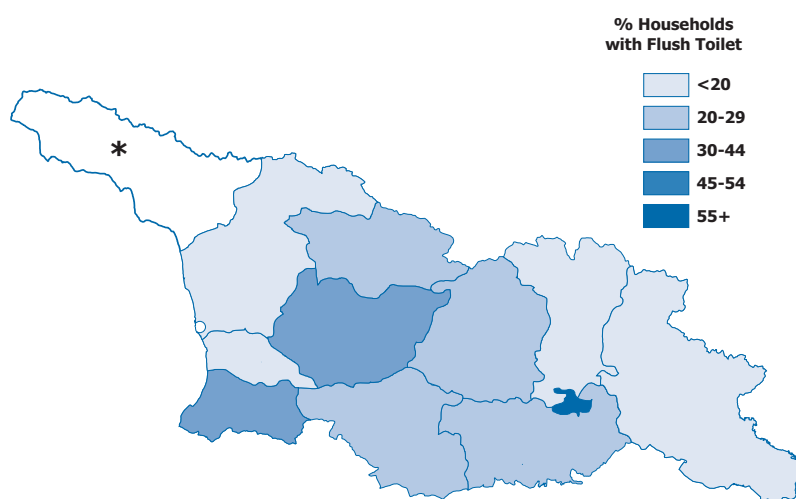
The source of drinking water for 76% of households is piped water either into the dwelling, compound, yard, or plot (Table 3.1.2). About 15% of households obtain their drinking water from wells and only for 3% of respondents the source of water is spring. Piped water is more common in urban areas (96%) than in rural areas (55%). The availability of piped water increases according to wealth index from 45% in lowest wealth quartile to almost 100% in highest wealth quartile (Table 3.1.3). Piped water is available in more than 80% of households in the Tbilisi, Adjara and Racha-Svaneti regions (Figure 3.1.2). Piped water is also the main source of drinking water in most other regions except Guria and Samegrelo regions, where most households obtain water from wells. Public taps are the second most important source of drinking water in Kakheti and Kvemo Kartli regions (Table 3.1.2). Overall 93 percent of households - 98 per cent of urban and 88 per cent of rural households in Georgia use an improved source of drinking water (water from unprotected wells or unprotected springs being considered as un-

Figure 3.1.2 | Percentage of Households with Piped Water, by Region



* Abkhazia: Autonomous region not under government control

Figure 3.1.3 | Percentage of Households with Flush Toilet, by Region



* Abkhazia: Autonomous region not under government control

safe). The lowest percentage for improved sources of water is in Samegrelo (69%). (Table 3.1.4).

Note: Tables 3.1.4 through 3.1.7 are tabulated using data from the household questionnaires, which include MICS indicators, as do Tables 3.3.1 through 3.3.6. The MICS Indicator Number for each topic appears below each table. (MICS: Multiple Indicator Cluster Survey, developed by UNICEF.)

Table 3.1.5 shows that for 76% of households the drinking water source is on the premises. For 20% of households, it takes less than 30 minutes to get to the water source and bring water, while 4% of households spend 30 minutes or more.

In 2010 almost all of the households were supplied with electricity for 24-hours per day and there were

only slight differences among the regions (Table 3.1.2). There was a dramatic increase in the availability of uninterrupted electrical power supply between 2005 and 2010 surveys, from 37% to 96% in 2010.

As shown in Table 3.1.2, 48% of households have flush toilets, while 50% have pit latrines. The presence of flush toilets at households differs dramatically between urban (84%) and rural (9%) regions. The highest prevalence of flush toilets was reported in Tbilisi (96%) and the lowest in Kakheti and Racha-Svaneti regions (8%) (Figure 3.1.3).

In Table 3.1.6 the pit latrine is the main toilet facility at households in most of the regions except Tbilisi and Adjara. Overall, 84 percent of households use some type of improved sanitation facility (sum of 7 types in Table 3.1.6). By residence this is 96% of urban house-

holds and 71% of rural households. Residents of Samtskhe-Javakheti are less likely than others to use improved sanitation facilities (53%). In rural areas the population is mostly using pit latrines with or without slabs (59% and 24% respectively, and pit latrines without slab are considered as unimproved), while in urban areas the most common facilities are flush toilets with connection to a sewerage system (82%).

Table 3.1.7 (last column) shows that 79% of the whole population use both improved water and sanitation facilities. A sharp gradient exists across the wealth quintiles, from 56% to 99% for this item.

Table 3.1.2, discussed above, indicates that the main source of energy used for cooking in households is natural gas (45%) followed by coal or wood (40%). Electricity is used only in about 4% of households for cooking. Natural gas is the main source of energy for cooking in urban households (74%), while most of the rural households (70%) use coal or wood for cooking. The use of natural gas is highest in Tbilisi (90%) and the lowest in Racha-Svaneti region (2%).

Nearly two thirds of households are heated with stoves (66%), followed by individual room heating (29%) with different kinds of space heaters. Central heating is used in only 1.4% of all households, reported mostly in Tbilisi. In 2% of households there was no heating available, more common in urban than in rural households.

Corrugated iron is the most common material used for roofing (36%), followed by sheet metal (33%) and tile or concrete (26%). Corrugated iron is mainly used in rural regions, while tile or concrete is more common in urban areas. The highest prevalence of households

roofed with corrugated iron is in the Guria region (70%), while roofing with tile or concrete predominates in Tbilisi (62%).

In summary, urban households are more likely to have piped water, a flush toilet, central heating, and natural gas for cooking. There is no difference in 24-hour electric power supply between urban and rural residence, as it is available for almost all households in both urban and rural places (Figure 3.1.4). The only dwelling characteristic that is more favorable for rural households is the number of rooms per person. Rural dwellings have more rooms per person and are less crowded than urban dwellings.

As shown in Table 3.1.8, television is the most common amenity/good found in 97% of Georgian households, with very little difference between urban and rural households. The availability of all other household amenities and goods is higher in urban than in rural places (Figure 3.1.5). Refrigerators and cellular telephones (one at least) are present in more than two thirds of all households (79% and 75% respectively). Land-line telephones were reported by more than half of respondents (56%) It should be noted that the urban/rural gap is very large for having a land-line telephone (73% vs. 38%), but it narrows significantly for ownership of cellular phones. While the percentage of urban households with cell telephones is 82%, a substantial proportion of rural households (67%) also have them. The proportion of households with at least one cell telephone ranges from a low 57% in Racha-Svaneti to a high 86% in Tbilisi (Figure 3.1.6).

Overall, 25% of households have a functioning automobile, and the ownership rates are highest in the Tbilisi and Samtskhe-Javakheti regions (31%) and the

Figure 3.1.4 Availability of Basic Services in the Household by Residence

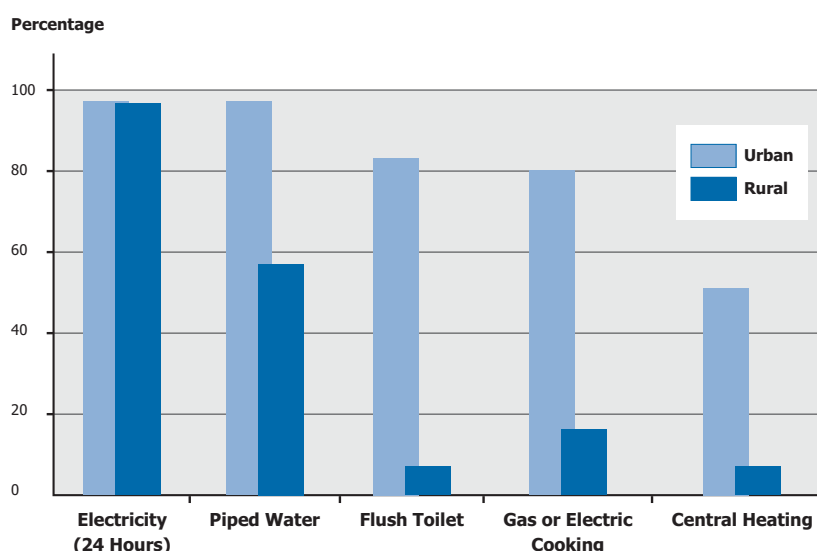


Figure 3.1.5 Availability of Household Goods by Residence

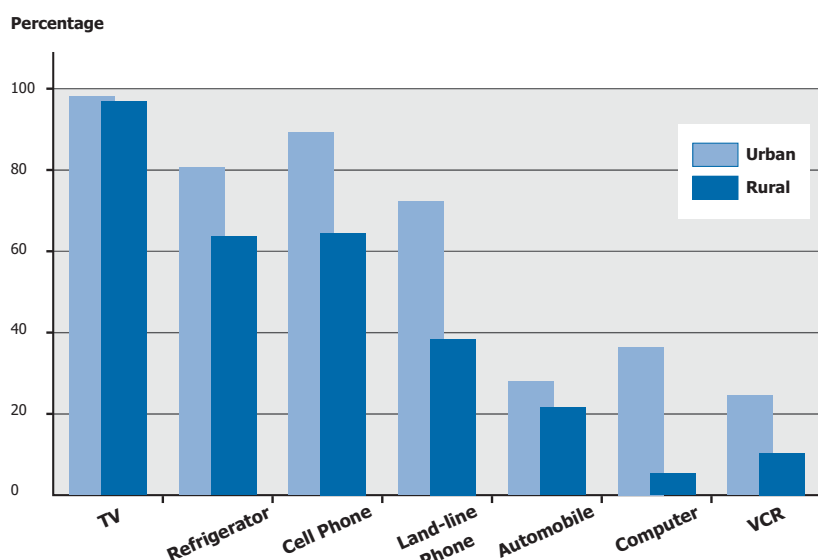
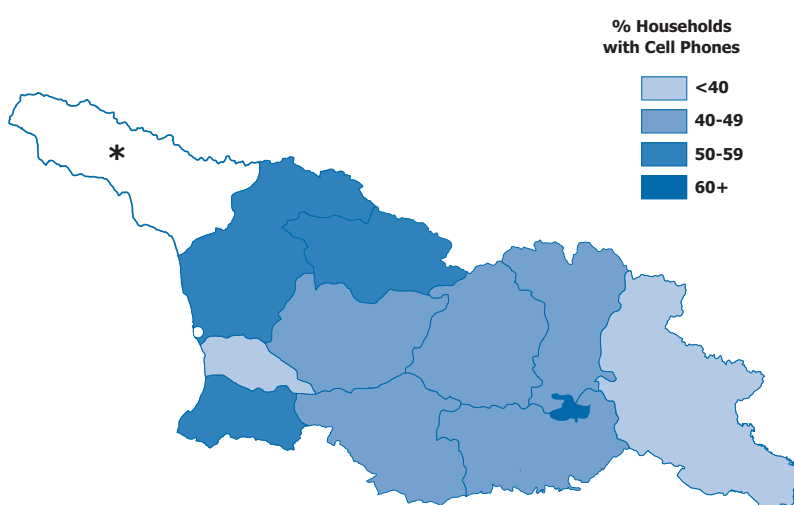


Figure 3.1.6 Percentage of Households with Cell phones, by Region



* Abkhazia: Autonomous region not under government control

lowest in Racha-Svaneti (13%). Computers and internet are present in about 20% of all households, but this varies greatly by residence. Computers exist in 35% of urban but only 6% of rural households. Similarly, 34% of urban households and only 4% of rural households have internet supply (Table 3.1.3).

Overall, one in five households has a satellite dish, but in this case it is more common in rural (29%) than in urban (14%) areas. Having a VCR/DVD was reported by 19% of all respondents, more in urban (26%) than in rural (11%) households. Air conditioners exist in only 4% of all households, mainly in urban areas. A vacation home (villa) is owned by 7% of respondents, with a great difference between urban and rural residents (12% and 1.2% respectively). The availability of all household amenities and goods is generally higher

in urban than in rural areas, except for TV sets, which are found in virtually all urban and rural households (Figure 3.1.5).

Figure 3.1.7 shows changes over 11 years in selected basic services in the households. While the availability of flush toilets has remained basically unchanged, the availability of electricity 24 hours per day has increased more than 10 times, from 9% in 1999 to 96% in 2010. More households now have land-line telephone service (56% vs. 36%) and 10 times more households have central heating. Changes in the availability of household goods are shown in Figure 3.1.8. The only substantial increase has been in ownership of cell telephones, from less than 10% in 1999 to almost 75% in 2010. In contrast, during these 11 years, the percentage of households with a villa declined sig-

Figure 3.1.7 Changes in Availability of Basic Services in the Household: GERHS 1999, 2005, and 2010

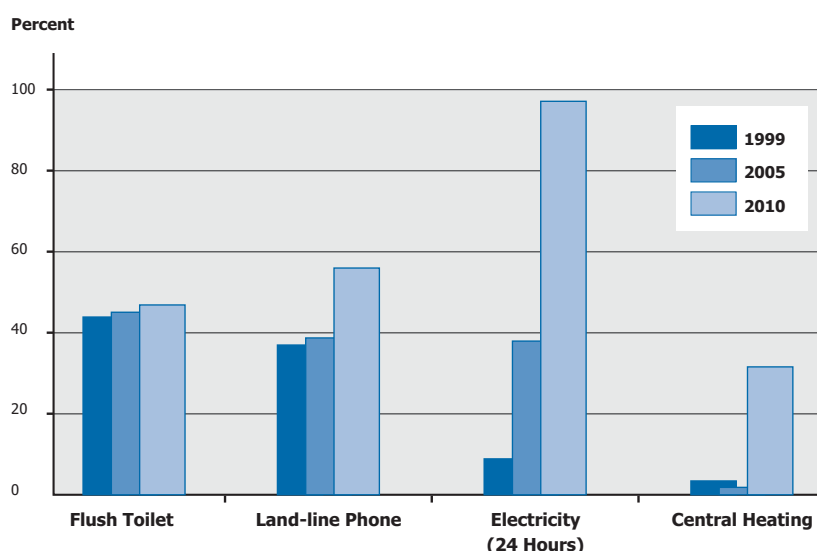
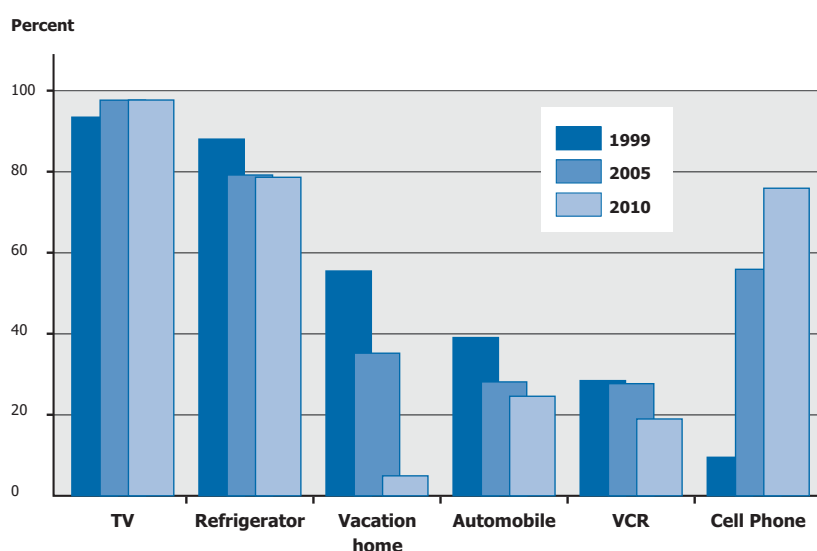


Figure 3.1.8 Changes in Ownership of Goods in the Household: GERHS 1999, 2005, and 2010



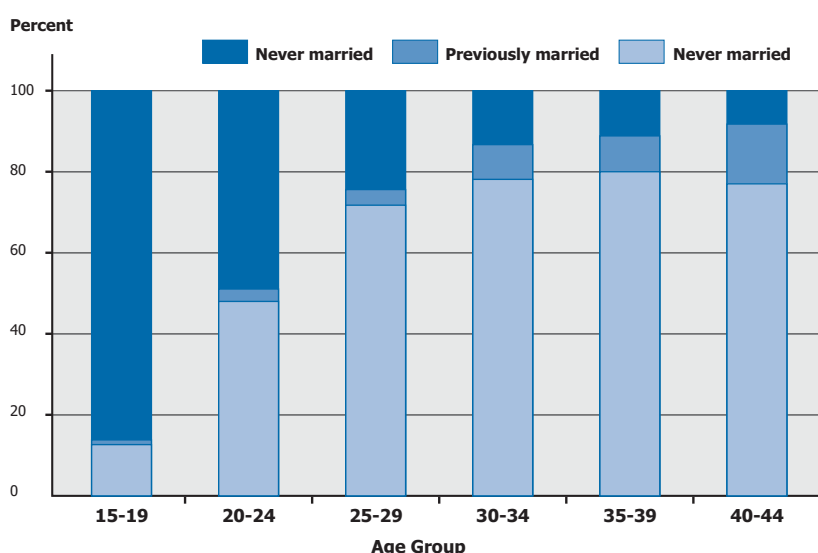
nificantly, and ownership of a refrigerator or a functioning automobile decreased slightly.

Table 3.1.3, discussed above, presents the proportion of households with selected characteristics (i.e. availability of basic services, amenities and goods) within each of the five wealth quintiles. As expected, the proportion of households with each specific characteristic increases as wealth quintile increases, with the exception of having uncrowded living conditions and a satellite dish. The proportion of uncrowded living conditions is best in the lowest two wealth quintiles and worsens considerably in the highest quintiles. Presence of a satellite dish is highest in the middle wealth quintile (31%) and lowest in the highest (16%) quintile. It should be noted that there is very little difference in the availability of 24-hour electricity supply and TV

sets among the various wealth quintiles. On the other hand, a dramatic variation appears in the availability of flush toilets, ranging from 0% in the lowest wealth quintile to 100% in the highest wealth quintile. Very large differences also exist in the availability of several other household characteristics, such as energy used for cooking, type of heating system, computer and internet across wealth quintiles.

The proportion of respondents living in a privately owned flat or house increased between 2005 and 2010 RHS from 85% to 93%, with the highest rate in Kakheti region (99%) and the lowest in Tbilisi (84%). Living in a rental space and living with immediate family is more common in urban than in rural areas and the highest proportion is observed in Tbilisi (12% and 3% respectively). The proportion of respondents liv-

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



ing with their immediate family decreased since 2005 and constitutes only about 2% of all respondents (see Table 3.1.9 for the 2010 data).

A typical household in the 2010 survey has on average 3.8 rooms, excluding the kitchen and bathroom. Rural households have more rooms than urban households do (4.6 vs. 3.0). Respondents living in the Kakheti region report the highest average number of rooms (5.2), followed by Guria, Samegrelo and Imereti regions with averages of 4.5 each. The lowest average number of rooms is reported by respondents living in Tbilisi (2.5) (Table 3.1.10).

On average there are 3.3 persons per household, more in rural (3.5%) than in urban (3.2%) areas. The average household size is lowest in Racha-Svaneti region (2.8 persons) and highest in Adjara and Samtskhe-Javakheti regions (3.9 and 3.8 persons, respectively). Headship was owned by males in 67% of all households. Household headship by males slightly predominates in rural than in urban areas (71% vs. 64%). The highest prevalence of male headship in households is reported in Adjara and Guria regions (71%), and the lowest prevalence in Tbilisi (64%) (Table 3.1.11).

Overcrowding in households can be approximately assessed by dividing the average number of persons (Table 3.1.11) by the average number of rooms (Table 3.1.10) in the household. Overall, there is an average 0.8 persons per room, with 1.1 in urban areas and 0.8 in rural areas. In Tbilisi there are on average 1.3 persons per room.

According to self-reported data about the family's material status as collected in the 2010 survey, 67% indicated that they "Can somehow satisfy our needs."

An additional 26% stated that they "Can hardly make ends meet." Only about 7% declared that they "Can easily satisfy our needs;" most of these live in the Adjara region. The proportion of households which "Can hardly make ends meet" is highest in rural areas (35%) and in Guria Region (45%) (Table 3.1.12).

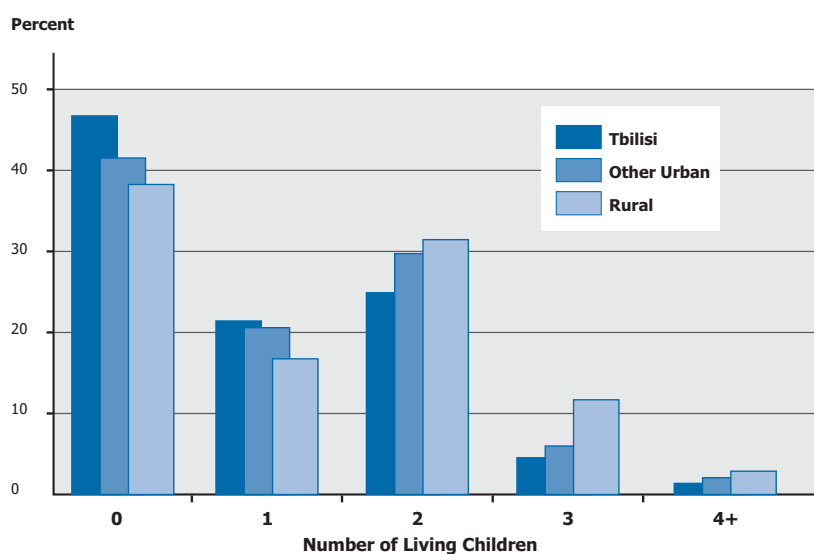
3.2 Characteristics of the Respondents

As shown in Table 3.2.1, the respondent age distribution is fairly uniform, both generally and across place of residence. Overall, 36% of the respondents were young adults (aged 15–24) at the time of interview, a percentage that does not vary significantly by residence.

Nearly 60% of the respondents were legally married or living in a consensual union; the vast majority were legally married (58%). The percentage of respondents who were married or living in a consensual union was much higher in rural areas (64%) than in Tbilisi (52%) or other urban areas (57%). Slightly more than one-third of the respondents have never been married or lived with a partner. In Tbilisi the proportion of women who have never been married is the highest (40%). Seven percent of the respondents stated that they had been previously married and were now either divorced or separated.

Figure 3.2.1 provides additional details on marital status by age groups. The vast majority of women aged 15–19 years have never been married or lived with a partner. Among women 20–24 years of age, one in two (49%) is married or living in a consensual union; by the time women reach 25–29 years of age, 71% are married. The proportion of married respondents continues to increase with age, and by the time women reach 40–44 years of age, 90% have been married.

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



The proportion of women who have previously been married increases from 0.8 % among women aged 15–19 years to 13% among women aged 40–44 years (Table 3.2.2).

Overall, 41% of all respondents aged 15–44 had no living children at time of interview. Percentages were highest among Tbilisi respondents (47%), and lowest among rural respondents (38%). Almost one in five respondents reported having one living child, while 30% reported having two living children, and 10% reported having three or more (Table 3.2.1). As in the 2005 survey, Tbilisi respondents reported having, on average, fewer living children (1.7) than respondents who live in other urban areas (1.8) and in rural areas (2.0) (Figure 3.2.2).

Georgian women are well-educated, as evidenced

by the fact that only 23% have less than a complete secondary education. In general, respondents living in Tbilisi and other urban areas were better educated than those living in rural areas (Figure 3.2.3). For example, as shown in Table 3.2.1, respondents living in Tbilisi were almost three times more likely than rural respondents to have received university training. The regions with the least educated populations are Kvemo Kartli, Samtskhe-Javakheti, Kakheti, and Guria: only 37%–42% of respondents have 12 or more years of education (Figure 3.2.4).

Not surprisingly, respondents living in these regions are the least likely to receive university training and, to a certain degree, technical training. Regarding higher education, the Tbilisi region stands out: 60% of respondents have undergone university training while only 13% have not completed secondary education

Figure 3.2.3 Educational Attainment among Women Aged 15–44, by Residence

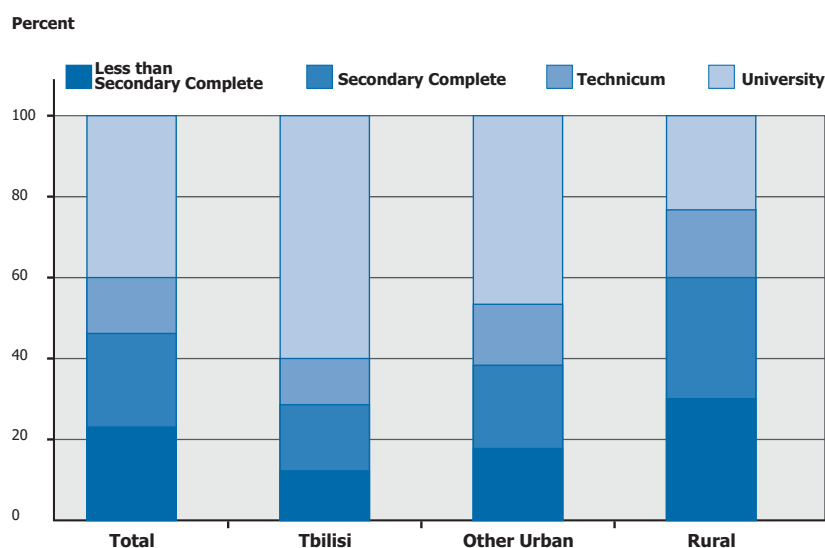
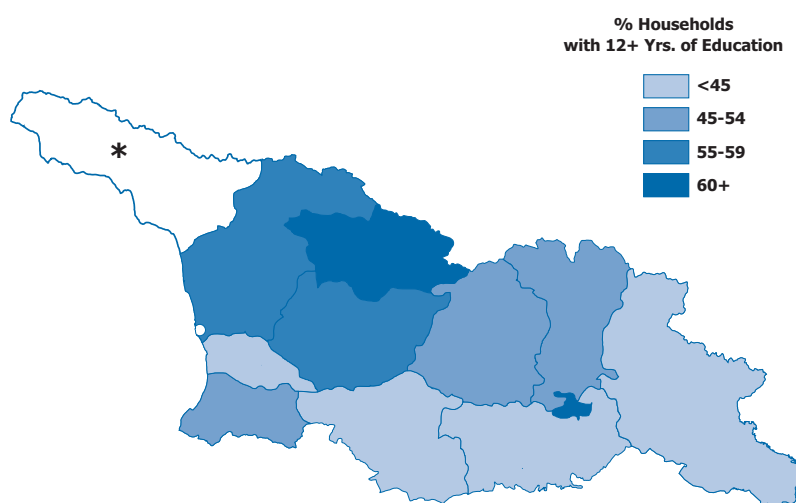


Figure 3.2.4 | Percentage of Women with Post-secondary Education, by Region



(Table 3.2.1). No other region in the country is within 20 percentage points of achieving the same educational attainment rates as Tbilisi. This disparity is likely due to better access to higher education facilities and faculty in Tbilisi.

Slightly more than one-third of the respondents lived in households within the two lowest wealth quintiles, while 21% lived in middle-quintile households, and 44% lived in households within the two highest wealth quintiles. The percentage living in the lowest two quintiles was highest for rural respondents (66%) and lowest for Tbilisi respondents (1%). In contrast, only 5% of rural respondents were classified as living in two highest quintiles, while virtually all respondents living in Tbilisi were classified as living in those quintiles (Table 3.2.1).

Only 21% of the respondents reported working outside of the home at least 20 hours per week. Rural women were less likely to work outside of the home (13%) than women residing in Tbilisi and urban areas (31% and 26%). The vast majority of the respondents reported themselves to be Georgian (87%), while 5% each reported to be of Azeri and Armenian descent. Respondents belonging to minority ethnic groups were more likely to live in rural areas than in urban areas (19% vs. 8%). The dominant religion is Georgian Orthodox (82%); next is the Muslim religion (11%), with 5% belonging to other Orthodox denominations. As shown in Table 3.2.1, the majority of Muslims live in rural areas, where they constitute 18% of the population.

Table 3.2.2 presents additional details on educational attainment for women aged 15-44. Overall, fewer than one in four (23%) Georgian women have

not completed secondary education while 39% are at the university or other postgraduate levels. With the exception of women aged 15–19 years, most of whom presumably are still in school, younger women are somewhat more likely than older women to have a university education. Women aged 40-44 are the most likely to report technical training as their highest education level. In Table 3.2.3 for females aged 6 and older, university and other postgraduate education is more common in urban (45%) than in rural (19%) areas. The highest prevalence of university and postgraduate education is reported in Tbilisi (53%), while the lowest is observed in Guria (15%) region. Educational attainment changes across the wealth quintiles from only 13% of women having higher education in the lowest quintile to 57% of women having university/postgraduate education in the highest quintile.

In Table 3.2.3, for women aged 6 and older, the median years of education completed is 10.8.

Table 3.2.4 summarizes the educational attainments of the male household population over age six. Overall, 25% of men have less than complete secondary education (below 10 years) and 29% have received university or other postgraduate education. The median years of education completed is 10.7, nearly the same as for women. Also, similar to women, the highest percentage of university or other postgraduate education for men is reported in Tbilisi and in the highest wealth quintile, while the lowest percentage is in the Guria region and in the lowest wealth quintile.

3.3. School Entries and Attendance Ratios

The series of six tables, Nos. 3.3.1 to 3.3.6, present additional educational information on school entries

and attendance. These are all from the MICS survey in 2010-11, and the MICS Indicator number appears below each table. They are summarized as follows.

Table 3.3.1 One indicator of interest concerns the movement from preschool to first grade. In Georgia 40% of children in the first grade attended preschool in the previous year.

Table 3.3.2 Among children at the entry age for grade one, 83% enter (84% for boys and 82% for girls, remarkably nearly the same.)

Table 3.3.3 Among all children of primary school age, 96% are attending school (net attendance ratios). That leaves 4% who are out of school when they are

expected to be attending. Slightly below the average were Kakheti and Kvemo Kartli, at 93%.

Table 3.3.4 The overall secondary school attendance ratio is 86%, leaving 14% out of school compared to 4% for primary school children. It is probable that some of the 14% are actually attending primary school.

Table 3.3.5 The transition rate from primary to secondary school is almost 100%, and it is nearly identical for both girls and boys.

Table 3.3.6 The very small difference between the sexes appears in the "gender parity" measure, for both primary and secondary school.

Table 3.1.1 Percentage Distribution of Households by Wealth Quintiles by Residence and Region
Reproductive Health Survey: Georgia, 2010

Characteristic	Wealth Quintile					Total	No. of Cases
	Lowest	Second	Middle	Fourth	Highest		
Total	20.0	20.0	20.2	19.8	20.0	100.0	12,904
Residence							
Urban	3.7	5.0	17.4	35.7	38.1	100.0	5,708
Rural	37.5	36.0	23.1	2.8	0.6	100.0	7,196
Residence							
Tbilisi	0.4	0.6	7.7	35.4	55.8	100.0	2,636
Other Urban	7.1	9.5	27.1	36.0	20.4	100.0	3,072
Rural	37.5	36.0	23.1	2.8	0.6	100.0	7,196
Region							
Kakheti	30.3	35.2	30.0	3.6	1.0	100.0	1,024
Tbilisi	0.4	0.6	7.7	35.4	55.8	100.0	2,636
Shida Kartli	25.9	32.9	27.2	9.8	4.2	100.0	817
Kvemo Kartli	23.3	20.5	23.7	18.4	14.0	100.0	1,020
Samtskhe-Javakheti	20.8	29.6	38.6	8.4	2.7	100.0	822
Adjara	14.0	20.6	25.9	26.6	12.9	100.0	621
Guria	50.4	24.9	17.4	6.0	1.2	100.0	1,003
Samegrelo	41.4	29.0	18.7	8.0	3.0	100.0	1,050
Imereti	19.0	23.9	22.2	22.7	12.2	100.0	1,633
Mtskheta-Mtianeti	24.4	29.1	26.6	14.1	5.8	100.0	821
Racha-Svaneti	57.1	27.8	13.6	1.4	0.1	100.0	1,457

Table 3.1.2 Availability of Basic Services in the Household by Residence and Region Reproductive Health Survey: Georgia, 2010

Characteristic	Total	Residence		Region										
		Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Electricity 24 hours	96.4	96.6	96.2	98.3	97.1	97.7	91.9	99.3	91.8	97.9	97.4	97.6	90.9	98.1
Yes	3.6	3.4	3.8	1.7	2.9	2.3	8.1	0.7	8.2	2.1	2.6	2.4	9.1	1.9
Water	53.3	86.8	17.4	19.4	96.8	30.7	44.8	55.8	63.0	16.7	19.8	49.1	38.2	15.9
Piped water (piped into house)	22.7	9.2	37.2	42.3	2.7	33.7	23.9	34.8	20.8	23.8	25.7	26.0	36.3	68.5
Piped water/public	5.8	0.8	11.2	19.6	0.3	11.6	13.7	7.2	2.9	5.7	2.0	2.1	8.0	7.1
Tube well, borehole	1.2	0.3	2.2	1.6	0.1	1.2	0.5	0.0	1.1	3.0	3.2	1.5	3.3	1.3
Protected well	8.4	1.1	16.2	11.0	0.0	5.8	2.8	0.4	1.1	46.2	19.8	16.0	6.8	1.0
Unprotected well	5.3	1.5	9.2	1.6	0.0	12.2	5.0	0.0	0.2	4.2	29.2	3.2	1.0	1.2
Protected spring	2.0	0.2	4.1	2.6	0.0	2.4	5.0	1.1	7.9	0.3	0.2	1.5	4.8	1.4
Unprotected spring	0.8	0.0	1.7	1.1	0.0	1.5	3.3	0.7	0.8	0.2	0.0	0.6	0.7	3.6
Other	0.4	0.0	0.8	0.8	0.0	0.9	0.9	0.0	2.3	0.0	0.0	0.1	0.9	0.1
Toilet Facilities	45.8	82.9	6.0	7.3	95.3	19.8	38.2	24.8	54.1	14.2	13.8	41.7	25.8	7.0
Flush toilet piped to sewer	2.2	1.3	3.2	6.8	1.1	0.7	2.7	1.9	5.3	0.7	0.5	1.4	5.4	1.4
Flush toilet piped to pit	1.9	0.9	2.9	2.7	0.5	1.6	2.6	2.8	1.3	1.0	4.9	1.3	1.7	3.6
Ventilated improved pit	34.5	11.1	59.6	64.5	2.0	54.8	42.3	26.6	12.7	69.3	67.8	36.6	33.9	58.2
Pit latrine with slab	14.0	3.4	25.3	18.4	1.0	20.9	13.9	38.7	11.4	14.7	13.0	18.7	32.9	29.6
Pit latrine without slab	1.4	0.0	2.9	0.3	0.0	0.0	0.1	4.5	15.1	0.2	0.0	0.2	0.2	0.1
Hanging latrine	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.5	0.0	0.0	0.0	0.0	0.1	0.1
No facility/Bush/Field	0.2	0.4	0.0	0.0	0.1	2.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0
Other														
Energy Used for	3.7	6.3	1.1	0.4	7.5	1.5	2.9	0.6	6.0	1.2	3.3	2.2	3.8	0.2
Electricity	44.8	73.7	13.8	26.2	89.8	29.3	51.8	9.9	26.9	8.1	3.7	43.8	33.0	1.5
Natural gas	39.8	11.5	70.1	57.6	1.1	55.7	36.1	64.7	39.3	81.3	75.5	40.7	54.8	96.2
Coal/Wood	11.6	8.5	15.0	15.8	1.6	13.6	9.2	24.8	27.9	9.5	17.4	13.3	8.4	2.1
Other														
Type of Heating System	1.4	2.6	0.1	0.1	4.1	0.5	0.3	0.4	1.6	0.1	0.1	0.4	0.6	0.1
Central heating	0.8	1.4	0.2	0.2	1.7	0.5	1.0	0.2	1.8	1.2	0.1	0.2	0.5	0.1
Own boiler	28.9	47.5	9.0	5.7	57.1	23.9	24.8	6.1	27.5	8.7	23.2	21.6	17.1	7.5
Individual room heating	66.5	45.0	89.6	93.0	32.7	74.7	71.5	93.1	65.4	89.5	75.5	75.8	80.3	92.1
Stove heating	2.1	3.3	0.8	1.0	4.2	0.5	2.2	0.2	1.9	0.5	1.0	1.7	1.2	0.2
No heating	0.3	0.2	0.3	0.1	0.1	0.0	0.3	0.0	1.8	0.0	0.0	0.4	0.4	0.0
Other														
Main Roof Material	26.5	45.3	6.5	3.1	61.8	8.8	17.2	4.7	18.7	7.1	13.5	22.2	25.3	3.4
Tile or concrete	36.0	19.6	53.6	42.7	6.8	47.1	48.7	58.9	51.7	69.7	49.2	38.5	34.0	23.1
Corrugated iron	33.2	28.3	38.3	52.8	23.7	42.8	27.4	35.4	27.5	22.5	33.7	36.1	36.1	68.9
Sheet metal	2.4	4.5	0.1	0.1	5.2	0.1	5.3	0.0	0.6	0.3	0.9	1.6	1.2	1.0
Asphalt shingles	1.3	1.6	1.1	0.7	2.0	0.9	0.6	0.6	0.6	0.2	2.6	1.0	2.2	2.5
Natural materials	0.5	0.7	0.4	0.6	0.5	0.2	0.9	0.4	0.8	0.2	0.1	0.7	1.2	1.1
Other														
No. of Cases	12,904	5,708	7,196	1,024	2,636	817	1,020	822	621	1,003	1,050	1,633	821	1,457

Table 3.1.3 Availability of Basic Services in the Household by Residence and Wealth Quintile. Reproductive Health Survey: Georgia, 2010

Characteristic	Total	Residence		Wealth Quintile				
		Urban	Rural	Lowest	Second	Middle	Fourth	Highest
Electricity 24 hours	96.4	96.6	96.2	94.6	96.4	97.0	96.0	97.9
Piped water	76.0	96.0	54.6	45.3	57.3	79.1	98.6	99.9
Flush toilet	48.0	84.2	9.3	0.0	2.4	40.6	97.8	100.0
Cooking with electricity or natural gas	48.6	80.0	14.9	0.2	11.8	46.7	87.7	96.9
Central or individual room heating	31.1	51.5	9.3	0.2	8.0	18.8	47.9	81.1
Uncrowded living conditions*	66.5	57.8	75.8	76.1	76.3	73.0	61.4	45.4
T.V.	96.6	97.9	95.1	89.3	98.0	97.8	98.0	99.8
Cellular phone	74.5	81.9	66.5	43.4	74.0	79.2	78.1	97.7
Refrigerator	76.8	89.1	67.9	41.7	76.2	85.2	90.4	96.9
Household phone	56.0	72.5	38.3	15.9	41.3	59.0	70.3	93.7
Working automobile	25.2	28.1	22.0	3.2	25.3	28.9	20.9	47.3
Computer	21.0	35.2	5.8	0.0	1.1	11.7	18.8	73.7
Internet	19.7	34.0	4.4	0.0	0.6	8.8	17.6	71.7
VCR/DVD	18.6	26.0	10.6	0.6	9.3	17.6	19.5	45.8
Satellite dish	21.3	13.9	29.2	17.6	29.0	30.7	13.0	16.1
Vacation home (villa)	6.9	12.2	1.2	0.2	1.0	1.8	4.2	27.3
Air conditioner	3.8	6.9	0.5	0.0	0.1	0.4	1.6	17.2
No. of Cases	12,904	5,708	7,196	3,312	2,815	2,603	2,121	2,053

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

Table 3.1.4 Use of Improved Water Sources

Percent Distribution of Household Population According to Main Source of Drinking Water and Percentage of Household Population Using Improved Drinking Water Sources, Georgia, 2010-2011

Characteristic	Main source of drinking water														Percentage using improved sources of drinking water [1]	Number of household members
	Improved sources							Unimproved sources								
	Piped water (piped into dwelling)	Piped water (piped into compound, yard or plot)	Piped water (piped to neighbor)	Piped water (public tap/standpipe)	Tube well, borehole	Protected well	Protected spring	Bottled water	Unprotected well	Unprotected spring	Tanker trucker	Carts with small tank/drum	Surface water (river, stream, dam, lake, pond, canal, irrigation)	Other		
Region																
Kakheti	19.4	41.1	4.8	15.7	1.7	11.2	2.8	.0	1.4	1.1	.1	.4	.0	.3	100.0	
Tbilisi	96.9	2.7	.2	.1	.1	.0	.0	.0	.0	.0	.0	.0	.0	.0	100.0	
Shida Kartli	30.9	32.4	1.7	9.2	1.7	6.1	2.4	.0	13.5	1.3	.0	.0	.0	.7	100.0	
Kvemo Kartli	42.9	23.7	1.3	13.2	.7	3.5	5.2	.4	4.7	3.6	.1	.5	.1	.0	100.0	
Samtskhe-Javakheti	56.1	33.7	2.4	5.5	.0	.4	1.2	.0	.0	.8	.0	.0	.0	.0	100.0	
Adjara	59.4	22.0	1.1	2.5	1.6	.8	9.1	.0	.1	.8	.0	.0	.0	2.6	100.0	
Guria	16.8	22.9	.8	5.0	3.1	47.0	.2	.0	3.9	.2	.0	.0	.0	.0	100.0	
Samegrelo	18.8	24.9	1.7	.2	3.5	19.9	.3	.0	30.6	.0	.0	.0	.0	69.4	100.0	
Imereti	49.7	25.1	.9	.9	1.9	16.2	1.6	.0	3.0	.6	.0	.0	.0	.0	100.0	
Mtskheta-Mtianeti	39.8	33.8	2.8	4.5	3.7	7.7	4.9	.1	1.2	.9	.0	.5	.1	.0	100.0	
Racha-Svaneti	17.4	67.4	2.5	3.6	.9	1.1	1.1	.0	1.5	4.3	.0	.1	.0	.0	100.0	
Residence																
Urban	86.9	8.9	.4	.3	.3	1.3	.2	.0	1.7	.0	.0	.0	.0	.0	100.0	
Rural	19.2	35.5	2.5	8.8	2.5	15.3	4.4	.1	9.0	1.8	.0	.2	.0	.6	100.0	
Education of Household Head																
None	67.8	15.9	.9	3.2	.9	5.8	1.6	.0	3.0	.5	.0	.1	.0	.3	100.0	
Primary	31.3	31.6	2.5	8.5	1.9	7.9	6.8	.0	5.5	3.7	.0	.2	.0	.0	100.0	
Secondary +	38.6	28.4	1.9	5.8	1.9	11.1	2.7	.1	7.9	1.0	.0	.1	.0	.4	100.0	
Missing/DK	100.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	100.0	
Wealth Index Quintiles																
Lowest	.1	43.3	2.8	8.8	2.0	20.1	5.5	.1	13.1	3.1	.0	.1	.0	.8	100.0	
Second	10.7	43.7	2.2	9.2	2.8	15.5	4.7	.1	8.9	1.6	.1	.1	.1	.6	100.0	
Middle	54.2	23.1	1.9	4.6	2.1	6.8	1.5	.0	5.3	.0	.0	.3	.0	.2	100.0	
Fourth	96.1	2.1	.3	.7	.1	.5	.2	.0	.1	.0	.0	.0	.0	.0	100.0	
Highest	99.9	.1	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	100.0	
Total	52.5	22.4	1.4	4.6	1.4	8.4	2.3	.0	5.4	.9	.0	.1	.0	.3	100.0	
MICS indicator 4.1; MDG indicator 7.8																

[1] MCS indicator 4.1; MDG indicator 7.8

Table 3.1.5
Time to Source of Drinking Water
Percent Distribution of Household Population According to Time to Go to Source of Drinking Water, Get Water, and Return,
for Users of Improved and Unimproved Drinking Water Sources, Georgia, 2010-2011

Characteristic	Time to source of drinking water					Total	No of household members
	Users of improved drinking water sources		Users of unimproved drinking water sources				
	Water on premises	Less than 30 minutes	30 minutes or more	Less than 30 minutes	30 minutes or more		
Region	65.3	28.0	3.4	2.0	1.3	100.0	4,079
Kakheti	99.8	.2	.0	.0	.8	100.0	10,506
Tbilisi	65.0	18.5	1.0	14.8	.0	100.0	3,052
Shida Kartli	68.2	14.2	8.5	6.2	2.9	100.0	4,692
Kvemo Kartli	92.1	5.8	1.2	.8	.0	100.0	2,148
Samtskhe-Javakheti	82.5	6.1	7.8	1.3	2.3	100.0	3,782
Imereti	40.5	51.8	3.6	3.8	.3	100.0	1,419
Adjara	45.4	23.0	1.0	30.2	.4	100.0	4,345
Samegrelo	75.8	18.4	2.2	2.5	1.2	100.0	7,005
Mtskheta-Mtianeti	76.5	17.8	3.0	2.1	.6	100.0	1,241
Racha-Svaneti	87.3	5.9	.8	5.8	.1	100.0	584
Residence	96.1	1.9	.2	1.5	.2	100.0	21,102
Urban	57.3	25.8	5.3	9.9	1.7	100.0	21,751
Rural	57.3	25.8	5.3	9.9	1.7	100.0	21,751
Education of Household Head	84.6	9.7	1.8	3.3	.6	100.0	20,846
None	65.5	18.1	7.0	7.0	2.4	100.0	1,577
Primary	68.9	18.1	3.4	8.3	1.2	100.0	20,424
Secondary +	100.0	.0	.0	.0	.0	100.0	5
Missing/DK	100.0	.0	.0	.0	.0	100.0	5
Wealth Index Quintiles	46.3	30.3	6.1	14.5	2.8	100.0	7,634
Lowest	56.6	26.8	5.2	9.9	1.4	100.0	9,175
Second	79.2	12.6	2.4	5.1	.7	100.0	9,180
Middle	98.5	1.1	.3	.1	.0	100.0	7,621
Fourth	99.9	.1	.0	.0	.0	100.0	9,242
Highest	99.9	.1	.0	.0	.0	100.0	9,242
Total	76.4	14.1	2.8	5.8	1.0	100.0	42,853

Table 3.1.6
Types of Sanitation Facilities
Percent Distribution of Household Population According to Type of Toilet Facility Used by the Household, Georgia, 2010-2011

Characteristic	Type of toilet facility used by household													Number of household members
	Type of toilet facility used by household													
	Improved sanitation facility						Unimproved sanitation facility							
Flush toilet piped to sewer system	Flush toilet piped to septic tank	Flush toilet piped to pit (latrine)	Flush toilet piped unknown place/not sure/dk where	Ventilated improved pit latrine	Pit latrine with slab	Composting toilet	Flush toilet piped to somewhere else	Pit latrine without slab	Bucket	Hanging toilet, hanging latrine	Other	No facility/bushfield	Total	
Region														
Kakheti	5.2	1.4	3.6	1.9	2.0	65.5	.3	2.1	18.0	.0	.0	.0	4,079	
Tbilisi	94.8	.5	.7	.1	.5	2.2	.0	.1	1.0	.0	.0	.1	10,506	
Shida Kartli	18.5	1.1	.6	1.1	1.7	57.0	.0	.1	19.2	.0	.0	1.5	3,052	
Kvemo Kartli	32.9	2.9	2.3	.1	3.1	44.9	.1	.3	13.4	.0	.0	.0	4,692	
Samtskhe-Javakheti	20.9	.4	1.1	.0	3.4	27.6	.0	.9	40.0	.0	.0	.1	2,148	
Adjara	47.9	2.0	1.4	1.9	1.4	12.9	2.0	1.6	12.5	.0	16.3	.0	3,782	
Guria	12.4	1.6	.4	.3	1.0	68.8	.2	.2	15.0	.0	.0	.0	1,419	
Samegrelo	11.3	1.3	.3	.1	5.2	68.0	.0	.0	13.8	.0	.0	.0	4,345	
Imereti	38.2	2.9	.5	.1	1.2	38.2	.4	.9	17.6	.0	.0	.0	7,005	
Mtskheta-Mtianeti	24.7	2.0	4.2	.0	1.7	35.1	.4	.7	31.1	.0	.0	.0	1,241	
Racha-Svaneti	6.0	1.3	1.1	.1	3.0	59.6	.2	.2	28.5	.0	.0	.0	584	
Residence														
Urban	81.9	1.0	.9	.1	.9	11.5	.0	.2	3.2	.0	.0	.3	21,102	
Rural	4.3	2.1	1.6	.7	2.9	58.8	.6	1.0	24.4	.0	3.4	.0	21,751	
Education of Household Head														
None	59.8	1.9	1.0	.3	1.3	25.2	.3	.4	9.2	.0	.5	.1	20,846	
Primary	13.1	2.4	2.0	2.6	1.4	44.4	1.6	.5	21.8	.0	9.9	.2	1,577	
Secondary +	27.2	1.2	1.4	.4	2.6	45.3	.0	.9	18.2	.0	2.3	.0	20,424	
Missing/DK	100.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	5	
Wealth Index Quintiles														
Lowest	.0	.0	.0	.0	2.6	63.8	.9	.0	30.5	.0	1.9	.1	7,634	
Second	.2	.2	.4	.9	2.7	65.1	.3	.3	24.9	.0	4.8	.2	9,175	
Middle	23.0	3.8	3.8	1.0	3.5	45.9	.3	2.1	14.7	.0	1.6	.3	9,180	
Fourth	91.2	3.3	1.6	.2	.6	.0	.0	.6	.3	.0	.0	.1	7,621	
Highest	98.9	.7	.4	.0	.0	.1	.0	.0	.0	.0	.0	.0	9,242	
Total	42.5	1.6	1.3	.4	1.9	35.5	.3	.6	14.0	.0	1.7	.1	42,853	

Table 3.1.7

Drinking Water and Sanitation Ladders

Percentage of Household Population by Drinking Water and Sanitation Ladders, Georgia, 2010-2011

Characteristic	Percentage of household population using:										Number of households
	Improved drinking water [1]		Unimproved drinking water	Total	Improved sanitation [2]	Unimproved sanitation		Total	Improved drinking water sources and improved sanitation		
	Piped into dwelling, plot or yard	Other improved				Unimproved facilities	Open defecation				
Region											
Kakheti	60.5	36.2	3.3	100.0	79.9	20.1	.0	100.0	79.1	4,079	
Ibilisi	99.6	.4	.0	100.0	98.8	1.2	.0	100.0	98.8	10,506	
Shida Kartli	63.3	21.2	15.5	100.0	79.2	20.8	.0	100.0	68.9	3,052	
Kvemo Kartli	66.6	24.3	9.1	100.0	86.2	13.7	.0	100.0	78.2	4,692	
Samtskhe-Javakheti	89.7	9.4	.8	100.0	53.3	46.5	.2	100.0	52.6	2,148	
Ajara	81.4	15.0	3.5	100.0	69.5	30.5	.0	100.0	66.4	3,782	
Guria	39.7	56.3	4.1	100.0	84.8	15.2	.0	100.0	81.0	1,419	
Samegrelo	43.8	25.6	30.6	100.0	86.2	13.8	.0	100.0	61.1	4,345	
Imereti	74.9	21.5	3.6	100.0	81.5	18.5	.0	100.0	79.9	7,005	
Mtskheta-Mtianeti	73.6	23.7	2.7	100.0	68.2	31.8	.0	100.0	66.5	1,241	
Racha-Svaneti	84.8	9.2	5.9	100.0	71.2	28.7	.0	100.0	68.5	584	
Residence											
Urban	95.7	2.5	1.7	100.0	96.3	3.7	.0	100.0	95.0	21,102	
Rural	54.8	33.6	11.6	100.0	71.1	28.8	.0	100.0	62.9	21,751	
Education of Household Head											
None	83.6	12.5	3.9	100.0	89.8	10.2	.0	100.0	87.1	20,846	
Primary	63.0	27.6	9.4	100.0	67.5	32.4	.1	100.0	61.7	1,577	
Secondary +	67.0	23.5	9.5	100.0	78.3	21.7	.0	100.0	71.4	20,424	
Missing/DK	100.0	.0	.0	100.0	100.0	.0	.0	100.0	100.0	5	
Wealth Index Quintiles											
Lowest	43.4	39.3	17.3	100.0	67.4	32.6	.0	100.0	56.3	7,634	
Second	54.4	34.3	11.3	100.0	69.7	30.2	.0	100.0	61.5	9,175	
Middle	77.3	16.9	5.8	100.0	81.3	18.7	.0	100.0	76.3	9,180	
Fourth	98.2	1.8	.1	100.0	98.9	1.1	.0	100.0	98.8	7,621	
Highest	99.9	.1	.0	100.0	100.0	.0	.0	100.0	100.0	9,242	
Total	74.9	18.3	6.8	100.0	83.5	16.5	.0	100.0	78.7	42,853	

[1] MICS indicator 4.1; MDG indicator 7.8

[2] MICS indicator 4.3; MDG indicator 7.9

Table 3.1.8
Availability of Various Household Amenities and Goods in the Household by Residence and Region
Reproductive Health Survey, Georgia, 2010

Characteristic	Total	Residence		Region										
		Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Ajara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
T.V.	96.6	97.9	95.1	97.0	97.9	96.1	94.5	96.2	96.3	97.5	95.9	97.7	91.6	90.7
Cellular phone	74.5	81.9	66.5	73.8	85.7	65.4	70.3	79.2	73.3	62.4	64.2	74.0	71.7	57.4
Refrigerator	78.8	89.1	67.9	76.8	92.3	72.7	73.4	73.1	81.0	58.9	72.2	77.7	69.5	57.2
Household phone	56.0	72.5	38.3	44.3	81.9	42.7	47.7	47.2	39.0	49.0	36.7	62.0	34.1	35.9
Working automobile	25.2	28.1	22.0	28.1	30.7	17.4	24.2	31.3	21.4	16.2	21.0	25.0	22.4	12.5
Computer	21.0	35.2	5.8	8.2	47.0	7.8	15.0	13.0	19.5	4.5	7.5	15.6	10.6	3.1
Internet	19.7	34.0	4.4	7.1	46.0	7.1	13.4	10.5	19.2	3.9	6.2	13.6	7.9	2.1
VCR/DVD	18.6	26.0	10.6	12.1	31.0	7.8	18.3	30.4	19.2	6.4	9.2	14.6	13.8	5.2
Satellite dish	21.3	13.9	29.2	29.0	8.3	15.8	33.2	65.0	39.3	12.7	18.1	13.2	30.3	37.7
Vacation home (villa)	6.9	12.2	1.2	0.8	17.5	1.6	3.5	1.8	8.7	1.8	1.7	4.4	2.1	1.1
Air conditioner	3.8	6.9	0.5	0.3	9.4	0.6	2.0	0.5	7.7	0.3	0.9	2.3	1.5	0.0
No. of Cases	12,904	5,708	7,196	1,024	2,636	817	1,020	822	621	1,003	1,050	1,633	821	1,457

Table 3.1.9

Type of Living Arrangements by Residence and Region
Reproductive Health Survey: Georgia, 2010

Type of Living Arrangements	Total	Residence		Region										
		Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Lives in privately owned flat or house	93.3	88.9	97.9	98.7	84.1	93.3	95.8	97.8	95.2	98.2	95.5	97.6	94.4	98.4
Lives in rental space (room, flat, or house)	4.4	8.0	0.5	1.0	11.9	0.7	2.6	0.9	4.2	0.6	2.1	1.3	2.1	0.8
Lives with immediate family	1.5	2.2	0.8	0.1	2.8	4.4	0.8	0.5	0.0	0.7	1.7	0.7	1.0	0.6
Lives with other relatives	0.3	0.3	0.3	0.2	0.4	0.0	0.4	0.5	0.3	0.2	0.4	0.2	1.1	0.1
Other	0.5	0.6	0.4	0.0	0.8	1.6	0.4	0.4	0.3	0.3	0.3	0.2	1.5	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	12,904	5,708	7,196	1,024	2,636	817	1,020	822	621	1,003	1,050	1,633	821	1,457

Table 3.1.10 Number of Rooms in the Household by Residence and Region
Reproductive Health Survey: Georgia, 2010

Number of Rooms*	Residence		Total	Region										
	Urban	Rural		Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
1	14.0	2.6	8.5	1.3	19.5	7.5	7.7	3.2	5.6	2.5	3.3	4.2	8.9	2.7
2	28.2	11.4	20.1	7.5	34.2	17.9	21.1	14.4	21.9	13.4	10.7	14.1	21.7	13.5
3	27.8	17.0	22.5	12.0	28.8	20.9	23.9	27.7	25.0	14.3	18.5	20.3	23.4	21.6
4	15.8	25.3	20.4	23.1	13.2	24.1	23.0	26.4	21.4	27.3	24.0	19.6	23.8	29.8
5	6.1	15.0	10.4	14.8	2.7	11.8	11.2	13.6	11.4	14.5	15.5	12.9	9.0	17.4
6	4.0	13.4	8.5	18.6	1.3	6.6	7.4	8.2	7.2	15.1	12.0	13.1	5.8	10.3
7 or more	4.1	15.3	9.5	22.7	0.4	11.3	5.7	6.6	7.4	13.1	16.0	15.8	7.4	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average No. of Rooms	3.0	4.6	3.8	5.2	2.5	3.9	3.6	3.9	3.7	4.5	4.5	4.5	3.6	4.0
No. of Cases	5,708	7,196	12,904	1,024	2,636	817	1,020	822	621	1,003	1,050	1,633	821	1,457

* Not including kitchen and bathroom

Table 3.1.11 Number of Persons Living in the Household by Residence and Region
Reproductive Health Survey: Georgia, 2010

	Residence		Region											
	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Household Headship	67.2	64.1	70.6	69.3	64.0	67.7	67.6	69.1	71.8	71.4	67.8	66.9	67.6	67.0
	32.8	35.9	29.4	30.7	36.0	32.3	32.4	30.9	28.2	28.6	32.2	33.1	32.4	33.0
Number of Persons	17.5	18.7	16.1	19.7	18.7	16.4	17.1	12.8	10.0	17.1	15.9	19.2	18.6	28.0
	2	21.1	21.1	18.3	19.9	24.1	21.1	20.3	14.0	26.4	22.6	24.1	20.7	25.9
	3	18.0	20.3	15.5	16.1	22.0	15.5	13.9	12.5	17.6	18.0	19.5	17.0	17.8
	4	18.6	19.6	17.4	18.3	19.9	17.0	20.6	19.2	20.9	15.6	16.9	17.5	16.8
	5	12.5	10.9	14.1	13.5	10.6	14.7	12.6	15.6	16.3	11.5	14.0	10.7	13.4
	6	7.7	6.0	9.5	9.5	5.5	7.7	9.1	10.6	14.0	6.9	5.5	7.2	8.4
	7 or more	4.8	3.4	6.2	4.7	3.3	4.5	5.6	9.0	7.2	4.5	5.6	4.2	4.3
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average No. of Persons	3.3	3.2	3.5	3.4	3.2	3.3	3.4	3.8	3.9	3.2	3.3	3.2	3.3	2.8
No. of Cases	12,904	5,708	7,196	1,024	2,636	817	1,020	822	621	1,003	1,050	1,633	821	1,457

Table 3.1.12 Self-Reported Evaluation of the Material Status of the Family by Residence and Region:
Households With Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Material Status of the Family	Total	Residence		Region										
		Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Can easily satisfy our needs	6.7	9.2	3.8	2.5	9.7	4.1	3.3	2.8	12.8	1.2	3.2	8.6	0.8	4.4
Can somehow satisfy our needs	67.3	72.9	60.8	72.5	75.1	62.7	60.9	71.0	54.4	53.4	69.4	67.7	58.2	56.8
Can hardly make ends meet	25.7	17.4	35.1	24.5	14.7	33.1	35.9	25.9	32.1	45.0	27.4	23.5	41.1	38.7
Does not know	0.3	0.4	0.2	0.5	0.5	0.0	0.0	0.3	0.7	0.4	0.0	0.2	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,292	2,975	3,317	498	1,426	392	546	481	419	401	477	805	393	454

Table 3.2.1 **Characteristics of Eligible Women
with Completed Interviews by Residence
Reproductive Health Survey: Georgia, 2010**

Characteristic	Total	Residence		
		Tbilisi	Other Urban	Rural
Age Group				
15–19	17.9	17.2	17.7	18.6
20–24	18.9	20.3	18.9	18.0
25–29	16.6	16.3	16.3	17.0
30–34	16.3	17.2	16.2	15.9
35–39	15.8	14.9	16.3	16.1
40–44	14.4	14.1	14.5	14.5
Marital Status				
Legally married	57.9	50.2	57.2	62.8
Consensual union	1.2	1.4	1.3	1.2
Previously married	6.5	8.7	7.2	4.8
Never married	34.4	39.8	34.2	31.2
Number of Living Children				
0	41.3	46.8	41.6	37.9
1	19.0	21.8	20.7	16.5
2	29.5	25.3	29.7	31.8
3	8.3	5.1	6.5	11.2
4 or more	1.9	1.1	1.5	2.6
Education Level				
Secondary incomplete or less	22.6	12.6	17.8	31.2
Secondary complete	24.7	17.5	21.7	30.6
Technicum	13.2	10.0	14.1	14.6
University/Postgraduate	39.4	60.0	46.5	23.6
Wealth Quintile				
Lowest	14.6	0.5	3.5	28.9
Second	19.5	0.3	7.6	37.3
Middle	21.5	4.6	26.0	28.9
Fourth	18.5	27.9	34.9	4.0
Highest	25.9	66.7	27.9	0.9
Employment				
Working	21.3	30.9	25.7	13.3
Not working	78.7	69.1	74.3	86.7
Ethnicity				
Georgian	86.9	91.3	92.5	81.2
Azeri	5.2	0.9	2.3	9.3
Armenian	5.2	4.2	2.8	7.0
Other	2.8	3.6	2.4	2.5
Religion				
Georgian Orthodox	82.4	92.1	89.2	73.0
Other Orthodox	4.9	4.8	3.3	6.0
Muslim	10.5	1.0	6.2	18.4
Other	1.6	1.7	0.9	2.0
No Religion	0.5	0.4	0.5	0.6
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	1,426	1,549	3,317

Table 3.2.2 Percentage Distribution of Women Aged 15–44 by Age, Marital Status and Education
Reproductive Health Survey: Georgia, 2010

Age Group	Marital Status				Total	No. of Cases
	Legally Married	Consensual Union	Previously Married	Never Married		
15–19	10.3	0.3	0.8	88.5	100.0	861
20–24	47.1	1.6	3.2	48.2	100.0	1,099
25–29	69.5	1.5	4.2	24.8	100.0	1,191
30–34	77.0	1.0	8.8	13.1	100.0	1,168
35–39	77.4	1.8	10.8	10.1	100.0	1,051
40–44	75.0	1.4	13.2	10.5	100.0	922
Total	57.9	1.2	6.5	34.4	100.0	6,292
Age Group	Education				Total	No. of Cases
	Secondary Incomplete or Less	Secondary Complete	Technicum	University/ Postgraduate		
15–19	57.4	29.6	2.4	10.7	100.0	861
20–24	12.7	31.4	12.7	43.3	100.0	1,099
25–29	14.1	24.9	11.9	49.2	100.0	1,191
30–34	16.7	22.8	14.0	46.5	100.0	1,168
35–39	16.8	22.4	14.6	46.2	100.0	1,051
40–44	15.5	14.5	26.5	43.5	100.0	922
Total	22.6	24.7	13.2	39.4	100.0	6,292

Table 3.2.3 Educational Attainment of the Female Household Population
Percent Distribution of the De Facto Female Household Population Age Six and Over
By Highest Level of Schooling Attended and Median Years of Schooling Completed, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Highest Level of School Attended							Total	No. of Cases*	Median Years Completed
	No Education	Preschool	Primary (Grades 1–6)	Lower Secondary (Grades 7–9)	Upper Secondary (Grades 10–12)	Vocational	Higher			
Total	2.8	1.8	8.8	11.5	31.0	11.9	32.2	100.0	21,117	10.8
Age Group										
3–9	23.5	24.8	51.6	0.1	0.0	0.0	0.0	100.0	1,466	1.0
10–14	0.6	0.0	45.7	52.0	1.7	0.0	0.0	100.0	1,263	5.5
15–19	0.9	0.0	0.8	14.9	63.3	3.6	16.6	100.0	1,415	10.1
20–24	1.2	0.0	1.0	5.3	30.4	10.8	51.4	100.0	1,444	12.1
25–29	0.8	0.0	1.5	7.3	28.0	10.2	52.1	100.0	1,380	13.1
30–34	1.1	0.1	0.6	8.2	27.2	12.0	50.7	100.0	1,331	12.5
35–39	0.7	0.0	0.6	6.3	29.0	12.0	51.4	100.0	1,303	12.7
40–44	0.5	0.0	0.4	4.8	24.0	19.7	50.6	100.0	1,278	12.4
45–49	0.9	0.0	0.3	4.2	35.3	20.9	38.3	100.0	1,783	11.5
50–54	1.3	0.1	1.4	6.1	35.3	18.5	37.4	100.0	1,686	11.4
55–59	1.3	0.0	1.5	7.6	36.0	19.3	34.2	100.0	1,407	11.2
60–64	1.5	0.0	3.6	9.2	37.0	15.5	33.1	100.0	1,267	11.0
65–69	1.4	0.0	4.0	14.2	39.7	13.0	27.7	100.0	920	10.5
70–74	1.6	0.0	6.7	18.1	42.8	12.3	18.5	100.0	1,416	9.9
75–79	3.2	0.3	9.8	20.7	39.0	10.0	17.0	100.0	803	9.7
80 or more	4.6	0.0	17.0	22.6	31.5	6.5	17.8	100.0	955	9.4
Residence										
Urban	1.7	2.4	7.3	7.2	24.1	12.0	45.4	100.0	9,279	11.7
Rural	4.1	1.2	10.3	16.0	38.2	11.7	18.6	100.0	11,838	10.0
Region										
Kakheti	7.7	1.7	10.3	17.2	32.5	12.6	18.1	100.0	1,694	10.0
Tbilisi	1.6	2.3	6.9	5.8	19.5	10.1	53.8	100.0	4,308	13.0
Shida Kartli	2.2	1.1	9.2	10.5	37.1	12.0	27.9	100.0	1,367	10.4
Kvemo Kartli	4.4	1.7	13.2	16.3	31.3	10.1	23.1	100.0	1,752	9.9
Samtskhe–Javakheti	3.2	1.2	10.2	11.9	40.4	9.6	23.5	100.0	1,555	9.8
Adjara	3.6	0.9	11.3	14.4	32.7	12.7	24.5	100.0	1,209	11.1
Guria	1.9	1.3	7.2	20.5	34.4	19.6	15.1	100.0	1,574	9.9
Samegrelo	2.1	1.3	6.4	11.2	43.4	10.1	25.5	100.0	1,728	10.4
Imereti	1.5	2.5	7.4	10.7	32.9	14.3	30.7	100.0	2,602	10.7
Mtskheta–Mtianeti	3.0	2.3	9.9	12.6	30.4	17.1	24.7	100.0	1,334	10.6
Racha–Svaneti	2.5	0.9	9.7	14.4	37.8	10.8	24.0	100.0	1,994	10.1
Wealth Quintile										
Lowest	5.2	0.7	11.0	20.3	39.9	9.9	13.1	100.0	4,748	9.6
Second	4.0	1.3	10.2	14.3	39.7	11.9	18.6	100.0	4,806	10.1
Middle	2.2	2.0	9.2	11.4	33.9	13.6	27.7	100.0	4,507	10.5
Fourth	1.9	2.4	6.8	7.2	26.0	14.3	41.3	100.0	3,341	11.5
Highest	1.3	2.5	6.9	5.3	17.0	9.6	57.4	100.0	3,715	14.0

* Excludes 2 women for whom the highest level of school attendance was unknown.

Table 3.2.4 Educational Attainment of the Male Household Population
 Percent Distribution of the De Facto Male Household Population Age Six and Over
 By Highest Level of Schooling Attended and Median Years of Schooling Completed, by Selected Characteristics
 Reproductive Health Survey: Georgia, 2010

Characteristic	Highest Level of School Attended							Total	No. of Cases*	Median Years Completed
	No Education	Preschool	Primary (Grades 1–6)	Lower Secondary (Grades 7–9)	Upper Secondary (Grades 10–12)	Vocational	University/ Postgraduate			
Total	3.1	2.1	9.2	10.3	34.9	11.0	29.4	100.0	19,482	10.7
Age Group										
3–9	25.0	24.0	50.9	0.1	0.0	0.0	0.0	100.0	1,606	1.0
10–14	1.1	0.2	49.4	48.5	0.7	0.1	0.0	100.0	1,338	5.2
15–19	1.1	0.0	0.8	15.3	66.0	2.5	14.4	100.0	1,582	10.0
20–24	1.2	0.0	1.1	6.1	41.4	7.6	42.7	100.0	1,548	11.6
25–29	0.5	0.0	1.1	6.8	36.4	8.7	46.5	100.0	1,507	11.8
30–34	1.1	0.1	0.7	6.4	36.0	11.3	44.5	100.0	1,410	11.7
35–39	1.0	0.0	0.8	4.5	39.6	13.4	40.6	100.0	1,292	11.5
40–44	0.9	0.1	0.4	4.3	36.5	17.5	40.2	100.0	1,302	11.5
45–49	0.6	0.0	0.5	3.2	37.8	19.6	38.2	100.0	1,481	11.4
50–54	1.0	0.0	1.3	3.8	39.9	19.5	34.5	100.0	1,450	11.3
55–59	1.2	0.0	0.7	4.8	37.0	20.3	36.0	100.0	1,209	11.4
60–64	0.6	0.0	1.6	7.7	39.9	17.4	32.8	100.0	982	11.0
65–69	0.8	0.0	2.2	13.8	43.4	13.3	26.6	100.0	701	10.7
70–74	1.3	0.0	3.6	17.1	40.9	13.3	23.7	100.0	944	10.1
75–79	2.9	0.2	11.1	20.8	39.0	8.8	17.1	100.0	543	9.6
80 or more	3.0	0.3	13.9	23.9	32.0	7.5	19.4	100.0	587	9.4
Residence										
Urban	2.2	2.9	8.6	6.6	26.5	10.5	42.7	100.0	7,936	11.6
Rural	4.0	1.4	9.8	13.6	42.4	11.4	17.4	100.0	11,546	10.0
Region										
Kakheti	7.6	1.4	10.3	13.7	40.1	11.4	15.6	100.0	1,647	10.0
Tbilisi	1.9	3.0	8.5	5.4	21.6	8.9	50.7	100.0	3,638	12.3
Shida Kartli	3.4	1.3	8.2	11.3	39.3	12.0	24.5	100.0	1,271	10.3
Kvemo Kartli	4.4	1.5	13.1	15.0	35.9	8.4	21.8	100.0	1,622	9.9
Samtskhe–Javakheti	4.3	1.2	10.1	8.4	45.7	10.1	20.1	100.0	1,410	9.9
Adjara	2.8	1.9	10.6	11.8	34.4	13.4	25.1	100.0	1,134	11.1
Guria	2.1	1.0	8.0	16.8	40.2	17.7	14.2	100.0	1,534	9.9
Samegrelo	2.8	1.4	7.4	9.2	48.0	8.5	22.6	100.0	1,661	10.3
Imereti	1.7	3.1	8.1	9.8	34.7	13.5	29.0	100.0	2,362	10.6
Mtskheta–Mtianeti	2.4	2.6	9.4	13.0	34.7	15.1	22.7	100.0	1,253	10.6
Racha–Svaneti	1.7	0.9	8.6	14.9	45.6	9.2	18.9	100.0	1,950	10.0
Wealth Quintile										
Lowest	4.9	0.9	10.2	16.8	44.9	10.4	12.0	100.0	4,376	9.7
Second	4.1	1.5	9.7	12.8	43.0	11.5	17.4	100.0	4,691	10.1
Middle	2.7	1.9	9.6	10.2	38.8	11.9	24.9	100.0	4,318	10.5
Fourth	2.1	2.4	8.3	7.2	28.5	13.1	38.4	100.0	2,798	11.4
Highest	1.8	3.7	8.4	4.7	18.9	8.3	54.2	100.0	3,299	13.3

* Excludes one man for whom the highest level of school attendance was unknown.

Table 3.3.1

School Readiness
Percentage of Children Attending First Grade of Primary School
Who Attended Pre-school the Previous Year, Georgia, 2010-2011

Characteristic	Percentage of children attending first grade who attended preschool in previous year [1]	Number of children attending first grade of primary school
Sex		
Male	42.5	227
Female	38.3	224
Region		
Kakheti	21.6	37
Tbilisi	52.3	86
Shida Kartli	25.9	27
Kvemo Kartli	41.7	36
Samtskhe-Javakheti	16.7	36
Adjara	48.0	25
Guria	34.2	41
Samegrelo	37.1	35
Imereti	43.8	73
Mtskheta-Mtianeti	53.6	28
Racha-Svaneti	22.2	27
Residence		
Urban	49.9	196
Rural	30.5	255
Wealth Index Quintiles		
Lowest	26.2	102
Second	28.3	89
Middle	39.9	101
Fourth	53.5	68
Highest	51.4	91
Total	40.4	451

[1] MICS indicator 7.2

Table 3.3.2 Primary School Entry
Percentage of Children of Primary School Entry Age
Entering Grade 1 (Net Intake Rate), Georgia, 2010-2011

Characteristic	Percentage of children of primary school entry age entering grade 1 [1]	Number of children of primary school entry age
Sex		
Male	84.1	476
Female	81.6	440
Region		
Kakheti	77.5	89
Tbilisi	86.9	183
Shida Kartli	82.4	51
Kvemo Kartli	78.7	89
Samtskhe-Javakheti	82.1	67
Adjara	84.8	46
Guria	83.3	72
Samegrelo	88.9	63
Imereti	80.0	135
Mtskheta-Mtianeti	84.5	58
Racha-Svaneti	85.7	63
Residence		
Urban	84.5	399
Rural	81.1	517
Wealth Index Quintiles		
Lowest	79.2	182
Second	81.7	208
Middle	76.8	210
Fourth	86.6	135
Highest	89.4	181
Total	82.8	916

[1] MICS indicator 7.3

Table 3.3.3 Primary School Attendance
Percentage of Children of Primary School Age
Attending Primary or Secondary School (Net Attendance Ratio), Georgia, 2010-2011

Characteristic	Male		Female		Total	
	Net attendance ratio (adjusted) [1]	Number of children	Net attendance ratio (adjusted) [1]	Number of children	Net attendance ratio (adjusted) [1]	Number of children
Region						
Kakheti	95.7	116	90.8	109	93.3	225
Ibilisi	96.6	265	97.4	234	97.0	499
Shida Kartli	96.6	89	100.0	85	98.3	174
Kvemo Kartli	92.4	145	94.7	113	93.4	258
Samtskhe-Javakheti	92.7	109	96.7	91	94.5	200
Adjara	95.9	73	96.3	80	96.1	153
Guria	99.0	103	93.4	91	96.4	194
Samegrelo	94.6	112	95.5	89	95.0	201
Imereti	94.7	170	97.2	144	95.9	314
Mtskheta-Mtianeti	98.8	84	96.4	84	97.6	168
Racha-Svaneti	99.2	118	96.3	107	97.8	225
Residence						
Urban	96.3	589	97.2	511	96.7	1100
Rural	94.5	795	95.1	716	94.7	1511
Age at beginning of school year						
6	83.5	219	85.7	209	84.6	428
7	97.1	227	97.5	201	97.3	428
8	99.0	238	98.1	191	98.6	429
9	99.4	199	98.4	196	98.9	395
10	98.0	278	98.7	226	98.3	504
11	95.0	223	98.8	204	96.8	427
Wealth Index Quintiles						
Lowest	93.1	267	91.7	259	92.4	526
Second	93.2	326	97.1	300	95.0	626
Middle	98.0	342	96.6	261	97.4	603
Fourth	97.6	191	96.6	183	97.1	374
Highest	94.8	258	97.8	224	96.2	482
Total	95.4	1384	96.1	1227	95.7	2611

[1] MICS indicator 7.4; MDG indicator 2.1

Table 3.3.4 Secondary School Attendance
Percentage of Children of Secondary School Age
Attending Secondary School or Higher (Adjusted Net Attendance Ratio), and Percentage of Children Attending Primary School, Georgia, 2010-2011

Characteristic	Male			Female			Total		
	Net attendance ratio (adjusted) [1]	Percent attending primary school	Number of children	Net attendance ratio (adjusted) [1]	Percent attending primary school	Number of children	Net attendance ratio (adjusted) [1]	Percent attending primary school	Number of children
Region									
Kakheti	72.7	11.6	121	81.8	6.4	110	77.1	9.1	231
Tbilisi	86.9	7.6	237	87.2	7.4	243	87.1	7.5	480
Shida Kartli	90.8	5.1	98	91.3	4.9	103	91.0	5.0	201
Kvemo Kartli	79.9	11.7	154	81.0	10.2	137	80.4	11.0	291
Samtskhe-Javakheti	81.2	11.9	101	83.9	11.0	118	82.7	11.4	219
Adjara	89.1	5.4	92	90.9	6.8	88	90.0	6.1	180
Guria	90.0	7.0	100	93.5	2.2	92	91.7	4.7	192
Samegrelo	86.6	6.7	119	90.2	2.7	112	88.3	4.8	231
Imereti	90.1	7.4	162	91.1	7.0	158	90.6	7.2	320
Mtskheta-Mtianeti	88.0	2.2	92	85.5	5.8	69	87.0	3.7	161
Racha-Svaneti	88.8	7.5	161	87.7	8.7	138	88.3	8.0	299
Residence									
Urban	87.9	7.4	576	87.7	6.9	572	87.8	7.2	1148
Rural	83.2	8.7	861	87.3	6.9	796	85.2	7.8	1657
Age at beginning of school year									
12	61.0	36.4	279	64.1	32.0	268	62.5	34.2	547
13	92.6	3.7	272	93.7	2.1	290	93.2	2.8	562
14	92.0	1.0	286	96.9	0.5	275	94.4	0.7	561
15	92.2	0.4	299	91.2	0.0	285	91.7	0.2	584
16	88.8	0.0	301	91.3	0.0	250	89.9	0.0	551
Wealth Index Quintiles									
Lowest	76.1	8.7	291	89.5	4.2	330	83.3	6.3	621
Second	85.6	9.9	373	83.6	8.7	292	84.7	9.4	665
Middle	88.4	5.8	328	84.9	10.1	313	86.7	7.9	641
Fourth	86.5	7.4	200	89.6	6.1	182	88.0	6.8	382
Highest	88.3	8.4	245	90.1	5.1	251	89.2	6.7	496
Total	85.4	8.1	1437	87.5	6.9	1368	86.4	7.5	2805

[1] MICS indicator 7.5

Table 3.3.5 Primary School Completion and Transition to Secondary School
Primary School Completion Rates and Transition Rate to Secondary School, Georgia, 2010-2011

Characteristic	Primary school completion rate [1]	Number of children of primary school completion age	Transition rate to secondary school [2]	Number of children who were in the last grade of primary school the previous year
Sex				
Male	89.3	279	100.0	244
Female	83.8	268	99.4	209
Region				
Kakheti	85.7	49	100.0	37
Tbilisi	84.7	111	98.8	86
Shida Kartli	85.4	41	100.0	34
Kvemo Kartli	89.1	64	100.0	44
Samtskhe-Javakheti	82.9	41	100.0	35
Adjara	85.7	28	100.0	28
Guria	84.4	32	100.0	34
Samegrelo	92.1	38	100.0	33
Imereti	84.2	57	100.0	47
Mtskheta-Mtianeti	96.9	32	100.0	29
Racha-Svaneti	100.0	54	100.0	46
Residence				
Urban	83.7	240	99.4	190
Rural	89.5	307	100.0	263
Wealth Index Quintiles				
Lowest	80.4	108	100.0	93
Second	89.6	128	100.0	102
Middle	91.5	125	100.0	110
Fourth	92.3	80	100.0	62
Highest	79.7	106	98.8	86
Total	86.6	547	99.7	453

[1] MICS indicator 7.7

[2] MICS indicator 7.8

Table 3.3.6 Education Gender Parity
Ratio of Adjusted Net Attendance Ratios of Girls to Boys, in Primary and Secondary School, Georgia, 2010 - 2011

Characteristic	Primary school adjusted net attendance ratio (NAR), girls	Primary school adjusted net attendance ratio (NAR), boys	Gender parity index (GPI) for primary school adjusted NAR [1]	Secondary school adjusted net attendance ratio (NAR), girls	Secondary school adjusted net attendance ratio (NAR), boys	Gender parity index (GPI) for secondary school adjusted NAR [2]
Region						
Kakheti	90.8	95.7	0.95	81.8	72.7	1.12
Tbilisi	97.4	96.6	1.01	87.2	86.9	1.00
Shida Kartli	100.0	96.6	1.03	91.3	90.8	1.00
Kvemo Kartli	94.7	92.4	1.02	81.0	79.9	1.01
Samtskhe-Javakheti	96.7	92.7	1.04	83.9	81.2	1.03
Adjara	96.3	95.9	1.00	90.9	89.1	1.02
Guria	93.4	99.0	0.94	93.5	90.0	1.04
Samegrelo	95.5	94.6	1.01	90.2	86.6	1.04
Imereti	97.2	94.7	1.03	91.1	90.1	1.01
Mtskheta-Mtianeti	96.4	98.8	0.98	85.5	88.0	0.97
Racha-Svaneti	96.3	99.2	0.97	87.7	88.8	0.99
Residence						
Urban	97.2	96.3	1.01	87.7	87.9	1.00
Rural	95.1	94.5	1.01	87.3	83.2	1.05
Wealth Index Quintiles						
Lowest	91.7	93.1	0.98	89.5	76.1	1.18
Second	97.1	93.2	1.04	83.6	85.6	0.98
Middle	96.6	98.0	0.99	84.9	88.4	0.96
Fourth	96.6	97.6	0.99	89.6	86.5	1.04
Highest	97.8	94.8	1.03	90.1	88.3	1.02
Total	96.1	95.4	1.01	87.5	85.4	1.02

[1] MICS indicator 7.9; MDG indicator 3.1

[2] MICS indicator 7.10; MDG indicator 3.1

4 CHAPTER

FERTILITY AND PREGNANCY EXPERIENCE

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

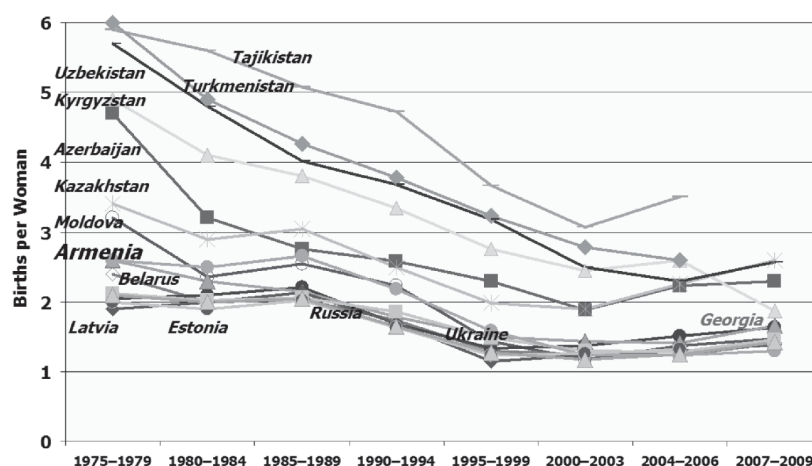
4.1 Fertility Levels and Trends

Demographically, Georgia has much in common with the other former Soviet-bloc countries, with whom it shares a common path of transition from communism and the inheritance of a centralized state-subsidized health care system. The total fertility rate (TFR)—the average number of children that would be born alive to a woman during her childbearing years if she were to experience the age-specific fertility rates of a given year—is used as an indicator for the study of fertility levels and trends; it is comparable across countries, since it is independent of differences in the size and structure of the population.

According to the official statistics, fertility has been declining steadily over the last three decades in the former Soviet Union countries with the most prominent declines observed between 1985 and 1995; however fertility levels, trends and the pace of decline differed between the Central Asia republics and the European part of the former Soviet Union (WHO, 2011a and 2011b). The decline in the TFR started sooner in Central Asia and the pace of decline was faster, resulting in the present convergence of fertility rates (Figure 4.1.1). In the mid-1980s, the disparity between regions with the highest (Central Asia) and the lowest fertility (European Soviet Union) was over

Figure 4.1.1

Trends in Total Fertility Rates in the Countries of the Former Soviet Union, 1975-2009



Source: WHO/Europe, European HFA Database, June 2011

3 births per woman. By the mid-1990s, this difference had decreased to 2 births per woman.

By 2005 it was less than one birth per woman, with Tajikistan (the only country with fertility of 3.5 births per woman) and Latvia representing the two extremes. Recently, however, the downward trend reversed in several countries. In Georgia and nine other countries (Armenia, Azerbaijan, Belarus, Estonia, Kazakhstan, Lithuania, Moldova, Ukraine and Uzbekistan), the 2007–2009 TFR is higher than it was in 2004–2006. A TFR of around 2.1 births per woman is considered to be the replacement level, that is, the average number of births per woman required to keep the long run population size constant in the absence of inward or outward migration. The TFR is still below the replacement level of 2.1 births per woman in all countries outside Central Asia, excepting Azerbaijan (2.3 births per woman). Among countries of the European former Soviet Union, Georgia has the second highest fertility rate, surpassed only by Azerbaijan.

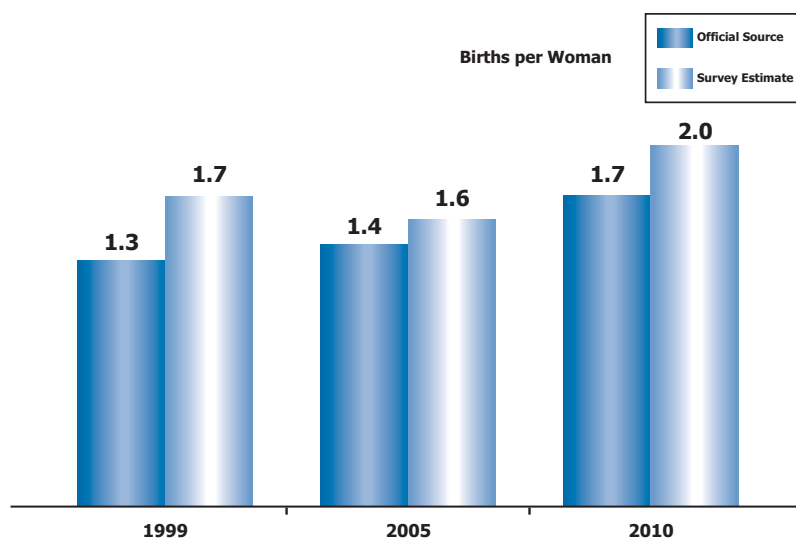
The information obtained from the birth histories collected in surveys is another source for computing total fertility rates. As with analyses performed in the 1999 and 2005 surveys, the pregnancy histories were used to calculate two of the most widely used measures of current fertility—the total fertility rate and its component age specific fertility rates. These measures are based on information from each woman's pregnancy history regarding the month and year of each live birth and the maternal age at the time of delivery. The (TFR) for a period is computed by accumulating the age-specific fertility rates (ASFRs) in each 5-year age group and multiplying the sum by five (the number of years in each group). The TFR for a period is thus defined as the average number of live births a

woman would have during her reproductive lifetime (ages 15–44) if she experienced the currently observed ASFRs for that period. ASFRs are expressed as the number of births to women in a given age group per 1,000 women per year. In this survey, as in the previous rounds, the ASFR for any five-year age group was calculated by dividing the number of births to women in that age group during the period 1 to 36 months preceding the survey, by the number of woman-years lived by women in that age group during the same period. Age-specific fertility rates are very useful in understanding the age pattern of fertility.

The TFR calculated from GERHS10 of 2.0 births per woman (95%CI=1.9–2.1) for the period 2007–2010 is the highest survey-based TFR ever reported for Georgia (Figure 4.1.2). The most recent period fertility rate is 25% higher than the TFR of 1.6 (95%CI=1.4–1.7) observed during 2002–2005, also calculated from the GERHS05 pregnancy histories (Serbanescu et al., 2007).

As in previous comparisons, the survey-based TFR for the most recent three years was higher than the corresponding TFR based on vital registration figures. In the previous Georgian survey rounds, the underestimation of births in the vital registration system was attributed mainly to two factors: 1) undercounting of births in the numerator, mainly due to delays in birth registration and 2) denominator inflation due to the use of inaccurate population projections (Serbanescu et al., 2001; Aleshina and Redmond, 2005). As shown later in this report, early registration (within the first 2 weeks after birth) was almost universal among children born in the last 5 years in Georgia, so under-registration of births is unlikely to explain differences in the TFR. The persistence of inflated denominators

Figure 4.1.2 Three-Year Period Total Fertility Rates: Survey Estimates and Official Sources: 1999, 2005, 2010



is still an issue, since the census projections are done without adjustment for out-migration and overestimate women of childbearing age. This may result in underestimation of the fertility rates and other official population-based statistics.

The ASFRs and corresponding TFR for the period 2007–2010 are shown in Table 4.1.1 and Figure 4.1.3. Traditionally, Georgian women initiate and complete childbearing at an early age, as reflected in very high age-specific fertility rates for young women. The highest fertility levels were at ages 20–24 and 25–29, accounting for 36% and 29%, respectively, of the TFR. Fertility among adolescent women contributed to only 10% of the TFR. Fertility among women aged 30–34 was the third-highest ASFR, contributing 15% of the TFR. Women aged 35–39 and 40–44 made minimal contributions; their ASFRs accounted for only 8% and 3%, respectively, of the TFR. Thus, 26% of the TFR was due to women aged 30 or older.

Using data from all Georgia reproductive health surveys, period fertility rates can be compared across three 3-year periods (Table 4.1.1 and Figure 4.1.4). In the most recent survey, there is an increase of 25% in the 3-year (2007–2010) TFR, compared to the rate during 2002–2005. Compared to the period 1996–1999, the TFR increased by 18%. Age-specific fertility rates increased in all but one age group, adolescent women, suggesting a gradual transition to fertility postponement in Georgia. In that group the ASFR dropped from 65 during 1996–1999, to 47 during 2002–2005, and to 39 during the most recent period (2007–2010). Altogether this was a 40% decline between 1996–1999 and 2007–2010.

At the same time, the ASFRs of women aged 20–24 and 25–29 increased by 26% and 25%, respectively. As

a result, their contribution to the TFR increased from 59% to 65% between 1996–1999 and 2007–2010. There was also a notable change in fertility among older women: the ASFRs of women aged 30–34, 35–39, and 40–44 increased by 29%, 43%, and 57%, respectively, though within low levels, as Figure 4.1.4 shows. Their contribution to the TFR increased from 22% to 26%.

Table 4.1.2 shows the number of children ever born among all women and women currently married who were interviewed in the GERHS10. Information on all past fertility reflects the accumulation of births over a woman's entire childbearing years and is useful in looking at how average family size varies across age groups. These data, however, have a limited relationship to current fertility levels.

Overall, 41% of all women aged 15–44 years were childless at the time of the interview, 18% reported giving birth to only one child, 29% to two children and 12% to three or more children. Although only 5% of women aged 15–19 years reported giving birth, 69% of women aged 25–29 had done so. About one in seven (15%) women aged 40–44 remained childless. Among currently married women, 26% have so far had only one child, 45% have had two children, and 19% have had three or more children. One in ten currently married women has never had a child. Almost one in two of the few married adolescent women (aged 15–19) have already had a first child; 79% at ages 20–24 have done so and 92% at ages 25–29 have done so. Five percent at ages 35–44 remained childless as of the survey, suggesting fertility impairment, because voluntary childlessness is rare in Georgia and most couples tend to have at least one child.

Figure 4.1.3 | Three-Year Period (2007–2010)
Age-Specific Fertility Rates

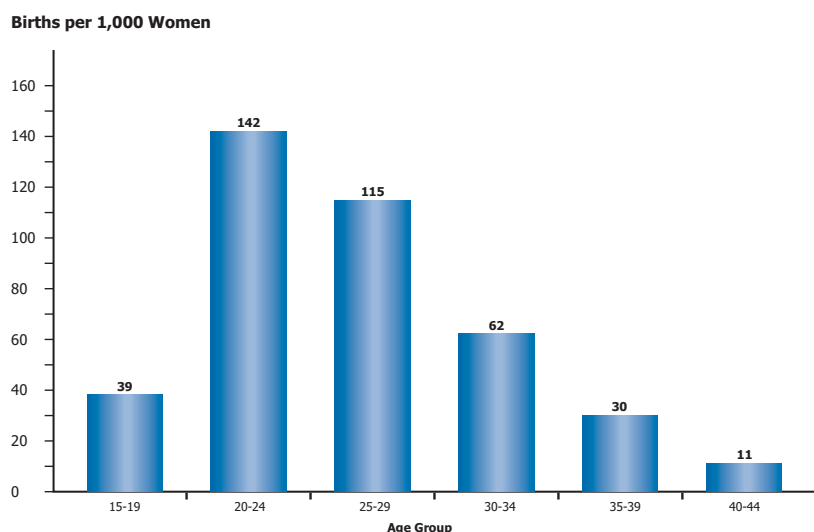
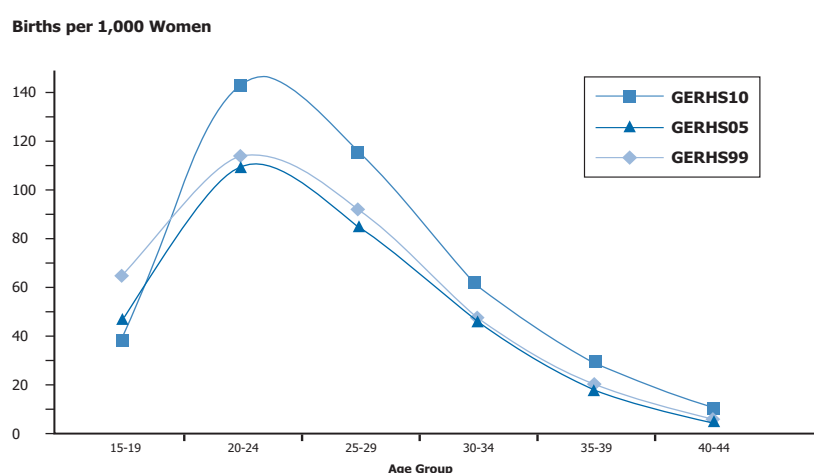


Figure 4.1.4 | Three-Year Period Age-Specific Fertility Rates 1999, 2005, 2010



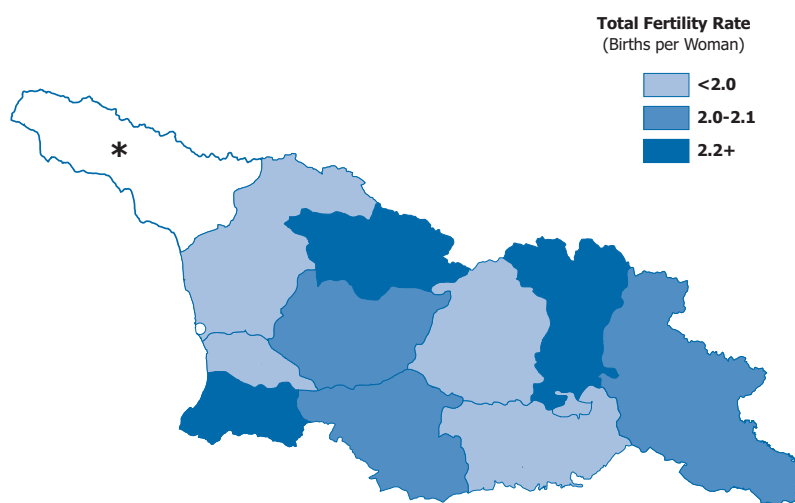
4.2 Fertility Differentials

In examining fertility determinants it is useful to compare various subgroups of women. Fertility varies with social, cultural, and economic factors, which influence decision making regarding the number of children a woman or couple decides to have.

Fertility among women living in urban areas, including Tbilisi, was almost 10% lower according to the TFR than among rural-dwelling women in the three-year period preceding the interview (Table 4.2). Most of the difference between the rural and urban fertility rates was due to higher ASFRs among rural residents aged 15–19, 20–24 and 25–29. Oddly, fertility at ages 30–34 was higher in urban than in rural areas.

By region, fertility was the lowest in Guria (1.7 TFR, and it was the highest in Mtskheta-Mtianeti and Racha-Svaneti (2.3), followed by Adjara (2.2) and Samtskhe-Javakheti and Kakheti (2.1) (Figure 4.2.1). The highest adolescent ASFR was reported by residents of Kakheti, Kvemo-Kartli, and Racha-Svaneti (Figure 4.2.2), probably because the average age of first marriage and first birth is lower in these regions than in the rest of the country. Fertility differences according to education were more pronounced among younger women. Generally, peak fertility occurred at ages 25–29 among women with the highest educational attainment, whereas peak fertility among women at lower educational levels occurred at ages 20–24. Fertility of the Azeri minority (2.4 TFR) was higher than that of the Georgians (2.0 TFR), the major ethnic group, due to much higher ASFRs among Azeri women aged 15–24 (Figure 4.2.3).

Figure 4.2.1 | Three-Year Period Total Fertility Rates by Region



* Abkhazia: Autonomous region not under government control

4.3 Nuptiality

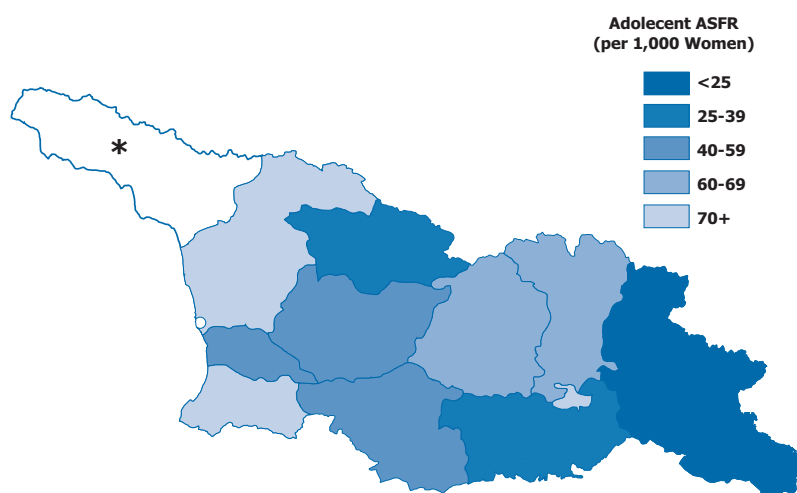
Because in Georgia nearly all exposure to the risk of pregnancy occurs among women who are married or in a consensual union, reproductive health behaviors are greatly influenced by marital status. A comparative report of surveys taken in 11 countries since 1996, covering a wide range of women's health topics, showed that the median age at first marriage among women of reproductive age in Eastern Europe and Central Asia is between 20 and 22 years of age (CDC and ORC/Macro, 2003). Most countries of the region exhibit the highest fertility rates among currently married young adults, for two reasons: the probability of having a child is much higher among married women and couples typically have a strong desire to initiate childbearing soon after marriage (first birth typically occurs within 2 years after the marriage). Thus, it is

important to know the marital distribution by age group and the changes over time in age at first union and at first birth.

The proportion of currently married women in Georgia (58%) was comparable to that of other countries of the region (ranging from 54% in Russia to 68% in Uzbekistan) (Figure 4.3.1). In addition, a small proportion of women (2%) were living in consensual unions, a rate that is similar to Central Asian countries, but much lower than in other countries of the region (10% of women in Russia, 6% in Romania, and 4% in Ukraine).

At the time of GERHS2010, 6.5% of women were previously married (e.g., widowed, divorced, or separated from a spouse or from a partner in a consensual union; see Table 4.3). More than one in three women

Figure 4.2.2 | Three-Year Period Age-Specific Adolescent Fertility Rates (Ages 15–19) by Region



* Abkhazia: Autonomous region not under government control

Figure 4.2.3 Three-Year-Period (2007–2010) Age-Specific Fertility Rates by Ethnicity

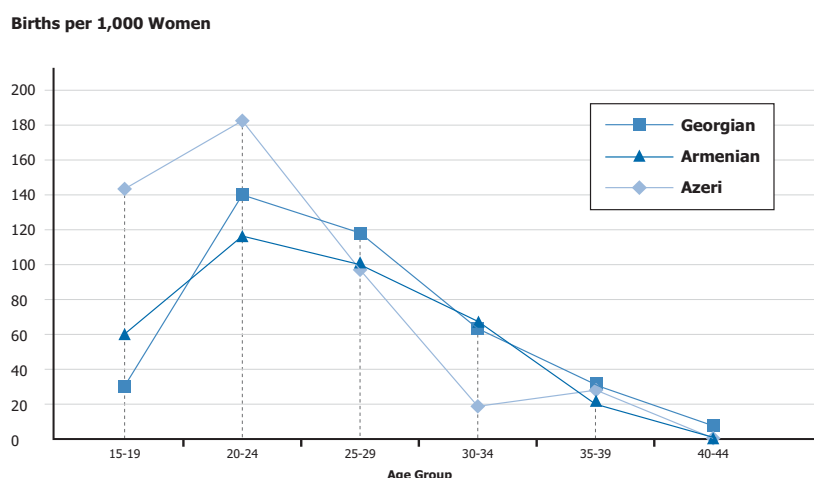
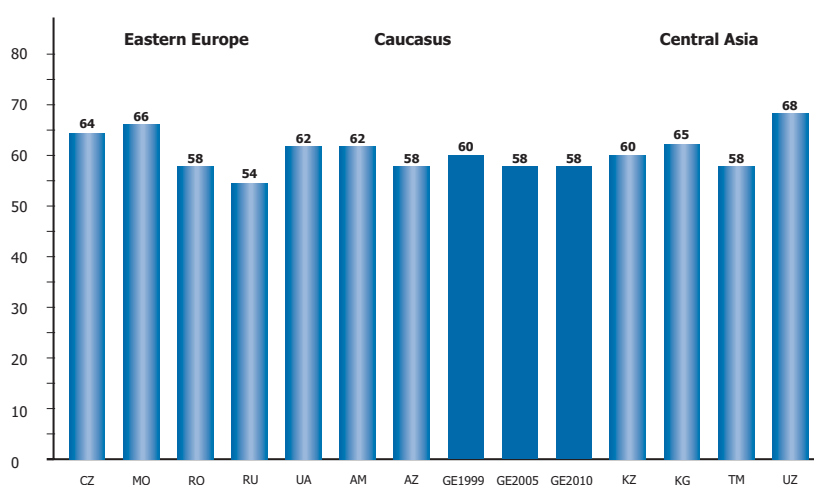


Figure 4.3.1 Percentage of Women Aged 15–44 Who Are Currently Married or in Consensual Unions*



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

(34%) had never been married or lived with a partner. The proportion of the currently married women aged 15–44 is unchanged between the 2005 and 2010 surveys (58%), but the proportion of de facto (consensual) marriages decreased (from 2% in 2005 to 1% in 2010).

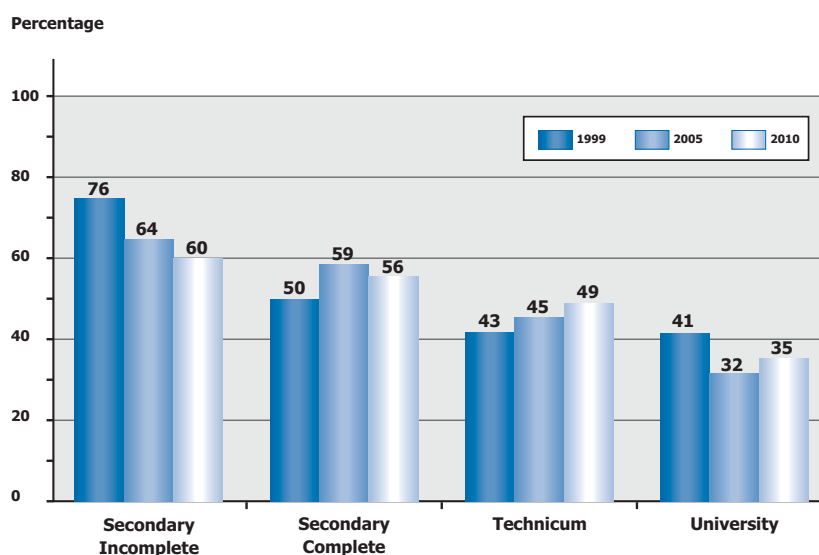
The proportion of currently married women (either legal or consensual marriage) was higher in rural areas than in urban areas (64% vs. 54%) and in the regions of Guria and Adjara (64%) and in Kakheti (63%) and Kvemo Kartli (63%). The proportion of previously married women was slightly higher in urban areas than in rural areas (8% vs. 5%), as was the proportion of never-married women (37% vs. 31%).

Rates of marriage increase rapidly with age from 10% among 15- to 19-year-olds to 47% among women aged

20–24, and to 69% among 25- to 29-year-olds; the rate reached a maximum of 75% for women aged 40–44. The proportion of never-married women decreased sharply with age from 88% among 15- to 19-year-olds to 48% among women aged 20–24, and to 25% among 25–29, and 13% among women aged 30–34. Among women aged 35 or older, about 10% had never been married.

The proportion of women married or in union was lower among women who did not complete secondary school 45% than among women with a complete secondary or technicum education (63% and 69%, respectively) and those with university or postgraduate education (58%). In studying the impact of education on marital levels, it should be kept in mind that the youngest women are less likely to marry because they are less likely to marry because they are still in school

Figure 4.3.2 Percent of Women Aged 20-24 Who Are Married, by Education Level: 1999, 2005, 2010



and the youngest age for official marital eligibility is 18 and with consent of parents – 16 years of age.

Among the younger women aged 20-24 however the likelihood of being in a marital relationship, either consensual or formal, was highly correlated with education. For example in 2010, 56%-60% of young women with high school education or less (secondary complete or incomplete) were in union, compared with 35%-49% of those with some post secondary education (Figure 4.3.2). This finding lends credence to the view that women tend to postpone marriage until after achieving their desired education goals. The trend between 1999 and 2010 shows that young women with less education are becoming less inclined to marry early.

4.4 Age at First Intercourse, Union, and Birth

Age at first union and age at first sexual intercourse play an important role in determining fertility. Delays in these events decrease the number of reproductive years that a woman spends at risk of getting pregnant. They can also have a direct impact to reduce current fertility rates since births in any one year are fewer when they are deferred to some time in the future.

Information on age at first sexual intercourse for all women is presented by age of the respondent at the time of interview in Table 4.4.1. The left side of the table shows the proportion of respondents within each 5-year age cohort who have ever had sexual intercourse (top panel), ever been in formal or consensual marriage (middle panel), and ever had a live birth (bottom panel), before reaching specific ages. For example, in the top panel, 30% of women now aged 25-29 had sex before age 20.

The overall median age (next to last column), for the age by which 50% of women aged 15-44 have experienced the event, and the median age within each age group, are also displayed for each event. By comparing the proportion of women in different age groups who experienced various events before age 20, it is possible to detect whether the average age of occurrence of each event has changed over time. For example, the proportion of women who had sexual intercourse before age 20 was 33% among women now aged 40-44, but otherwise it declined from a high 43% for women now aged 35-39 to 29% among 20-24-year-olds.

There is very little gap between sexual exposure and entry into a union. Across age cohorts, the proportion of respondents who reported sexual experience before marriage remained very low because the proportion of women married by age 20 is almost identical with the proportion of sexually experienced women (Figure 4.4.1). Similarly, the median age at first intercourse for each cohort was only slightly lower than the corresponding median age at first marriage. Thus, the 2010 survey confirms an earlier finding that in Georgia sexual abstinence before marriage is a common practice. Apparently, traditional norms are strong and have not been altered by recent changes that have influenced young adult reproductive behaviors in the industrialized world and in some of the Eastern European former Soviet-bloc countries.

The long term decline in the proportion of women who married before age 20 documents the trend away from early marriage. Since the number of women pursuing higher education attainment has also risen, it is very likely that young Georgian women tend to delay the first union and first birth to a later age, after gaining qualifications and steady income. This trend is particularly interesting and has potential implications for future fertility patterns and fertility control measures.

In 2010, the median ages at first union and first birth were 21.9 and 23.6 respectively (Figure 4.4.2). Georgian women continue to marry considerably earlier than in Western Europe, where the average age at the first marriage is about 27 years (UNECE, 2002). The median age at first intercourse is older in 2010 than in 2005 (21.8 vs. 21.3). The proportion of young adults who reported premarital sexual intercourse, although very low, almost doubled between 2005 and 2010 surveys (from 2.7% in 2005 to 5% in 2010) while the proportion with any sexual experience remained almost unchanged (66%).

Urban women reported the initiation of sexual activity, union, and childbearing 1.7 to 2 years later than rural women (Table 4.4.2). The highest median age for all these events was reported by women residing in Tbilisi, suggesting that the high cost of living, the pres-

ence of educational opportunities, and a competitive career market in the capital may delay sexual debut, union and childbearing. Interestingly, women residing in Racha-Svaneti (mountainous area) reported similarly high median ages for the onset of sexual activity, union and childbearing, but probably for entirely different reasons: judging from the scarcity of the population of reproductive age in the region (documented in the census and in the 2010 RHS), a possible explanation is that much of the male population is seeking higher education training and employment elsewhere. Differentials in median age of experiencing sexual activity, union, and childbearing are closely related to education. The median age of these events was 5 years older in women with university education compared to those who had not completed secondary education.

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

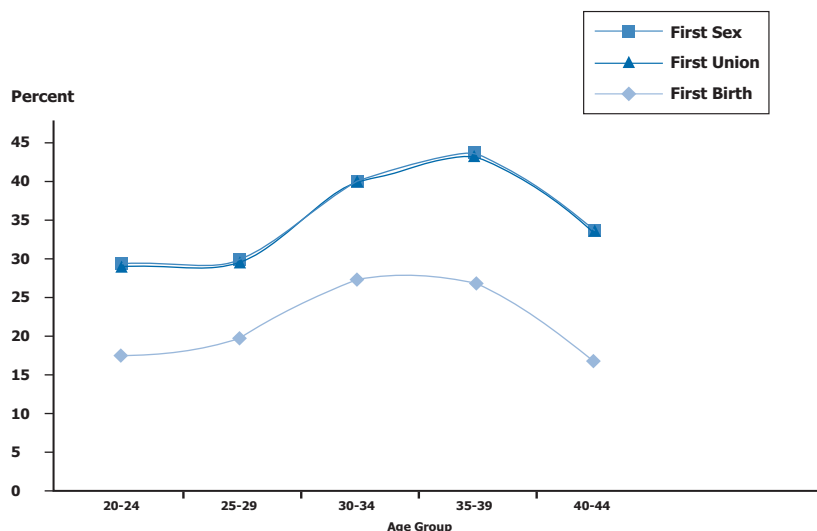
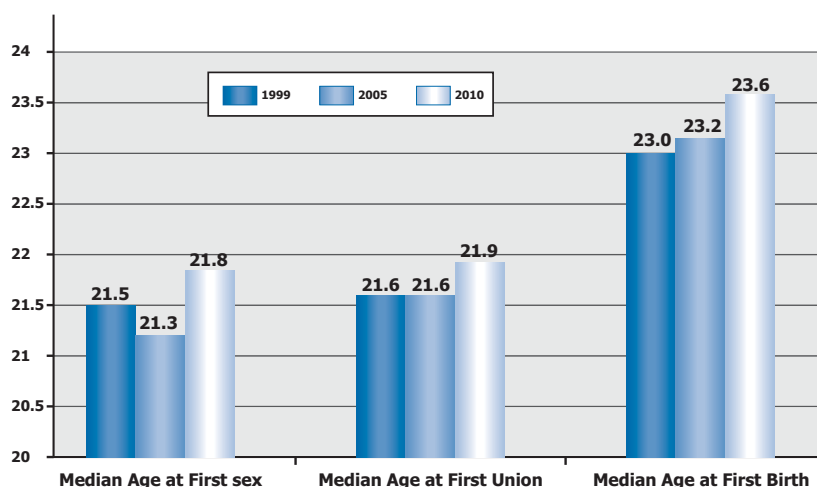


Figure 4.4.2 Median Age at First Sex, First Union and First Age Among Women Aged 15-44 Years: 1999, 2005, 2010



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 for the selection of a contraceptive method that best suits the reproductive stage and fertility preferences of each individual. As shown in Table 4.5, about 34% of all women aged 15-44 reported that they had never had sexual intercourse. Sexual experience includes the 5% of all women who were pregnant, and the 3% reporting postpartum abstinence at the time of the interview. Nearly half, 48%, were currently active, with sexual experience in the last month, and another 10% irregularly.

Among women who were married or living with a partner, 80% reported having had intercourse at least once within the past month, and 3% had had intercourse within the previous 3 months, plus the 13% who were pregnant or postpartum. Conversely, only 12% of previously married women had had intercourse within the past 3 months. Most of them (70%) reported that their last sexual intercourse occurred over 12 months ago, perhaps while they were still married. Almost none (0.1%) of never-married women reported having had any sexual experience, yet another documentation of the strong social prohibition against sex before marriage in Georgia.

Almost one in three young adult women (i.e., those aged 15-24) (bottom panel) reported sexual intercourse, including the 10% who were pregnant or early postpartum. About 71% of women in the two groups

aged 25 or older reported sexual experience. Of those, more than two-thirds had had intercourse within the past month.

4.6 Planning Status of the Last Pregnancy

Unintended pregnancy is an important public health problem around the world, occurring in all cultures and affecting women of all ages and all socio-economic and educational backgrounds. Accurate documentation of reproductive intentions is important for understanding a population's fertility rates, fertility-related behaviors, and contraception needs. Unintended pregnancies are more likely to be associated with elective termination of pregnancy, inadequate prenatal care, unfavorable maternal behaviors, and pregnancy or perinatal complications (Brown and Eisenberg, 1995). Unintended pregnancy has long been acknowledged as an important health, social and economic problem that creates hardships for women and their infants. Those consequences, in turn, have a broad societal impact such as the burden placed on the family, the increase in governmental health expenditures and the financial assistance for women living in poverty.

Conventional measures of unintended pregnancy are designed to capture a woman's intentions before she became pregnant (Henshaw, 1998). Thus, for each pregnancy ended since January 2005, all respondents were asked about the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either planned (i.e., wanted at the time it occurred), mistimed (i.e., occurred earlier than desired), unwanted (i.e., occurred when no children, or no more children, were desired), or unsure. Mis-

Figure 4.6.1 Demographic Terminology for Pregnancy Intentions

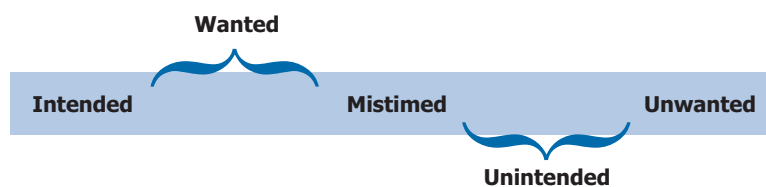
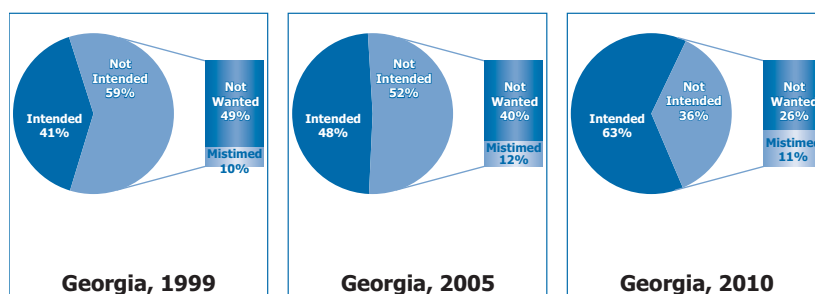


Figure 4.6.2 Planning Status of the Last Pregnancy Among All Women Aged 15-44 Years: 1999, 2005, 2010



timed and unwanted pregnancies together constitute unintended or “unplanned” pregnancies (Westoff, 1976) (Figure 4.6.1).

Reliable information on pregnancy intention, however, is difficult to collect. One common problem is the underreporting of pregnancies that ended in induced abortions. Because the majority of these pregnancies are mistimed or unwanted, unplanned pregnancies will be underreported to the extent that abortions are underreported. However, abortion underreporting does not appear to be a major concern in GERHS10 (see Chapter 5). Another problem may be due to retrospective rationalization and ambivalence about pregnancy intention when the outcome is a live birth. Compared to self-assessments of pregnancy intention at the time of conception, retrospectively reported intentions after the child is born tend to be more positive (Miller, 1994). Thus, the data presented here represent conservative estimates of the true levels of unintended pregnancy.

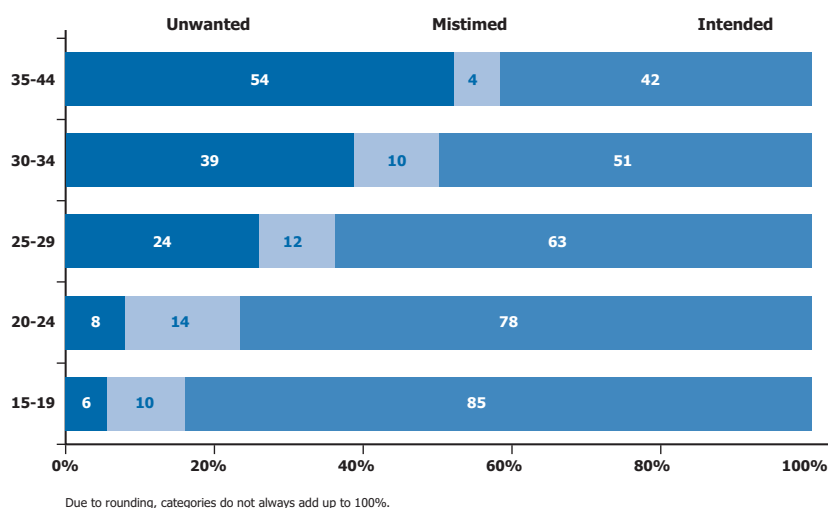
In GERHS10, almost two thirds (63%) of women who have been pregnant in the past 5 years reported the last pregnancy as planned; 10% reported the last pregnancy as mistimed and 26% as unwanted, resulting in a total of 36% unplanned, i.e. not intended (Table 4.6). This compares with a level of 52% of women reporting their last pregnancy as unplanned (not intended) in 2005 and 59% in 1999 (Figure 4.6.2). As in previous surveys, the majority of unplanned pregnancies were unwanted, but mistimed pregnancies were a larger share of all unintended pregnancies (11% of 36%) or 31% than ever before (23% in 2005 and only 17% in 1999). This shows the continuing need for attention to contraceptive services for couples wishing to space, with good timing.

As Table 4.6 shows, the majority of women whose last pregnancy resulted in a live births said the birth was planned (94%). Conversely, only 3% of women whose last pregnancy ended in induced abortion reported that the conception was planned. A relatively high proportion (19%) of women whose last pregnancy ended in miscarriage or stillbirth reported the conception as unwanted. This is almost 10 times the proportion found among women with live births (2%), suggesting that either unintendedness had a negative influence on pregnancy development and outcome or that some of these outcomes may have been in fact induced abortions, misreported as other fetal losses. The high rate of unwanted conceptions for pregnancies ending in miscarriage or stillbirth was similar to that observed in the 1999 and 2005 (Serbanescu et al., 2001, 2007).

Overall, the proportion of planned pregnancies surpassed those unplanned in all age groups except for women aged 35–44 years and those with three or more children, where the proportion fell below 50%. The proportion of pregnancies that were unplanned increased dramatically at the higher ages and family sizes (Figure 4.6.3). However among young women, aged 15–19, only 16% of pregnancies were unplanned and most of their unplanned pregnancies were mistimed rather than unwanted. The unwanted-to-mistimed ratio for these women was about 0.6:1, that is 5.8/9.7, and it was the same at ages 20–24. However it then reversed, and ranged from 2.1:1 to 3.8:1 to 14.9:1 across the next higher age groups. The higher the age the more conceptions were regarded as unwanted as opposed to merely mistimed.

Thus, mistimed pregnancies are rapidly replaced by unwanted pregnancies with an increase in maternal

Figure 4.6.3 Planning Status of the Most Recent Pregnancy by Maternal Age among Women Aged 15–44



age, primarily because the desire for birth-spacing is replaced by the desire to terminate childbearing. As a result, virtually all unintended pregnancies were unwanted at older ages. Women who had never given birth and women with only one child (presumably younger women) were less likely to report that their last pregnancy was unwanted than were women with two or more live births (Figure 4.6.4).

Rates of unplanned pregnancy were higher among women with the lowest education level and those with the lowest wealth quintile. They were also higher among women with an Azeri or Armenian background than among Georgian women.

4.7 Future Fertility Preferences

Knowledge about fertility expectations in a population is essential for helping couples to avoid unplanned pregnancies and attain their desired family size. Public health officials and health care providers need to be informed about fertility preferences so they can accurately help couples lower rates of unplanned pregnancies and induced abortion.

In all surveys, the desire for more children was explored by asking women if they intend to have (a/an-other) child in the future. Respondents who said that they would like to have more children were asked if they want to get pregnant right away, if they want to get pregnant within one year, within 1–2 years, or after 2 years.

The data presented in Table 4.7.1 and Figure 4.7.1 demonstrate that more than one in three women currently married or in consensual union wanted more children; an additional 6% were unsure if they wanted

to have more. Nine percent of women reported that either they or their partners were infecund. Those women were not asked about their future fertility preferences.

Future fertility preferences are strongly influenced by the number of living children. For example, 70% of married women with no children wanted to have a child and almost all of them (66%/69.6%=95%) wanted to have a child within two years. Among women with one living child, 71% wanted to have another child in the future, including 37% who said at some time within the next two years (sum of “right away” through want in 1-2 years). This percentage decreased rapidly to 21% among women with two children, and 8% among women with three or more children. Conversely, the intention to have no more children increased rapidly with increasing number of living children (Figure 4.7.2). Among women who had had three or more children, the majority (81%) were ready to terminate childbearing. Conversely, among those with no living children, only 1% said they did not want children.

The changes in fertility preferences across the three RHS surveys in Georgia are very relevant in interpreting the recent transition to higher fertility rates as documented in 2010. As shown in Figure 4.7.3, the proportion of women who stated they want to have more children increased from 25% in 1999 to 35% in 2010, a 40% increase. This trend was consistent regardless of the number of living children. Particularly notable is the relatively high proportion of women with two or more children (21%) who said in 2010 they want more children, compared to only 12% in 1999.

Figure 4.6.4 Planning Status of the Most Recent Pregnancy by Number of Living Children Among Married Women Aged 15–44

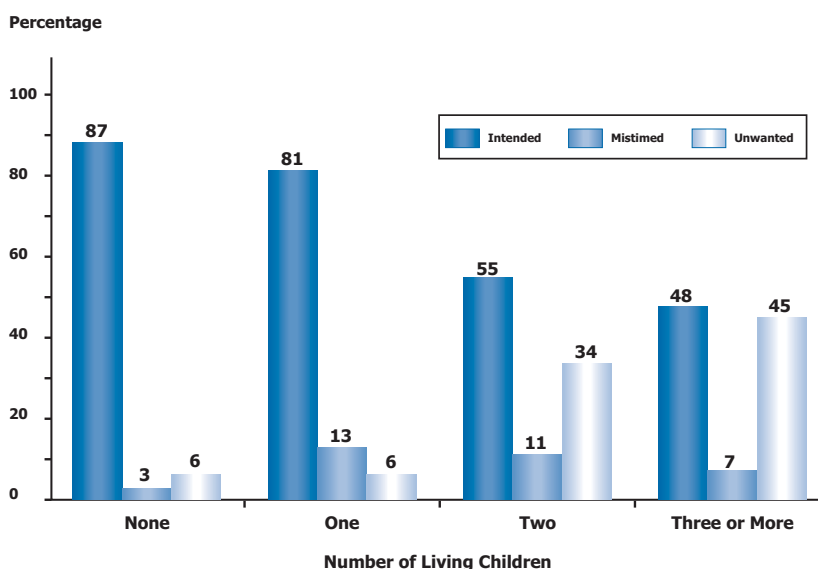


Figure 4.7.1 Future Fertility Preferences
Among Married Women Aged 15–44

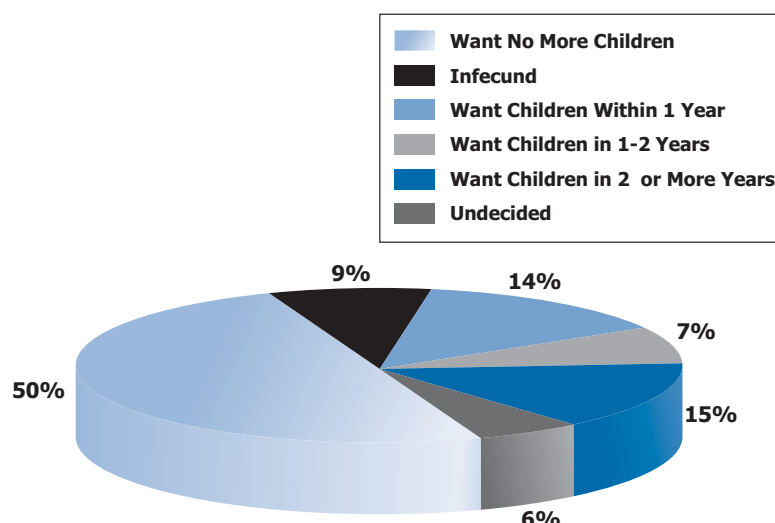
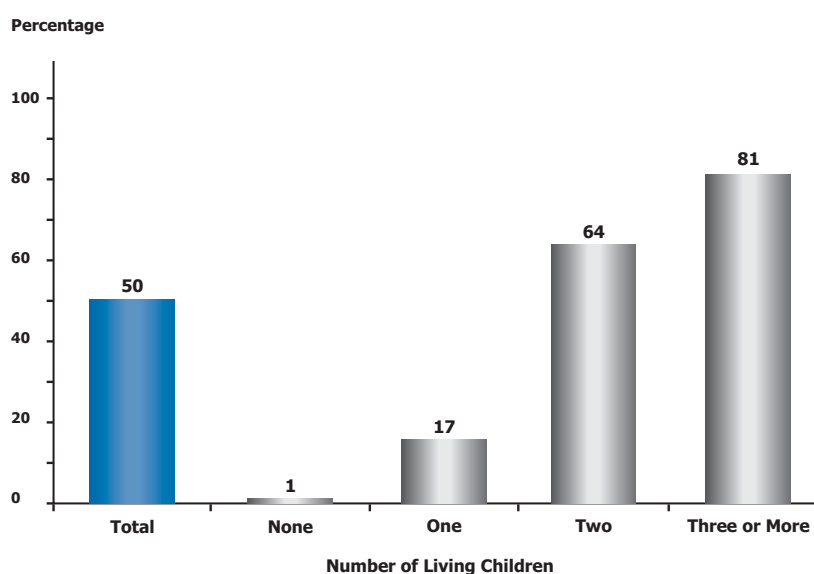


Figure 4.7.2 Intention to Have No More Children by Number of Living Children among Married Women Aged 15–44



The study of fertility patterns in Georgia has demonstrated a high concentration of childbearing at relatively young ages. Not surprisingly, the desire to have children was very high among young Georgian women (89% among 15–19 year-olds and 73% among 20–24 year-olds), declining to 47% at ages 25–29 and declining further among women aged 30 or older (bottom panel of Table 4.7.1). About half of those wanting a(another) child wanted it within two years (Figure 4.7.4): for example 45% at ages 15–19 out of the 89% just mentioned who wanted a(another) child at some time in the future. On the other hand, among women aged 29 or younger who desired additional children, one in two wanted to wait at least two years (e.g. 34.8/72.8 at ages 20–24). Women aged 30 or older who wanted more children were more likely to want

the child within the next two years and by age 40 nearly all did so.

Between 1999 and 2010, there were notable changes in the timing of having a(another) child by the current age. Among the youngest women, the proportion who wanted a child within two years had declined sharply, by over a fourth, from 61% to 44% but no declines appeared in the proportions of women aged 30 or older wanted to have a (another) child within the next two years. These findings are consistent with the observed decline in adolescent age specific fertility rates and the increased fertility of women aged 30 years or older and may predict future increases of childbearing among older women.

Figure 4.7.3 Intention to Have More Children by Number of Living Children, for Married Women Aged 15–44: 1999, 2005, 2010

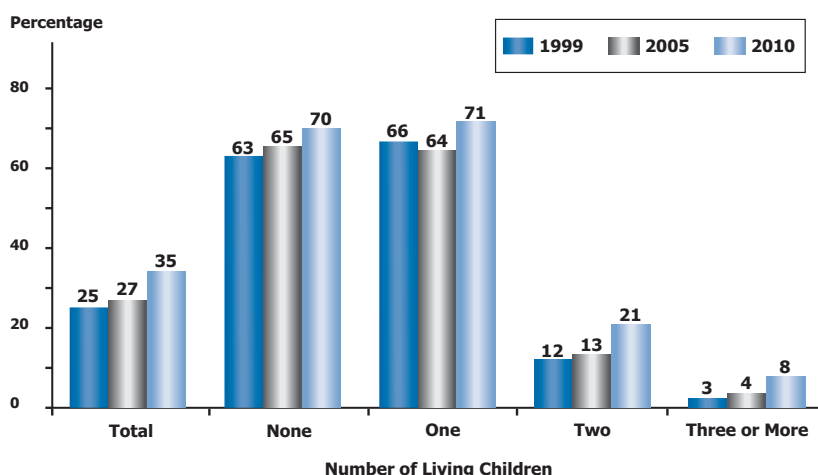
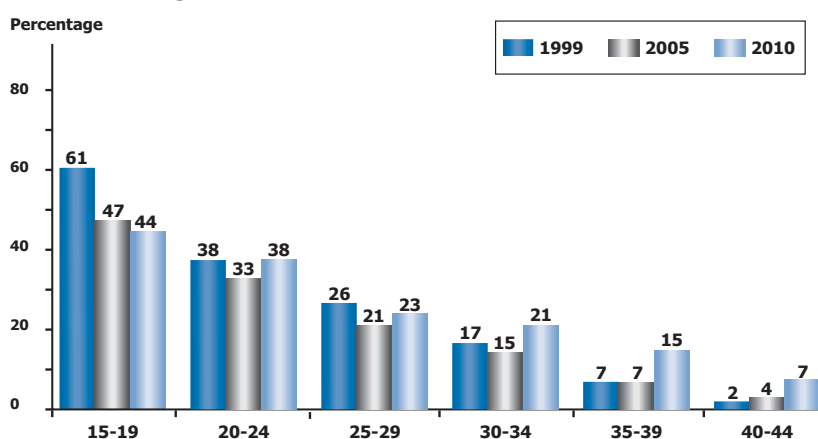


Figure 4.7.4 Intention to Have Children within Two Years by Age Group among Married Women Aged 15–44 1999, 2005, 2010



A more accurate analysis concerning women who want no more children is obtained by restricting the view to only fecund women, i.e. those who can get pregnant and may be at risk of unintended pregnancy (Table 4.7.2). Further the exclusion of infecund women permits a better examination of trends. (Between 1999 and 2010 there was a notable reduction in the infecund group, from 14% to 9%). The inverse relationship between wanting no more children and parity is now more pronounced. Overall, 54% of Georgian women who could conceive reported that they did not want to have more children, but this proportion increased from 18% among those with one living child to 87% among those with three or more children (Figure 4.7.5). Among women with one child, the desire to have no more children was higher for urban women than for rural women (21% vs. 15%) and it increased directly with the education level.

At any parity, the intention to terminate childbearing was directly correlated with age. This pattern is similar to the one documented in the 1999 and 2005 surveys,

but fewer women with two or more children in 2010 said they do not want to have a (another) child than in 1999 or 2005.

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

4.8 Infertility Problems

The 2010 survey included a module designed to assess current infertility levels and document existing reproductive health services for women with impaired fecundity. Infertility is often cited as a reproductive health concern in Eastern Europe given the dramatic declines in fertility, widespread use of abortion,

increase in sexually transmitted infections and PID cases, and deficient health infrastructure. Although no clear documentation demonstrates that infertility rates in Georgia are increasing, anecdotal evidence leads to widespread beliefs that Georgian women seek treatment for infertility services more often than in the past, either because they may suffer from pelvic infections (as complications of abortion or childbirth) or because they experience a strong cultural pressure to conceive soon after marriage. Given that data on infertility and receipt of infertility services have implications for projecting future demand for services and health care costs, the survey included a series of questions about service attendance and diagnosed problems.

The term “impaired fecundity” in this chapter refers to a couple’s impaired ability to conceive or maintain pregnancy either because of a known medical condition or because of absence of conception after at least two years of exposure to unprotected intercourse. As shown in Table 4.8.1, 10% of sexually experienced women or their partners had at some time received any infertility services and been diagnosed with impaired fecundity. The proportion of women with the “ever” diagnosis was higher in Tbilisi than in other urban or rural areas, probably because women in Tbilisi have better access to medical services that can diagnose fecundity impairment. However among the five percent of women who reported a current fecundity impairment, Tbilisi had the smallest proportion, and rural areas had the highest proportion with problems.

Current fecundity impairment increased directly with age, from 1.5% among 20- to 24-year-olds to 13% among women aged 40 or older. An exceptionally high proportion of nulliparous women reported current and ever-impaired fecundity (also known as primary impaired fecundity). Also, the proportion of women

with ever-impaired fecundity was over three times higher among women who had had episodes of PID than among those without PID.

Among the 10% of sexually experienced women who had attended infertility services at some time, about 25% (not shown) had pursued special medical help during the 12 months prior to the interview.

Infertility problems diagnosed while seeking medical help to become pregnant are presented in Table 4.8.2. (Patients can report multiple diagnoses, so some rows add to more than 100%; other rows are less than 100% due to 75 cases with missing information). Most problems concerned ovulation difficulties, but the rest were about evenly divided at 10% to 15% each. The diagnoses varied considerably by residence and by region, as well as by most other subgroups shown in the table.

In conclusion for Chapter 4, the decline in fertility observed in Georgia in the 1990s and early 2000s was likely precipitated by the economic and social impact of the post-Communist transition. The recent fertility recovery documented in the 2010 survey coincided with the recent economic growth and political stability in the country. Currently, the adolescent fertility rate has declined but women at higher ages have an increased desire for additional children and are less likely to experience unintended pregnancies than their counterparts five years ago. Consequently, an increasing number of women have the number of children they want when they want them and fewer state they want no more children. As such, it is essential for the family planning efforts in Georgia to provide contraception advice that adequately takes into account the fertility preferences of individuals and their plans for the onset, spacing, and completion of childbearing.

Figure 4.7.5 Intention to Have No More Children by Number of Living Children among Fecund Married Women Aged 15–44: GERHS 1999, 2005, 2010

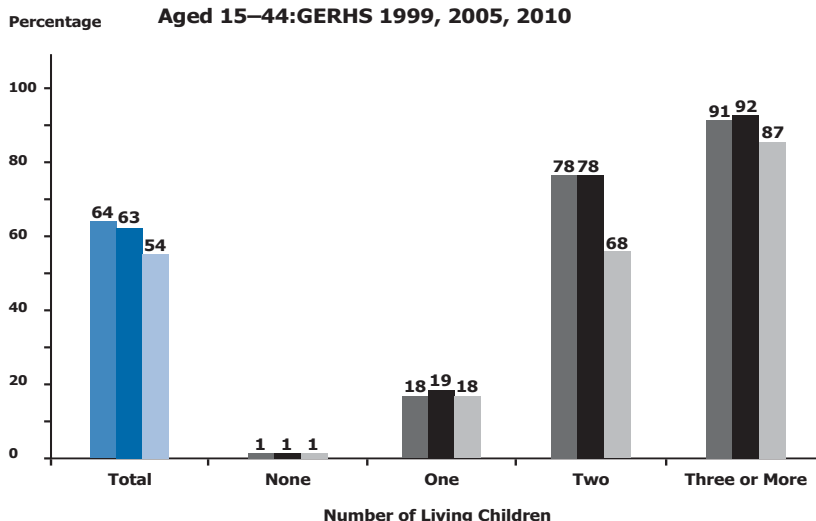


Table 4.1.1

**Three-Year Age-Specific Fertility Rates and Total Fertility Rates
for Three Time Periods Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 1999, 2005 and 2010**

Age Group (Years)	Age-Specific Fertility Rate (per 1,000 Women)*		
	2007–2010 GERHS10 [†]	2002–2005 GERHS05 [‡]	1996–1999 GERHS99 [¶]
15–19	39	47	65
20–24	142	109	113
25–29	115	85	92
30–34	62	47	48
35–39	30	18	21
40–44	(11)	(7)	(7)
Total Fertility Rate (Per Woman)	2.0	1.6	1.7
General Fertility Rate (per 1,000 Women/Year)	72	55	66

* Age at birth.

† Births and exposure occurring between October 2007 and September 2010.

‡ Births and exposure occurring between March 2002 and February 2005.

¶ Births and exposure occurring between December 1996 and November 1999.

() Time exposed partially truncated because the sample does not include all women exposed during the reference period.

Table 4.1.2

**Number of Children Born Alive by Current Age of Respondents
Among All Women and Among Married Women Aged 15–44
Reproductive Health Survey: Georgia, 2010**

Number of Children Born Alive	All Women						
	Total	Age Group					
		15–19	20–24	25–29	30–34	35–39	40–44
0	41.1	94.8	59.3	31.2	19.1	15.2	15.3
1	18.4	4.6	27.3	27.5	18.0	16.8	15.4
2	28.5	0.5	12.0	33.5	45.7	44.8	42.0
3	9.3	0.1	1.3	7.3	13.4	16.9	20.6
4 or more	2.7	0.0	0.0	0.5	3.8	6.2	6.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,292	861	1,099	1,191	1,168	1,051	922
Number of Children Born Alive	Married Women						
	Total	Age Group					
		15–19	20–24	25–29	30–34	35–39	40–44
0	9.7	55.5	20.6	8.0	5.7	5.0	4.7
1	26.0	39.6	52.5	35.5	18.0	15.5	12.4
2	45.4	4.2	24.1	46.0	55.7	52.5	49.5
3	14.8	0.7	2.6	9.8	16.3	19.6	25.5
4 or more	4.1	0.0	0.1	0.7	4.3	7.5	7.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,098	124	610	863	948	836	717

Table 4.2

**Three-Year* Age-Specific Fertility Rates and Total Fertility Rates
by Selected Characteristics Among All Women Aged 15–44**
Reproductive Health Survey: Georgia, 2010

Characteristic	Age-Specific Fertility Rate (per 1,000) [†]						Total Fertility Rate (Births per Woman)
	15–19	20–24	25–29	30–34	35–39	40–44	
Total	39	142	115	62	30	11	2.0
Residence							
Urban	25	134	108	70	29	8	1.9
Rural	57	151	123	54	31	13	2.1
Region							
Kakheti	77	168	85	40	21	24	2.1
Tbilisi	21	127	121	73	32	13	1.9
Shida Kartli	33	133	131	59	30	0	1.9
Kvemo Kartli	64	129	118	50	22	6	1.9
Samtskhe-Javakheti	55	132	131	61	15	30	2.1
Adjara	19	166	142	58	31	26	2.2
Guria	45	138	86	53	20	0	1.7
Samegrelo	23	171	86	80	20	0	1.9
Imereti	53	135	105	62	46	0	2.0
Mtskheta-Mtianeti	39	167	148	57	26	26	2.3
Racha-Svaneti	65	198	96	67	35	5	2.3
Education Level							
Secondary incomplete or less	44	162	88	37	32	26	1.9
Secondary complete	48	166	118	54	25	7	2.1
Technicum	36	160	100	66	37	14	2.1
University/postgraduate	16	118	126	75	28	5	1.8
Wealth Quintile							
Lowest	53	148	112	47	27	12	2.0
Second	57	182	111	62	25	15	2.3
Middle	47	132	117	68	37	12	2.1
Fourth	20	118	100	61	35	3	1.7
Highest	27	133	130	69	25	11	2.0
Ethnicity							
Georgian	30	141	117	65	30	9	2.0
Azeri	143	184	96	18	29	0	2.4
Armenian	59	118	101	70	22	0	1.9
Other	66	144	111	60	40	73	2.5

* Births and exposure occurring between October 2007 and September 2010.

† Births per 1000 women per year, by age at birth

Table 4.3 Current Marital Status of Women Aged 15–44 Years by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Current Marital Status				Total	No. of Cases
	Legally Married	Consensual Union	Previously Married	Never Married		
Total	57.9	1.2	6.5	34.4	100.0	6,292
Residence						
Urban	53.6	1.3	8.0	37.1	100.0	2,975
Rural	62.8	1.2	4.8	31.2	100.0	3,317
Region						
Kakheti	62.8	0.6	6.5	30.1	100.0	498
Tbilisi	50.2	1.4	8.7	39.8	100.0	1,426
Shida Kartli	60.0	1.2	5.5	33.3	100.0	392
Kvemo Kartli	61.9	1.6	7.6	29.0	100.0	546
Samtskhe–Javakheti	58.5	2.6	3.9	34.9	100.0	481
Adjara	63.6	0.9	5.5	30.0	100.0	419
Guria	63.6	.	3.2	33.2	100.0	401
Samegrelo	55.5	1.2	5.0	38.3	100.0	477
Imereti	61.2	1.0	5.6	32.2	100.0	805
Mtskheta–Mtianeti	60.6	2.7	5.1	31.6	100.0	393
Racha–Svaneti	57.2	0.5	4.3	38.0	100.0	454
Age Group						
15–19	10.3	0.3	0.8	88.5	100.0	861
20–24	47.1	1.6	3.2	48.2	100.0	1,099
25–29	69.5	1.5	4.2	24.8	100.0	1,191
30–34	77.0	1.0	8.8	13.1	100.0	1,168
35–39	77.4	1.8	10.8	10.1	100.0	1,051
40–44	75.0	1.4	13.2	10.5	100.0	922
Education Level						
Secondary incomplete or less	45.5	0.7	5.7	48.2	100.0	1,330
Secondary complete	63.5	1.5	4.9	30.0	100.0	1,568
Technicum	68.7	2.0	7.2	22.1	100.0	903
University/postgraduate	58.0	1.2	7.6	33.2	100.0	2,491
Wealth Quintile						
Lowest	62.1	1.0	5.7	31.2	100.0	1,093
Second	62.8	1.1	5.3	30.8	100.0	1,385
Middle	59.7	1.9	4.7	33.7	100.0	1,413
Fourth	52.4	1.0	8.3	38.4	100.0	1,037
Highest	54.3	1.2	8.0	36.5	100.0	1,364
Ethnicity						
Georgian	57.0	1.3	6.3	35.3	100.0	5,488
Azeri	72.3	.	5.9	21.8	100.0	276
Armenian	57.1	1.7	5.6	35.5	100.0	364
Other	60.6	0.6	14.0	24.8	100.0	164
Employment						
Working	55.6	1.3	11.9	31.2	100.0	1,410
Not working	58.5	1.2	5.0	35.2	100.0	4,882

Table 4.4.1 Percentage of All Women Who Had Their First Sexual Relation, First Union, And First Birth Before Selected Ages, by Current Age
Reproductive Health Survey: Georgia, 2010

Current Age	Age at First Sexual Intercourse					Has Had Sexual Intercourse	Never Had Intercourse	Median Age	No. of Cases*
	<15	<18	<20	<22	<25				
15–19	0.5	(8.4)	(11.5)	NA	NA	11.5	88.5	†	861
20–24	1.2	14.4	29.5	(46.1)	(52.2)	52.2	47.8	†	1,099
25–29	0.9	14.6	30.0	45.5	65.9	75.3	24.7	22.4	1,191
30–34	2.0	24.4	40.9	52.3	67.7	86.9	13.1	21.1	1,166
35–39	0.7	21.6	43.2	55.9	69.6	90.1	9.9	20.6	1,051
40–44	0.7	11.2	32.8	51.4	67.5	89.5	10.5	21.6	922
Total	1.0	15.7	30.8	43.1	54.6	65.7	34.3	21.8	6,290
Current Age	Age at First Union					Ever in Union	Never Had Intercourse	Median Age	No. of Cases
	<15	<18	<20	<22	<25				
15–19	0.4	(8.3)	(11.5)	NA	NA	11.5	88.5	†	861
20–24	1.1	14.0	28.8	(45.6)	(51.8)	51.8	48.2	†	1,099
25–29	1.2	14.7	29.6	45.6	65.8	75.2	24.8	22.6	1,191
30–34	2.2	24.9	41.0	52.7	66.7	86.9	13.1	21.4	1,168
35–39	0.9	22.1	42.9	55.6	69.3	89.9	10.1	21.0	1,051
40–44	0.6	11.0	32.4	51.2	66.7	89.5	10.5	21.9	922
Total	1.0	15.7	30.6	43.0	54.3	65.6	34.4	21.9	6,292
Current Age	Age at First Live Birth					Has Had Live Birth	Never Had Live Birth	Median Age	No. of Cases
	<15	<18	<20	<22	<25				
15–19	0.2	(3.0)	(5.2)	NA	NA	5.2	94.8	†	861
20–24	0.0	6.1	17.7	(32.3)	(40.7)	40.7	59.3	†	1,099
25–29	0.1	6.9	20.2	35.1	55.8	68.8	31.2	24.1	1,191
30–34	0.2	11.8	29.0	42.2	57.4	80.9	19.1	23.4	1,168
35–39	0.2	9.5	26.3	44.3	60.9	84.8	15.2	22.8	1,051
40–44	0.2	4.7	17.3	36.7	58.4	84.7	15.3	23.4	922
Total	0.1	6.9	19.0	32.0	45.3	58.9	41.1	23.6	6,292

* Excludes 2 women who did not report the age at first intercourse.

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

() Age not yet attained by women aged 15–19

NA Exposure time partially truncated; not all cases have reached that age.

Table 4.4.2 Median Age at First Sexual Intercourse, First Union, and First Birth
by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Median Age at First Intercourse	Median Age at First Union	Median Age at First Birth
Total	21.8	21.9	23.6
Residence			
Urban	22.6	22.8	24.6
Rural	20.9	21.1	22.6
Region			
Kakheti	20.7	20.7	22.2
Tbilisi	23.5	23.7	25.3
Shida Kartli	20.6	20.9	22.3
Kvemo Kartli	20.8	21.1	22.6
Samtskhe-Javakheti	20.3	20.5	21.9
Adjara	21.0	21.2	22.8
Guria	21.4	21.6	23.2
Samegrelo	22.8	23.1	24.4
Imereti	21.7	22.0	23.6
Mtskheta-Mtianeti	20.9	21.3	23.1
Racha-Svaneti	23.3	23.6	25.2
Education Level			
Secondary incomplete or less	19.3	19.5	20.9
Secondary complete	20.1	20.2	21.7
Technicum	21.8	21.9	23.5
University/postgraduate	24.1	24.4	25.9
No. of Cases	6,290	6,292	6,292

**Table 4.5 Sexual Activity Status by Current Marital Status and Current Age
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010**

Sexual Activity Status	Total	Marital Status		
		Married	Previously Married	Never Married
Never had intercourse	34.2	0.0	0.0	99.7
Currently pregnant	4.6	7.6	1.3	0.0
Postpartum	3.1	5.2	0.0	0.0
Within the last month	47.6	79.8	5.9	0.1
1–3 months	2.4	3.4	6.0	0.0
Over 3 months ago but within last year	1.7	1.5	11.9	0.0
One year or longer	5.8	2.0	70.2	0.0
Unknown interval	0.6	0.4	4.8	0.1
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	4,098	389	1,805
Sexual Activity Status	Total	Current Age		
		15–24	25–34	35–44
Never had intercourse	34.2	67.7	19.0	10.2
Currently pregnant	4.6	7.0	4.7	1.5
Postpartum	3.1	3.4	4.7	0.9
Within the last month	47.6	18.5	61.7	67.7
1–3 months	2.4	0.8	1.8	5.1
Over 3 months ago but within last year	1.7	1.0	2.1	2.1
One year or longer	5.8	1.1	5.7	11.5
Unknown interval	0.6	0.5	0.4	1.0
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	1,960	2,359	1,973

Table 4.6 Planning Status of the Last Pregnancy by Selected Characteristics
Among Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Planning Status of Last Pregnancy					
	Planned	Mistimed	Unwanted	Not Sure	Total	No. of Cases
Total	63.1	10.5	25.7	0.6	100.0	2,986
Pregnancy Outcome						
Current pregnancy	86.7	9.2	3.5	0.5	100.0	294
Live Birth	93.8	3.8	2.1	0.3	100.0	1,526
Induced Abortion	3.1	22.4	73.5	0.9	100.0	953
Other pregnancy outcome*	70.6	8.1	19.2	2.1	100.0	213
Residence						
Urban	66.5	11.4	21.6	0.5	100.0	1,354
Rural	59.7	9.6	29.9	0.8	100.0	1,632
Maternal Age at End of Pregnancy [†]						
15–19	84.5	9.7	5.8	.	100.0	193
20–24	78.0	13.6	8.1	0.4	100.0	836
25–29	63.4	11.5	24.3	0.8	100.0	885
30–34	50.6	10.2	38.5	0.6	100.0	633
35–44	41.7	3.6	53.5	1.2	100.0	439
Number of Living Children						
0	87.2	2.9	5.7	4.2	100.0	72
1	80.9	12.7	6.1	0.3	100.0	956
2	54.7	10.7	33.8	0.7	100.0	1,484
3 or more	47.8	6.6	45.1	0.5	100.0	474
Education Level						
Secondary complete or less	57.2	10.8	31.3	0.7	100.0	1,373
Technicum	65.5	10.6	23.8	0.2	100.0	405
University/Postgraduate	68.8	10.1	20.4	0.7	100.0	1,208
Wealth Quintile						
Lowest	57.8	9.5	31.4	1.3	100.0	497
Second	61.3	9.5	28.6	0.5	100.0	709
Middle	60.6	10.5	28.1	0.8	100.0	661
Fourth	69.2	11.0	19.6	0.2	100.0	475
Highest	65.4	11.6	22.5	0.5	100.0	644
Ethnicity						
Georgian	63.9	10.9	24.7	0.4	100.0	2,541
Azeri	54.3	6.7	36.3	2.7	100.0	166
Armenian	57.9	8.9	31.6	1.6	100.0	193
Other	68.3	11.2	20.5	0.0	100.0	86

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

† Age of the woman at the time of pregnancy outcome, except for 294 pregnant women for whom the age is as of the interview.

Table 4.7.1 Fertility Preferences by Number of Living Children and Age Group Among Married Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Preference for Children	Total	Number of Living Children*			
		0	1	2	3 or more
Want more children	35.3	69.6	70.8	20.5	7.9
Want pregnancy right away	9.5	54.7	14.2	3.6	1.9
Want a child within a year	4.0	8.1	7.0	2.3	2.3
Want a child 1-2 years	7.3	3.2	16.1	5.1	1.0
Want a child 2 or more years	14.5	3.6	33.5	9.5	2.7
Undecided	6.3	0.4	3.9	9.0	4.7
Want no (no more) children	49.7	0.8	16.6	63.7	80.8
Subfecund, infecund couple	8.7	29.2	8.7	6.7	6.7
Total	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,098	281	1,110	2,053	654

Preference for Children	Total	Age Group					
		15–19	20–24	25–29	30–34	35–39	40–44
Want more children	35.3	88.9	72.8	47.0	31.1	17.4	7.2
Want pregnancy right away	9.5	29.9	14.1	11.5	9.0	7.1	3.2
Want a child within a year	4.0	3.6	6.4	3.3	4.5	3.9	2.2
Want a child 1-2 years	7.3	11.2	17.5	8.3	7.1	3.8	1.1
Want a child 2 or more years	14.5	44.2	34.8	23.9	10.5	2.6	0.7
Undecided	6.3	3.7	8.1	9.0	8.3	4.9	1.8
Want no (no more) children	49.7	7.4	17.6	38.7	53.2	66.4	72.6
Subfecund, infecund couple	8.7	0.0	1.5	5.3	7.4	11.4	18.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	4,098	124	610	863	948	836	717

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

Table 4.7.2 Percentage of Fecund Married Women Aged 15–44 Years Saying They Want No More Children, by Number of Living Children and Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Total	Number of Living Children*			
		0	1	2	3 +
Total	54.4	1.1	18.2	68.3	86.6
No. of Cases	3,728	192	1,007	1,920	609
Residence					
Urban	50.2	1.0	20.9	66.9	81.2
Rural	58.6	1.4	14.5	69.6	89.5
Age Group					
15–24	16.1	0.0	6.2	39.1	52.9
25–34	49.4	1.7	15.0	59.2	82.6
35–44	81.2	3.2	52.6	86.9	90.7
Education Level					
Secondary complete or less	59.1	1.5	16.0	72.1	90.2
Technicum	58.3	0.0	18.4	72.5	89.4
University/Postgraduate	47.7	1.3	20.1	62.4	77.9

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

Table 4.8.1 Percentage of Sexually Experienced Women Aged 15–44 Who Reported Fecundity Impairment and Received Services by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

	<u>Current Impaired Fecundity (%)</u>	<u>Ever Had Impaired Fecundity (%)</u>	No. of Cases
Total	5.1	10.5	4493
<u>Residence</u>			
Tbilisi	5.8	12.9	943
Other Urban	7.5	10.6	1105
Rural	8.9	9.3	2445
<u>Region</u>			
Kakheti	9	9	380
Tbilisi	5.8	12.9	943
Shida Kartli	8	10.1	285
Kvemo Kartli	6.4	9	420
Samtskhe-Javakheti	7.2	8.1	350
Adjara	7.4	10.4	317
Guria	10.8	7.5	290
Samegrelo	8.2	5.4	326
Imereti	10.4	13	586
Mtskheta-Mtianeti	8.3	10.2	292
Racha-Svaneti	12.3	9.7	304
<u>Ethnicity</u>			
Georgians	8	10.8	3859
Other	6.2	8.6	634
<u>Age Group</u>			
15-19	--	10.3	130
20-24	1.5	9.6	642
25-29	5.6	10	910
30-34	7.5	10.9	1036
35-39	10.8	10.3	946
40-44	12.9	11.7	829
<u>Experienced PID</u>			
Ever Had	11.9	21.1	1292
Never Had	6	6.1	3201
<u>Number of Living Children</u>			
0	18.7	33.1	477
1	7.9	12.6	1286
2	6.2	5.6	2069
3	4.5	5.9	539
4 or more	4.2	2.9	122

Table 4.8.2 Percentage of Sexually Experienced Women Aged 15–44 Years with Diagnosed Infertility Problems by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

	Problems with ovulation (includes hormonal dysfunction), %	Blocked tubes, %	Endometriosis, %	Semen or sperm problems (low count, poor motility, varicocele), %	Inflammation, %	Cyst, %	Viral Infection, %	Any other infertility problems, %	No. of Cases
Total	36.2	14.8	10.4	15.3	7.1	3.9	4.7	14.7	468
<u>Residence</u>									
Tbilisi	29.9	10.4	15.3	12.5	4.9	3.5	4.9	10.4	117
Other Urban	45.1	16.3	10.4	24.2	7.0	4.5	5.4	8.1	122
Rural	35.4	17.0	7.0	11.9	8.8	3.9	4.2	21.4	229
<u>Region</u>									
Kakheti	50.0	15.0	15.0	17.5	5.0	5.0	2.5	22.5	38
Tbilisi	29.9	10.4	15.3	12.5	4.9	3.5	4.9	10.4	117
Shida Kartli	41.2	8.8	.	5.9	2.9	8.8	5.9	29.4	31
Kvemo Kartli	33.3	13.3	4.4	13.3	8.9	4.4	8.9	31.1	37
Samtskhe-Javakheti	23.5	26.5	14.7	11.8	2.9	.	2.9	23.5	30
Adjara	43.9	26.8	2.4	19.5	19.5	2.4	.	12.2	35
Guria	36.0	20.0	20.0	16.0	.	.	8.0	16.0	22
Samegrelo	55.0	10.0	.	20.0	15.0	10.0	.	.	18
Imereti	34.5	16.1	9.2	21.8	4.6	2.3	5.7	8.0	78
Mtskheta-Mtianeti	40.5	10.8	29.7	2.7	10.8	8.1	10.8	8.1	32
Racha-Svaneti	26.5	23.5	14.7	14.7	8.8	5.9	.	11.8	30
<u>Ethnicity</u>									
Georgians	37.0	14.4	9.9	16.2	6.3	4.0	4.1	13.9	406
Other	30.4	17.8	13.9	8.5	13.6	3.5	9.4	19.7	62
<u>Age Group</u>									
15-19	49.8	6.9	7.7	.	.	.	11.5	12.4	12
20-24	39.8	15.1	11.4	18.6	8.1	3.0	6.9	12.5	53
25-29	42.0	12.1	6.5	10.7	8.4	1.5	5.1	9.6	94
30-34	30.2	16.6	12.2	18.6	5.8	5.8	4.3	16.2	110
35-39	34.1	14.9	9.6	19.3	2.5	6.7	4.1	16.4	103
40-44	35.3	16.0	12.4	11.8	12.3	2.4	3.1	16.9	96
<u>Number of Living Children</u>									
None	34.4	15.3	6.6	28.1	4.6	2.6	6.4	12.8	166
One or more	37.1	14.5	12.3	8.7	8.4	4.6	3.8	15.5	302

5 CHAPTER

INDUCED ABORTION

The Georgia reproductive health surveys have included extensive questions about women's abortion experience. The abortion module, which was specifically designed by CDC/DRH to capture details on unintended pregnancy and pregnancy termination in Eastern Europe, explores women's lifetime and recent abortion experiences. The module contains questions that prompt each respondent to report a complete lifetime pregnancy history, which includes information on each pregnancy outcome (i.e., live birth, stillbirth, miscarriage or abortion) in reverse chronological order. For abortions, each respondent is asked the date of the pregnancy termination, pregnancy duration, and intendedness of pregnancy at the time of conception (for abortions completed in the 5 years immediately before the survey). For each induced abortion completed in the past 5 years, the following additional data are collected: reasons for the abortion, partner's attitudes toward it, use of contraception at the time of conception, details related to the abortion procedure and care received, experience of early and late postabortion complications, and receipt of postabortion counseling and contraceptive methods.

Abortion-related questions are asked once more in the contraceptive module to give women another opportunity to disclose their experiences. Although complete pregnancy histories are taken, respondents are prompted to report again on the most recent pregnancy outcomes in a month-by-month calendar of pregnancy experience and contraceptive use covering of the five years immediately preceding the survey. The calendar histories ask about contraception, pregnancy status, and other events during a fixed period (usually 5 years) prior to the survey. They record pregnancy and contraception events together in one place and increase the recall of reproductive health events and their timing. They also allow for internal checks of accuracy of reporting and provide interviewers with a visual tool to help clarify inconsistencies.

After consistency checks were performed, the data collected on pregnancy histories were used to calculate age-specific and total abortion rates, in a manner similar to age-specific and total fertility rates. It should be noted that survey-based abortion statistics are often a preferred source of information about abortion in many countries in Eastern Europe (see below). The use of self-reports allows direct estimates of abortion levels among all subgroups of women (including those who seek care outside the formal health system. They provide geographic, demographic and socioeconomic characteristics of women who have had abortions (thus identifying subgroups with high unmet need for

family planning. They also simplify analysis because both the numerator and denominator of interest are readily measurable, and they allow abortion to be examined in context with other sexual and reproductive health data. Survey data also have the benefit of placing abortion research within a broader context of social and reproductive health behaviors, such as fertility and union dynamics, demand for contraceptive methods and unmet need for family planning.

5.1 Abortion Levels and Trends

Prior to 1991, a characteristic feature of the countries of Eastern Europe was their heavy reliance on abortion as a means of fertility control. In these countries, abortion had long been readily available, whereas effective means of contraception were often lacking. Following the example of the USSR, these countries legalized abortion in the mid-1950s, well ahead of the Western European countries, and had some of the most liberal abortion policies in the world. In all but two countries, abortion was legal without restrictions as to reason during the first 12–14 weeks of gestation and up to 22–25 weeks for socio-economic and medical reasons. Abortion was severely restricted only in Romania (where abortion on demand was outlawed in 1966 but liberalized again in 1989), and Albania, where the first liberal abortion law was introduced in 1995 (Rahman A et al. 1998). Currently, all countries in Central and Eastern Europe, excepting Poland, have liberal abortion laws. Because abortion has long been legal, readily available, and widely practiced in the region, social stigma is typically less pronounced than in Western Europe. However, some countries have recently experienced an increased opposition to abortion from religious leaders, former Communists, and nationalist organizations, which may influence the social acceptability of abortion.

In the absence of reliable contraceptive methods, abortion rates in the Soviet Union often exceeded the fertility rates. For example, for the entire Soviet Union in 1989, the abortion-to-live-birth-ratio was 1.3 to one, the abortion rate was 96 per year per 1,000 women aged 15–49, and the lifetime induced abortion rate was 3.3 abortions per woman. Russia, Belarus, and Ukraine had consistently reported the highest abortion rates, whereas the rates in Central Asia were substantially lower (Goskomstat USSR, 1990).

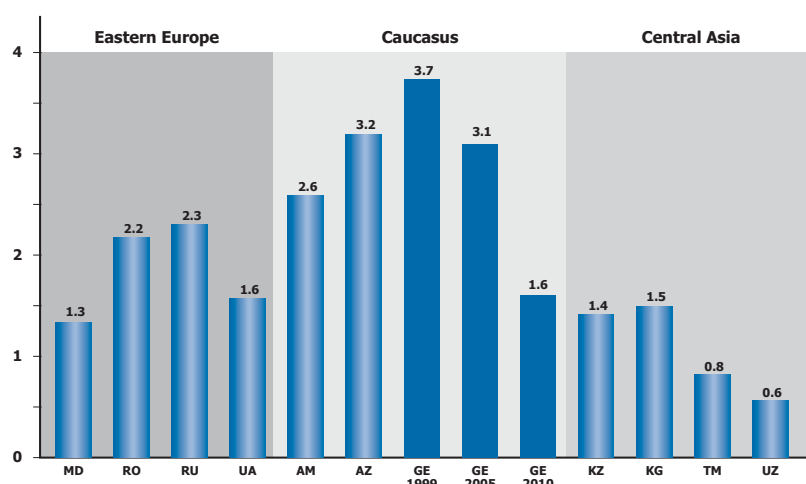
After the mid-1990s, however, the use of modern effective methods of contraception increased, with a corresponding decrease in the abortion rates (Popov and David, 1999). Nevertheless, reliance on abortion as a means of fertility control is still high in some countries (Figure 5.1.1).

Survey-based estimates have typically shown the highest abortion rates to be in the Caucasus region where, at current age-specific rates, a woman would typically have more than 2 abortions during her lifetime in Azerbaijan and Armenia. The total induced abortion rate as documented in the Georgian surveys dropped considerably over the past 10 years, from 3.7 abortions per woman in 1999 (at that time, the highest documented rate in the world), to 3.1 abortions per woman in 2005, and to 1.6 abortions per woman in 2010. However, there are no recent reproductive or demographic health survey data in Eastern Europe so the most recent abortion level in Georgia cannot be compared to abortion rates for the same period (2007–2010) from other countries.

Accurate estimates of abortion incidence are difficult to obtain in any country. The accuracy of abortion statistics depends on the presence and quality of the health information infrastructure, the methodologies employed to measure abortion rates at health facility or population levels, abortion's legal status, and societal and cultural norms (Alan Guttmacher Institute, 1999; Rossier, 2003). In countries where abortion is legal, abortion data are generally collected by government agencies that compile statistics from health facilities and abortion providers. Official statistics on abortion are available for all the former Soviet-bloc countries, but the post-Soviet era has seen a deterioration of abortion reporting. Under the former regime, abortion data were compiled by government agencies from information provided by state-run health facilities, which sometimes misreported unfavorable health statistics. The post-Soviet economic transition led to other data problems, such as those caused by the failure to record or report abortions in underfunded state-run health facilities, as well as the expansion of the private health sector whose activities are usually not included in official statistics, and, to a smaller extent, the persistence of abortions performed outside clinical settings (Serbanescu and Morris 2003). The use of inflated population projections to calculate abortion rates was another factor that may have played a role in lowering abortion rates, particularly in the Caucasus region.

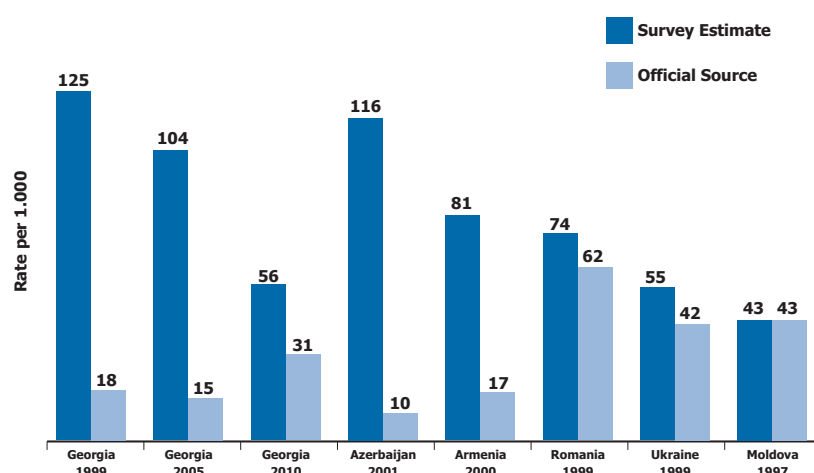
The RHS surveys in Eastern Europe provide a quick and affordable way to obtain more complete data on abortion than those provided by the routine health information systems. Despite a certain degree of sampling error and some inherent limitations (omissions, misclassification of abortions that are obtained outside the legal system, and poor recall of events that occurred long before the survey date), survey-based measurements in Eastern Europe generally give a better estimate of abortion rates and ratios than the of-

Figure 5.1.1 Total Abortion Rates (per Woman): Recent Survey Estimates in Eastern Europe and Eurasia



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

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



Source: CDC and ORC Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*; Serbanescu et al., 2007.

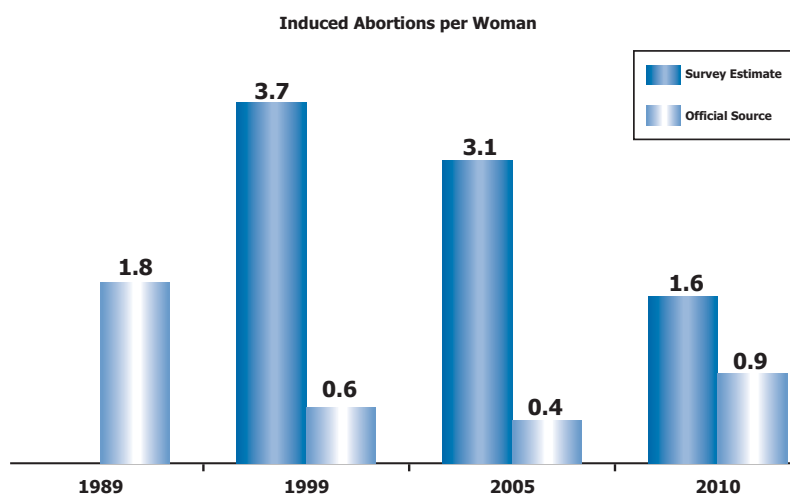
ficial statistics. Figure 5.1.2 compares abortion statistics from the surveys and from government sources in terms of the general abortion rate (GAR), a summary measure that tells the annual number of abortions per 1,000 women of reproductive age. With the exception of Moldova, where there is good agreement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

The survey data also allow for calculation of the total abortion rate (TIAR), which tells the number of abortions a woman would have in her lifetime under the

current age specific abortion rates (ASIARs). The official statistics do not routinely calculate total abortion rates. Based on the most recent ASIARs for abortions performed in governmental facilities, as reported by the Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA), the estimated TIAR for the period 2007–2010 was 0.9 abortions per woman, which is 44% lower than the rate documented in the survey but an improvement from the underreporting documented in previous surveys (over 80% underreporting of the TIAR in 1999 and 2005).

As shown in Figure 5.1.3, the abortion trends in Georgia are very different based the official statistics when compared to the survey reports and do not inform health policies about the real demand for contraceptive methods and unmet need for family planning. Reported vital statistics data indicate a steep decline

Figure 5.1.3 Trends in the Period Total Induced Abortion Rate
Survey Estimates and Governmental Sources
Georgia 1999, 2005, 2010



in the total abortion rate since the break up of the former Soviet Union (from 1.8 abortions per woman in 1989, to 0.6 abortion per woman in 1997–1999, to 0.4 abortion per woman in 2002–2004) and a recent increase to almost one abortion per woman for the period 2008–2010. This trend, however, is not paralleled in the RHS data. Previous RHS surveys showed a steep increase in the TIAR after 1990, with a peak of 3.7 abortions per woman in 1996–1999. The abortion rate declined gradually to a level of 3.1 abortions per woman (95%CI= 2.9–3.4 abortions per woman) in 2002–2005. Between the 2005 and 2010 surveys, the abortion rate dropped significantly to 1.6 abortions per woman (95%CI= 1.5–1.8 abortions per woman), a 48% decline from 3.1 (Table 5.1 and Figure 5.1.4.)

The abortion decline documented in the surveys is consistent with the increase in fertility levels, fertility desires and use of modern contraceptive methods (Figure 5.1.4). However, to verify that potential changes in women's willingness to disclose abortion experiences did not affect significantly the downward abortion trend, a check of survey-based abortion levels was performed as follows. Without the existence of reliable national data, there are few options for estimating the level of completeness of abortion reporting in population-based surveys. But consistency of reporting on abortion may be examined by comparing abortion rates for the same cohorts of women in the same period of time from successive surveys. The 5-year, age-specific abortion rates of women aged 15–39 in the period 6–8 years before the most recent cycle of the survey (GERHS10) was found to be within confidence intervals of the corresponding abortion rates for the same calendar period (2002–2005) using data from the GERHS05 survey (Figure 5.1.5).

Table 5.1 also presents age specific abortion rates for women aged 15–44 years for three time periods. To avoid age truncation, the most recent 3-year period before each survey is used. The rates were calculated by using the month and year of each abortion and the age of the woman at the time of the pregnancy's termination. The survey data were also used to calculate the general abortion rate (the number of abortions per year per 1,000 women aged 15–44), averaged over the 3 years preceding each survey. The rate dropped from 125 in 1996–1999 to 104 in 2002–2005 and 56 in 2007–2010.

(The comparative figures in the official statistics were 18, 15, and 31 abortions per 1,000 women, respectively (see Figure 5.1.2 above)

The survey-based estimate of the abortion-to-live-birth ratio changed from to 2.1 induced abortions for each live birth (2.1:1) in GERHS99, to 1.5:1 in GERHS05 to 0.8:1 in GERHS10. Thus, birth experience surpassed abortion experience in 2010 for the first time since survey-based reports were collected. This was mainly achieved by a combination of increases in fertility and declines in abortion in the age-groups 20–24, 25–29, and 30–34, which contribute the most to both total fertility and total abortion rates (Figure 5.1.6).

Unlike fertility, which is most concentrated at ages 20–24 years, abortion rates are most concentrated at ages 25–29 years (102 induced abortions per year per 1,000 women) and 30–34 years (83 per 1,000), the two age groups that account for more than half (56%) of the TIAR. The third highest age specific abortion rate (57 per 1000), contributing to 25% of the TIAR, occurred among women aged 35–39 years. The ASIARs were significantly higher than ASFRs only

Figure 5.1.4 Changes in Fertility, Abortion Rate and Contraceptive Prevalence between 1999 and 2010

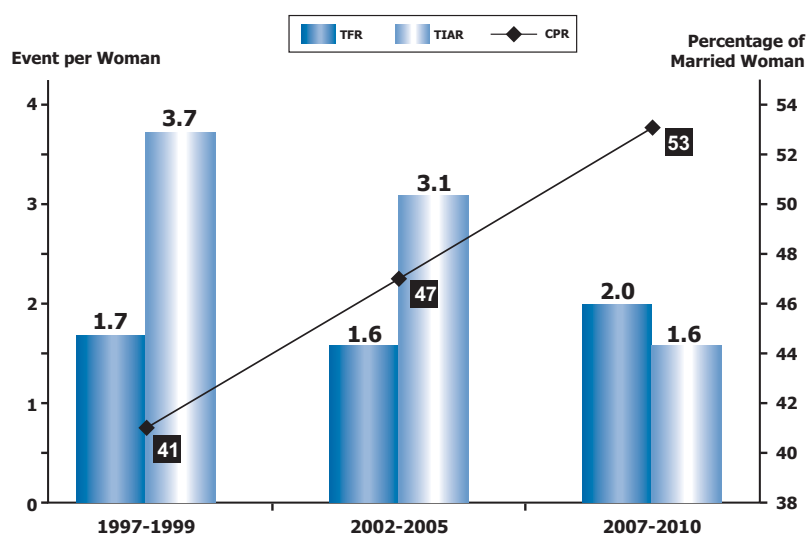


Figure 5.1.5 Total Fertility Rate and Total Abortion Rate for Women Ages 15–39 in the Period 2002–2005 Using GERHS05 and GERHS10

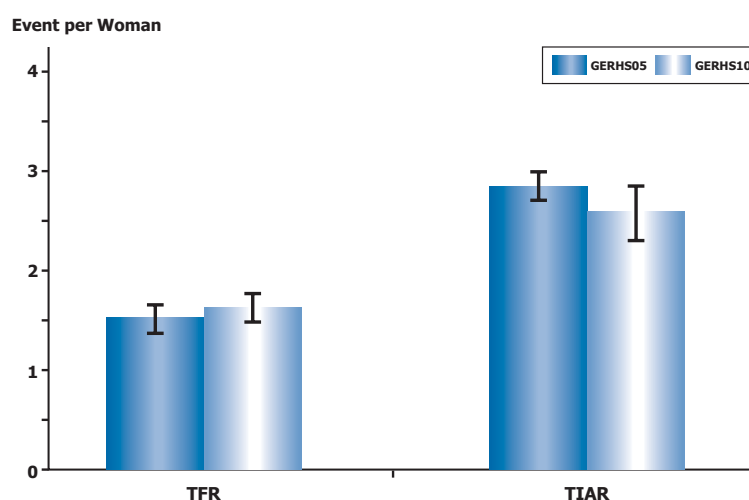


Figure 5.1.6 Three-Year-Period (2007–2010) Age-Specific Fertility and Abortion Rates per 1,000 Women Aged 15–44

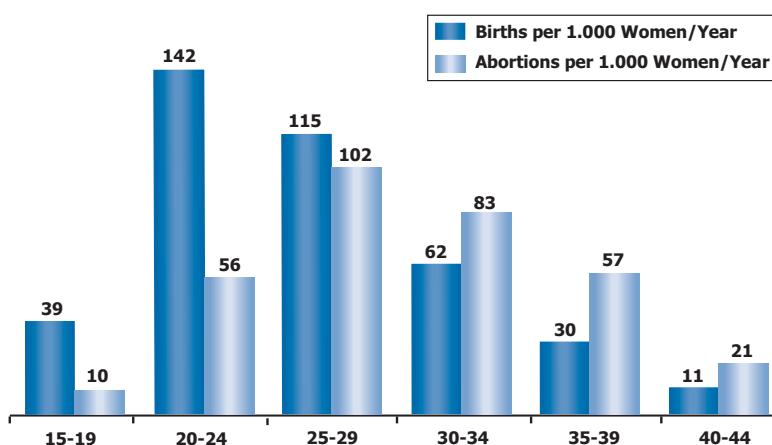


Figure 5.1.7 Three-Year-Period Age-Specific Abortion Rates for Three Time Periods among All Women Aged 15–44 Georgia 1999, 2005, 2010

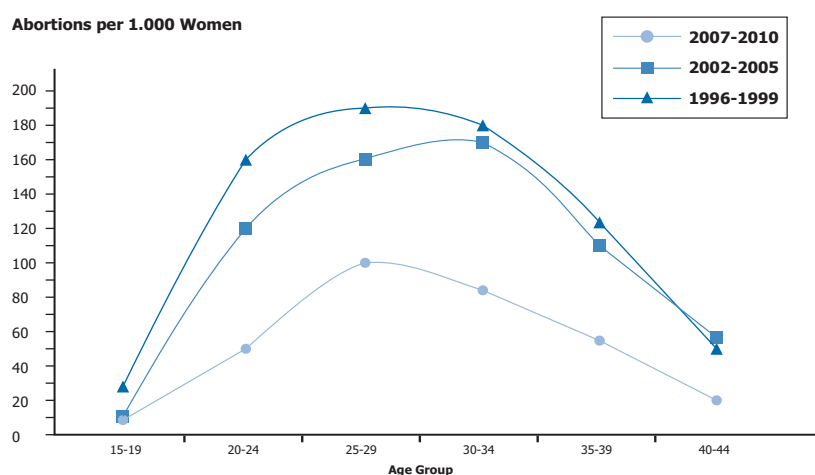
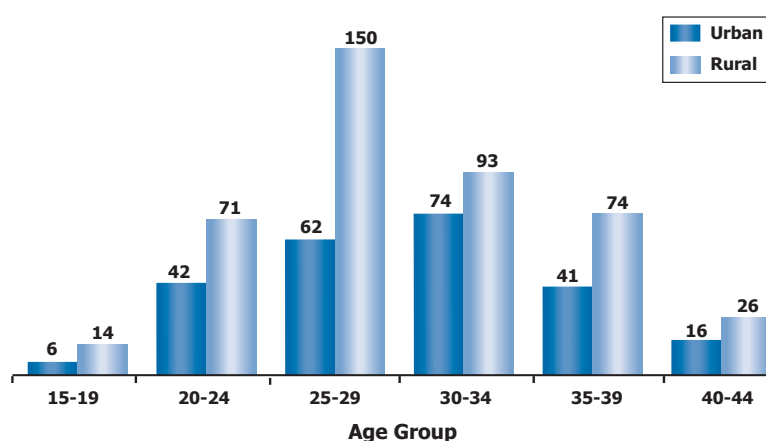


Figure 5.2.1 Three-Year-Period (2007–2010) Age-Specific Abortion Rates (per 1,000 Women Aged 15–44) by Residence



among women aged 30 or older, suggesting that most Georgian women continue to achieve their desired family size before age 30 after which, in the event of having unplanned pregnancies they are more likely to end them in induced abortions (Figure 5.1.7).

Strong age-specific distribution patterns were also documented in previous surveys (Table 5.1 and Figure 5.1.7). Very large declines in the rates occurred at ages 20 through 39, with a modest change in the six year period between the first and second surveys, and then an especially sharp one in the five year period between the second and third surveys. Overall the abortion rate at ages 20-24 fell by a full 65%. In the next higher age groups, for 25-29, 30-34, and 35-39, the declines were 47%, 46%, and 53%.

The figure shows rates; in terms of absolute numbers the savings in abortions were greatest between ages 20 and 29 since the numbers of married women in the base are largest there.

5.2 Induced Abortion Differentials

Table 5.2.1 shows total and age-specific abortion rates among all women by the women's background characteristics. Women in rural areas continue to have much higher age-specific abortion rates than urban women (Figure 5.2.1). Abortion rates were higher among rural women than urban women at all ages, but the greatest difference (2.4 times higher) was observed among women aged 25–29 years, the group that accounts for the largest contribution to the TIAR.

Total abortion rates were highest among residents of Kvemo Kartli (2.4 abortions per woman), and among residents of Shida Kartli, Samegrelo, Guria, Mtskheta-Mtianeti, and Kakheti (1.9–2.2 abortions per woman) (Figure 5.2.2). The lowest TIARs were documented in Tbilisi, Racha-Svaneti, and Adjara (1.1–1.2 abortions per woman). The TIAR was highest for women with less than complete secondary education; on average, they underwent 1.7 abortions more than women with

a university education (2.7 vs. 1.0 abortion per woman).

The TIAR was also inversely correlated with the wealth quintile of the households, declining from around two abortions per woman in households in the lowest wealth quintiles to about one abortion per woman the highest quintile. Abortion rates were highest among women of the Azeri ethnic group (3.3 abortions per woman) and lowest among Georgian women, at 1.5 abortions per woman). Azeri women consistently reported the highest abortion rates at any age, but the largest differences with Georgian women were among 25–29 year-olds and 30–39 year-olds, the age groups that contribute to over 75% of the TIAR (Figure 5.2.3).

Abortions are somewhat concentrated among a subset of women, since only 37% of all women report any lifetime experience with the method (Table 5.2.2). That figure reflects the near absence of abortions among the unmarried or those recently married, many of whom are seeking their first child. Among those with experience, women cluster toward a smaller number of abortions: 55% report only one or two; 70% report one to three. Nevertheless, at the other extreme, 11% report having had seven to ten or more. Abortion experience is greater in rural than in urban areas, but is less among the less educated. The bottom three quintiles report more experience than the upper two; this may be related to rural residence and older age. The Azeri ethnic group is notable for a higher experience with lifetime experience and more with numerous abortions than the other groups.

Most abortions (59%) were performed at 7-9 weeks of gestation (Table 5.2.3). The decision to perform abortion after 10 weeks of gestation correlated with three

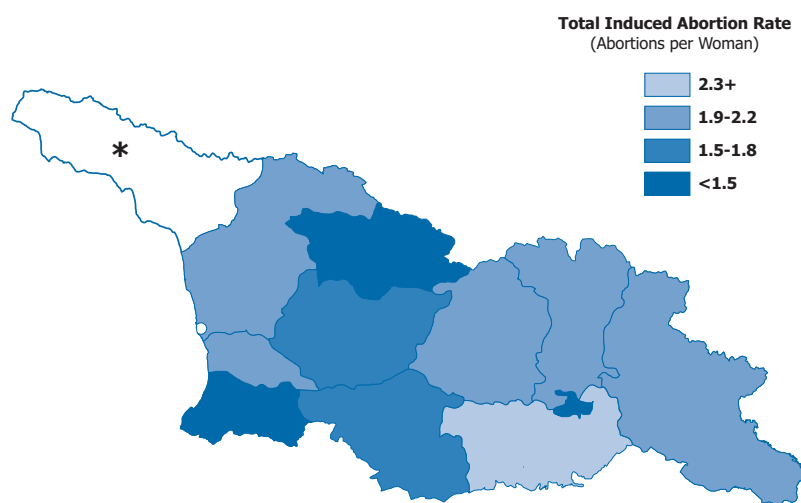
or more children. In the group of respondents with no children only 5% had abortions later, while it reached 16% for women with three children and 29% for women with four or more children.

5.3 Abortion Services

As part of the former USSR, Georgia was subject to liberal abortion legislation issued by the Soviet Supreme Council in November 1955. The law remained in force for many years, essentially unchanged except for several minor additions and modifications. Briefly, these changes allowed for abortion by electric vacuum aspiration; permitted abortions in the first seven weeks of pregnancy (mini-abortions) to be performed in ambulatory clinics; authorized abortion on medical and social grounds up to 28 weeks of gestation; and legalized “commercial” abortions in private clinics and for-fee sections of state hospitals (USSR MOH, Order No. 234 of March 1982, order No. 757 of June 1987 and Order No.1342 of December 1987).

These provisions constituted the foundation for legal abortion in Georgia until 1997, when the new health care law included detailed provisions concerning abortion and contraception practices (Government of Georgia, 1997). Under the current law, abortion is permitted without restrictions as to reason during the first 12 weeks and for social or medical reasons beyond 12 weeks (IPPF, 2007). A written consent of the woman and pre-abortion counseling are necessary before the abortion. Parental consent is required for adolescent girls under 16 years of age. Induced abortion can be performed only by gynecologists, using either vacuum aspiration or sharp curettage; abortion procedures are permitted only in medical facilities that have been state-certified for performing abor-

Figure 5.2.2 | **Three-Year-Period (2002–2005) Total Induced Abortion Rate by Region**



* Abkhazia: Autonomous region not under government control

Figure 5.2.3 | **Three-Year-Period (2007–2010) Age-Specific Abortion Rates by Ethnicity**

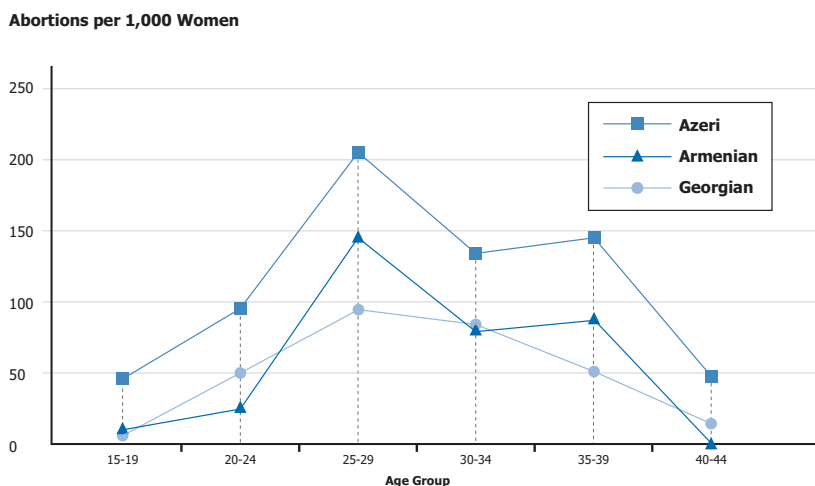
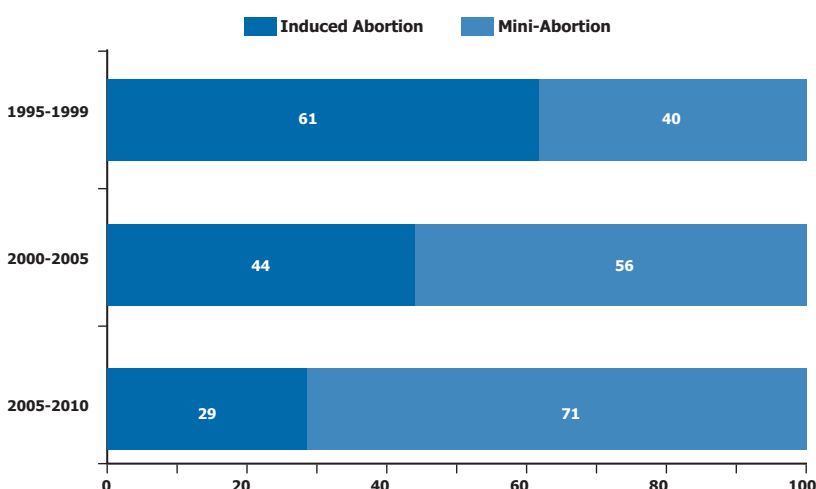


Figure 5.3.1 | **Percentage Distribution of Abortions by Type of Procedure (abortions in 5 years prior to survey)**



tion. Abortion patients are typically released the same day of the procedure if they do not have postabortion complications. Outpatient medical facilities (e.g., women's consultation clinics and private clinics) can perform induced abortion only by vacuum aspiration.

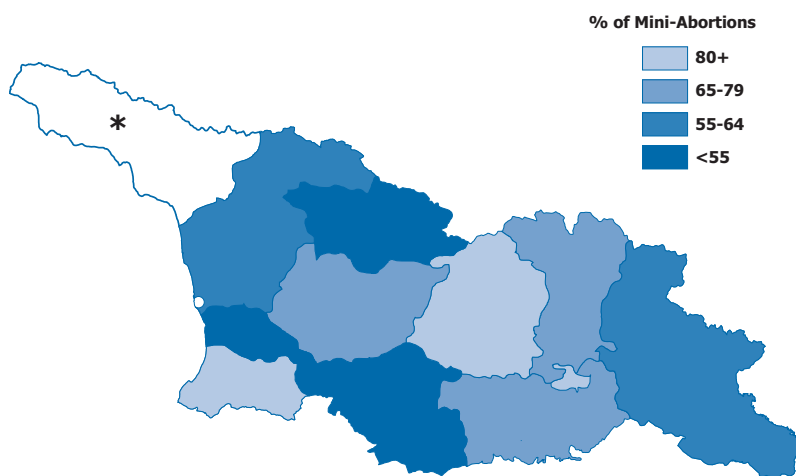
The cost of abortion procedures is not covered by health insurance, but it is relatively low. Unofficial payments or payments for "extra" services, such as anesthesia, can increase the cost by a considerable amount.

The standard abortion module in the RHS surveys includes information on respondents' last four abortions performed during the five years prior to the survey. For each abortion questions are asked about the reason for the abortion; the place where the procedure was performed; abortion registration and payments;

use of local or general anesthesia and antibiotic prescriptions; number of nights, if any, spent in the hospital after the procedure; any early or late complications after the abortion; and the type of counseling received before and/or after the abortion. Data are collected starting with the most recent procedure, in an attempt to minimize recall biases.

Of all abortions reported by survey respondents in the five years prior to 2010, the majority (71%) were mini-abortions (Table 5.3.1 and Figure 5.3.1). The high proportion of mini-abortions contrasts with the level documented in 1999 and 2005, when only 40% and 56% of all abortions, respectively, were reported as mini-abortions. Mini-abortions were more prevalent among respondents residing in Tbilisi, Shida-Kartli and Adjara (over 80% of all abortions) (Figure 5.3.2). Urban residents (81%) were more likely to have had

Figure 5.3.2 | Percentage of Mini-Abortions Among All Abortions in the Past 5 Years by Region



* Abkhazia: Autonomous region not under government control

mini-abortions than rural residents (63%). The proportion of abortions classified as mini-abortions decreased somewhat with woman's age and increased directly with education and higher wealth quintiles.

As shown in Table 5.3.2 and Figure 5.3.3, most induced abortions occurring in 2005 or later were performed in gynecological wards (56%); 42% were performed in ambulatory clinics, such as women's consultation clinics (WCCs); and 2% were performed outside medical facilities. Abortions performed in ambulatory clinics were more prevalent in Tbilisi and other urban areas (70% and 51%) than in rural areas (30%). Compared to previous surveys, the place of most abortion procedures in urban areas gradually shifted from hospitals to ambulatory settings—the proportion of abortions performed in ambulatory clinics increased from 38% in 1999, to 42% in 2005, to 60% in 2010—but remained predominantly hospital-based in rural areas (data not shown). The proportion of abortions performed in ambulatory clinics increased with education and higher wealth quintiles.

Almost 2% of pregnancy terminations were reported to have taken place outside the health system. Because abortions performed outside medical facilities (self-induced, performed by lay persons, or performed by doctors outside the health system) are illegal, it is likely that women were reluctant to admit these outcomes, in spite of the interviewer's assurance of anonymity. Therefore, this figure is probably an underestimate of the proportion of abortions performed outside the health facilities.

As Table 5.3.3 shows, there were 2054 abortions that occurred to the respondents between January 2005 and the date of the interview, approximately a five

year period. (Some respondents reported more than one abortion.) For only 548 (26.4%) of the pregnancies did the women report using any contraceptive method prior to the pregnancy (at the time of conception). (Again, some respondents reported more than one pregnancy with contraceptive use.)

So about one out of four abortions (26%) was reportedly due to contraceptive method failure, most of them (76%) due to failure while using a traditional method (either withdrawal or periodic abstinence). There was little variation in reporting contraceptive method failure leading to an abortion, except for lower rates among residents of Samegrelo and Shida Kartli, and a high rate for Samtskhe-Javakheti. Among women of other ethnic groups than Georgian, modern methods played a small role. However, failure of traditional methods was more likely to be reported by women in rural areas, older women, women with the lowest wealth quintile, and women of Azeri or Armenian ethnic background.

In Georgia, almost all abortions are performed for a fee, which may vary from one facility to another. At the time of the survey, mean charges for an abortion procedure were almost 48 Georgian Lari or GEL (about US\$29.00), which represents an increase of 65% compared to the average cost in 2005 (not shown). The amount paid for an abortion ranged from no payment to over 100 GEL. Only 2.3% of abortions were performed at no charge; 29% of abortion payments were 34 GEL or less, 23% were between 35–49 GEL, and 45% were 50 GEL or more, including 6% that were more than 100 GEL (Table 5.3.4 and Figure 5.3.4).

Average abortion payments were lower among rural women than urban women and increased directly to-

Figure 5.3.3 Location of Abortions Performed in the Last 5 Years, Georgia, 1999, 2005, and 2010

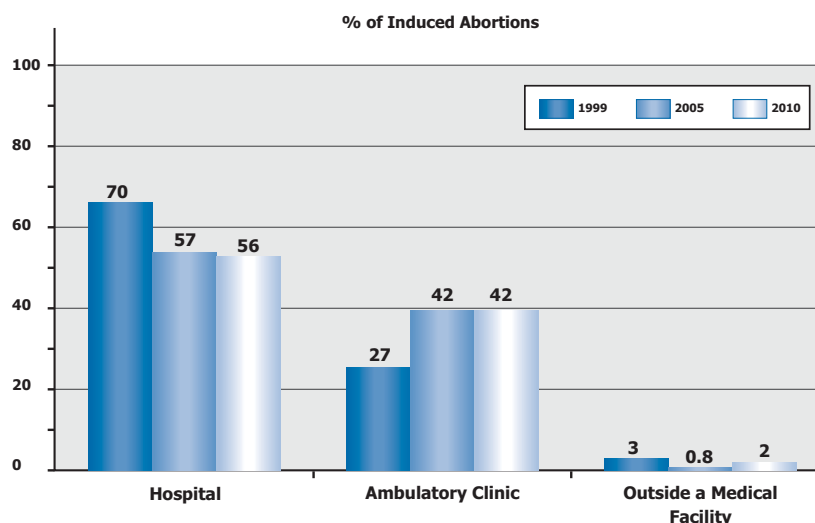
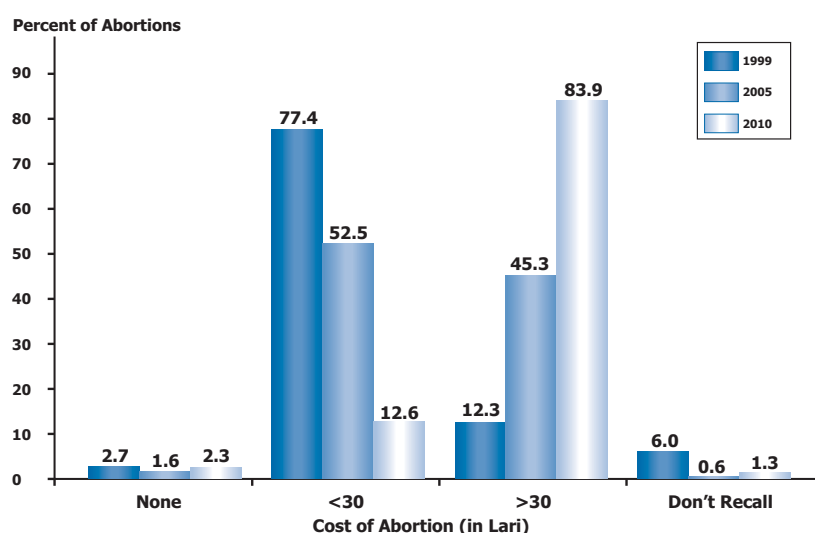


Figure 5.3.4 Cost of a Procedure for Pregnancy Termination Among Abortions Performed in the Last 5 Years Georgia, 1999, 2005, and 2010



ward the higher wealth quintiles of the households. On average, the cost of an induced abortion was 10 GEL more than of a mini-abortion; similarly, abortions performed at 10 or more weeks of pregnancy were more costly than abortions performed in the first 9 weeks of pregnancy (64.8 GEL vs. 45.8 GEL). The average abortion payment did not vary by the two types of medical facilities.

Women who decide to end their pregnancies in abortion and do not adopt an effective contraceptive method afterwards are likely to be at high risk for another unintended pregnancy during the immediate post-abortion period. Family planning counseling around the time of the abortion procedure is mandated as part of the Georgian health care law.

The Ministry of Labor, Health and Social Affairs introduced in 2000 a decree regarding family planning counseling after abortions performed in WCC (Women's Consultation Clinics) (MoLHSA, Decree number 136, 2000). In paragraph 11, the decree states that every woman who has terminated a pregnancy through vacuum aspiration should be given information on modern methods of contraception (attending physician required to obtain the patient's signature to certify counseling was provided) and a method should be selected after counseling. Training on family planning counseling and service provision is currently included in the post-graduate and licensing programs for Ob/Gyns and reproductologists. Despite legal regulations along with significant amounts of resources and technical efforts invested in family planning counseling by the donors, the receipt of family plan-

ning services around the time of having an abortion remains quite limited.

Similar to previous surveys, GERHS10 asked all respondents who had an abortion in the last five years if they 1) received any family planning advice either before or after the abortion procedure; 2) received any contraceptive method or a prescription for any method; and 3) were referred to a family planning facility following the procedure. As Table 5.3.5 indicates, only one in three (33%) respondents with a history of at least one abortion on request in the last five years reported receiving contraceptive counseling (10% before and 13% after, the rest at both times.)

Contraceptive counseling was the highest in Imereti (46%) and the lowest in Samtskhe-Javakheti (14%). It increased slightly with education and wealth quintile and was higher among Georgian women than among women of other ethnic backgrounds. Unfortunately, receipt of contraception counseling did not vary significantly by the abortion order (Figure 5.3.5). Although the highest exposure to counseling was reported by women with four or five abortions, women with six or more repeat abortions had the same likelihood of receiving contraceptive information, supplies, or a prescription for supplies as did women with only one abortion in the last 5 years.

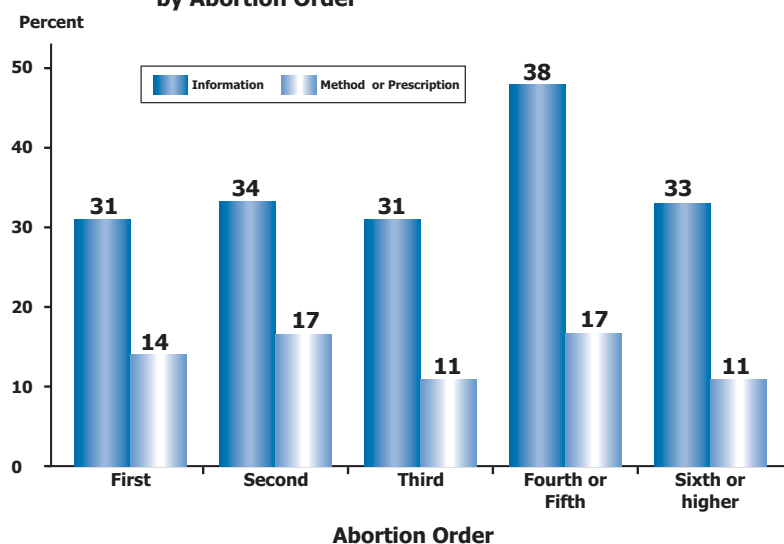
Only 6.6% of all women with a history of abortion in the past five years (20% of women who received counseling) received a contraceptive method to prevent future unintended pregnancies. An additional 7.4% of women received a prescription for contraceptive supplies (22% of all women counseled). Both receipt

of contraceptive supplies and receipt of prescription were low across all subgroups, excepting among women in Imereti (16% and 10%, respectively). Receipt of contraceptive information in 2010 was more than twice the level documented in the 1999 survey (33% vs. 15%); more importantly, receipt of either a contraceptive method or prescription for a method had almost tripled, from 5% to 14% (Figure 5.3.6).

These findings demonstrate a great need to improve and expand availability of counseling, referrals, and provision of contraceptives at the time of the abortion procedure. This will require more rigorous oversight of adherence to current regulations concerning provision of family planning advice and services post-abortion. Additionally, systems must be in place to support full integration of family planning services at facilities where abortion is provided. Client education may also facilitate changes in their perceptions of and expectations for abortion services, which may increase demand for counseling, referrals, and provision of contraceptive methods.

One issue concerns the use of ultrasound during the pregnancy, either to measure the length of gestation or to determine the sex of the fetus. Table 5.3.6 is restricted to women who terminated their pregnancies by abortion; of them, about half (51.8%) had ultrasound to measure gestation duration. Only 3% reported having had it to know the sex of the fetus. The later increased by age to 5% but sharply by number of living children to a high 20% at four or more. It was also quite high, at 16.8%, where the gestational age was 10 or more weeks long. Contrarily, it was quite low, at 1.1% among women having a mini-abortion.

Figure 5.3.5 Receipt of Contraceptive Information, Methods, or Prescription at the Time of an Abortion in the Last 5 Years by Abortion Order



5.4 Abortion Complications

Although standard surgical abortion is remarkably safe when compared to childbirth or other surgical procedures, it has an inherent risk of complications (Cates W. Jr., 1982). Legally induced abortions are associated with a certain risk of postoperative complications, whose incidence and severity are strongly correlated with age of gestation, parity, woman's age, surgical procedure, operator's skill, type of anesthesia, and preexisting pathology (Tietze and Henshaw, 1986). Abortions performed at 7 to 9 weeks of gestation have significantly fewer complications than those performed between 10 and 14 weeks. Similarly, abortions performed by vacuum aspiration have fewer complications than the classic D&C procedure. Additionally, legality alone does not make the procedure safe. Shortage of equipment, crowded facilities, poor hygienic conditions, and inadequate standards of care may increase the risk of post-abortion complications. These factors may turn women seeking pregnancy termination away from hospitals or may increase the waiting time between an initial consultation and admission to a designated facility. When delays in hospital admission would place the gestation age beyond the 12-week legal limit, women may seek an illegal, risky abortion outside a licensed facility. Unsafe abortion carries a high risk of mortality and morbidity.

Reproductive health surveys conducted in the region asked all respondents with abortions in the 5 years preceding a survey about the occurrence of medical complications after pregnancy termination, but cannot document abortion-related mortality. Survey estimates of postabortion complications are usually based on symptoms or conditions reported by respondents and therefore may be less accurate than hospital

based statistics. As shown in Figure 5.4.1, the rates of early complications (within 6 months) and late complications (6 months or later) ranged from 5%–16% and 1%–6%, respectively. These rates are high relative to those reported for first-trimester abortions in the United States (0.3%) (Finer and Zolna, 2011).

The 2010 survey in Georgia showed that 10% of all abortions performed since 2005 were followed by immediate complications (6.4%) or late sequelae (3.6%) (Table 5.4.1). Reports of early and late complications did not vary significantly by respondents' background characteristics. However the prevalence of early complications increased by nearly a third (to 8.2%) after 10 weeks of gestation and by nearly half (to 9.5%) after D&C procedures than after mini-abortions.

The prevalence of postabortion complications is higher in 2010 than it was in 2005; 10% of pregnancy terminations were followed by early or late complications in 2005–2010 compared to 6.3% in 2000–2004 (Figure 5.4.1). The elevation in abortion morbidity is registered in all categories, as being above 6.3% in all cases (Table 5.4.1).

One of the risk factors that is strongly associated with morbidity from legal abortion is gestational age at the time of the abortion. Between 2005 and 2010, the proportion of late abortions (after 12 weeks of gestation) among all abortions increased from 1% to more than 11%. That unfortunate result appears to override other influences. For example there were changes in clinical practice, with 41.5% of all abortions followed with antibiotic treatment in 2010 compared to just 32% in 2005. Despite that the number of complications increased. The use of anesthesia very slightly decreased from 58.0% to 56.6%. The percentage of

Figure 5.3.6 Receipt of Contraceptive Counseling at the Time of an Abortion in the Last 5 Years Georgia, 1999, 2005, and 2010

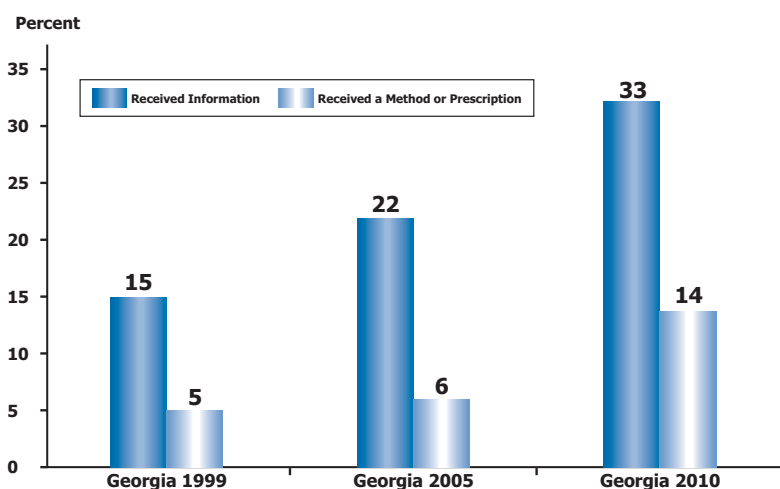
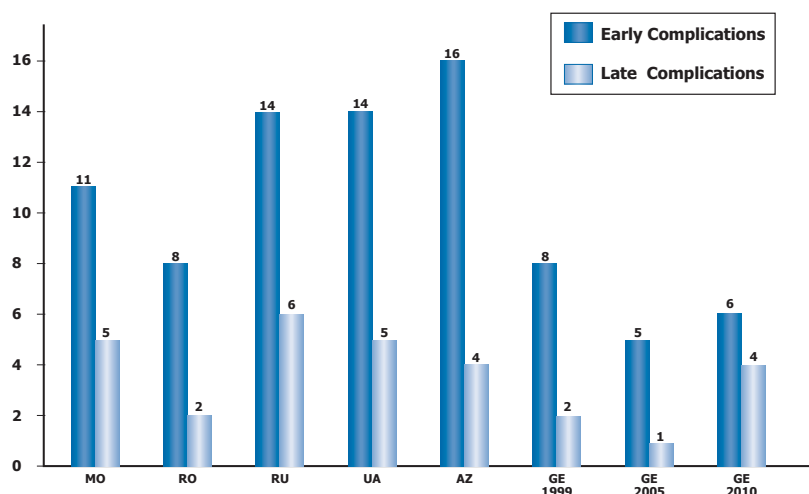


Figure 5.4.1 | Prevalence of Early and Late Post-Abortion Complications: Eastern Europe and Georgia Surveys



Note: MO = Moldova; RO = Romania; RU = Russia; AZ = Azerbaijan; GE = Georgia

abortions that were hospitalized for postabortion complications decreased (from 12% in 2005 to 0.6% in 2010), due partly to the increase in mini-abortions.

Fifty-nine percent of complicated abortions had prolonged pelvic pain; other complaints included fever (37%), severe bleeding (34%), infectious vaginal discharge (22%), and perforation (1.7%) (Table 5.4.2). With the exception of uterine perforation and severe bleeding, it is difficult to assess how serious the other early complications were. As mentioned, only 0.6% of immediate complications required one or more nights of hospitalization.

5.5 Reasons for Abortion

The life circumstances within which women decide to have an abortion bear directly on the issue of access to abortion services; they also provide evidence of how barriers to these services may affect women's lives. A comparative report of surveys taken since 1996, covering a wide range of women's health topics, showed that women's reported reasons for ending pregnancies have been consistent in the region (Figure 5.5.1). Most of the abortions in the five years preceding the surveys occurred because a woman wanted no more children or because the family socio-economic circumstances could not support another child. Overall, between 66% and 95% of abortions were for these two reasons (CDC and Macro, 2003).

The 2010 survey in Georgia showed that most of the abortions in the five years preceding the survey were obtained because the woman wanted no more children (51%) (Table 5.5) or because the family socio-economic circumstances could not support another child (20%), due to low income, unemployment, fear

of losing a job, or crowded living conditions. Nearly one in five abortions (18%) was obtained because the woman wanted to space her childbearing. Another 8% were obtained for health-related reasons: 5% for maternal health reasons (i.e., pregnancy was threatening the woman's physical or mental health), and about 3% because of fetal defects or potential risks for the baby. Next, 1.5% reflected partner-related reasons (e.g., the partner objected to the pregnancy). Finally, note that 1.4% of women stated they obtained abortions because of the sex of the fetus, which was known prior to the decision to terminate the pregnancy (data not shown). In terms of trends, compared to 1999, women in 2010 were less likely to have abortions for limiting fertility and more likely to have them for spacing and for health reasons.

The use of abortion for limiting childbearing was mentioned more often by rural women (who already have a higher mean number of living children than urban women), and by women over age 34 (62%), who also have more children. A woman's desire for no (more) children as a reason for abortion was strongly correlated with pregnancy order, from 18% among women pregnant for the second time to 40% among women with two previous pregnancies and 62% among those with four or more previous pregnancies. Use of abortion for spacing the next birth was more common among non-Tbilisi urban residents, women aged 15-24 years, women belonging to the second wealth quintile, and those with one previous pregnancy. Socioeconomic reasons were reported more often in Tbilisi and in the lowest wealth quintile.

Thus, women seeking abortions are mostly motivated by their family size and by socio-economic impacts on the family members, especially their children. The

Figure 5.5.1 Most important Reason for Having an Induced Abortion Among Women Aged 15 – 44 With at Least one Abortion in the Past 5 Years: Eastern Europe RHS Survey Data and GERHS2010

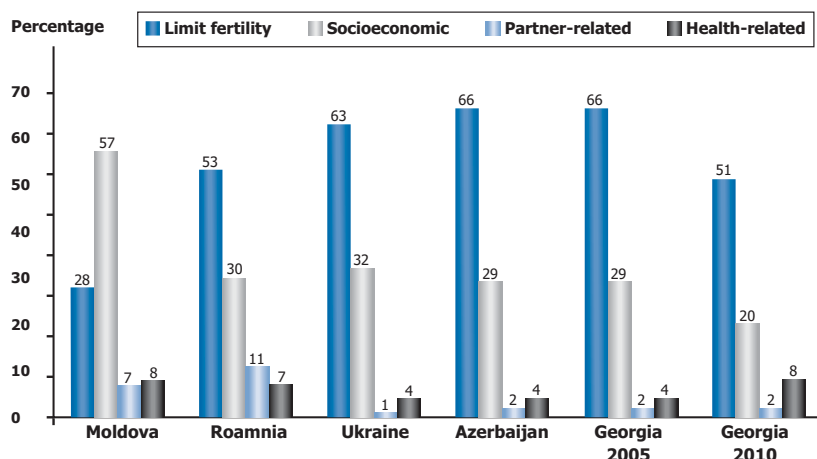
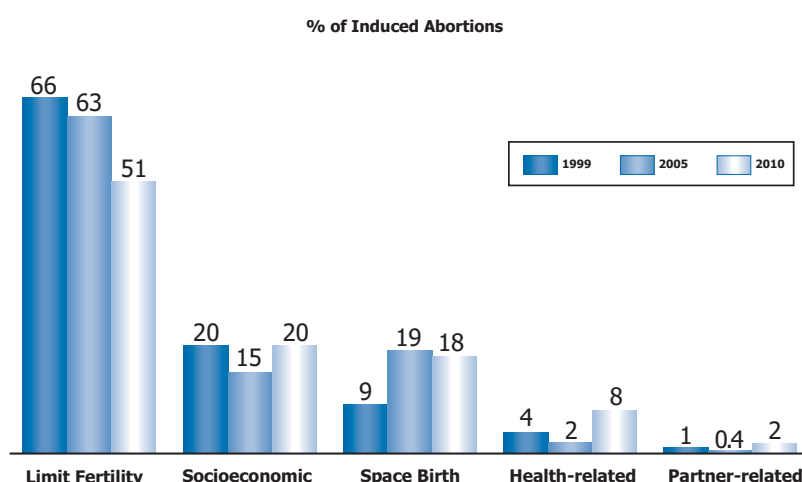


Figure 5.5.2 Most Important Reason for Pregnancy Termination Among Abortions Performed in the Last 5 Years Georgia, 1999, 2005, and 2010



primary reason given for having abortions was “wanting no more children,” indicating that the pregnancies were unintended ---- another indication of insufficient family planning services in the country. Compared to 1999 (Figure 5.5.2), proportionately more abortions now are for spacing, or are done for health reasons. Fortunately, partner related reasons are very minor, indicating that women independently make the decision to have an abortion or are in agreement with their partner.

In conclusion, survey-based abortion estimates in Georgia are still higher than the official statistics, presumably because government reporting systems from which official statistics are derived suffer from underreporting. Because it is likely that some abortion under-reporting has also taken place in the survey, survey-based levels of abortion should be viewed as conservative estimates of the true magnitude of abor-

tion practices at the population level. Beyond providing a more accurate documentation of abortion levels and trends, survey estimates have broader scope regarding the burden of unwanted pregnancy and the need for increased access to and use of contraceptive services.

The 2010 Georgia survey shows that since 2005, better access to contraception has already led to a reduction in unintended pregnancy and a decrease in the national abortion rate. The fact that an increasing proportion of women having abortions are living in rural areas, are poor and less educated, underscores the importance of subsidized family planning services and expanded coverage of these services as effective means of reducing the incidence of both unintended pregnancy and abortion. The ICPD Programme of Action urges countries to reduce the recourse to abortion through availability of post-abortion counseling,

education, and family-planning. Since 1999, Georgia has made substantial progress: abortion rates have been falling while more women have adopted modern contraception and fewer have an unmet need for modern contraception. Still, more efforts are needed to achieve further reduction in abortion rates, particularly when half of abortions occur because the woman does not want any more children.

However, family planning cannot prevent all unintended pregnancies because no contraceptive method is perfectly fail-safe. Reliance on traditional methods of contraception—common among the rural, poor,

and less educated women —is particularly associated with method-failure and subsequent abortion. While the national family planning efforts need to be intensified and users of traditional methods need to be educated about the availability of more effective methods, access to safe abortion should continue to be made available. Worldwide, abortions performed in safe conditions are associated with very low rates of morbidity and mortality. Efforts to further replace abortion with contraception should focus on increasing access to a variety of high quality, affordable birth control methods and not on limiting availability of safe abortion services.

Table 5.1 Three-Year Age-Specific Abortion Rates and Total Abortion Rates for Three Time Periods among All Women Aged 15–44
Reproductive Health Survey: Georgia, 1999, 2005, 2010

Age Group	Age-Specific Induced Abortion Rate (per 1,000)*		
	2007–2010 GERHS10 [†]	2002–2005 GERHS05 [‡]	1996–1999 GERHS99 [¶]
15–19	10	13	29
20–24	56	126	162
25–29	102	164	191
30–34	83	167	179
35–39	57	110	122
40–44	(21)	(54)	(49)
Total Abortion Rate	1.6	3.1	3.7
General Abortion Rate (per 1,000 Women/Year)	56	104	125

* Age at induced abortion.

† Abortions occurring between October 2007 and September 2010.

‡ Abortions occurring between March 2002 and February 2005.

¶ Abortions occurring between December 1996 and November 1999.

() Time exposed partially truncated because the sample does not include all women exposed during the reference period.

Table 5.2.1 Three-Year Period Age-Specific Abortion Rates and Total Abortion Rates*
by Selected Characteristics among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Age-Specific Induced Abortion Rate (per 1,000) [†]						Total Abortion Rate (Abortions per Woman)
	15–19	20–24	25–29	30–34	35–39	40–44	
Total	10	56	102	83	57	21	1.6
Residence							
Urban	6	42	62	74	41	16	1.2
Rural	14	71	150	93	74	26	2.1
Region							
Kakheti	30	58	100	46	135	18	1.9
Tbilisi	9	44	53	73	36	13	1.1
Shida Kartli	7	133	144	72	61	22	2.2
Kvemo Kartli	11	53	170	111	106	19	2.4
Samtskhe–Javakheti	3	40	77	95	70	37	1.6
Adjara	0	51	87	49	20	32	1.2
Guria	12	59	156	144	44	7	2.1
Samegrelo	6	77	169	92	48	18	2.1
Imereti	10	47	101	96	40	32	1.6
Mtskheta–Mtianeti	8	77	113	127	58	13	2.0
Racha–Svaneti	13	21	43	81	60	0	1.1
Education Level							
Secondary incomplete or less	14	125	186	85	89	32	2.7
Secondary complete	10	76	151	107	110	19	2.4
Technicum	4	54	68	85	40	28	1.4
University/Postgraduate	4	26	62	70	29	11	1.0
Wealth Quintile							
Lowest	12	72	179	79	70	33	2.2
Second	13	61	139	86	73	24	2.0
Middle	10	71	113	101	59	22	1.9
Fourth	11	55	71	62	57	14	1.4
Highest	3	32	52	82	38	14	1.1
Ethnicity							
Georgian	7	51	90	82	52	20	1.5
Azeri	45	92	207	132	144	46	3.3
Armenian	12	27	146	80	82	0	1.7
Other	30	212	168	17	41	25	2.5

* Abortions occurring between October 2007 and September 2010.

† Age at induced abortion.

Table 5.2.2 Women Aged 15–44 Who Had at Least One Abortion and Number of Lifetime Abortions by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Ever Had an Abortion	No. of Cases	Number of Lifetime Induced Abortions Among Women Who Have Ever Had an Abortion							Total	No. of Cases
			1	2	3	4	5–6	7–9	10+		
Total	37.1	6,292	31.4	23.5	15.4	9.1	10.0	4.3	6.3	100.0	2,568
Region											
Tbilisi	31.8	1,426	38.8	22.0	15.2	8.3	7.0	3.2	5.5	100.0	490
Other Urban	35.4	1,549	30.2	26.0	16.9	8.1	9.7	5.1	3.9	100.0	594
Rural	41.2	3,317	28.6	23.1	14.8	9.8	11.5	4.4	7.8	100.0	1,484
Age Group											
15–19	2.2	861	85.6	14.4	0.0	0.0	0.0	0.0	0.0	100.0	25
20–24	13.8	1,099	55.3	29.3	6.4	6.7	2.3	0.0	0.0	100.0	186
25–29	35.5	1,191	44.4	23.7	15.9	5.8	6.1	2.2	1.8	100.0	436
30–34	54.6	1,168	30.9	24.0	14.9	9.0	11.5	4.8	4.9	100.0	663
35–39	60.6	1,051	23.1	25.3	16.2	11.2	11.4	5.2	7.6	100.0	637
40–44	67.6	922	23.5	20.1	17.7	10.0	12.1	5.7	10.8	100.0	621
Number of Living Children											
None	3.4	2,276	68.9	17.0	6.2	7.9	0.0	0.0	0.0	100.0	96
One	39.4	1,286	53.4	21.6	11.5	4.6	4.6	3.3	1.0	100.0	518
Two	69.5	2,069	24.8	24.4	17.9	10.3	11.0	4.6	7.0	100.0	1,456
Three	77.5	539	18.8	23.4	15.8	11.7	15.4	4.7	10.2	100.0	417
Four or more	68.5	122	30.2	28.2	6.7	3.6	9.5	8.9	12.8	100.0	81
Education Level											
Secondary incomplete or less	32.0	1,330	24.5	21.3	15.4	10.1	12.6	4.6	11.6	100.0	486
Secondary complete	39.1	1,568	33.7	24.6	12.7	8.2	10.2	5.8	4.8	100.0	691
Technicum/University	38.4	3,394	32.8	23.8	16.7	9.1	9.0	3.5	5.0	100.0	1,391
Wealth Quintile											
Lowest	40.8	1,093	28.9	25.1	13.6	8.9	11.1	3.7	8.8	100.0	469
Second	39.4	1,385	27.9	25.3	16.2	7.9	10.6	4.4	7.8	100.0	602
Middle	40.2	1,413	29.0	21.7	14.6	11.8	11.4	5.4	6.1	100.0	620
Fourth	31.4	1,037	35.8	23.8	15.1	8.1	8.8	3.7	4.7	100.0	369
Highest	34.8	1,364	35.5	22.6	16.9	8.1	8.3	4.1	4.5	100.0	508
Ethnicity											
Georgian	36.5	5,488	32.0	23.8	15.6	9.3	10.0	4.0	5.3	100.0	2,197
Azeri	47.2	276	20.0	18.4	18.4	7.6	13.8	4.9	16.9	100.0	143
Armenian	35.4	364	38.7	26.5	8.9	9.8	3.5	5.7	6.9	100.0	150
Other	42.3	164	26.2	23.2	15.0	3.4	12.9	9.2	10.2	100.0	78

Table 5.2.3 Gestational Age at the Time of Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Gestational Age (in Week)				Total	No. of Cases
	< 7	7–9	10–12	13+		
Total	27.9	59.2	11.9	1.1	100.0	2,054
Residence						
Tbilisi	30.7	60.4	7.9	1.0	100.0	333
Other Urban	29.8	60.7	8.0	1.5	100.0	435
Rural	26.1	58.2	14.8	0.9	100.0	1,286
Age Group						
15–19	17.9	70.3	11.9	0.0	100.0	18
20–24	21.5	63.8	13.4	1.2	100.0	208
25–29	32.7	56.4	9.9	1.0	100.0	540
30–34	25.2	62.6	11.2	1.1	100.0	648
35–39	29.9	57.1	12.5	0.5	100.0	424
40–44	26.8	55.2	15.7	2.2	100.0	216
Number of Living Children						
None	46.2	48.4	5.4	0.0	100.0	9
One	27.6	58.6	10.7	3.1	100.0	334
Two	29.9	59.5	9.8	0.7	100.0	1,280
Three	24.7	58.2	16.5	0.6	100.0	350
Four or more	9.5	61.6	28.9	0.0	100.0	81
Education Level						
Secondary incomplete or less	26.1	56.0	17.0	1.0	100.0	456
Secondary complete	23.8	63.5	12.4	0.3	100.0	668
Technicum/University	31.6	57.8	8.9	1.7	100.0	930
Wealth Quintile						
Lowest	17.6	61.9	19.8	0.7	100.0	419
Second	29.8	58.3	11.1	0.8	100.0	504
Middle	27.4	59.3	12.4	0.9	100.0	506
Fourth	26.8	66.1	5.3	1.8	100.0	282
Highest	36.0	52.6	10.2	1.3	100.0	343
Ethnicity						
Georgian	29.8	58.9	10.0	1.2	100.0	1,661
Azeri	25.8	59.1	14.6	0.5	100.0	181
Armenian	18.8	59.1	21.1	1.0	100.0	141
Other	8.2	63.9	27.9	0.0	100.0	71
Pregnancy end						
Induced abortion	2.6	53.6	40.2	3.6	100.0	645
Mini-abortion	38.3	61.5	0.2	0.0	100.0	1,409

Table 5.3.1 **Type of Pregnancy Termination by Selected Characteristics among Pregnancies Ended in Abortion in 2005–2010**
Reproductive Health Survey: Georgia, 2010

Characteristic	Type of Pregnancy Termination			
	Induced abortion	Mini-abortion	Total	No. of Cases
Total	29.3	70.7	100.0	2,054
Residence				
Urban	19.3	80.7	100.0	768
Rural	36.6	63.4	100.0	1,286
Region				
Kakheti	43.4	56.6	100.0	185
Tbilisi	18.7	81.3	100.0	333
Shida Kartli	17.1	82.9	100.0	183
Kvemo Kartli	31.4	68.6	100.0	253
Samtskhe-Javakheti	50.8	49.2	100.0	160
Adjara	19.6	80.4	100.0	90
Guria	47.4	52.6	100.0	163
Samegrelo	40.5	59.5	100.0	169
Imereti	27.0	73.0	100.0	265
Mtskheta-Mtianeti	22.2	77.8	100.0	152
Racha-Svaneti	45.8	54.2	100.0	101
Age Group				
15–24	28.6	71.4	100.0	501
25–34	27.9	72.1	100.0	1,196
35–44	34.3	65.7	100.0	357
Order of Abortion				
First	28.8	71.2	100.0	576
Second	26.5	73.5	100.0	417
Third	27.2	72.8	100.0	291
Fourth	31.8	68.2	100.0	185
Fifth	32.3	67.7	100.0	135
Sixth or higher	31.8	68.2	100.0	450
Education				
Secondary complete or less	34.6	65.4	100.0	1,124
Technicum	33.1	66.9	100.0	286
University/Postgraduate	18.7	81.3	100.0	644
Wealth quintile				
Lowest	46.8	53.2	100.0	419
Second	31.8	68.2	100.0	504
Middle	29.1	70.9	100.0	506
Fourth	13.8	86.2	100.0	282
Highest	22.6	77.4	100.0	343
Ethnicity				
Georgian	27.4	72.6	100.0	1,661
Azeri	37.2	62.8	100.0	181
Armenian	38.1	61.9	100.0	141
Other	34.0	66.0	100.0	71

Table 5.3.2 Place of Pregnancy Termination by Selected Characteristics among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Place of Pregnancy Termination				No. of Cases
	Hospital/ Maternity Ward	Ambulatory Clinics	Outside a Medical Facility	Total	
Total	55.8	42.2	1.9	100.0	2,054
Residence					
Urban	38.6	59.6	1.8	100.0	768
Rural	68.4	29.6	2.0	100.0	1,286
Residence					
Tbilisi	29.4	69.6	1.0	100.0	333
Other Urban	46.9	50.7	2.4	100.0	435
Rural	68.4	29.6	2.0	100.0	1,286
Region					
Kakheti	71.2	23.2	5.6	100.0	185
Tbilisi	29.4	69.6	1.0	100.0	333
Shida Kartli	59.0	40.5	0.5	100.0	183
Kvemo Kartli	60.1	37.5	2.4	100.0	253
Samtskhe-Javakheti	72.4	27.1	0.6	100.0	160
Adjara	47.3	46.4	6.3	100.0	90
Guria	75.5	21.9	2.6	100.0	163
Samegrelo	51.6	47.9	0.5	100.0	169
Imereti	69.3	30.0	0.7	100.0	265
Mtskheta-Mtianeti	54.0	44.9	1.1	100.0	152
Racha-Svaneti	88.8	10.3	0.9	100.0	101
Age Group (at Abortion)					
15–24	62.2	36.9	0.9	100.0	501
25–34	53.4	44.2	2.4	100.0	1,196
35–44	55.3	43.1	1.6	100.0	357
Order of Abortion					
First	58.1	40.5	1.4	100.0	576
Second	52.4	46.3	1.3	100.0	417
Third	51.9	45.6	2.4	100.0	291
Fourth	53.1	44.7	2.3	100.0	185
Fifth	61.2	37.2	1.5	100.0	135
Sixth or higher	58.1	39.3	2.7	100.0	450
Education					
Secondary complete or	60.4	37.1	2.5	100.0	1,124
Technicum	58.4	40.6	1.0	100.0	286
University/Postgraduate	47.0	51.8	1.2	100.0	644
Wealth quintile					
Lowest	76.0	22.7	1.3	100.0	419
Second	68.4	29.6	2.0	100.0	504
Middle	55.0	41.0	4.0	100.0	506
Fourth	43.3	55.7	1.1	100.0	282
Highest	34.3	65.2	0.5	100.0	343
Ethnicity					
Georgian	54.0	44.0	2.0	100.0	1,661
Azeri	77.4	20.5	2.1	100.0	181
Armenian	59.0	39.5	1.4	100.0	141
Other	33.4	66.7	0.0	100.0	71
Type of Abortion					
Induced abortion	65.9	30.5	3.5	100.0	645
Mini-abortion	51.7	47.1	1.2	100.0	1,409

**Table 5.3.3 Use of Contraception at the Time of Conception by Selected Characteristics
Among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010**

Characteristic	Contraceptive Use			No. of Cases
	Any Method %	Any Traditional Method %	Any Modern Method %	
Total	26.4	20.1	15.6	2,054
Residence				
Urban	26.6	17.4	18.9	768
Rural	26.2	22.1	13.2	1,286
Region				
Kakheti	20.2	15.2	12.1	185
Tbilisi	26.1	14.3	21.7	333
Shida Kartli	16.1	13.7	13.2	183
Kvemo Kartli	34.1	28.7	14.3	253
Samtskhe-Javakheti	49.2	41.4	12.7	160
Adjara	25.0	20.5	5.4	90
Guria	19.8	15.1	9.9	163
Samegrelo	11.1	7.9	6.8	169
Imereti	32.3	26.0	24.3	265
Mtskheta-Mtianeti	26.1	22.7	15.3	152
Racha-Svaneti	34.6	29.9	15.0	101
Age at Abortion				
15–24	23.9	16.1	15.1	501
25–34	25.2	18.9	15.6	1,196
35–44	33.2	29.0	16.1	357
Education				
Secondary complete or less	24.3	20.5	10.3	1,124
Technicum	26.2	21.0	19.5	286
University/Postgraduate	30.0	19.2	23.2	644
Wealth quintile				
Lowest	28.7	24.9	14.7	419
Second	23.4	20.6	9.8	504
Middle	23.8	20.0	11.7	506
Fourth	23.4	14.7	18.8	282
Highest	32.9	19.4	25.1	343
Ethnicity				
Georgian	26.5	19.4	18.5	1,661
Azeri	28.5	27.5	2.5	181
Armenian	35.0	28.5	8.7	141
Other	7.2	4.9	4.0	71
Pregnancy ended by				
Induced abortion	22.5	18.8	11.7	645
Mini-abortion	28.0	20.7	17.2	1,409

**Table 5.3.4 Cost of a Procedure for Pregnancy Termination by Selected Characteristics
Among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010**

Characteristic	Mean Payment [†]	Cost of Abortion (in GEL)*								
		None	< 30	30–34	35–49	50–99	100 or more	Do not Remember	Total	No. of Cases
Total	48.2	2.3	12.6	16.0	22.6	39.4	5.9	1.3	100.0	2,054
Residence										
Tbilisi	61.5	3.1	4.1	7.4	18.9	49.1	15.3	2.0	100.0	333
Other Urban	46.0	1.9	12.2	18.2	23.3	39.3	4.4	0.7	100.0	435
Rural	44.5	2.2	15.7	18.1	23.6	36.0	3.2	1.3	100.0	1,286
Age group (at Abortion)										
15–24	50.8	1.6	9.7	14.1	23.7	43.5	6.3	1.1	100.0	501
25–34	46.2	2.7	15.1	15.5	22.1	38.5	4.8	1.3	100.0	1,196
35–44	51.2	1.9	8.7	19.6	22.9	37.0	8.5	1.4	100.0	357
Order of Abortion										
First	53.2	3.1	8.3	12.3	19.0	46.5	9.1	1.7	100.0	576
Second	50.6	1.1	11.2	14.5	24.4	40.5	6.7	1.6	100.0	417
Third	49.5	1.9	13.9	14.8	21.1	41.8	5.5	1.1	100.0	291
Fourth	45.6	2.0	12.5	19.5	26.8	34.1	4.4	0.7	100.0	185
Fifth	43.6	2.3	15.4	17.1	26.4	37.2	1.6	0.0	100.0	135
Sixth or higher	41.8	2.7	17.3	20.6	23.6	31.2	3.3	1.4	100.0	450
Education Level										
Secondary incomplete or less	47.1	2.2	11.2	22.6	22.6	33.8	6.4	1.3	100.0	456
Secondary complete	45.6	1.9	14.7	15.1	24.4	38.5	3.9	1.5	100.0	668
Technicum/University	50.7	2.6	11.9	13.1	21.4	42.9	7.0	1.2	100.0	930
Wealth Quintile										
Lowest	40.6	2.5	20.7	20.8	22.8	30.7	2.4	0.2	100.0	419
Second	42.6	2.0	12.2	21.0	22.7	39.8	1.0	1.3	100.0	504
Middle	49.2	2.0	16.1	14.5	23.9	35.1	5.9	2.5	100.0	506
Fourth	49.5	2.9	6.0	11.0	27.0	47.0	5.0	1.0	100.0	282
Highest	59.3	2.3	6.8	11.3	17.6	45.8	15.0	1.2	100.0	343
Ethnicity										
Georgian	48.5	2.2	12.0	16.0	22.9	40.6	5.5	0.9	100.0	1,661
Azeri	40.2	3.6	22.1	21.8	14.5	32.7	2.5	2.8	100.0	181
Armenian	49.0	3.7	9.0	9.9	23.9	47.2	4.9	1.5	100.0	141
Other	62.3	0.0	4.8	9.7	35.5	23.2	21.5	5.2	100.0	71
Type of Abortion										
Induced Abortion	54.8	3.3	12.4	15.3	16.7	39.5	11.4	1.4	100.0	645
Mini-abortion	45.5	1.9	12.7	16.2	25.0	39.3	3.6	1.3	100.0	1,409
Abortion Facility										
Hospital/ maternity	48.2	1.4	14.2	17.6	22.0	36.8	6.8	1.2	100.0	1,207
Ambulatory clinics	49.2	1.2	10.4	14.1	24.1	43.9	4.8	1.5	100.0	810
Outside a medical	26.6	53.3	14.0	10.1	7.5	13.1	2.0	0.0	100.0	37
Gestational Age										
10 weeks or more	64.8	1.4	7.1	13.4	17.5	39.9	18.5	2.2	100.0	291
<10 weeks	45.8	2.4	13.4	16.3	23.4	39.3	4.0	1.2	100.0	1,763
Antibiotics–Abortion										
Yes	53.5	1.8	11.1	13.9	18.7	43.9	9.2	1.3	100.0	845
No	44.5	2.6	13.7	17.4	25.3	36.1	3.5	1.3	100.0	1,209

* At the time of the survey approximately 1.65 GEL=1.00 USD

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

Table 5.3.5 Selected Family Planning Services Offered at the Time of Legally Performed Abortions
by Selected Characteristics among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Contraception Counseling			Distribution of Contraceptive Methods, Prescriptions for Methods, or Referrals			No. of Cases
	Any Counseling	Before Abortion	After Abortion	Method Distributed	Prescription Offered	Referral Offered	
Total	33.1	9.9	13.2	6.6	7.4	2.7	2,054
Residence							
Urban	35.6	10.5	13.6	6.1	9.2	3.3	768
Rural	31.3	9.4	12.8	6.9	6.1	2.3	1,286
Region							
Kakheti	25.8	4.5	10.6	7.6	4.5	1.5	185
Tbilisi	36.3	9.7	11.8	4.1	9.7	1.5	333
Shida Kartli	40.0	13.2	19.0	4.4	9.8	1.0	183
Kvemo Kartli	25.6	7.8	14.7	4.4	9.2	2.4	253
Samtskhe-Javakheti	13.8	5.5	5.0	4.4	2.8	0.0	160
Adjara	33.0	17.0	9.8	5.4	7.1	5.4	90
Guria	29.2	8.9	9.9	5.2	1.6	4.2	163
Samegrelo	30.0	4.2	15.8	5.3	1.6	4.7	169
Imereti	45.7	15.0	15.7	15.7	10.0	4.7	265
Mtskheta-Mtianeti	31.8	10.8	8.5	2.3	3.4	0.0	152
Racha-Svaneti	29.9	2.8	13.1	5.6	12.1	3.7	101
Age Group (at Abortion)							
15–24	33.7	11.3	13.5	7.9	8.1	3.4	501
25–34	34.0	8.8	13.9	6.2	8.2	2.3	1,196
35–44	29.7	11.3	10.4	6.1	4.2	3.0	357
Education							
Secondary complete or less	32.3	9.3	13.6	6.3	7.2	2.1	1,124
Technicum	27.1	7.7	8.1	3.7	7.5	0.9	286
University/Postgraduate	36.8	11.7	14.5	8.2	7.7	4.3	644
Wealth quintile							
Lowest	25.2	9.9	8.9	4.9	5.0	1.8	419
Second	35.5	9.4	14.7	11.1	6.3	4.1	504
Middle	32.0	8.4	16.5	5.1	7.5	1.1	506
Fourth	37.1	10.3	12.5	5.6	8.1	6.2	282
Highest	35.6	11.7	12.0	5.4	10.3	1.0	343
Ethnicity							
Georgian	34.9	10.5	13.4	7.6	6.9	3.2	1,661
Azeri	28.4	7.7	13.7	3.7	9.7	0.0	181
Armenian	26.3	9.0	13.7	1.9	8.9	1.9	141
Other	21.2	4.2	7.2	1.1	8.6	1.1	71
Order of Abortion							
First	30.5	10.5	12.1	7.4	7.0	3.7	576
Second	34.4	12.4	12.7	7.5	9.6	2.9	417
Third	30.6	9.0	11.9	5.6	5.2	1.2	291
Fourth-fifth	38.2	11.4	14.7	8.8	7.7	3.1	320
Sixth or higher	33.2	6.4	14.6	4.1	7.3	1.9	450

Table 5.3.6 **Use of Ultrasound Prior to the Pregnancy Termination by Selected Characteristics Among Pregnancies Ended in Abortion in 2005–2010**
Reproductive Health Survey: Georgia, 2010

Characteristic	Had Ultrasound Assessment of Gestational Age	Had Ultrasound Assessment of Gender	No. of Cases
Total	51.8	3.3	2,054
Residence			
Urban	67.1	4.6	768
Rural	40.5	2.4	1,286
Residence			
Tbilisi	82.4	4.9	333
Other Urban	53.4	4.3	435
Rural	40.5	2.4	1,286
Age Group (at Abortion)			
15–24	52.1	2.7	501
25–34	51.4	2.9	1,196
35–44	52.7	5.1	357
Number of Living Children			
0	*	*	9
1	64.2	1.8	334
2	52.3	2.9	1,280
3	43.1	2.6	350
4 or more	32.9	20.0	81
Education Level			
Secondary incomplete or less	44.2	5.0	456
Secondary complete	43.0	4.1	668
Technicum/University	61.9	1.9	930
Wealth Quintile			
Lowest	33.3	2.2	419
Second	36.8	1.8	504
Middle	49.9	4.8	506
Fourth	70.1	3.0	282
Highest	73.4	4.5	343
Ethnicity			
Georgian	55.9	2.8	1,661
Azeri	25.1	3.5	181
Armenian	30.6	3.9	141
Other	68.6	10.8	71
Type of Abortion			
Induced abortion	43.9	8.5	645
Mini-abortion	55.0	1.1	1,409
Abortion Facility			
Hospital/maternity ward	47.8	3.4	1,207
Ambulatory clinics	58.2	3.0	810
Outside a medical facility	26.9	6.5	37
Gestational Age			
<10 weeks	50.7	1.3	1,763
10+	58.7	16.8	291

* Fewer than 25 cases in this category.

Table 5.4.1 Abortion Clinical Practice and Prevalence of Early and Late Complications by Selected Characteristics Among Pregnancies Ended in Abortion in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Clinical Practice				Postabortion Complications			
	Anesthesia	Antibiotic Treatment	One or More Nights Hospitalized	No. of Cases	Early Complications	No. of Cases	Late Complications	No. of Cases*
Total	56.6	41.5	0.6	2,054	6.4	2,054	3.6	2,020
Residence								
Tbilisi	59.1	50.1	0.5	333	6.9	333	2.6	328
Other Urban	58.2	44.3	0.8	435	5.4	435	3.0	430
Rural	55.1	37.5	0.6	1,286	6.6	1,286	4.2	1,262
Age Group (at Abortion)								
15–24	59.7	43.3	0.1	501	5.3	501	2.9	493
25–34	56.0	40.6	0.9	1,196	6.6	1,196	3.1	1,176
35–44	54.6	42.2	0.6	357	7.0	357	5.9	351
Order of Abortion								
First	62.4	43.6	0.5	576	5.8	576	2.8	560
Second	58.0	41.6	1.1	417	6.8	417	3.8	414
Third	52.8	43.8	0.8	291	6.6	291	4.3	290
Fourth	57.6	47.7	0.0	185	6.3	185	4.6	181
Fifth	53.9	46.0	0.0	135	5.2	135	2.3	135
Sixth or higher	51.1	34.1	0.6	450	6.9	450	3.9	440
Education Level								
Secondary incomplete or less	58.3	33.4	0.0	456	4.1	456	3.4	448
Secondary complete	54.5	41.9	0.9	668	8.6	668	4.1	653
Technicum/ University	57.2	45.5	0.8	930	6.0	930	3.4	919
Wealth Quintile								
Lowest	51.6	35.6	0.6	419	5.0	419	3.2	407
Second	46.8	33.4	0.6	504	7.1	504	3.8	496
Middle	64.8	39.4	0.3	506	6.4	506	4.5	503
Fourth	56.0	45.6	1.0	282	3.8	282	2.8	275
Highest	63.0	55.2	0.8	343	8.7	343	3.4	339
Ethnicity								
Georgian	58.3	45.0	0.6	1,661	6.6	1,661	3.5	1,636
Azeri	40.9	20.4	0.5	181	5.8	181	5.5	177
Armenian	60.4	24.7	0.5	141	6.5	141	2.1	136
Other	58.5	51.3	1.1	71	3.2	71	3.2	71
Type Abortion								
Induced Abortion	68.1	40.7	1.0	645	9.5	645	6.6	638
Mini-abortion	51.8	41.9	0.5	1,409	5.1	1,409	2.3	1,382
Where Abortion								
Hospital/ maternity Ward	58.3	41.3	0.4	1,207	6.6	1,207	4.2	1,185
Ambulatory clinics	55.3	42.9	0.9	810	6.1	810	2.7	799
Outside a Medical Facility	35.1	18.4	0.0	37	7.5	37	5.3	36
Gestational Age								
<10 weeks	53.3	40.7	0.6	1,763	6.1	1,763	2.6	1,734
10+	79.0	47.0	0.9	291	8.2	291	10.1	286
Early Complications								
Absent	56.2	39.9	0.0	1,928	0.0	1,928	1.4	1,897
Present	62.2	65.1	9.8	126	100.0	126	36.4	123

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

Table 5.4.2

Induced Abortions Performed in 2005–2010 by Type of Early Complications and by Gestational Age – Reproductive Health Survey: Georgia, 2010

Characteristic	Total	Gestational Age (in weeks)	
		< 7 weeks	7 or more
Prolonged pelvic pain	58.6	50.4	62.0
Fever (over 38°)	36.7	27.3	40.6
Severe Bleeding	34.5	32.7	35.2
Infectious vaginal discharge	22.3	36.1	16.7
Perforation	1.7	0.0	2.4
Other problem	4.1	2.6	4.7
No. of Abortions with Early Complications	126	30	96

Table 5.5 Most Important Reason for Abortions Performed in 2005–2010 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Reason for Abortion						Total	No. of Cases
	Want No (More) Children	Socioeconomic Reasons	Want to Postpone Childbearing	Risk to Maternal or Fetal Health	Partner Objected to Pregnancy	Sex Selection		
Total	51.1	20.2	18.1	7.8	1.5	1.4	100.0	2,054
Residence								
Tbilisi	46.3	24.0	14.3	9.7	2.8	2.8	100.0	333
Other Urban	46.6	17.1	21.7	12.1	1.1	1.5	100.0	435
Rural	54.5	20.0	18.0	5.4	1.1	0.9	100.0	1,286
Age Group (at Abortion)								
15–24	33.9	17.1	38.3	9.3	0.1	1.3	100.0	501
25–34	54.7	21.5	13.8	6.8	2.2	1.0	100.0	1,196
35–44	61.7	20.0	5.7	8.7	0.9	3.0	100.0	357
Wealth Quintile								
Lowest	54.9	25.1	13.0	5.5	0.5	1.0	100.0	419
Second	53.5	19.1	22.5	3.8	0.6	0.5	100.0	504
Middle	53.3	18.3	19.4	5.0	2.1	1.9	100.0	506
Fourth	45.2	23.3	19.4	11.4	0.0	0.7	100.0	282
Highest	46.9	16.9	15.2	14.6	3.6	2.7	100.0	343
Order of All the Pregnancies								
First	*	*	*	*	*	*	100.0	20
Second	18.0	12.9	55.2	10.9	2.9	0.0	100.0	240
Third	40.0	18.1	28.0	12.0	0.4	1.5	100.0	329
Fourth	50.0	20.5	16.5	9.8	1.1	2.1	100.0	328
Fifth or Higher	61.7	22.3	8.5	4.5	1.6	1.4	100.0	1,137

* Fewer than 25 cases in this

6 CHAPTER

MATERNAL AND CHILD HEALTH

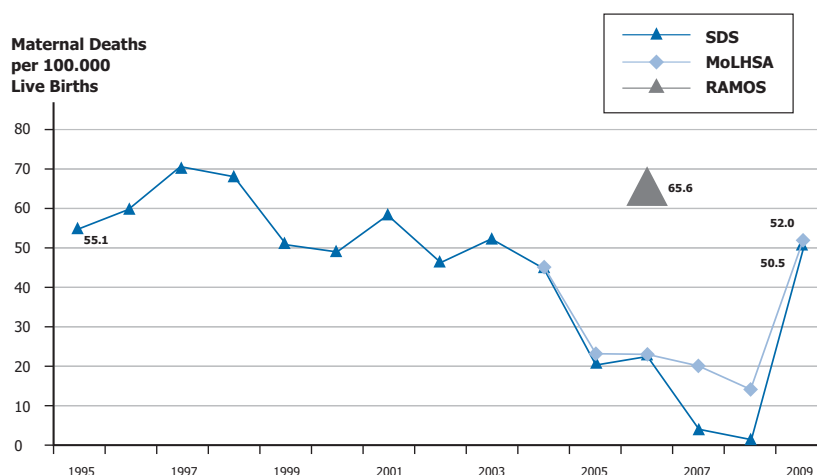
Pregnancy and childbirth complications are the leading cause of disability and death for women of reproductive age in developing countries. The World Health Organization (WHO) documents an enormous toll of maternal and child mortality and morbidity worldwide: An estimated 358,000 maternal deaths occurred during pregnancy, childbirth, or the postnatal period in 2008, down from 546,000 in 1990 (WHO, 2010a). Approximately 8.8 million children die every year before their fifth birthday, including 3.8 million infants who died during the first 28 days after birth, 1.8 who died in the postneonatal period but before one year of age, and 3.2 million who died after the first but before the fifth birthday (You et al., 2010; UNICEF, 2009). The health and survival of newborn children is closely linked to that of their mothers because lack of care or inadequate care during pregnancy, childbirth, and the postpartum period is associated with inadequate postnatal infant care; children whose mothers die of pregnancy related causes are more likely to die than those whose mothers are still alive (UNICEF, 2005).

A number of factors can impact the health of a woman, the health of her baby, and the outcome of her pregnancy, including utilization of health care services related to pregnancy, location and type of assistance at delivery, and postpartum behaviors, including breastfeeding. As with previous survey rounds in Georgia, the 2010 study collected detailed information regarding the actual experiences of respondents during pregnancy, delivery, and the postpartum period. These topics, as well as infant and child mortality, are examined in this chapter. All estimates reported here are based on respondents' reports as recorded in a lifetime pregnancy history and a detailed birth history for all births carried to term since January 2005. Because of the limited sample size and the fertility and mortality levels (which are not very high), the maternal mortality ratio cannot be directly estimated using a survey-based approach (i.e. the sisterhood method). Figures presented here are based on official reports and on the nationwide Reproductive Age Mortality Survey (RAMOS) of female deaths aged 15–49 in 2006 (Serbanescu et al., 2009)

6.1 Maternal Mortality Statistics

Five years before the deadline to achieve the Millennium Development Goals, the reduction of maternal mortality by three-quarters and the under-five mortality by two-thirds between 1990 and 2015 remain elusive targets for most countries. In Georgia, for example, the official maternal mortality ratio increased by almost 20% between 1990 and 2000 (from 41 to

Figure 6.1 Maternal Mortality in Georgia
Official Estimates and RAMOS Estimates for 1995–2009



Source: SDS estimates available at <http://statistics.ge>; Georgian MoLHSA estimates in L. Sakvarelidze, 2010; RAMOS estimates in Serbanescu et al., 2009.

49 maternal deaths per 100,000 live births), with a peak rate in 1997 (70.6 maternal deaths per 100,000 live births). From 2000–2008 the rate fell substantially, only to increase abruptly in 2009 to 51 deaths per 100,000 live births, higher than in 1990 (Figure 6.1). The official source for maternal mortality levels and trends is the civil registration system, which records deaths by cause on a continuous basis. The Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA), which monitors the number of maternal deaths in the health management information system, generally reports similar figures. The recent RAMOS conducted in 2008–2009 showed that both under-reporting of all deaths and misclassification of causes of death are important sources of error in the measurements of maternal mortality. The study identified deaths using multiple sources and investigated these deaths by completing detailed family questionnaires with relatives of the deceased women and conducting interviews and record reviews at the medical facilities that provided care prior to death. The study identified 2.8 times more maternal deaths in 2006 than officially reported (MMR=66/100,000); 68% of maternal deaths followed deliveries, 16% followed other pregnancy outcomes, and 16% were undetermined. Hemorrhage, puerperal infection, and pregnancy-induced hypertension accounted for most direct obstetric maternal deaths; about 40% of deaths were due to indirect causes, most of them not captured in the official statistics (Serbanescu et al., 2009).

6.2 Prenatal Care

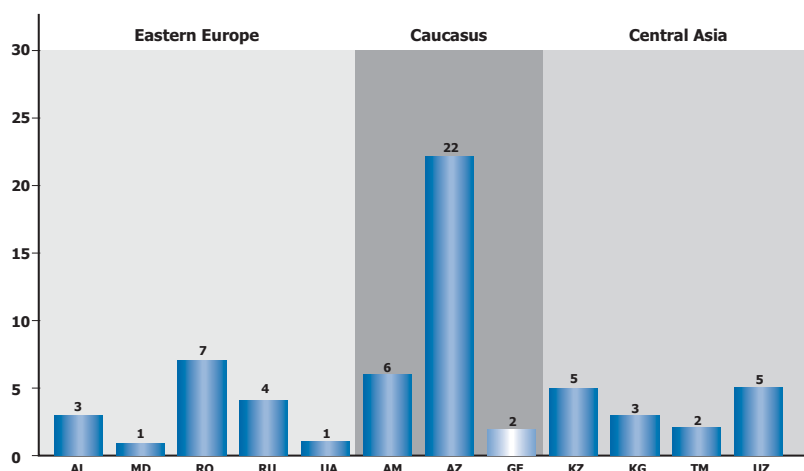
Prenatal care is important for preventing, identifying, and treating conditions that can affect the health of an expectant mother or her baby. To ensure optimal health of mother and child, experts recommend that

prenatal care be initiated during the first trimester of pregnancy, continue throughout gestation at specified intervals, and be comprehensive (i.e., includes risk assessment, risk reduction or treatment of medical conditions, and counseling). Comprehensive prenatal care can decrease perinatal maternal and infant morbidity and mortality by identifying and addressing potential risk factors that contribute to poor outcomes. Population-based surveys conducted in former Soviet-bloc countries since the breakup of the Soviet Union have documented very high prenatal care coverage in the region, with only one country (Azerbaijan) reporting a relatively high proportion of pregnant women with no prenatal care (Figure 6.2.1) (CDC and Macro, 2003).

Until 1995, recommendations for prenatal care in Georgia followed the standards set by the Soviet Union, which were similar to those used in industrialized countries. Standard prenatal care (for uncomplicated pregnancies) included routine visits according to gestational age, as follows: monthly visits before 12 weeks of pregnancy; bi-monthly visits from 12 to 30 weeks of gestation; and weekly or bi-monthly visits until delivery.

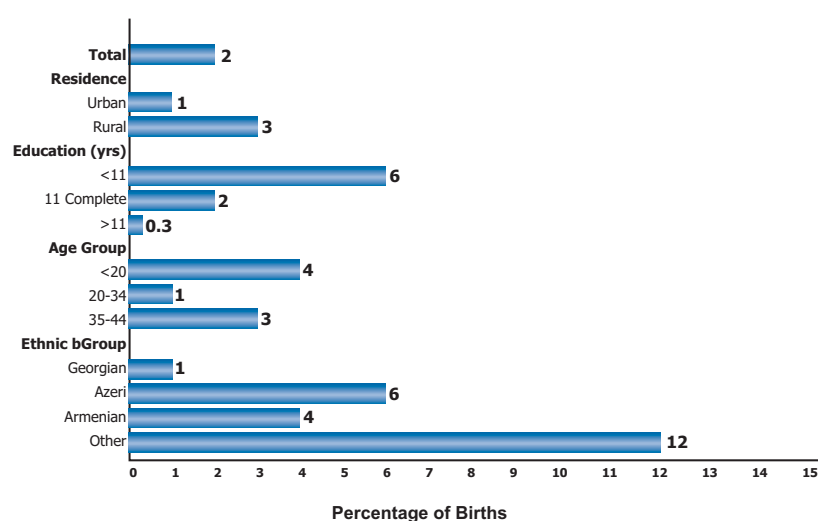
In Georgia the transition of the health care system from support by government financing to a payroll-tax-based system led to the adoption of a new four-visit prenatal care protocol in 1996, which was later modified according to WHO recommendations introduced in 2002 (WHO, 2002). The new WHO prenatal care model recommends that the first prenatal care visit include a comprehensive assessment of health conditions and potential risk factors to classify pregnant women into two groups: those who will follow the basic prenatal care program (about 75% of all pregnant women) and those who need referral to a

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



Source: Most recent RHS or DHS survey in AL=Albania, 2008; MD=Moldova, 2005; RO=Romania 2004; RU=Russia 1999; UA=Ukraine 2007; AM=Armenia 2005; AZ=Azerbaijan 2006; GE=Georgia 2010; KZ=Kazakhstan, 1999; KG=Kyrgyz Republic, 1997 TM=Turkmenistan, 2000; UZ=Uzbekistan, 1996

Figure 6.2.2 Percentage of Women Receiving No Prenatal Care
by Selected Characteristics—Births in 2005–2010



higher level of care. Components of the basic model of prenatal care include screening for and treating locally endemic illnesses in accordance with national protocols (e.g., screening for syphilis); education of the woman and her family members on signs of pregnancy complications requiring medical attention; and counseling on nutrition, birth preparedness, breastfeeding, and post-partum family planning.

Under the 1997 Georgian Law on Health Care, Article 132, maternity care is currently covered through mandatory medical insurance (Government of Georgia, 1997). In accordance with the new WHO protocol, the basic-benefit package for obstetric care covers four free-of-charge prenatal visits per pregnancy (at 13, 20–22, 30–32 and 36 weeks of pregnancy). The protocol for each visit includes oral history, clinical examination, laboratory tests, ultrasound examination (at

20–22 weeks), screening (for syphilis, Rh isoimmunization, and HIV), and counseling.

Women who are identified as having risk factors during the first visit are referred for more specialized care and/or further testing. A free-of-charge delivery voucher in the amount of 400 Georgian Lari (GEL), or about USD 228.00, is provided to socially vulnerable populations; vouchers for other pregnant women cover only 200 GEL (about USD 114.00) toward delivery costs (CoReform Project, 2005). Women seeking delivery vouchers are required to be enrolled at a Women's Consultation Center and must complete the minimum of four prenatal visits.

Although recommended by the WHO model, post-partum care is not covered under the state program. Once the health reform process is complete, it is anticipated that family practitioners will provide most

Figure 6.2.3 Percentage of Women Receiving No Prenatal Care by Residence Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

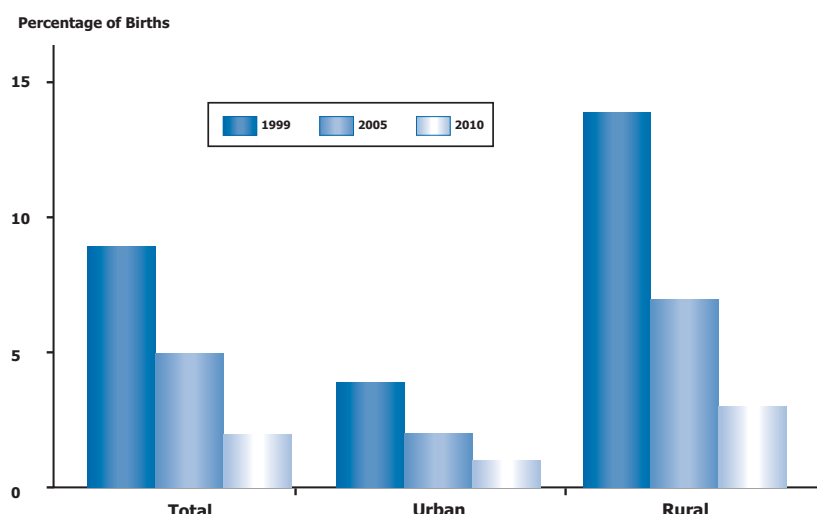
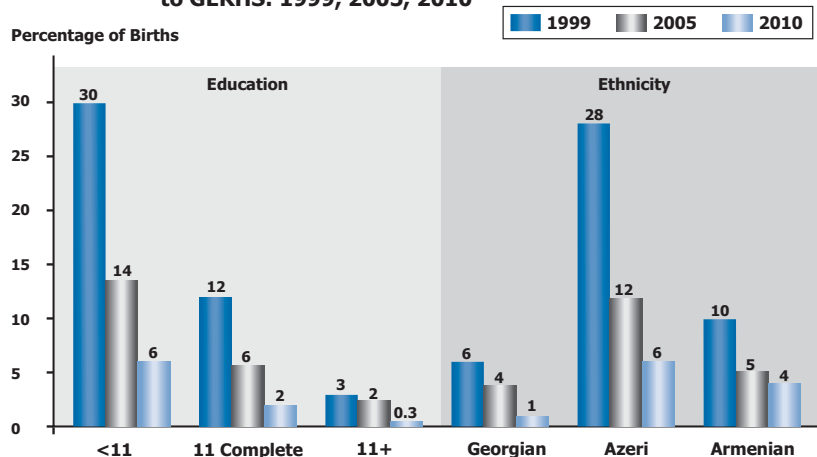


Figure 6.2.4 Percentage of Women Receiving No Prenatal Care by Selected Characteristics Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



postpartum care and will refer mothers with any signs of complications to specialized care.

Table 6.2.1 presents the percentage of births (live births and stillbirths) from January 2005 to date of interview for which the respondents reported that they received prenatal care. Although differences in prenatal care may exist between women having stillbirths and those having live births, the small number of stillbirths reported for the period under consideration does not allow the separate study of pregnancies ended in stillbirth.

Use of prenatal care was almost universal: 98% of pregnant women received at least one prenatal examination. The percentage of pregnant women receiving no prenatal care ranged from less than one percent in Imereti and Tbilisi to 7% in the Kakheti region. The probability of not receiving prenatal care was highest among rural residents, women whose maternal

age was less than 20 years at time of delivery (4%), women with less than a secondary complete education (6%), women living in households with the lowest wealth quintile (6%), and those for whom the child's birth order was third or higher (5%). Women with a minority ethnic background were more likely to report that they received no prenatal care, compared to Georgian women (Figure 6.2.2).

Prenatal care coverage has improved significantly since 1999. According to the results of the 1999 Reproductive Health Survey, 9% of mothers who gave birth in the 5 years prior to the survey received no prenatal care, compared to only 5% in 2005 and 2% in 2010 (Figure 6.2.3).

Compared to 1999, the greatest reductions in the number of women receiving no prenatal care in 2010 were in rural areas (from 14% to 3%), among women with less than complete secondary education (from

Figure 6.2.5 Initiation of Prenatal Care in the First Trimester by Selected Characteristics Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

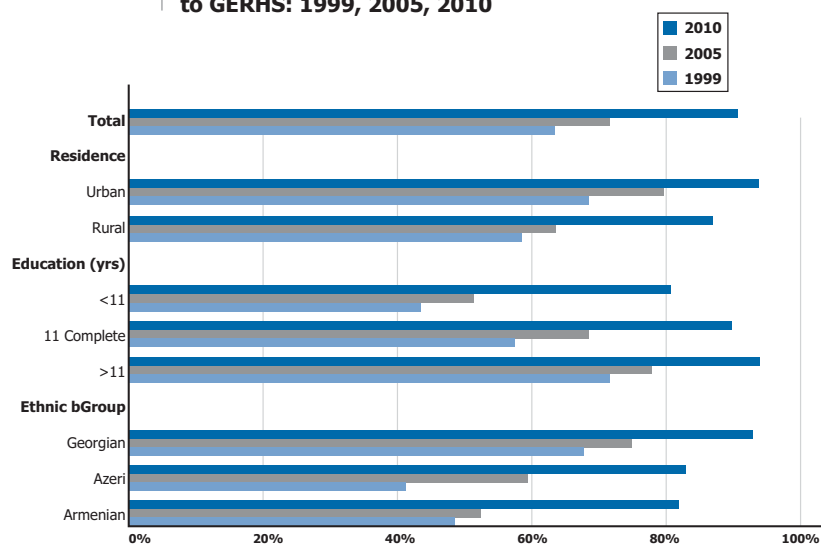
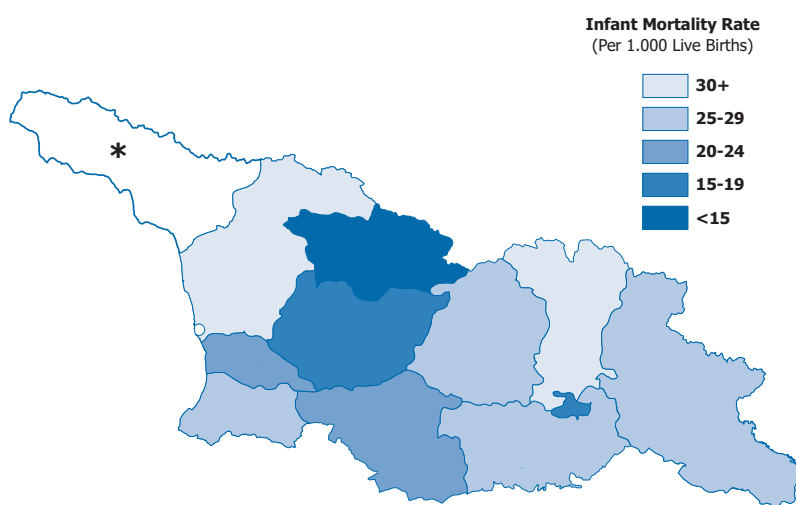


Figure 6.2.6 Completion of at Least 4 Care Visits by Region Births in 2000-2005



* Abkhazia: Autonomous region not under government control

30% to 6%), and among Azeri women (from 28% to 4%) (Figures 6.2.3 and 6.2.4).

The majority (90%) of respondents initiated prenatal care during the first trimester of their pregnancy (Table 6.2.1). Urban women were more likely than rural women to initiate prenatal care during the first trimester (93% vs. 86%), as were women living in the regions of Tbilisi (94%) and Adjara (93%), compared to those living in the other regions of the country. Receipt of prenatal care in the first trimester increased directly with maternal education and the wealth quintile of the households. Overall, initiation of prenatal care in the first trimester increased from 63% in 1999 to 71% in 2005, to 90% in 2010 and the improvement was consistent across all subgroups (Figure 6.2.5).

Overall, the majority (90%) of pregnant women received four or more prenatal care examinations, including 12% who received 10 or more visits (Table 6.2.1). On average, pregnant women received 6.5 prenatal care visits (not shown). Completion of four or more prenatal visits was more common in urban areas than in rural areas (95% vs. 86%) and in the regions of Shida-Kartli (98%), Tbilisi (96%) and Imereti (96%), and least common in the regions of Racha-Svaneti (78%) and Kvemo Kartli (80%) (Figure 6.2.6). The mean number of prenatal care visits also varied by region (from over seven visits per pregnancy in Tbilisi and Imereti to five in Samtskhe-Javakheti and Guria, but no region reported less than five visits, on average (data not shown)).

Figure 6.2.7 Completion of 4+ Prenatal Care Visits By Residence and Education Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

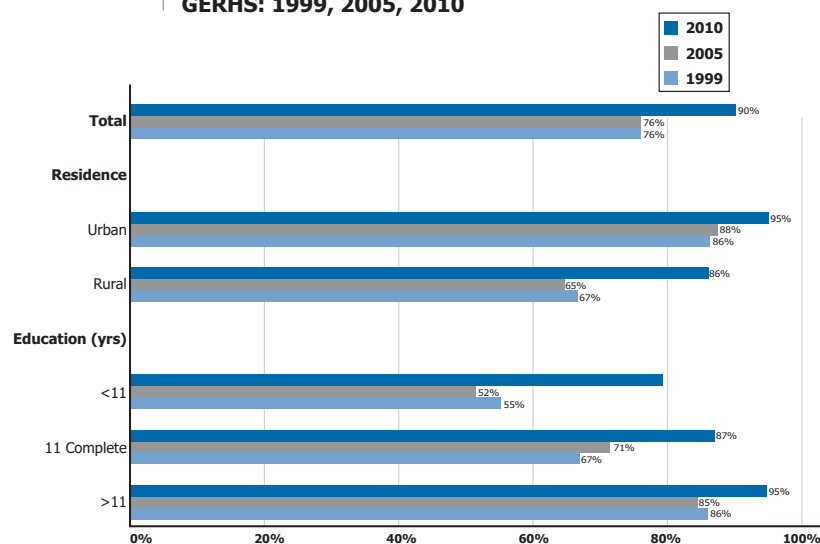
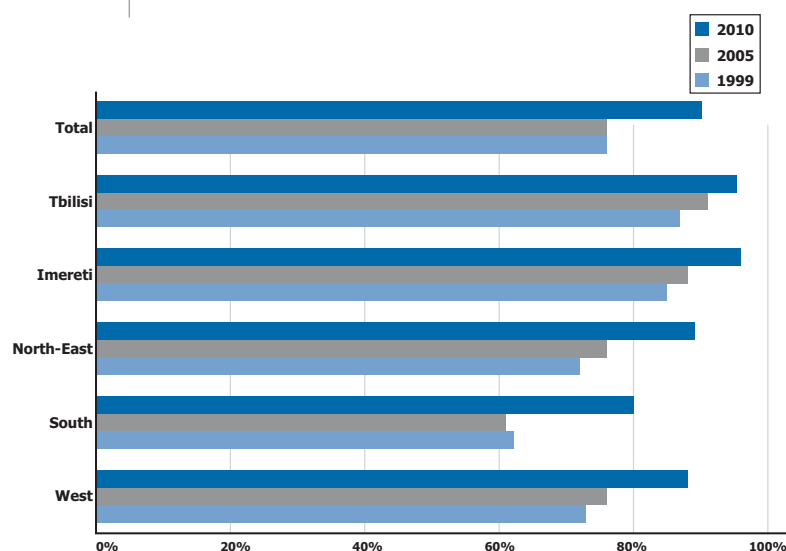


Figure 6.2.8 Completion of at Least 4 Prenatal Care Visits by Region Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



As expected, the percentage of pregnant women receiving four or more prenatal examinations increased as their educational attainment and socioeconomic status increased, from a low 79% among women with less than a full secondary education to 95% among women with high education, and from 78% among women within the lowest wealth quintile to 97% among women within the highest wealth quintile. The percentage of pregnant women receiving four or more prenatal examinations did not vary significantly with maternal age, but was inversely related to the birth order, from a high of 94% among first order births to a low of 80% among third or higher order births. Minority women were less likely to have had four or more prenatal examinations than Georgian women.

The percentage of pregnancies receiving 10 or more prenatal examinations was the highest in Tbilisi and

Imereti and increased as the educational attainment and socioeconomic status of the expectant mothers increased.

All prenatal care indicators improved between 1999 and 2010. The overall use of prenatal care and the early initiation of care in the first trimester increased from 91% to 98% and from 63% to 90%, respectively, and the percentage of pregnant women receiving four or more examinations increased from 76% to 90%. Contrary to previous surveys, the improvements included some of the most disadvantaged groups of women, rural residents, those with less than a complete secondary education, and residents of the southern regions (Figures 6.2.7 and 6.2.8). The improvements in antenatal care are likely due to a shift in the proportion of pregnant women who reported no or low attendance in 1999 and 2005, toward more in the cat-

Figure 6.2.9 Number of Prenatal Care Visits
Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

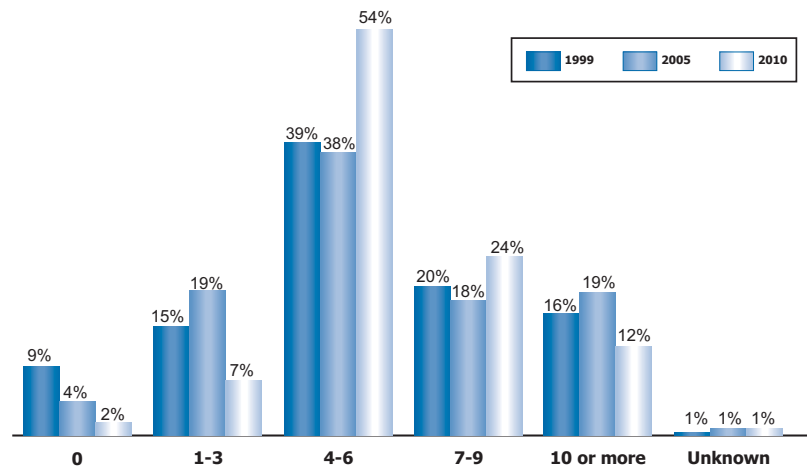
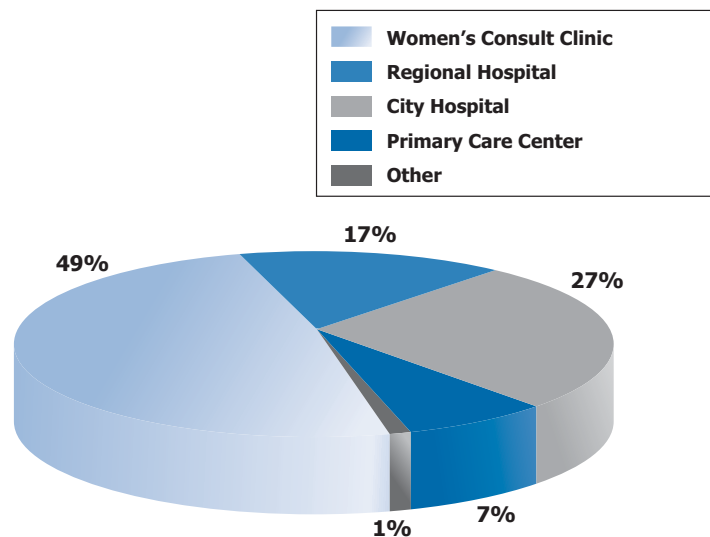


Figure 6.2.10 Place of Most Prenatal Care Visits
Births in the Last 5 Years: GERHS10



egories of 4-6 and 7-9 visits in 2010. The proportion at 1-3 months fell in 2010 in favor of increases for more visits (Figure 6.2.9).

As shown in Figure 6.2.10, one in two women with births in 2005-2010 received most of their prenatal care from women's consultation clinics (49%); 44% received their care from regional or city maternity hospitals. Only 7% received care from primary health care or family medicine centers, while 1% received care from other sources.

As in the previous surveys, the 2010 study included additional questions to assess adequacy of prenatal care content. Specifically, respondents were asked about what types of counseling they received and what assessments were performed during the prenatal visits.

Dissemination of health messages is an important component of prenatal care visits. In the absence of routine preconception care, the first prenatal visit is a critical opportunity to screen women for behavioral risk factors (e.g., tobacco and alcohol use), medical and genetic risks, and occupational risks, as well as to provide comprehensive counseling. Counseling should cover maternal behaviors and exposures that may affect the health of the fetus, nutrition, the importance of rest, and early signs and symptoms of pregnancy complications. In addition, as the time of delivery approaches, counseling should prepare women for what they will face when giving birth and provide accurate information regarding labor, delivery, and techniques to reduce pain and anxiety during labor. Also, counseling about breastfeeding and family planning after birth should be initiated during the prenatal period.

and reinforced during postpartum care.

As shown in Table 6.2.2, 89% of women who attended prenatal care clinics received some counseling about nutrition during pregnancy; 81% received information about delivery; and 79% received information about breastfeeding. Two in 3 women received information on potential complications during pregnancy and their early signs; 63% of pregnant women and 60%, respectively, received information on the negative effects of smoking and alcohol use during pregnancy; 59% of women received information about postnatal care; and a low 39% received information about family planning after birth. Maternal characteristics that appear to be associated with lower levels of counseling for most of the topics include rural residence, residence in Samtskhe-Javakheti and Samegrelo, less than complete secondary education, and membership in the lowest wealth quintile. The proportion of women receiving information during prenatal care visits was directly correlated with the number of prenatal visits (see bottom of Table 6.2.2).

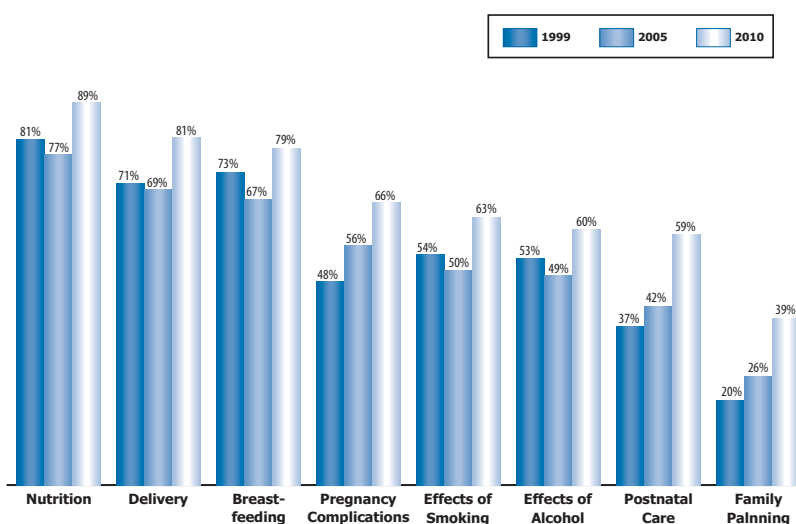
Compared to 1999 and 2005, the overall level of counseling improved in 2010 for all topics (Figure 6.2.11). The greatest improvement occurred in the proportion of women who received counseling on family planning after birth—which almost doubled from 20% in 1999 to 39% in 2010—and in the proportion of women who received information about postnatal care—which increased from 37% to 59%. The proportion of women who were counseled about warning signs of pregnancy complication increased from 48% to 66%. The percentages for smoking and alcohol also rose. But despite all these substantial increases, these topics still lag behind the 2010 levels for the other three topics in Figure 6.2.11.

In addition to counseling, prenatal care should include a careful medical history of the woman and her family, to include information about risk factors and genetic disorders; a detailed obstetrical history; clinical and obstetrical examination; measurements of maternal weight, height, and blood pressure; urine tests; basic blood tests; an ultrasound exam (during the second visit); and tests for various types of infection (e.g., syphilis and HIV). Tables 6.2.3 and 6.2.4 show the percentage of women receiving prenatal care who underwent selected examinations and measurements. Overall, almost all women (92%–99%) had at least one routine measurement of weight and height, blood pressure, urine tests, and basic blood tests. About 65% had an HIV test during the prenatal period, compared to 46% in 2005 (a 50% increase); and 97% had at least one ultrasound exam.

Compared to previous surveys, the 2010 study found that not only did the practice of measurements and lab work during pregnancy improve overall, but also that it improved in the most disadvantaged groups. Contrary to previous surveys, the receipt of measurements and tests during prenatal care in 2010 varied little by maternal characteristics. The only notable exception remains HIV screening during pregnancy, which was much more likely to be performed in urban areas than in rural areas (75% vs. 55%). It also varied by region (with the lowest coverage in Samtskhe-Javakheti and Adjara), was directly correlated with education and socio-economic status, and was the least likely to be performed when most of the prenatal care was obtained in a primary care or family medicine center.

More than three-fourths of women (77%) reported receiving their first ultrasound exam during the first

Figure 6.2.11 Type of Counseling Received during Prenatal Care Births in the 5 Years Prior to GERHS: 1999, 2005 and 2010



trimester of pregnancy, a substantial increase from 2005, when only 44% of women received the test then. This finding suggests that ultrasound examination is now increasingly used as part of the initial pregnancy assessment—to confirm pregnancy, ensure that it is neither molar nor ectopic, assess gestational age, and determine the due date.

6.3 Intrapartum Care

The vast majority of births since January 2005 were delivered in health care facilities; only 2% of the births were delivered elsewhere (Table 6.3.1). Essentially all births in urban areas were delivered in medical facilities. The percentage of home births was uniformly very low, with the exception of Kakheti region (8%), women with less than complete secondary education (6%) and those residing in households within the lowest wealth quintile (4%), and women of Azeri or other ethnic group background (5% and 9%, respectively).

Overall, between the 2005 and 2010 surveys, the percentage of births attended at home dropped precipitously (from about 8% to 2%). The largest declines were noticeable in regions with high home delivery rates (Figures 6.3.1 and 6.3.2). Deliveries at home among residents of Kakheti fell by 73% (from 30% to 8%). Home deliveries in Kvemo-Kartli and Guria, where in 2005 they represented 15% and 12% of all births, were almost eliminated. Steep declines were also reported among women of a minority ethnic group. Among Azeri women, the decline in home deliveries was remarkable, from 40% in 2005 to 5% in 2010.

Table 6.3.2 shows the average amount of time spent in a medical facility prior to the delivery, and also the length of stay after the delivery. The average time spent prior to delivery was about 4 hours and varied little by the characteristics of the mothers or by the

type of delivery. Considering that the average duration of labor is between ten hours for nulliparous women and six hours for multiparous women, most women were admitted for delivery around or right after the onset of labor.

Standards of care in Georgia stipulate 4 days of postpartum hospital care after uncomplicated deliveries, 5 days after pregnancy or delivery complications, and 6 days after deliveries by cesarean section. The 2010 data show that 56% of women who gave birth in a medical facility were discharged in the first 4 days after delivery, while 25% were discharged after 5 days and 15% after 6 or 7 days. A small percentage of women (4%) were discharged eight or more days after delivery (Table 6.3.2). Hospital stays of 6 days or more were experienced by almost one in two (48%) of women who delivered by cesarean section and 29% of those who had pregnancy complications.

Among the births that took place in a medical facility, 24% were delivered by cesarean section, ranging from a high of 33% in the region of Samegrelo to a low of 9% in the region of Samtskhe-Javakheti (Table 6.3.3 and Figure 6.3.3). As in many countries, the probability of delivering by cesarean section increases with maternal age, educational attainment, and socioeconomic status. Women who reported complications during pregnancy were significantly more likely to deliver by cesarean section than were women without complications: 36% vs. 22%. Forty-one percent of women who reported being in labor for more than 12 hours had delivered by C-section, compared to only 8% of women who were in labor for shorter durations.

Respondents were asked to identify the most important reason why they had delivered by cesarean section (Figure 6.3.4). The most frequent reasons given by the respondents included a previous C-section

Figure 6.3.1 Percentage of Home Deliveries by Region
Births in the 5 Years Prior to GERHS: 2005 and 2010

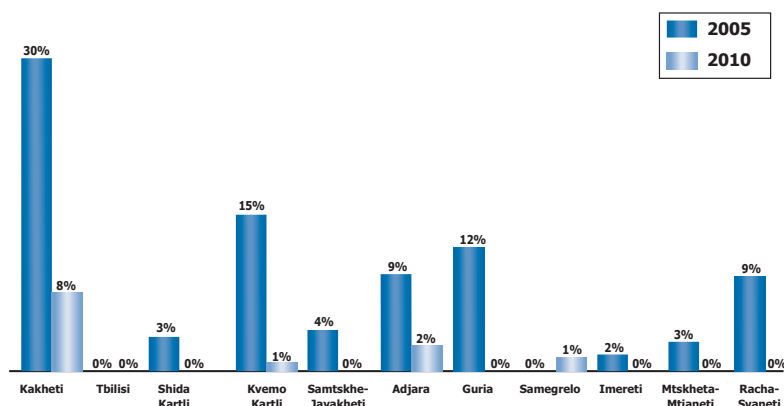


Figure 6.3.2 Percentage of Home Deliveries, by Ethnic Group
Births in the 5 Years Prior to GERHS: 1999, 2005 and 2010

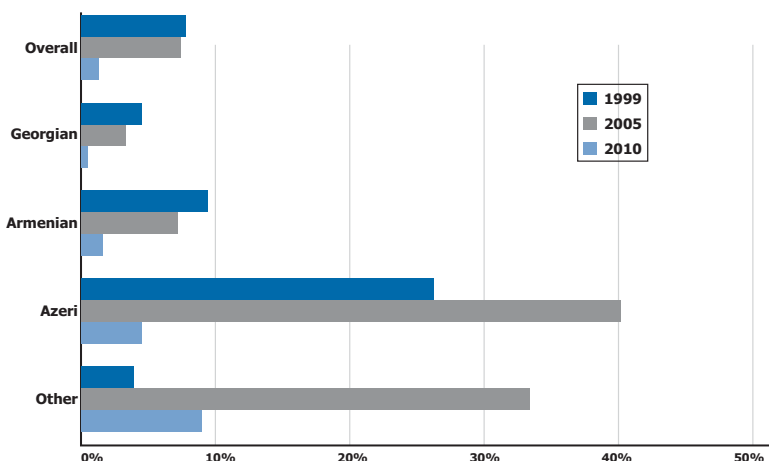
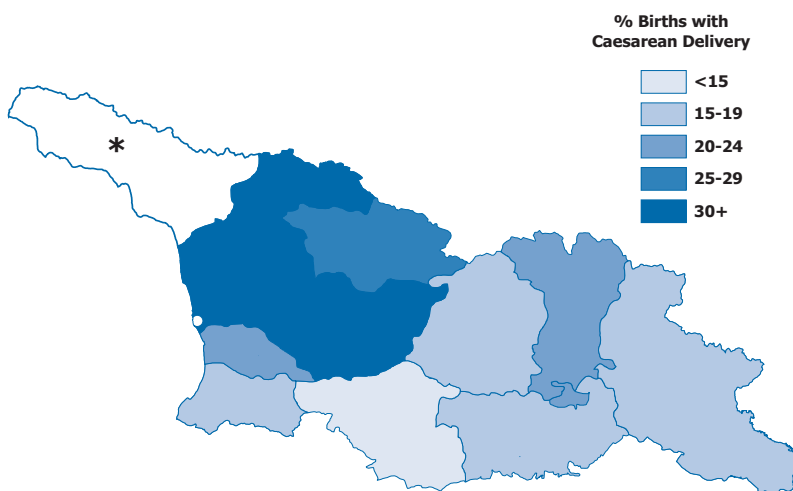


Figure 6.3.3 | **Percentage of Caesarean Deliveries by Region - Births in 2000–2005**



* **Abkhazia: Autonomous region not under government control**

(20%), fetal malpresentation (17%), cesarean section performed on request (16%), fetal distress (13%); prolonged labor (11%); fetopelvic disproportion (10%); and severe bleeding (2%); 11% reported that they received a cesarean section due to “other” factors. According to the Georgian Obstetrics and Gynecology Association, patient request of cesarean section delivery is not considered a medical indication. Compared to the 1999 survey, the prevalence of cesarean deliveries more than tripled in every region; the greatest percentage increase was in the North-East region (5 times higher prevalence in 2010 than in 1999) and in Imereti (4 times higher prevalence in 2010 than in 1999) (Figure 6.3.5). Most of these increases are attributable to the adoption of more inclusive indications for cesarean delivery into clinical practice.

In Georgia, almost all deliveries (88%) assisted by skilled birth attendants are performed for a fee, which varies by type of facility and type of delivery (Table 6.3.4). At the time of the survey, mean delivery charges were 453 GEL (about USD 260.00). Reported delivery payments were lower among rural women than urban women, and among abortions performed outside of Tbilisi. Fees increased directly with education and SES (wealth quintile). The amount paid for a delivery ranged from no payment to over 600 GEL. Only 12% of deliveries incurred no charge while 28% required payments of 600 or more Lari; deliveries by C-section were 1.7 times more expensive than vaginal deliveries and more than half required payments of 600 or more Lari.

6.4 Postpartum Care

Post-delivery assessments of the health of both mother and infant are important, as is comprehensive counseling. Care of a new mother after delivery helps ensure that she is in good physical health and is prepared to care for her infant. The postpartum period is a critical time for health care providers to evaluate the physical and psychological health of the new mother and her infant, to detect and treat postpartum complications, and to provide counseling and support needed to address any specific problems related to care of the child (WHO, 2002). As discussed above, the WHO postpartum four-visit model is not currently included in the state program. However, because the majority of deliveries take place in maternity hospitals, some immediate postpartum care to the mother and her newborn is provided by attending physicians and nurses during the post-birth hospital stay (4–6 days). Any postpartum care that is provided after the hospital discharge, tends to be focused on health and development of the newborn; maternal health usually receives little follow-up (CoReform Project, 2005)

As shown in Table 6.4.1, only 23% of mothers received postpartum care after they left the hospital. Although this is an improvement over the 1999 level, there was almost no change compared to the 2005 level. Further, Georgia ranks last in the region with regard to the percentage of women receiving such care, which highlights the need to include postpartum coverage under the state maternal and child care program (Figure 6.4.1).

Levels of postpartum care ranged from a low of 16% in the regions of Guria, Samegrelo, and Shida Kartli to a high of 32% in the region of Mtskheta-Mtianeti (Figure 6.4.2). Rates increased with educational attainment and wealth quintile but were especially elevated among women who experienced postpartum complications compared to those without complications: 44% vs. 21%. In 2010 about three out of four women who received postpartum care (73%–79%) were counseled at least once on breastfeeding, breast care, child care, immunization, and nutrition (Figure 6.4.3). Notably, only 43% of the women received counseling on family planning. Compared to 1999, rates of coun-

Figure 6.3.4 Main Reason for Caesarean Delivery - Births in 2005–2010

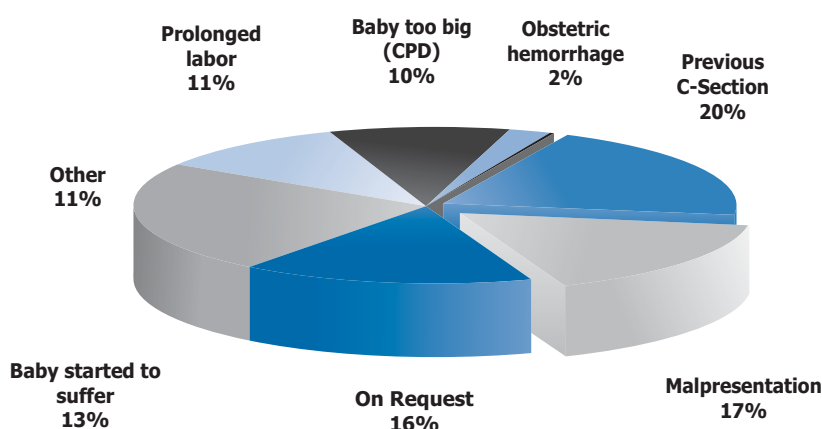


Figure 6.3.5 Percentage of Caesarean Deliveries by Region Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

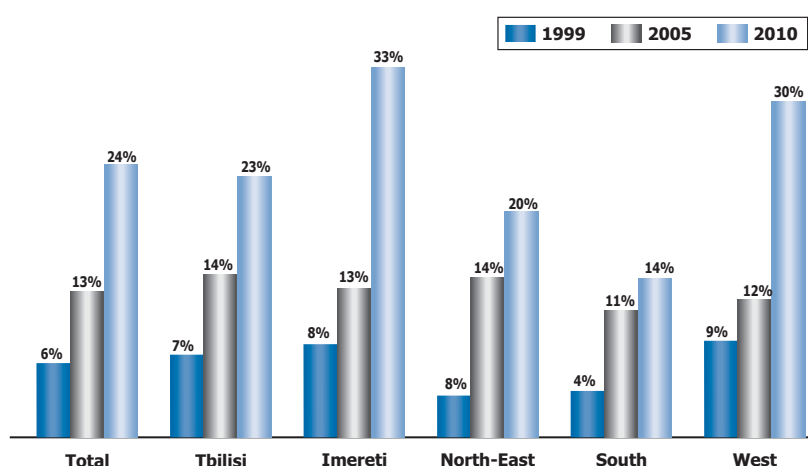


Figure 6.4.1 Percentage of Mothers Receiving Postpartum Care Births in the 5 Years Prior to the Survey Selected Countries in Eastern Europe and Caucasus

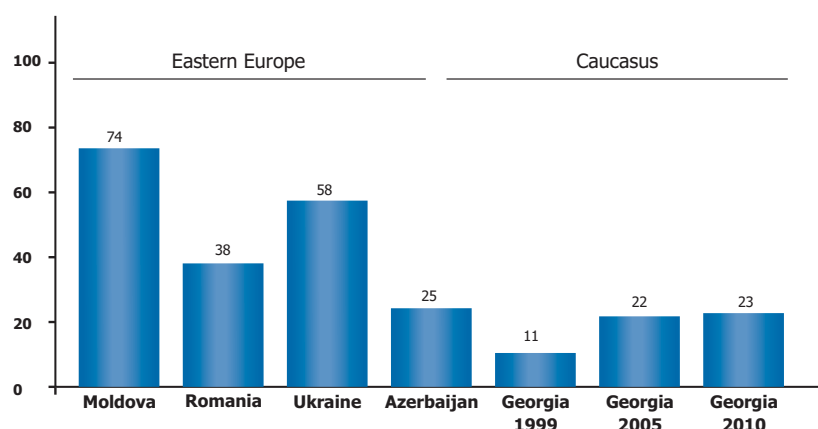
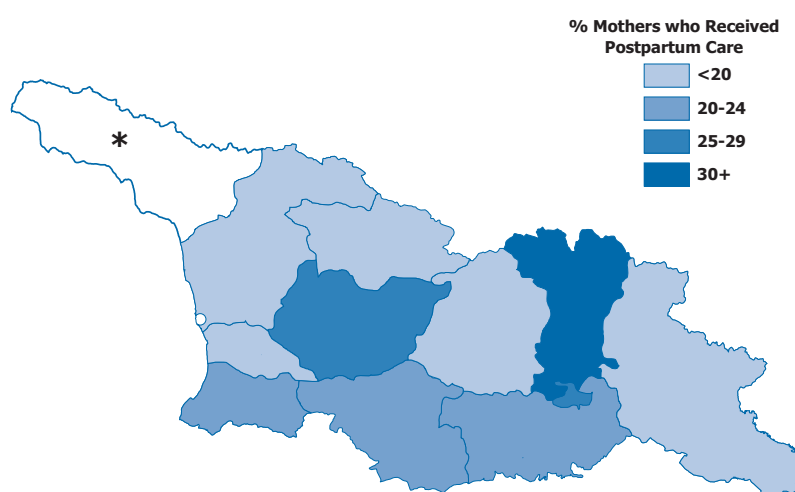


Figure 6.4.2 Percentage of Mothers Receiving Postpartum Care by Region—Births in 2005–2010



* Abkhazia: Autonomous region not under government control

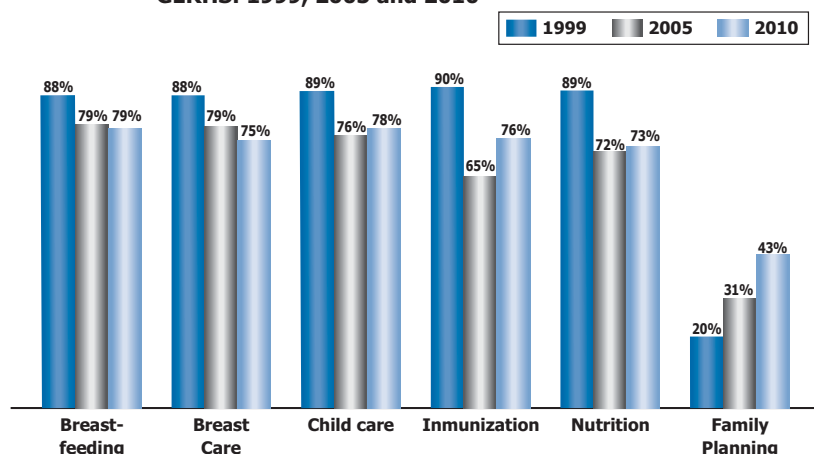
seling on all topics unfortunately fell in both 2005 and 2010. Only family planning counseling rates increased, from 20% in 1999, to 31% in 2005 and 43% in 2010. However even the 43% remains less than half of the 23% of mothers who received any postpartum care at all.

WHO recommends that the first postpartum visit take place within one week after birth (WHO, 2002). As shown in Table 6.4.2, 31% of the subgroup that received any postpartum care reported making the postpartum visit during the first six days after delivery, while an additional 42% made their initial visit one to two weeks after delivery, and 27% made their initial visit more than two weeks after delivery.

The survey asked each mother if a health professional checked the baby's health and, if so, how soon after

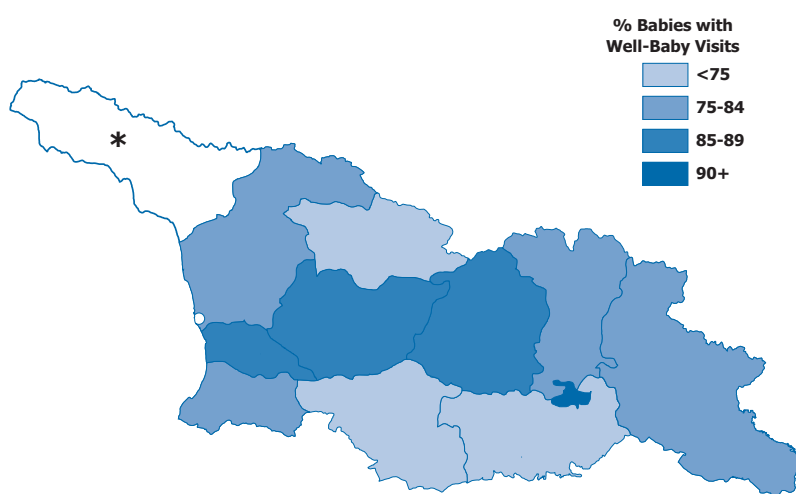
delivery the examination was made. As shown in Table 6.4.3, overall, 84% of newborns received a well-baby checkup. Well-baby care was higher among urban than rural residents (90% vs. 79%) and ranged from lows of 72%–75% in the regions of Racha-Svaneti, Samtskhe-Javakheti, and Kvemo Kartli to a high of 92% in the region of Tbilisi (Figure 6.4.4). As with other indicators discussed in this chapter, the likelihood of receiving well-baby care increases as the educational attainment and socioeconomic status of the mother increase. Among the respondents who took their newborn to a health professional to be examined, 22% took their infant during the first six days following delivery, while 53% made their initial visit one to two weeks after delivery. An additional 24% took their newborn for an examination more than two weeks following delivery.

Figure 6.4.3 Type of Postpartum Counseling Among Women Who Received Postpartum Care Births in the 5 Years Prior to GERHS: 1999, 2005 and 2010



As shown in Table 6.4.4, virtually all (97%) babies there is a linear relationship between the quantity of

Figure 6.4.4 Completion of Well-Baby Check-Ups by Region—Live Births in 2005–2010



* Abkhazia: Autonomous region not under government control

born alive in 2005–2010 were registered, according to the mother. The majority of mothers registered their births during the first six days following delivery (81%), while an additional 16% did so one to four weeks after delivery. Urban women were more likely than rural women to register their births soon after delivery.

6.5 Smoking and Drinking During Pregnancy

Use of tobacco and alcohol during pregnancy are major risk factors for pregnancy outcomes. Maternal smoking is linked to low birth weight, preterm deliveries, sudden infant death syndrome, and respiratory problems in the newborn (DiFranza and Lew, 1996). Research also suggests that woman who drink alcohol while pregnant are more likely to have miscarriages, stillbirths, and premature deliveries (Wilsnack SC et al., 1984; Kesmodel U et al., 2002). No amount of alcohol is considered safe to drink during pregnancy, and

alcohol consumed and the chances of birth defects (fetal alcohol syndrome) or physical and mental developmental problems.

Respondents who gave birth during the five years prior to the 2010 survey were asked “On average, how many cigarettes did you smoke per day after you were pregnant?” and “How many times per week did you drink alcoholic beverages during the pregnancy?” As shown in Table 6.5, only 4.2% of the women were smokers at the time that they discovered they were pregnant, and less than half of them (1.8%) continued to smoke after they found out they were pregnant. Smoking during pregnancy was highest in Tbilisi (4.6%), among women whose households were within the highest wealth quintile (3.4%), and among women of “other” ethnicity (5.4%). Most of the mothers who smoked during pregnancy smoked 1-4 cigarettes per day. Only 1.1% of women reported drinking during

pregnancy; most of these women (61%) consumed alcohol less than once per week (data not shown).

6.6 Pregnancy and Postpartum Complications

As shown previously in Table 5.2.3, routine measurement of blood pressure was almost always (96%) reported as being part of the risk assessment during prenatal visits. Of the women whose blood pressure was measured, 10% were identified as having high blood pressure (Table 6.6.1). The prevalence of reported high blood pressure during pregnancy was highest among women whose maternal age at delivery was 35–44 years (21%). Overall, 1% of the women were hospitalized due to high blood pressure; higher hospitalization levels were reported by women residing in Kakheti (2%) and those who had most of their prenatal care visits in city maternity hospitals (2%).

Nearly 16% of women with births in the last five years reported pregnancy complications requiring medical attention (Table 6.6.2). The conditions mentioned most often were risk of preterm delivery (8%), anemia related to pregnancy (4%), water retention or edema (3%), high blood pressure (3%), and bleeding either early or late (3%). Pregnancy complications requiring medical attention were more prevalent among women living in Mtskheta-Mtianeti (24%), Shida Kartli (22%) and Imereti (21%) and women whose age at delivery was 35–44 years (20%). Almost one in three women with pregnancy complications reported that they had been hospitalized for these conditions (data not shown).

Postpartum complications reported by women who gave birth in the five years prior to the survey are shown in Table 6.6.3. Overall, 11% of the women reported at least one postpartum complication. The complications mentioned most often were severe bleeding, painful uterus, high fever, breast infection,

infectious vaginal discharge, painful urination, and infection of the surgical wound.

6.7 Poor Birth Outcomes

As in the previous rounds, the 2010 study collected a complete pregnancy history, asking each woman about her lifetime pregnancy experiences, including information about pregnancies resulting in fetal death. Multiple definitions are in use in different countries based on different parameters (i.e. gestational age or weight at birth) and standards of viability. For international comparability, the 2010 survey used the WHO recommendations and included in the calculation of stillbirth rate all infants born dead after 28 completed weeks of gestation (roughly weighing 1,000 grams or more at birth). Thus, stillbirth rate data presented here refer to late fetal deaths, i.e. the number of babies born dead after 28 weeks of gestation per 1,000 total births. Of all births that occurred during the five years prior to the survey, 8 per 1,000 (95%CI=3.1-13 per 1,000) were stillbirths (Table 6.7). This rate is lower than the rate of 13.4 per 1,000 reported by governmental sources for the 2005-2010 periods (WHO, 2011a, 2011b).

Stillbirth rates were twice as high in urban areas as in rural areas and were the highest in Mtskheta-Mtianeti (21.8 per 1,000), followed by Kakheti, Tbilisi, and Racha-Svaneti. The stillbirth rate was highest among woman who did not receive any prenatal care (50.0), women who suffered complications during their pregnancies (33.5), and women with prolonged labor (29.6).

Overall, the low birth weight rate, which is the percentage of live births with birth weight under 2,500 grams, was 4.2% among infants born alive. Slightly higher rates were reported by women living in the regions of Mtskheta-Mtianeti (7.6%), women with a

Figure 6.8.1 Percentage of Children Ever Breastfed
Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

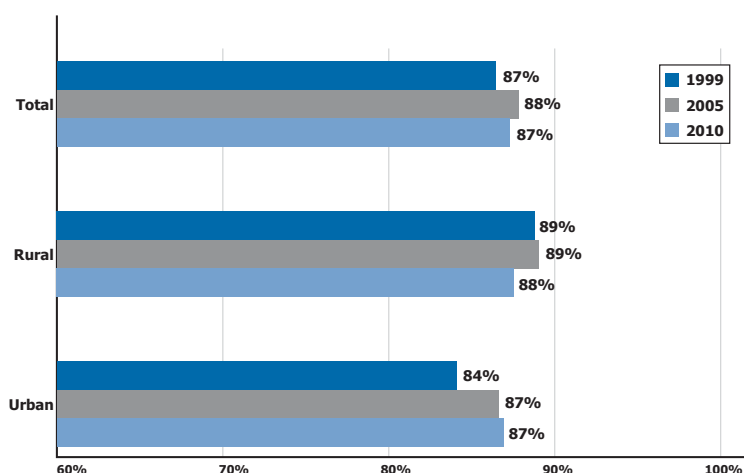


Figure 6.8.2 Initiation of Breastfeeding Following Birth (in Hours)
Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

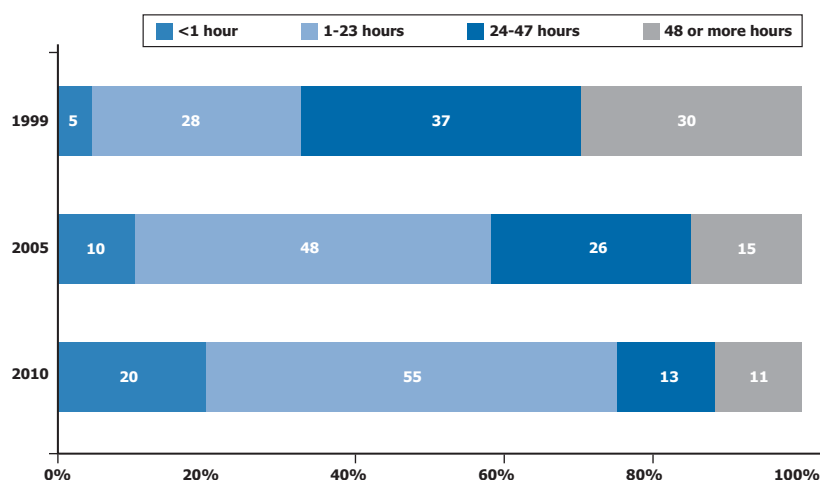
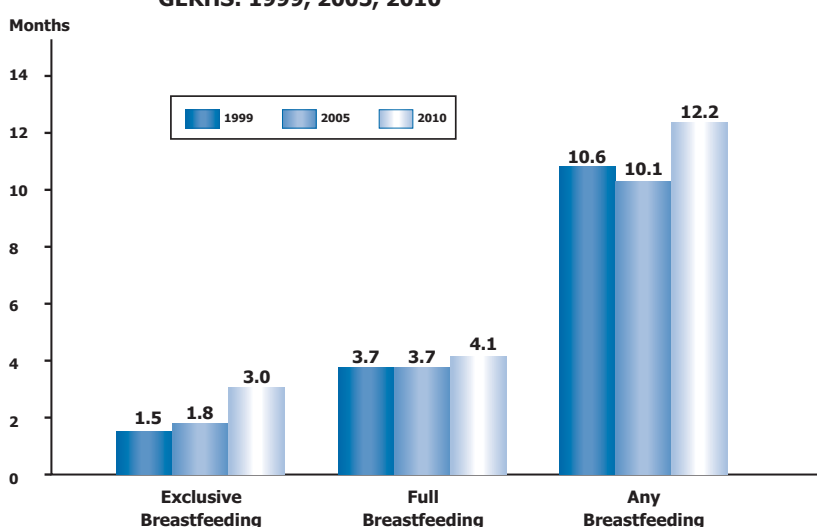


Figure 6.8.3 Average Duration of Breastfeeding (in Months) by Type of Breastfeeding Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



maternal age of 35-44 years (11.1%), women who delivered by cesarean section (7.7%), and women who experienced complications during their pregnancies (10.9%).

The reported prematurity rate (percentage of live births delivered before 37 weeks of gestation) for the same time period was 3.8%. Higher prematurity rates were associated with the same maternal and pregnancy characteristics identified for higher risk of low birth weight.

6.8 Breastfeeding

WHO recommends that all infants are fed exclusively on breast milk from birth to 6 months of age, followed by continued breastfeeding, together with appropriate complementary feeding, for up to two years of age or beyond (WHO, 2002). An infant is considered

to be “exclusively” breastfed if he or she receives only breast milk and is “predominately” breastfed if he or she receives breast milk accompanied by water, water-based drinks, fruit juice, or other liquids (except non-human milk and food-based fluids) (WHO, 1991). Children with exclusive or predominant breastfeeding are considered to be “fully” breastfed.

Table 6.8.1 and Figure 6.8.1 show that, 87% of infants born since January, 2005 were breastfed. This rate is essentially unchanged from the 1999 and 2005 surveys. Differences in breastfeeding by residence, region, maternal age, educational attainments, and birth order were slight, although Georgian women reported lower rates of ever-breastfeeding than women of other ethnicities. Among babies who weighed less than 2,500 grams at birth, only 64% were reported to have been breastfed (see bottom of Table 6.8.1).

According to WHO recommendations, early breast-feeding (i.e., within the first hour of life) should be encouraged after all spontaneous deliveries. However, only 20% of infants were breastfed within the first hour following birth. The percentage of infants that were breastfed within the first hour ranges from a high 33% in Samtskhe-Javakheti and Mtskheta-Mtianeti to a low of 9% in Adjara. An additional 55% of infants were breastfed within 1-23 hours after birth. Thus, overall, 75% of the infants were breastfed within the first day. Among infants delivered by Cesarean section, only 50% were breastfed within the first day, while 25% were breastfed for the first time within 48 hours, and another 25% later. Since the 1999 survey, the proportion of babies who were breastfed within the first hour after birth increased by 4 times (from 5% in 1999 to 10% in 2005, and 20% in 2010), while the proportion of those who received breast milk 1-23 hours after birth doubled, from 28% to 55% (Figure 6.8.2).

The proportion of children under 5 years old still being breastfed at the time of the survey was calculated by months of age (0-59 months); the denominator included all live births in the 5 years preceding the survey, regardless of survival. Those proportions were summed to calculate the mean duration of breast-feeding. This method is known as the “current status mean” method (WHO, 1991). Durations of exclusive and full breastfeeding were calculated in the same way.

Table 6.8.2 and Figure 6.8.3 show data on the mean duration of breastfeeding. The mean duration of any breastfeeding was 12.2 months, 2 months longer than the 10.1 months recorded in the 2005 survey. The mean duration of full breastfeeding (either exclusive breastfeeding or predominately breastfeeding) was

4.1 months, longer than the 3.7 months documented in the 1999 and 2005 surveys.

Perhaps the most important gain was in the duration of exclusive breastfeeding (only breast milk), which doubled from the level documented in the 1999 survey (from 1.5 to 3.0 months).

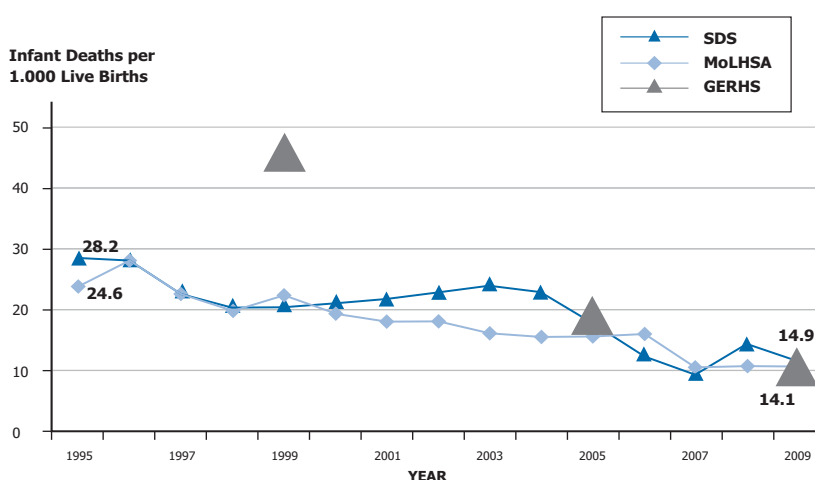
Breastfeeding increases especially as birth order increases: patterns for “any breastfeeding” were similar across most categories shown in Table 6.8.2, excepting birth order. Smaller differences appeared by residence and wealth quintile.

6.9 Infant and Child Mortality

The reduction of mortality among children under five by two-thirds between 1990 and 2015 is centrally formulated in the Millennium Development Goal 4 (MDG 4). In view of the short time left to meet the goal, efforts must be scaled up worldwide to save the lives of children in their first 5 years of life; therefore demand is increasing for reliable national data on under-5 mortality levels and trends to guide national action priorities and further research.

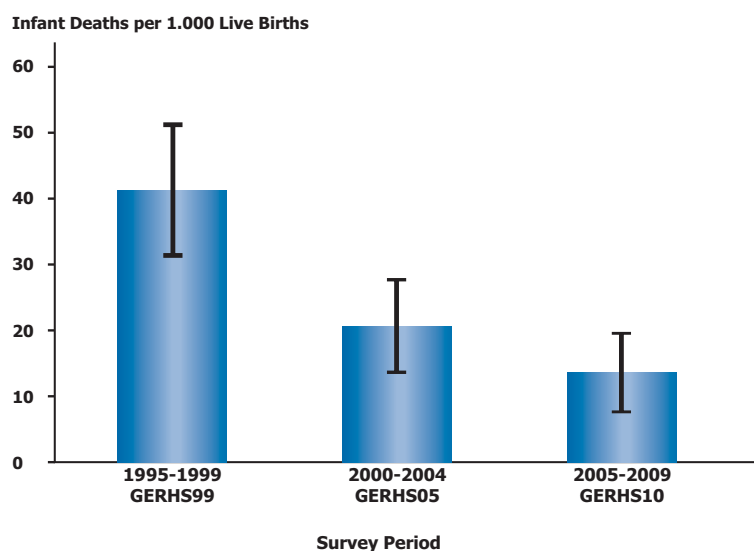
Globally, average infant mortality rates have fallen steadily over recent years, from 65 per 1,000 in 1990 to 62 per 1,000 in 2000 and 42 per 1,000 in 2009 (UNICEF, 2001 and 2011). Consequently, rates of mortality among all children under five have fallen from 95 per 1,000 live births in 1990 to 84 per 1,000 live births in 2000 and 79 per 1,000 live births in 2004 and 60 per 1,000 live births in 2009 (UNICEF, 2001 and 2011). Yet, 8.8 million children still die each year, including about 5.6 million infants who die before they are one year old; 99% of these deaths occur in low- and middle-income countries. A substantial propor-

Figure 6.9.1 Infant Mortality in Georgia
Official Estimates and Survey Estimates for 1995–2009



Source: Revised SDS estimates available at <http://statistics.ge>; Georgian MoLHSA estimates in L. Sakvarelidze, 2010

Figure 6.9.2 Infant Mortality Rates
Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



tion of infant and child mortality is due to newborn mortality; in 2009, the neonatal death rate was 24 per 1,000 live births, representing 39% of all deaths in children under 5 years of age and more than half of infant mortality. The major direct causes of neonatal deaths globally are infections (36%), premature birth (28%), and asphyxia (23%) (Lawn et al., 2005). Among children under five, 68% of deaths are attributable to infectious diseases, including pneumonia (18%), diarrhea (15%), malaria (8%), neonatal sepsis (6%), AIDS (2%). Preterm birth complications (12%) and asphyxia at birth (9%) were other major causes of death among children under five (Black et al., 2010).

As in the previous surveys, the 2010 data were used to calculate mortality levels among respondents' children, specifically, infant mortality (i.e., deaths before the first birthday), child mortality (i.e., deaths between 12 and 59 completed months of age), and under-5 mortality (i.e., deaths before the fifth birthday). Infant mortality was further divided into two periods: neonatal (0–28 days) and post-neonatal (29 days to 11 completed months). The survey estimated levels and trends in infant and child mortality based on birth histories and child survival information. The questionnaire included a series of questions for each live birth: date of birth, sex of child, survival status, and for children who had died, age at death. This information allows a direct calculation of infant and child mortality rates for precise periods of time, by means of life tables.

Survey data-based mortality estimates should be viewed as minimum estimates because they may be subject to underreporting. For example, information on a deceased child whose mother has also died will simply not be gathered; some mothers may not acknowledge a child who died shortly after birth; others

may not recall the exact date of birth or may be unwilling or unable to recall at what age a child died. Despite these limitations, population-based survey estimates of infant and child mortality are quite robust and have proved instrumental in countries where official birth and death rates are incomplete or inaccurate. Because surveys count events experienced by a randomly selected sample, rather than the entire population, the resulting estimates are subject to a certain degree of sampling error (see Appendix B). To adjust for sampling error, 95% confidence intervals around survey estimates were calculated; consequently, we can say that the true value of a statistic lies within the boundaries of the 95% confidence interval.

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

Figure 6.9.1 presents various estimates of changes in the infant mortality rate in Georgia, using data from all available surveys and official statistics. The most recent available figures for 2009 are in good agreement among all sources (14.1–14.9 deaths per 1,000 live births). The figure includes the three values shown by the triangles for estimates based on the three GERHS surveys. The final points, for 2009, represent the lowest rates since 1990.

Figure 6.9.3 Neonatal Mortality Rates
Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

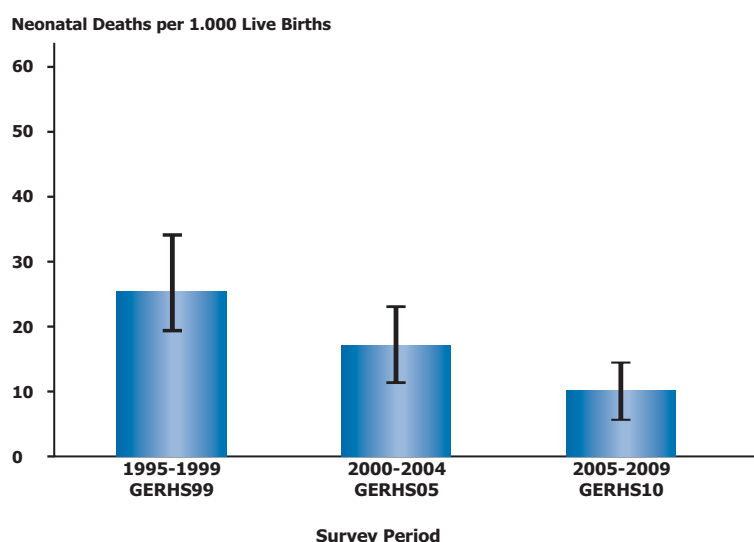
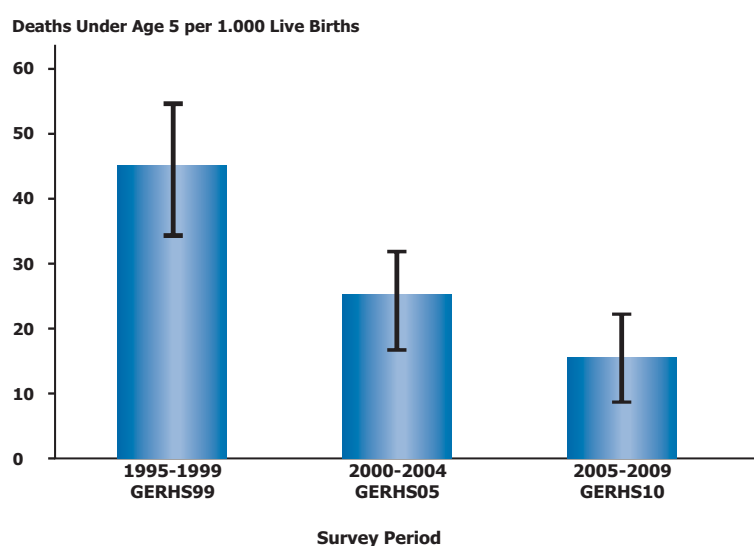


Figure 6.9.4 Deaths Under Age 5 per 1,000 Live Births
Prior to GERHS: 1999, 2005, 2010



The pattern of change is obscured in the official vital records because of substantial underreporting prior to 2002, particularly in the figures published by the national State Department of Statistics (SDS). Starting with 2002, the government of Georgia, in collaboration with UNFPA and other international donors, launched an initiative to improve the vital registration system (WHO and CMSI, 2003). The MoLHSA put forth recommendations for implementation and calculation of child health indicators, revised the format of the medical death certificate, and provided instructions for completing and issuing the certificate (Order Nos. 141 of Oct. 2000 and 94/0 of Dec. 2000). A presidential decree—Decree 31 of December 10, 2002—put forth new rules for birth and death registration (Government of Georgia, 2002). Thus, infant mortality trends that are based on official estimates are difficult to interpret because the changes in birth and death registration after 2002 are likely to have improved

the completeness and accuracy of official estimates whereas the figures prior to 2002 underestimate the true mortality levels.

Table 6.9.1 presents mortality estimates for the 5 year periods prior to the 2010, 2005 and 1999 surveys. For example the estimated infant mortality rate for the period January 2005–December 2009 was 14.1 per 1,000 live births and the child mortality (1-4) rates was 2.3, so these sum to the under-5 mortality rate of 16.4 per 1,000. The neonatal mortality rate was estimated at 9.5 per 1,000, while the post-neonatal mortality rate was estimated at 4.5 per 1,000, and these sum to the infant mortality rate of 14.1. Thus, the neonatal rate is twice as high as the post-neonatal rate and constitutes 67% of the infant mortality rate and 58% of the under-5 mortality rate. This finding is not unexpected: child mortality after the first month of life declines faster than neonatal mortality does; hence,

the actual proportion, or share, of deaths that occur in the first four weeks of life (neonatal period), and particularly in the first seven days (early neonatal period) increase over time (Lawn et al., 2005).

A comparison with previous survey estimates shows a significant decline in both the neonatal and post-neonatal mortality rates, which in turn have significantly lowered the infant and under-5 mortality rates over the past 15 years (Table 6.9.1 and Figures 6.9.2–6.9.4). Neonatal mortality declined from 25 in 1995–1999 to 16.8 in 2000–2004 to 9.5 in 2005–2009. Infant mortality declined from 41.6 in 1995–1999 to 21.1 in 2000–2004 and 14.1 in 2005–2009. The under-5 mortality rate dropped from 45.3 to 25.0 and 16.4, respectively births—a 64% decline. Thus, according to the survey estimates, Georgia has indeed achieved MDG-4 by 2010 (Figure 6.9.5).

Focusing on the 2010 survey results for 2000–2009 in Table 6.9.2, the highest infant and under-5 mortality rates were found among children living in rural areas

and those born in households within the lowest SES group. Previous surveys showed that the infant mortality rate for babies born to Azeri and Armenian mothers was twice that of their Georgian counterparts, but the 2010 data no longer show that gap. At first glance in Figure 6.9.6, both the infant and under-5 mortality rates for ethnic minorities clearly declined between 1999 and 2010 more abruptly than did the rates among Georgian children—from 50.0 deaths per 1,000 [95%CI=30.7–71.2] and 57.0 per 1,000 [95%CI=33.6–74.2] to 23.5 deaths per 1,000 [95%CI=8.7–38.3] and 26.3 deaths per 1,000 [95%CI=10.5–42.1], respectively. However because of fewer deaths among the smaller ethnic groups than among Georgians, the decline for the former did not reach statistical significance. However, the decline in infant and under-5 mortality rates for Georgian children was significant, from 38.3 deaths per 1,000 [95%CI=31.6–45.0] and 42.4 per 1,000 [95%CI=35.9–49.8] to 23.8 deaths per 1,000 [95%CI=17.8–29.9] and 25.9 deaths per 1,000 [95%CI=19.5–32.1], respectively.

Figure 6.9.5 Mortality Rates Under Age five in the 5 Years Prior to GERHS: 1999, 2005, 2010

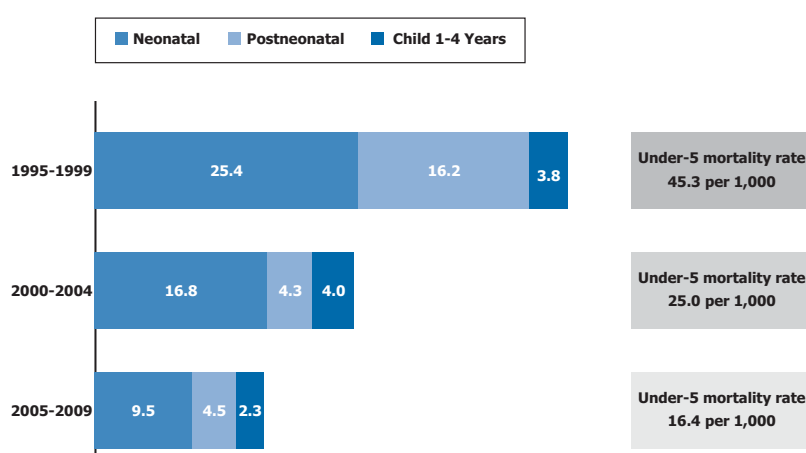


Figure 6.9.6 Mortality Rates Under Age 5 by Ethnicity in the 10 Years Prior to GERHS: 1999 and 2010

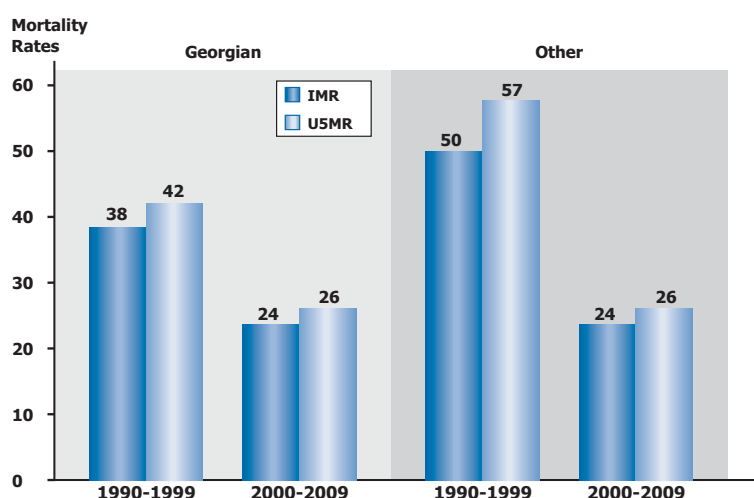
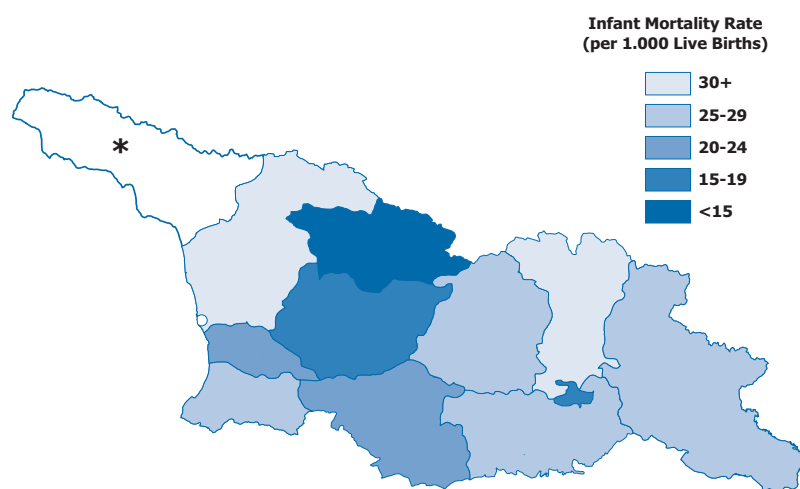


Figure 6.9.7 | **Infant Mortality Rate (per 1,000)**
by Region—Live Births in the 10 Years Prior to the Survey



* Abkhazia: Autonomous region not under government control

The lowest infant mortality rates were reported in Racha Svaneti, Tbilisi, and Imereti while the highest rates were reported in Samegrelo and Mtskheta-Mtianeti. Those two regions and Kakheti and Shida Kartli had the highest under-5 mortality rates (Figure 6.9.7).

Both infant mortality and under-5 mortality increased sharply with birth order. Specifically, the children at highest risk of dying were those born to women with at least two previous births.

Unexpectedly, the under-5 mortality rate is quite elevated for the birth interval of 24-47 months, which is usually a low risk interval.

Gender differentials in mortality rates (see bottom of Table 6.9.2) were obvious in the neonatal and post-neonatal periods, probably because girls have a well-known biological survival advantage soon after birth (Ulizzi and Zonta, 2002).

In conclusion, child survival in Georgia improved substantially over the past 15 years, mainly through

significant reductions in neonatal and post-neonatal mortality. Given that neonatal deaths continue to account for most of infant mortality and 58% of under-5 deaths in Georgia, further reductions in child mortality will depend heavily on continuing the improvements in survival during the neonatal period. Reductions in neonatal deaths, particularly early neonatal deaths, will rest on the provision of effective, individualized maternal and child care. Early neonatal deaths that occur during the first seven days and account for most of the neonatal deaths can be reduced by preventing birth asphyxia, prematurity, and maternal morbidity during labor and postpartum. Late neonatal deaths, which are mainly due to infections, can be prevented through correct management of neonatal infections by better access to emergency obstetric and neonatal care. Overall, neonatal mortality rates can be lowered by educating women regarding the benefits of spacing their births, by ensuring access to family planning services, and by improving maternal nutrition and breastfeeding.

Table 6.2.1 Initiation of Prenatal Care by Pregnancy Trimester and Number of Prenatal Visits by Selected Characteristics Among Births in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Trimester of First Prenatal Visit					Number of Prenatal Visits						Total	No. of Cases
	No Visits	1st	2nd	3rd	Not Stated	No Visits	1–3	4–6	7–9	10+	Not Stated		
Total	1.6	89.8	7.5	0.3	0.7	1.6	7.3	54.3	23.9	12.0	0.9	100.0	2,617
Residence													
Urban	0.6	93.1	5.8	0.2	0.2	0.6	4.2	52.3	26.2	16.1	0.7	100.0	1,193
Rural	2.7	86.4	9.2	0.5	1.2	2.7	10.5	56.4	21.5	7.8	1.1	100.0	1,424
Region													
Kakheti	7.1	79.6	7.8	1.2	4.3	7.1	6.7	60.8	17.3	5.5	2.7	100.0	224
Tbilisi	0.6	93.6	5.4	0.2	0.3	0.6	3.7	50.8	27.1	17.6	0.2	100.0	567
Shida Kartli	0.0	91.4	8.6	0.0	0.0	0.0	2.2	62.7	23.8	11.4	0.0	100.0	168
Kvemo Kartli	4.7	86.4	8.5	0.0	0.4	4.7	14.0	50.8	21.7	7.0	1.9	100.0	234
Samtskhe–Javakheti	0.0	89.8	8.1	1.2	0.8	0.0	18.7	63.8	10.6	6.1	0.8	100.0	214
Adjara	0.5	93.2	5.4	0.0	1.0	0.5	7.8	65.9	17.1	8.3	0.5	100.0	176
Guria	0.0	86.2	13.2	0.0	0.6	0.0	9.4	76.1	8.8	3.8	1.9	100.0	140
Samegrelo	1.4	91.9	5.7	0.5	0.5	1.4	12.0	50.7	26.8	7.7	1.4	100.0	184
Imereti	0.3	90.0	9.5	0.3	0.0	0.3	3.3	45.0	32.2	18.7	0.5	100.0	349
Mtskheta–Mtianeti	2.6	84.3	12.2	0.9	0.0	2.6	10.0	52.4	26.6	7.9	0.4	100.0	200
Racha–Svaneti	1.5	87.2	10.7	0.5	0.0	1.5	20.4	43.9	26.0	8.2	0.0	100.0	161
Age Group (at Birth)													
< 20	3.8	88.3	5.7	0.0	2.2	3.8	6.0	57.5	24.0	8.3	0.4	100.0	313
20–24	1.1	89.2	8.7	0.4	0.6	1.1	7.5	58.8	22.6	9.3	0.7	100.0	956
25–34	1.3	90.9	7.0	0.3	0.5	1.3	7.0	51.1	24.2	15.5	0.9	100.0	1,164
35–44	2.9	88.9	7.2	1.0	0.0	2.9	10.8	45.2	28.3	10.3	2.4	100.0	184
Education Level													
Secondary incomplete or less	5.8	79.6	11.3	0.2	3.1	5.8	13.9	56.0	18.4	4.9	0.9	100.0	422
Secondary complete	2.0	89.2	8.1	0.5	0.2	2.0	9.7	55.4	20.8	11.2	0.9	100.0	738
Technicum/University	0.3	93.0	6.1	0.3	0.3	0.3	4.3	53.3	26.9	14.4	0.8	100.0	1,457
Wealth Quintile													
Lowest	5.9	82.5	11.2	0.3	0.1	5.9	15.1	53.2	17.0	8.2	0.6	100.0	428
Second	1.4	87.6	8.6	0.7	1.8	1.4	10.9	56.0	23.0	7.5	1.3	100.0	628
Middle	1.5	89.4	7.8	0.4	0.9	1.5	6.9	61.2	20.8	8.5	1.1	100.0	587
Fourth	1.2	89.9	7.9	0.2	0.7	1.2	3.9	52.4	26.6	14.6	1.2	100.0	413
Highest	0.0	96.0	4.0	0.1	0.0	0.0	2.6	49.1	29.1	19.0	0.2	100.0	561
Birth Order													
First birth	0.9	93.3	5.0	0.1	0.7	0.9	4.5	54.0	26.0	14.0	0.7	100.0	1,293
Second birth	1.5	87.3	9.8	0.7	0.7	1.5	8.9	55.7	22.7	10.5	0.7	100.0	937
Third or higher	4.6	83.6	10.7	0.2	0.8	4.6	13.3	52.3	19.3	8.5	1.9	100.0	387
Ethnicity													
Georgian	0.7	91.5	7.1	0.3	0.3	0.7	5.7	54.5	25.3	13.0	0.8	100.0	2,248
Azeri	6.0	81.7	7.8	0.0	4.5	6.0	15.9	55.6	15.8	4.5	2.2	100.0	145
Armenian	3.6	80.7	11.5	0.9	3.3	3.6	23.7	53.9	11.1	7.3	0.5	100.0	145
Other	12.2	77.1	10.1	0.6	0.0	12.2	9.0	48.9	22.3	7.6	0.0	100.0	79
Baby's Weight at Birth*													
< 2500 grams	2.8	87.8	8.2	0.0	1.2	2.8	13.8	40.2	18.0	20.5	4.7	100.0	125
>= 2500 grams	1.4	90.1	7.4	0.4	0.7	1.4	7.0	55.2	24.2	11.6	0.7	100.0	2,481

* Excludes 11 births with unknown weight at birth.

Table 6.2.2 Percentage of Births For Which Mothers Received Specific Types of Information During Prenatal Care Visits, Among Births in 2005–2010 with Any Prenatal Care, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Nutrition	Delivery	Breast-feeding	Pregnancy Complications	Effects of Smoking	Effects of Alcohol	Postnatal Care	Family Planning	No. of Cases
Total	89.4	81.2	78.6	66.0	62.6	59.6	58.6	39.2	2,575
Residence									
Urban	92.1	84.7	83.1	70.6	67.9	63.8	63.1	42.1	1,184
Rural	86.6	77.6	73.8	61.2	57.1	55.1	53.8	36.1	1,391
Region									
Kakheti	85.7	80.2	74.7	66.7	64.6	64.1	59.1	44.7	211
Tbilisi	91.2	84.3	83.7	68.4	66.1	62.4	60.9	37.3	563
Shida Kartli	93.5	74.1	68.6	64.3	57.3	50.8	54.6	20.0	168
Kvemo Kartli	81.7	79.3	74.8	54.9	56.1	54.1	50.0	33.7	223
Samtskhe–Javakheti	78.9	59.3	61.0	42.7	50.8	49.6	42.3	22.4	214
Adjara	94.6	82.8	78.9	57.4	62.7	57.4	52.0	40.2	175
Guria	87.4	84.9	83.0	71.1	62.9	61.6	62.3	22.6	140
Samegrelo	93.7	80.1	79.1	67.0	49.0	44.2	55.3	31.6	181
Imereti	90.5	86.4	83.6	80.0	72.6	71.3	71.8	60.0	348
Mtskheta–Mtianeti	89.2	83.0	78.0	68.6	63.7	60.5	57.0	42.2	194
Racha–Svaneti	88.1	83.4	78.2	72.0	55.4	55.4	64.8	43.0	158
Education Level									
Secondary incomplete or less	82.5	73.5	69.0	60.3	50.8	50.0	50.6	30.9	400
Secondary complete	89.3	80.6	80.6	62.8	62.8	59.9	57.6	36.2	724
Technicum/University	91.4	83.5	80.2	69.0	65.7	62.0	61.2	42.8	1,451
Wealth Quintile									
Lowest	83.6	72.2	72.5	58.4	53.2	52.4	49.3	28.1	410
Second	86.3	78.4	72.2	62.6	58.8	54.3	53.9	39.4	619
Middle	90.0	81.7	77.7	65.6	60.3	58.9	59.4	39.0	579
Fourth	92.7	86.4	84.9	69.6	70.7	66.7	60.8	41.9	406
Highest	92.5	84.3	83.6	70.7	67.2	63.6	65.1	43.0	561
Birth Order									
First birth	89.8	81.3	79.8	67.1	64.6	60.9	58.6	39.2	1,285
Second birth	90.5	82.5	78.4	66.0	61.9	59.3	59.4	38.5	924
Third or higher	85.7	77.5	74.6	61.9	57.1	55.4	56.4	40.5	366
Number of Prenatal Visits*									
1–3	81.6	68.0	67.6	56.7	53.7	49.9	52.1	26.3	223
4–6	87.7	79.2	76.2	63.5	58.5	54.6	55.1	36.1	1,445
7–9	93.2	86.0	83.2	70.6	68.7	67.7	63.8	45.2	604
10+	95.0	89.5	87.4	75.1	75.1	72.0	68.6	49.3	279
Place of Prenatal									
Primary care clinic /Fam.med.center	91.2	81.2	73.1	58.0	56.0	57.1	56.1	43.0	172
Women's consultation clinic	90.9	82.8	79.5	68.7	67.2	62.4	60.3	38.9	1,206
Regional maternity/hospital	83.4	76.4	74.9	56.0	51.8	50.5	52.2	35.5	471
City maternity/hospital	90.5	81.4	80.7	69.6	62.9	61.0	60.2	41.3	715

* Excludes 24 births with unknown number of prenatal care visits.

† Excludes 11 births with other source of prenatal care.

Table 6.2.3

Selected Measurements Performed During Prenatal Care Visits by Selected Characteristics Among Births in 2005–2010 with Any Prenatal Care by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Basic Blood Test	Urine Test	Weight Measured	Height Measured	Blood Pressure Measured	HIV Test	No. of Cases
Total	99.2	99.3	99.0	98.1	96.2	65.1	2,575
Residence							
Urban	99.3	99.2	99.2	98.6	96.5	74.5	1,184
Rural	99.2	99.3	98.8	97.7	95.8	55.4	1,391
Region							
Kakheti	97.5	98.3	98.7	96.6	96.2	58.6	211
Tbilisi	99.4	99.4	99.2	98.5	97.5	78.9	563
Shida Kartli	100.0	100.0	100.0	98.4	94.1	74.6	168
Kvemo Kartli	99.6	99.2	99.2	97.6	97.6	54.9	223
Samtskhe-Javakheti	98.8	98.8	95.5	96.3	92.3	43.9	214
Adjara	99.5	99.5	99.5	97.1	92.2	46.6	175
Guria	99.4	99.4	98.7	99.4	93.7	56.0	140
Samegrelo	99.5	99.5	99.5	99.5	97.1	68.9	181
Imereti	99.2	99.2	98.7	99.0	97.4	70.0	348
Mtskheta-Mtianeti	100.0	100.0	99.1	99.1	96.4	53.4	194
Racha-Svaneti	97.4	97.9	97.4	95.3	95.9	49.2	158
Age Group (at Birth)							
< 25	98.8	99.0	98.8	97.7	95.7	61.4	1,251
25–34	99.6	99.5	99.2	98.5	96.3	69.0	1,145
35–44	99.9	99.9	98.3	99.0	98.0	66.4	179
Education Level							
Secondary incomplete or less	98.2	98.7	98.5	95.5	94.7	46.6	400
Secondary complete	99.6	99.6	99.2	99.0	96.5	60.0	724
Technicum/University	99.4	99.3	99.0	98.4	96.4	72.5	1,451
Wealth Quintile							
Lowest	98.4	98.4	98.4	97.2	95.6	54.0	410
Second	99.0	99.4	99.3	97.5	95.2	56.2	619
Middle	99.4	99.4	98.4	98.2	95.9	60.1	579
Fourth	99.5	99.5	99.1	97.9	98.2	67.5	406
Highest	99.5	99.4	99.4	99.2	96.1	80.7	561
Birth Order							
First birth	99.1	99.2	98.9	98.4	95.7	65.8	1,285
Second birth	99.4	99.3	99.3	98.6	96.6	65.2	924
Third or higher	99.5	99.5	98.3	96.1	96.7	62.3	366
Number of Prenatal Visits*							
1–3	98.4	97.8	97.2	96.0	95.5	47.2	223
4–6	99.0	99.1	98.7	97.7	95.3	63.3	1,445
7–9	99.8	99.8	99.8	99.4	97.4	68.1	604
10+	99.7	99.7	99.3	98.9	97.9	79.6	279
Place of Prenatal Care†							
Primary care clinic/Fam.med.center	96.5	97.1	97.1	94.7	91.4	49.3	172
Women's consultation clinic	99.5	99.5	99.0	98.7	95.5	68.6	1,206
Regional maternity/hospital	99.6	99.6	99.1	96.7	97.3	50.6	471
City maternity/hospital	99.3	99.3	99.3	98.8	97.7	71.7	715

* Excludes 24 births with unknown number of prenatal care visits.

Table 6.2.4 Use of Ultrasound Exams During Pregnancy and Time of First Exam by Selected Characteristics Among Births in 2005–2010 with Any Prenatal Care
Reproductive Health Survey: Georgia, 2010

Characteristic	Had Ultrasound Exam		Time of First Ultrasound Exam (in Weeks)					Total	No. of Cases
	%	No. of Cases	≤ 13	14–19	20–26	27+	Does Not Remember		
Total	97.4	2,575	77.2	11.4	8.3	2.2	0.9	100.0	2,489
Residence									
Urban	98.9	1,184	84.4	9.1	5.3	1.1	0.1	100.0	1,167
Rural	95.7	1,391	69.5	13.8	11.4	3.4	1.8	100.0	1,322
Region									
Kakheti	92.0	211	77.1	7.3	12.4	1.4	1.8	100.0	194
Tbilisi	99.2	563	88.5	8.5	2.5	0.5	0.0	100.0	558
Shida Kartli	99.5	168	73.4	15.2	10.9	0.5	0.0	100.0	167
Kvemo Kartli	96.7	223	73.9	8.4	12.6	4.2	0.8	100.0	215
Samtskhe–Javakheti	96.3	214	67.9	17.3	11.4	3.0	0.4	100.0	206
Adjara	98.5	175	63.2	16.4	10.4	4.0	6.0	100.0	172
Guria	98.1	140	63.5	22.4	10.9	3.2	0.0	100.0	137
Samegrelo	97.6	181	84.6	7.5	6.5	1.5	0.0	100.0	176
Imereti	96.9	348	73.8	13.8	8.5	3.7	0.3	100.0	337
Mtskheta–Mtianeti	96.4	194	74.0	11.2	12.6	2.3	0.0	100.0	188
Racha–Svaneti	87.6	158	63.9	12.4	20.7	3.0	0.0	100.0	139
Age Group (at Birth)									
< 25	96.8	1,251	74.7	12.3	9.2	2.4	1.4	100.0	1,205
25–34	98.2	1,145	80.2	10.3	7.3	1.7	0.4	100.0	1,115
35–44	95.6	179	76.2	11.9	7.4	3.8	0.6	100.0	169
Education Level									
Secondary incomplete or less	92.5	400	68.7	9.7	13.5	2.6	5.5	100.0	367
Secondary complete	97.7	724	69.5	15.1	11.9	3.3	0.2	100.0	702
Technicum/University	98.5	1,451	83.0	10.1	5.2	1.6	0.1	100.0	1,420
Wealth Quintile									
Lowest	95.6	410	68.0	14.3	14.2	3.5	0.0	100.0	386
Second	96.1	619	71.1	11.6	11.0	4.4	2.0	100.0	591
Middle	96.6	579	73.8	13.9	7.7	2.2	2.3	100.0	557
Fourth	98.8	406	76.8	13.4	8.2	1.5	0.0	100.0	400
Highest	99.0	561	89.6	6.5	3.6	0.2	0.0	100.0	555
Birth Order									
First birth	97.6	1,285	81.8	9.4	6.5	1.8	0.5	100.0	1,246
Second birth	97.1	924	73.6	13.9	9.0	2.6	1.0	100.0	891
Third or higher	97.0	366	69.6	12.3	12.9	2.7	2.4	100.0	352
Number of Prenatal Visits*									
1–3	92.2	223	47.6	24.0	18.2	9.6	0.6	100.0	200
4–6	97.6	1,445	75.9	11.8	9.5	1.5	1.2	100.0	1,410
7–9	98.2	604	82.5	9.0	5.9	2.0	0.6	100.0	586
10+	99.3	279	89.5	6.9	2.0	1.6	0.0	100.0	276
Place of Prenatal Care†									
Primary care clinic/Fam.med.center	92.0	172	77.5	11.5	7.3	2.4	1.2	100.0	159
Women's consultation clinic	98.0	1,206	77.2	11.4	8.6	1.4	1.4	100.0	1,171
Regional maternity/hospital	96.8	471	69.2	11.2	13.8	5.0	0.7	100.0	452
City maternity/hospital	97.8	715	81.9	11.7	4.4	1.8	0.2	100.0	696

* Excludes 17 births with unknown number of prenatal care visits.

† Excludes 11 births with other source of prenatal care.

Table 6.3.1 Place of Delivery for Births in 2005–2010 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Place of delivery				Total	No. of Cases
	City Maternity Hospital	Regional Maternity Hospital	Other	At home		
Total	54.7	43.6	0.5	1.2	100.0	2,617
Residence						
Urban	56.8	42.6	0.6	0.0	100.0	1,193
Rural	52.6	44.6	0.5	2.4	100.0	1,424
Region						
Kakheti	47.1	44.7	0.8	7.5	100.0	224
Tbilisi	55.9	44.0	0.2	0.0	100.0	567
Shida Kartli	74.0	25.9	0.0	0.0	100.0	168
Kvemo Kartli	37.6	60.9	0.8	0.8	100.0	234
Samtskhe–Javakheti	30.1	69.9	0.0	0.0	100.0	214
Adjara	45.3	52.2	0.0	2.4	100.0	176
Guria	53.5	46.5	0.0	0.0	100.0	140
Samegrelo	78.5	18.7	1.4	1.4	100.0	184
Imereti	62.4	36.3	1.3	0.0	100.0	349
Mtskheta–Mtianeti	51.9	47.6	0.0	0.4	100.0	200
Racha–Svaneti	68.9	28.1	2.0	1.0	100.0	161
Age Group (at Birth)						
< 20	50.7	45.8	0.3	3.2	100.0	313
20–24	57.1	41.4	0.7	0.8	100.0	956
25–34	55.2	43.6	0.3	0.9	100.0	1,164
35–44	46.4	50.6	1.7	1.1	100.0	184
Education Level						
Secondary incomplete or less	41.8	51.4	1.2	5.6	100.0	422
Secondary complete	54.4	44.3	0.5	0.8	100.0	738
Technicum/University	58.6	41.0	0.4	0.1	100.0	1,457
Wealth Quintile						
Lowest	49.9	45.8	0.3	4.1	100.0	428
Second	54.7	41.7	1.2	2.4	100.0	628
Middle	53.1	46.1	0.5	0.3	100.0	587
Fourth	57.4	42.4	0.3	0.0	100.0	413
Highest	56.9	42.7	0.3	0.0	100.0	561
Ethnicity						
Georgian	59.1	39.8	0.5	0.5	100.0	2,248
Azeri	24.0	70.1	1.3	4.6	100.0	145
Armenian	20.1	78.3	0.0	1.6	100.0	145
Other	51.8	39.2	0.0	9.1	100.0	79
Birth Order						
First birth	57.6	41.5	0.5	0.4	100.0	1,293
Second birth	54.1	44.0	0.6	1.4	100.0	937
Third or higher	46.1	50.0	0.6	3.3	100.0	387
Baby's Weight at Birth*						
< 2500 grams	55.1	43.0	0.0	1.9	100.0	125
>= 2500 grams	54.8	43.7	0.6	0.9	100.0	2,481

* Excludes 11 births with unknown weight at birth.

Table 6.3.2 Average Time between Admission and Delivery, and Nights Spent in a Medical Facility by Selected Characteristics Births in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Average Time (in Hours)		Nights Spent in a Medical Facility Between Delivery and Discharge				Total	No. of Cases
	%	No. of Cases*	≤ 4	5	6–7	8+		
Total	3.8	2,077	56.3	25.1	14.7	4.0	100.0	2,589
Residence								
Urban	3.9	946	55.9	26.9	13.8	3.4	100.0	1,193
Rural	3.8	1,131	56.6	23.3	15.5	4.5	100.0	1,396
Region								
Kakheti	4.0	159	65.3	17.4	14.0	3.4	100.0	209
Tbilisi	4.0	469	60.3	26.0	10.7	2.9	100.0	567
Shida Kartli	3.3	141	57.8	28.1	12.4	1.6	100.0	168
Kvemo Kartli	4.0	189	64.8	21.9	10.9	2.3	100.0	232
Samtskhe–Javakheti	3.4	194	67.9	23.2	7.3	1.6	100.0	214
Adjara	3.1	136	40.5	24.5	26.5	8.5	100.0	171
Guria	4.1	109	47.2	23.9	24.5	4.4	100.0	140
Samegrelo	3.8	133	51.9	28.6	15.5	3.9	100.0	181
Imereti	4.5	250	48.1	28.6	17.4	5.9	100.0	349
Mtskheta–Mtianeti	3.0	169	57.9	20.2	17.5	4.4	100.0	199
Racha–Svaneti	3.6	128	43.3	34.0	17.5	5.2	100.0	159
Age Group (at Birth)								
< 20	4.5	254	59.9	27.0	11.4	1.6	100.0	307
20–24	3.9	797	57.9	26.2	13.6	2.3	100.0	948
25–34	3.8	902	54.1	25.4	15.1	5.4	100.0	1,152
35–44	2.7	124	55.0	14.5	22.5	8.0	100.0	182
Education Level								
Secondary incomplete or less	3.6	326	63.3	23.5	10.4	2.8	100.0	401
Secondary complete	3.9	599	56.5	25.0	14.2	4.3	100.0	733
Technicum/University	3.9	1,152	54.2	25.6	16.0	4.2	100.0	1,455
Wealth Quintile								
Lowest	3.8	340	55.1	22.4	18.5	4.0	100.0	416
Second	3.7	489	56.2	23.5	16.0	4.3	100.0	614
Middle	3.7	472	58.8	24.6	13.0	3.6	100.0	585
Fourth	4.2	329	54.6	25.4	15.3	4.7	100.0	413
Highest	3.9	447	55.9	28.2	12.5	3.4	100.0	561
Birth Order								
First birth	4.5	1,028	54.1	26.3	16.1	3.5	100.0	1,289
Second birth	3.2	745	59.0	24.4	12.5	4.1	100.0	927
Third or higher	3.1	304	57.3	22.6	14.8	5.4	100.0	373
Baby's Weight at Birth								
< 2500 grams	3.5	79	38.4	16.1	23.5	21.9	100.0	123
≥ 2500 grams	3.9	1,994	57.1	25.6	14.2	3.1	100.0	2,461
Unknown	†	4	†	†	†	†	100.0	5
Type of Delivery								
Vaginal	3.8	1,911	65.8	24.7	7.9	1.6	100.0	2,001
Cesarean Section	4.8	166	25.9	26.3	36.3	11.5	100.0	588
Pregnancy Complications								
Any Complication	4.2	278	39.5	31.7	20.6	8.2	100.0	379
No Complication	3.8	1,796	59.3	23.9	13.6	3.2	100.0	2,207
Does not remember	†	3	†	†	†	†	100.0	3

* Excludes 406 women who had C–section before labor and 106 with unknown duration of labor.

† Fewer than 25 cases in this category.

Table 6.3.3 **Percentage of Births Delivered by Cesarean Section by Selected Characteristics**
Among Births in 2005–2010 Delivered in Medical Facilities
Reproductive Health Survey: Georgia, 2010

Characteristic	Cesarean Deliveries %	No. of Cases
Total	23.9	2,589
Residence		
Urban	26.0	1,193
Rural	21.7	1,396
Region		
Kakheti	19.5	209
Tbilisi	22.8	567
Shida Kartli	19.5	168
Kvemo Kartli	16.4	232
Samtskhe–Javakheti	8.9	214
Adjara	28.5	171
Guria	23.3	140
Samegrelo	33.0	181
Imereti	32.5	349
Mtskheta–Mtianeti	21.5	199
Racha–Svaneti	25.3	159
Age Group (at Birth)		
< 20	15.5	307
20–24	19.3	948
25–34	27.2	1,152
35–44	40.4	182
Education Level		
Secondary incomplete or less	16.4	401
Secondary complete	20.5	733
Technicum/University	27.5	1,455
Wealth Quintile		
Lowest	20.0	416
Second	22.5	614
Middle	22.6	585
Fourth	26.9	413
Highest	26.1	561
Birth Order		
First birth	25.7	1,289
Second birth	23.9	927
Third or higher	17.2	373
Pregnancy Complications		
Any Complication	35.7	379
No Complication	21.7	2,207
Does not remember	*	3
Baby's Weight at Birth		
< 2500 grams	37.5	123
>= 2500 grams	23.2	2,461
Unknown	*	5
Prolonged Labor[†]		
No	8.0	2,045
Yes	41.1	32
Does not remember	19.4	106

* Fewer than 25 cases in this category.

† Excludes 406 C-sections performed before the onset of labor.

Table 6.3.4 Cost of a Procedure for Delivery Among Deliveries Ended in 2005–2010
By Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Cost of Delivery									Total	No. of Cases*
	Mean Payment	None	< 200	200–299	300–399	400–499	500–599	600 +	Does not Remember		
Total	452.7	11.8	10.0	10.8	11.4	15.0	11.8	28.0	1.2	100.0	2,583
Residence											
Tbilisi	589.9	8.9	5.4	6.7	6.4	11.5	16.2	43.6	1.2	100.0	567
Other Urban	454.8	9.5	8.9	11.0	13.8	16.4	10.8	28.2	1.4	100.0	621
Rural	377.6	14.6	13.1	12.9	12.8	16.2	9.8	19.3	1.2	100.0	1,395
Mother's Age (at Birth)											
15–24	442.0	10.7	10.8	11.9	12.1	15.5	12.5	25.8	0.7	100.0	1,253
25–34	456.6	12.3	9.6	10.3	10.6	14.8	11.4	29.1	1.9	100.0	1,149
35–44	501.4	16.3	8.0	6.9	10.9	12.8	8.6	35.5	1.0	100.0	181
Order of Live Births											
First birth	481.6	10.3	8.8	10.3	10.7	16.1	12.1	30.7	1.0	100.0	1,286
Second birth	439.2	12.0	11.1	10.5	11.7	15.6	11.5	26.3	1.2	100.0	924
Third birth	375.4	15.2	13.4	11.5	12.7	11.9	11.9	21.0	2.4	100.0	282
Fourth or higher	399.0	21.6	7.8	18.0	14.1	4.0	8.3	24.7	1.4	100.0	91
Education Level											
Secondary incomplete or less	341.3	15.0	14.6	13.5	16.3	12.3	10.4	15.3	2.7	100.0	400
Secondary complete	405.8	9.9	12.8	12.3	13.9	17.8	12.1	20.7	0.6	100.0	732
Technicum/University	505.1	11.9	7.5	9.4	8.8	14.4	12.0	34.9	1.2	100.0	1,451
Wealth Quintile											
Lowest	312.7	17.9	14.4	14.2	13.7	15.0	10.5	12.5	1.7	100.0	416
Second	365.2	12.9	12.9	13.3	14.4	15.8	10.4	19.1	1.3	100.0	611
Middle	431.0	12.3	13.4	11.8	13.0	16.1	9.4	23.0	1.0	100.0	584
Fourth	498.8	9.9	7.0	10.6	9.5	16.1	12.7	33.0	1.3	100.0	412
Highest	585.8	8.7	4.6	6.3	7.5	12.7	14.9	44.2	1.2	100.0	560
Ethnicity											
Georgian	460.7	11.7	10.1	10.0	10.5	15.7	12.1	28.8	1.0	100.0	2,230
Azeri	377.4	12.8	10.2	17.3	16.2	9.4	11.5	18.6	4.1	100.0	136
Armenian	356.6	10.8	11.1	19.8	20.5	10.9	7.0	18.6	1.2	100.0	143
Other	522.4	13.2	6.3	5.8	11.3	13.6	10.6	38.0	1.3	100.0	74
Place of Delivery											
Regional hospital, maternity	413.5	13.7	10.2	11.1	12.9	14.4	13.4	22.8	1.5	100.0	1,156
City hospital	484.5	9.7	10.0	10.7	10.0	16.1	10.5	32.1	1.0	100.0	1,345
Referral hospital	454.5	19.0	10.2	8.6	10.7	7.3	10.5	31.1	2.6	100.0	73
Other medical facility	†	†	†	†	†	†	†	†	†	100.0	9
Type of Delivery											
Vaginal Delivery	385.2	12.5	12.7	12.8	13.0	15.6	12.3	19.5	1.5	100.0	2,000
Cesarean section	667.2	9.6	1.5	4.4	6.1	13.0	9.9	55.1	0.3	100.0	583

* Excludes 6 women who did not remember if they had paid for delivery.

† Fewer than 25 cases in this category.

Table 6.4.1 Receipt of Postpartum Care and Information Given During Postpartum Visits
Among Births in 2005–2010, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Postpartum Care		Information Received During Postpartum Care						
	%	No. of Cases	Breast Feeding %	Breast Care %	Child Care %	Immunization %	Nutrition %	Family Planning %	No. of Cases
Total	23.0	2,617	78.6	74.9	77.9	75.6	73.2	43.0	611
Residence									
Tbilisi	27.6	567	85.0	81.7	84.4	85.6	82.8	46.1	160
Other Urban	28.6	626	77.4	74.6	75.5	72.7	72.5	47.7	172
Rural	17.9	1,424	74.4	69.6	74.4	69.6	66.1	37.0	279
Age Group (at Birth)									
< 20	20.1	313	81.1	75.6	80.4	81.4	74.8	39.1	65
20–24	21.8	956	77.9	72.9	73.7	71.0	71.2	39.2	212
25–34	24.9	1,164	75.8	73.3	78.0	75.2	72.1	43.9	290
35–44	23.1	184	96.2	93.2	93.3	90.9	87.8	61.7	44
Education Level									
Secondary incomplete or less	16.6	422	77.7	68.9	74.3	74.5	72.9	32.2	76
Secondary complete	18.0	738	78.1	72.3	79.2	71.2	67.5	33.7	134
Technicum/University	27.3	1,457	78.9	76.7	78.1	77.1	75.1	47.9	401
Wealth Quintile									
Lowest	12.3	428	73.7	67.0	73.7	67.9	65.3	36.2	69
Second	16.3	628	81.7	77.5	81.4	77.2	72.8	35.9	110
Middle	23.3	587	76.7	70.8	74.0	67.5	65.3	41.8	143
Fourth	30.7	413	74.6	70.2	73.5	72.3	71.9	41.4	118
Highest	29.4	561	82.3	81.3	82.7	84.0	81.4	49.9	171
Birth Order									
First birth	25.4	1,293	74.2	69.8	72.5	73.1	70.3	38.6	335
Second birth	22.1	937	83.8	80.3	83.3	76.3	75.9	46.0	206
Third or higher	17.3	387	85.1	84.3	88.6	85.8	79.9	56.8	70
Pregnancy Complications*									
Any Complication	27.6	380	71.6	71.9	68.9	68.6	62.3	36.3	112
No Complication	22.2	2,234	80.2	75.5	79.9	77.1	75.7	44.5	498
Postpartum Complications									
Any Complication	43.6	296	64.1	64.6	65.5	62.3	56.4	26.3	132
No Complication	20.5	2,321	82.5	77.6	81.2	79.1	77.7	47.5	479

* Excludes 3 births with missing information on pregnancy complications.

Table 6.4.2 Time Between Delivery and First Postpartum Visit by Selected Characteristics Among Mothers Who Had Any Postpartum Care after Delivering a Live Birth in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Time Between Delivery and First Postpartum Visit (in Weeks)				Total	No. of Cases
	< 1	1–2	> 2	Does Not Remember		
Total	30.8	42.0	26.6	0.6	100.0	611
Residence						
Tbilisi	27.8	39.4	32.2	0.6	100.0	160
Other Urban	29.2	44.9	25.3	0.5	100.0	172
Rural	34.4	41.9	23.1	0.6	100.0	279
Age Group (at Birth)						
< 20	31.8	37.7	30.6	0.0	100.0	65
20–24	33.8	37.4	28.4	0.5	100.0	212
25–34	28.1	44.6	26.4	0.8	100.0	290
35–44	31.5	54.3	14.1	0.0	100.0	44
Education Level						
Secondary incomplete or less	53.5	33.2	13.3	0.0	100.0	76
Secondary complete	24.8	45.3	28.8	1.0	100.0	134
Technicum/University	28.7	42.5	28.3	0.5	100.0	401
Wealth Quintile						
Lowest	35.5	44.4	15.0	5.1	100.0	69
Second	39.7	38.1	22.1	0.0	100.0	110
Middle	32.9	40.7	26.4	0.0	100.0	143
Fourth	26.6	46.2	27.1	0.0	100.0	118
Highest	26.9	41.4	31.2	0.5	100.0	171
Place of Delivery						
Regional maternity, hospital	35.1	45.8	18.7	0.5	100.0	287
City maternity, hospital	26.1	39.4	34.2	0.3	100.0	314
Other	*	*	*	*	100.0	3
At home	*	*	*	*	100.0	7
Birth Order						
First birth	29.1	41.5	29.0	0.4	100.0	335
Second birth	29.1	45.8	24.1	1.0	100.0	206
Third or higher	44.3	33.2	22.5	0.0	100.0	70

* Fewer than 25 cases in this category.

Table 6.4.3 Use of Well-Baby Care and Time Between Delivery and First Visit by Selected Characteristics Among Live Births Delivered in Hospitals in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Well-Baby Visit		Time Between Delivery and First Postnatal Well-Baby Clinic Visit (in Weeks)				Total	No. of Cases
	%	No. of Cases*	< 1	1–2	> 2	Does Not Remember		
Total	84.1	2,624	21.7	53.4	23.7	1.2	100.0	2,369
Residence								
Urban	89.5	1,199	26.0	56.2	17.3	0.5	100.0	1,131
Rural	78.7	1,425	16.8	50.2	30.9	2.1	100.0	1,238
Region								
Kakheti	79.6	223	19.8	53.7	24.2	2.2	100.0	200
Tbilisi	91.9	572	28.6	56.7	14.0	0.8	100.0	553
Shida Kartli	87.0	168	7.0	46.5	44.2	2.3	100.0	157
Kvemo Kartli	74.7	233	19.3	55.0	24.3	1.4	100.0	196
Samtskhe–Javakheti	72.6	215	7.6	41.1	49.7	1.5	100.0	173
Adjara	81.7	179	28.8	59.9	11.3	0.0	100.0	150
Guria	86.2	141	11.4	60.4	27.5	0.7	100.0	132
Samegrelo	82.5	186	20.9	42.9	32.5	3.7	100.0	167
Imereti	85.7	349	19.5	56.3	23.4	0.8	100.0	325
Mtskheta–Mtianeti	83.5	197	26.5	41.7	31.8	0.0	100.0	185
Racha–Svaneti	72.4	161	15.5	36.6	47.8	0.0	100.0	131
Age Group (at Birth)								
< 24	84.3	1,266	20.0	53.5	24.7	1.8	100.0	1,143
25–34	84.7	1,170	24.0	52.9	22.3	0.8	100.0	1,062
35–44	79.6	188	19.0	55.2	25.8	0.0	100.0	164
Education Level								
Secondary incomplete or less	78.8	420	21.8	46.6	29.1	2.6	100.0	354
Secondary complete	79.3	743	16.4	53.7	27.4	2.5	100.0	639
Technicum/University	88.0	1,461	24.0	55.0	20.7	0.3	100.0	1,376
Wealth Quintile								
Lowest	75.4	430	16.7	46.4	35.1	1.8	100.0	353
Second	79.9	627	17.2	51.5	28.2	3.1	100.0	549
Middle	82.1	588	17.4	51.9	30.1	0.6	100.0	532
Fourth	86.6	414	27.0	53.2	18.8	1.0	100.0	383
Highest	92.4	565	27.3	59.2	13.3	0.2	100.0	552
Place of Delivery								
Regional maternity, hospital	82.2	1,160	20.5	56.5	21.7	1.4	100.0	1,018
City maternity, hospital	87.4	1,346	22.8	51.1	25.0	1.0	100.0	1,255
Referral hospital	65.5	76	20.5	51.2	28.3	0.0	100.0	63
Other medical facility	†	9	†	†	†	†	100.0	9
At home	53.9	27	14.9	49.8	21.1	14.3	100.0	18
Other	†	6	†	†	†	†	100.0	6
Birth Order								
First	85.9	1,305	21.4	54.1	23.2	1.4	100.0	1,207
Second	84.3	943	21.6	54.8	22.5	1.0	100.0	846
Third or more	77.3	376	23.0	46.7	29.1	1.2	100.0	316

* Includes 29 twins.

† Fewer than 25 cases in this category.

Table 6.4.4 Percentage of Babies with Birth Certificates and Time Between Delivery and Issuance of the Certificate By Selected Characteristics Among Live Births in 2005–2010—Reproductive Health Survey: Georgia, 2010

Characteristic	Baby Registered		Interval Between Delivery and Birth Certificate (in Weeks)					Total	No. of Cases
	%	No. of Cases*	< 1	1–2	3–4	> 4	Does Not Remember		
Total	97.3	2,624	81.2	14.0	2.4	1.1	1.4	100.0	2,558
Residence									
Urban	98.1	1,199	84.0	12.5	1.8	0.7	1.0	100.0	1,176
Rural	96.5	1,425	78.2	15.4	3.0	1.4	1.9	100.0	1,382
Region									
Kakheti	92.5	223	72.0	18.6	3.0	1.3	5.1	100.0	210
Tbilisi	98.2	572	83.9	13.2	1.9	0.6	0.5	100.0	562
Shida Kartli	98.4	168	76.4	19.2	4.4	0.0	0.0	100.0	165
Kvemo Kartli	95.7	233	82.9	10.6	4.1	1.6	0.8	100.0	223
Samtskhe–Javakheti	98.8	215	88.6	2.9	2.0	2.4	4.1	100.0	212
Adjara	98.1	179	78.4	19.6	1.5	0.0	0.5	100.0	175
Guria	94.4	141	82.1	11.3	0.7	4.6	1.3	100.0	137
Samegrelo	97.6	186	75.4	19.3	1.9	1.9	1.4	100.0	181
Imereti	98.5	349	85.0	10.4	2.1	0.8	1.8	100.0	344
Mtskheta–Mtianeti	97.3	197	78.4	16.5	2.8	1.4	0.9	100.0	193
Racha–Svaneti	96.9	161	82.1	10.5	3.7	3.7	0.0	100.0	156
Age Group (at Birth)									
< 24	97.4	1,266	80.0	14.6	2.5	1.5	1.4	100.0	1,240
25–34	97.3	1,170	84.0	12.2	2.2	0.6	1.1	100.0	1,137
35–44	96.3	188	72.3	20.2	3.2	0.6	3.7	100.0	181
Education Level									
Secondary incomplete or less	92.2	420	77.8	15.2	2.8	2.0	2.1	100.0	394
Secondary complete	97.5	743	81.9	12.5	2.3	1.1	2.2	100.0	724
Technicum/University	98.7	1,461	81.7	14.3	2.3	0.8	0.9	100.0	1,440
Wealth Quintile									
Lowest	93.8	430	77.9	16.0	3.4	1.8	1.0	100.0	412
Second	97.4	627	76.5	17.9	2.0	1.0	2.6	100.0	612
Middle	98.1	588	80.1	12.7	2.8	2.1	2.4	100.0	574
Fourth	96.4	414	81.4	15.4	2.5	0.3	0.5	100.0	401
Highest	99.0	565	87.4	9.8	1.8	0.5	0.5	100.0	559
Place of Delivery									
Regional maternity, hospital	97.6	1,160	82.0	13.2	2.0	1.2	1.7	100.0	1,131
City maternity, hospital	97.7	1,346	82.5	13.6	2.5	0.9	0.6	100.0	1,317
Referral hospital	96.2	76	65.5	28.0	1.5	0.0	5.0	100.0	74
Other medical facility	†	9	†	†	†	†	†	100.0	9
At home	67.3	27	14.2	20.7	25.3	10.0	29.8	100.0	21
Other	†	6	†	†	†	†	†	100.0	6
Birth Order									
First	97.2	1,305	80.3	14.9	2.6	1.2	1.0	100.0	1,274
Second	97.8	943	82.5	13.3	2.4	0.6	1.2	100.0	923
Third or more	96.3	376	80.9	12.4	1.7	1.6	3.4	100.0	361

* Includes 29 twins.

† Fewer than 25 cases in this category.

Table 6.6.1 Routine Measurement of Blood Pressure (BP) During Pregnancy, Reported High Blood Pressure (HBP) During Pregnancy, and Hospitalization Rate for HBP by Selected Characteristics Among Births in 2005–2010 Among Women with Any Prenatal Care
Reproductive Health Survey: Georgia, 2010

Characteristic	Routine Measurement of Blood Pressure		Told Had High Blood Pressure		Pregnancies Hospitalized for HBP (Exclusive)	Pregnancies Hospitalized for HBP (Not Exclusive)	No. of Cases
	%	No. of Cases	%	No. of Cases	%	%	
Total	96.2	2,575	9.7	2,468	0.3	1.0	2,575
Residence							
Urban	96.5	1,184	9.7	1,140	0.3	0.7	1,184
Rural	95.8	1,391	9.7	1,328	0.2	1.2	1,391
Region							
Kakheti	96.2	211	9.6	203	0.0	2.1	211
Tbilisi	97.5	563	10.1	548	0.3	0.8	563
Shida Kartli	94.1	168	9.8	160	0.0	1.1	168
Kvemo Kartli	97.6	223	8.3	217	0.4	1.2	223
Samtskhe–Javakheti	92.3	214	8.8	200	0.0	0.0	214
Adjara	92.2	175	12.8	159	0.0	0.5	175
Guria	93.7	140	6.7	130	0.0	0.0	140
Samegrelo	97.1	181	10.5	175	0.0	1.5	181
Imereti	97.4	348	8.7	338	0.8	1.0	348
Mtskheta–Mtianeti	96.4	194	9.8	186	0.0	0.9	194
Racha–Svaneti	95.9	158	8.1	152	0.0	0.0	158
Age Group (at Birth)							
< 24	95.7	1,251	8.2	1,194	0.3	0.5	1,251
25–34	96.3	1,145	9.5	1,099	0.2	1.5	1,145
35–44	98.0	179	21.4	175	0.6	1.0	179
Education Level							
Secondary incomplete or less	94.7	400	7.7	377	0.0	0.7	400
Secondary complete	96.5	724	9.9	694	0.6	1.0	724
Technicum/University	96.4	1,451	10.2	1,397	0.1	1.0	1,451
Wealth Quintile							
Lowest	95.6	410	8.2	389	0.3	1.5	410
Second	95.2	619	10.1	589	0.2	0.9	619
Middle	95.9	579	11.3	557	0.0	1.1	579
Fourth	98.2	406	9.4	399	0.0	1.2	406
Highest	96.1	561	9.1	534	0.6	0.5	561
Place of Prenatal							
Primary care clinic/Fam.med.center	91.4	172	6.9	157	0.0	0.6	172
Women's consultation clinic	95.5	1,206	9.9	1,151	0.2	0.3	1,206
Regional	97.3	471	11.2	457	0.3	1.0	471
City maternity/hospital	97.7	715	9.1	692	0.5	1.9	715
Other	*	11	*	11	*	*	11
Birth Order							
First	95.7	1,285	10.2	1,227	0.4	1.1	1,285
Second	96.6	924	8.6	890	0.1	0.8	924
Third or more	96.7	366	11.0	351	0.0	0.8	366

* Fewer than 25 cases in this category.

Table 6.6.2 Pregnancy Complications That Required Medical Attention by Selected Characteristics Among Births in 2005–2010 Among Women with Any Prenatal Care
Reproductive Health Survey: Georgia, 2010

Characteristic	Pregnancy Complication											No. of Cases
	At Least One Pregnancy Complication %	Risk of Preterm Delivery %	Anemia Related to Pregnancy %	Water Retention or Edema %	High BP Related to Pregnancy %	Weak Cervix %	Bleeding During First 6 Months %	Urinary Tract Infection %	Bleeding After 6 Months %	Rh Isoimmunization %	Other %	
Total	15.7	7.9	3.6	3.3	3.0	2.1	1.9	1.5	1.1	1.0	1.6	2,575
Residence												
Urban	15.0	7.1	3.7	3.1	2.7	2.6	2.1	1.4	1.4	0.9	1.6	1,184
Rural	16.3	8.6	3.6	3.6	3.4	1.6	1.6	1.7	0.8	1.1	1.5	1,391
Region												
Kakheti	12.7	6.8	5.9	2.5	2.5	1.7	1.3	0.4	1.3	2.1	0.8	211
Tbilisi	13.6	6.8	3.5	2.0	3.1	2.6	2.2	0.6	1.5	0.6	0.9	563
Shida Kartli	22.2	9.2	3.8	2.7	4.3	2.7	5.9	2.2	1.1	3.2	2.2	168
Kvemo Kartli	14.2	8.5	3.3	4.9	2.4	1.6	1.6	1.2	0.4	0.4	1.2	223
Samtskhe–Javakheti	14.2	6.5	0.8	2.4	3.7	2.0	2.0	1.2	0.4	1.2	0.4	214
Adjara	17.2	10.3	0.5	4.4	3.9	1.0	1.5	2.9	1.5	0.5	2.0	175
Guria	4.4	0.6	1.3	1.3	0.6	0.6	1.3	0.6	0.0	0.0	0.0	140
Samegrelo	11.7	7.8	2.4	2.9	2.4	2.4	0.5	1.0	1.0	1.0	1.0	181
Imereti	20.8	9.2	6.2	4.9	3.3	1.5	1.3	3.1	1.0	1.0	3.6	348
Mtskheta–Mtianeti	23.8	9.4	5.8	5.8	2.2	6.3	1.8	0.9	0.4	0.4	2.7	194
Racha–Svaneti	7.3	3.1	2.6	1.6	0.0	2.1	2.1	4.1	0.0	0.0	0.0	158
Age Group (at Birth)												
< 24	14.2	7.4	3.1	2.3	2.2	2.2	1.4	1.3	0.8	0.8	1.2	1,251
25–34	16.6	7.9	4.2	4.2	3.2	1.9	2.7	2.0	1.4	1.0	2.3	1,145
35–44	19.8	11.0	4.1	4.8	8.2	3.0	0.0	0.2	0.7	2.6	0.0	179
Education Level												
Secondary incomplete or less	13.2	7.1	1.6	4.2	2.0	2.4	0.0	1.2	0.6	0.7	1.9	400
Secondary complete	15.9	7.3	4.1	2.9	2.8	2.1	2.1	2.2	1.2	1.2	1.5	724
Technicum/university	16.2	8.4	4.0	3.3	3.4	2.0	2.3	1.3	1.1	1.0	1.6	1,451
Wealth Quintile												
Lowest	15.0	6.4	3.2	3.6	3.1	1.4	1.0	2.3	0.8	2.4	1.8	410
Second	15.8	8.2	3.0	2.7	2.5	1.5	1.9	1.5	1.3	0.5	1.5	619
Middle	15.8	7.4	4.1	4.7	4.1	1.8	1.6	1.9	0.9	1.1	2.1	579
Fourth	17.7	10.6	4.7	4.7	2.3	4.4	2.8	1.5	2.8	0.5	1.7	406
Highest	14.5	7.0	3.3	1.8	3.0	1.7	1.9	0.8	0.2	1.0	1.0	561
Birth Order												
First	17.1	9.1	3.7	3.2	3.3	2.5	2.3	1.8	1.4	0.7	1.6	1,285
Second	13.7	6.4	3.3	3.4	2.8	1.6	1.5	1.2	0.9	0.9	1.3	924
Third or more	15.3	6.9	4.4	3.7	2.7	1.9	1.4	1.3	0.5	2.4	2.1	366

Table 6.6.3 Postpartum Complications by Selected Characteristics among Births in 2005–2010
Reproductive Health Survey: Georgia, 2010

Characteristic	Postpartum Complication										No. of Cases
	At Least One Postpartum Complication %	Severe Bleeding %	Painful Uterus %	High Fever %	Breast Infection %	Bad-smelling Vaginal Discharge %	Painful Urination %	Infection of Surgical Wound %	Faint/coma %	Other %	
Total	11.2	3.5	3.5	3.3	2.5	2.0	1.9	1.7	0.7	0.6	2,617
Residence											
Urban	12.6	4.6	3.8	3.8	3.2	2.2	2.2	1.9	0.8	0.8	1,193
Rural	9.7	2.4	3.1	2.7	1.8	1.8	1.7	1.5	0.6	0.3	1,424
Region											
Kakheti	13.3	3.5	4.3	3.5	2.7	2.0	2.7	1.6	0.0	0.0	224
Tbilisi	13.0	3.5	4.1	4.0	4.3	2.5	2.5	2.6	0.8	0.9	567
Shida Kartli	10.8	0.5	3.8	3.2	3.2	3.8	0.5	1.1	1.1	0.0	168
Kvemo Kartli	9.3	3.5	5.0	3.1	1.2	1.2	2.3	0.8	0.8	0.8	234
Samtskhe–Javakheti	6.1	3.7	1.6	0.4	0.4	0.4	0.4	1.2	0.4	0.4	214
Adjara	10.2	2.9	2.0	4.4	1.5	2.0	2.0	2.4	1.5	0.5	176
Guria	5.0	0.6	0.6	3.1	0.6	0.6	0.6	1.3	0.0	0.6	140
Samegrelo	5.7	0.5	1.9	1.9	1.0	1.0	0.5	1.9	0.5	0.0	184
Imereti	12.8	6.1	2.8	3.1	2.3	1.5	2.0	1.0	0.5	0.8	349
Mtskheta–Mtianeti	16.2	6.1	6.6	3.5	2.2	6.6	3.5	0.4	1.7	0.9	200
Racha–Svaneti	15.8	5.6	3.6	2.6	5.1	4.1	1.5	2.0	0.0	0.0	161
Age Group (at Birth)											
< 24	10.2	2.5	3.4	2.6	2.2	1.8	1.4	1.2	0.4	0.6	1,269
25–34	12.8	4.4	4.0	4.3	3.1	2.3	2.5	2.2	1.0	0.6	1,164
35–44	8.1	4.9	1.2	1.6	0.8	1.6	1.7	1.8	0.6	0.2	184
Education Level											
Secondary incomplete or less	8.4	2.9	2.2	2.4	1.6	1.5	0.5	1.3	0.7	0.3	422
Secondary complete	10.2	2.6	2.7	2.7	1.4	1.9	1.5	1.1	0.5	0.4	738
Technicum/University	12.4	4.1	4.2	3.8	3.3	2.3	2.5	2.1	0.8	0.7	1,457
Wealth Quintile											
Lowest	9.2	3.4	2.4	2.1	0.7	1.2	0.7	1.7	0.5	0.8	428
Second	8.0	2.7	2.8	1.8	1.3	1.2	1.2	1.3	0.7	0.0	628
Middle	11.7	3.6	3.9	3.8	2.3	2.7	2.6	1.7	1.1	0.4	587
Fourth	14.4	3.8	3.9	4.9	4.0	2.0	1.9	1.2	0.5	0.7	413
Highest	12.4	4.0	4.0	3.7	3.6	2.6	2.7	2.3	0.7	1.0	561
Birth Order											
First	11.4	2.9	3.5	3.9	2.9	2.0	2.1	2.1	0.8	0.7	1,293
Second	10.3	3.3	3.2	2.8	2.0	1.7	1.7	1.1	0.5	0.6	937
Third or more	12.2	6.0	3.9	2.3	2.1	2.8	2.1	1.7	1.1	0.3	387
Type of Delivery											
Vaginal	9.8	3.2	3.5	2.7	2.0	1.7	1.8	1.0	0.5	0.6	2,029
Cesarean Section	15.5	4.3	3.4	5.1	4.2	3.0	2.4	4.0	1.4	0.6	588
Baby's Weight at Birth											
< 2500 grams	37.3	24.9	8.9	7.8	2.0	8.5	3.0	2.8	2.2	1.5	125
≥ 2500 grams	9.9	2.5	3.2	3.0	2.5	1.7	1.9	1.6	0.6	0.5	2,481
Unknown	*	*	*	*	*	*	*	*	*	*	11

* Excludes 11 births with unknown baby's weight at birth.

Table 6.8.1 Percentage of Children Born in 2005–2010 Ever Breastfed and Time of Initiation of Breastfeeding by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Children Ever Breastfed		Initiation of Breastfeeding					Total	No. of Cases
	%	No. of Cases*	<1 Hour	1–23 Hours	24–47 Hours	48 Hours or More	Unknown		
Total	87.4	2,624	19.7	54.5	13.3	11.3	1.2	100.0	2,278
Residence									
Urban	87.1	1,199	19.6	53.7	13.2	12.9	0.7	100.0	1,040
Rural	87.7	1,425	19.9	55.4	13.4	9.6	1.7	100.0	1,238
Region									
Kakheti	90.6	223	14.7	69.3	8.7	3.9	3.5	100.0	201
Tbilisi	88.3	572	22.1	54.5	11.9	11.0	0.5	100.0	503
Shida Kartli	85.9	168	13.8	41.5	24.5	20.1	0.0	100.0	144
Kvemo Kartli	88.3	233	21.6	57.3	8.8	9.7	2.6	100.0	204
Samtskhe–Javakheti	90.3	215	33.0	54.0	6.3	6.3	0.4	100.0	195
Adjara	83.7	179	8.6	56.3	23.6	11.5	0.0	100.0	146
Guria	82.5	141	18.9	45.5	18.9	16.7	0.0	100.0	117
Samegrelo	82.5	186	18.9	65.7	9.1	5.1	1.1	100.0	151
Imereti	88.8	349	19.8	47.4	14.1	17.2	1.4	100.0	311
Mtskheta–Mtianeti	86.2	197	32.6	42.0	13.5	10.4	1.6	100.0	168
Racha–Svaneti	85.7	161	24.4	38.7	22.6	13.1	1.2	100.0	138
Age Group (at Birth)									
< 24	89.6	1,266	19.6	55.7	14.2	9.1	1.5	100.0	1,129
25–34	86.0	1,170	20.1	53.8	12.0	13.4	0.7	100.0	997
35–44	81.0	188	18.8	50.6	15.1	13.3	2.2	100.0	152
Education Level									
Secondary incomplete or less	88.1	420	16.2	64.6	11.6	5.1	2.6	100.0	366
Secondary complete	84.9	743	20.1	55.7	13.2	10.4	0.6	100.0	626
Technicum/University	88.4	1,461	20.6	51.1	13.9	13.4	1.1	100.0	1,286
Ethnicity									
Georgian	86.5	2,250	19.1	53.0	14.8	12.3	0.8	100.0	1,933
Azeri	92.0	145	18.5	65.9	7.7	4.1	3.8	100.0	133
Armenian	93.9	148	36.1	49.2	4.2	6.1	4.4	100.0	139
Other	91.1	81	13.4	73.3	4.3	7.9	1.1	100.0	73
Birth Order									
First	87.2	1,305	17.4	54.1	14.0	13.6	1.0	100.0	1,129
Second	88.6	943	22.3	53.3	13.4	9.8	1.1	100.0	827
Third or more	85.0	376	21.9	58.9	10.6	6.5	2.1	100.0	322
Type of Delivery									
Vaginal	88.6	2,022	23.8	57.8	9.9	7.2	1.2	100.0	1,787
Cesarean Section	83.6	602	6.1	43.5	24.6	24.8	1.0	100.0	491
Baby Weight at Birth									
< 2500 grams	64.2	113	11.0	40.4	18.8	28.3	1.5	100.0	68
>= 2500 grams	88.7	2,474	20.1	55.2	13.2	10.4	1.2	100.0	2,187
Unknown	64.2	37	†	†	†	†	†	100.0	23

* Includes 29 twins.

† Fewer than 25 cases in this category.

Table 6.8.2 Mean Duration of Breastfeeding in Months by Type of Breastfeeding and Selected Characteristics, for Live Births Aged 0–59 months
Reproductive Health Survey: Georgia, 2010

Characteristic	Exclusive Breastfeeding *	Full Breastfeeding	Any Breastfeeding
Total	3.0	4.1	12.2
Residence			
Tbilisi	2.9	3.8	10.3
Other Urban	2.8	3.4	12.1
Rural	3.1	4.5	13.2
Child's Sex			
Boy	2.5	3.7	12.8
Girl	3.4	4.4	11.2
Age Group (at Birth)			
<30	3.2	4.2	12.1
30–44	2.9	4.0	12.4
Education Level			
Secondary complete or less	3.3	4.5	12.8
Technicum/university	2.7	3.8	11.6
Ethnicity			
Georgian	2.9	4.0	11.9
Other	3.3	4.7	12.5
Quintile			
Lowest	4.1	5.2	13.9
Second	1.8	3.2	11.5
Middle	2.7	3.8	12.4
Fourth	3.1	4.3	11.8
Highest	2.7	3.2	10.2
Birth Order			
First	3.1	4.3	11.2
Second	2.9	4.1	13.0
Third or more	3.3	4.2	15.2

* Exclusive breastfeeding: child is fed only breast milk.

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

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

Table 6.9.1 Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)
Among Children Born During the 5 Years Before the Survey
Reproductive Health Surveys: Georgia 1999, 2005 and 2010

Mortality Rates	GERHS10: January 2005 – December 2009		GERHS05: January 2000 – December 2004		GERHS99: January 1995 – December 1999	
	Rate	CI	Rate	CI	Rate	CI
Infant Mortality	14.1	(7.8–20.4)	21.1	(13.5–28.7)	41.6	(31.0–52.2)
Neonatal	9.5	(5.4–13.4)	16.8	(10.7–22.9)	25.4	(17.0–33.8)
Postneonatal	4.5	(0.0–9.1)	4.3	(1.2–7.4)	16.2	(9.1–23.3)
Child Mortality (1–4)	2.3	(0.0–4.6)	4.0	(0.5–8.5)	3.8	(0.9–6.7)
Under-5 Mortality (0–4)	16.4	(9.6–23.2)	25.0	(16.4–33.6)	45.3	(34.5–56.1)
Number of Cases	2,170		1,909		2,507	

Table 6.9.2 Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)
by Selected Characteristics Among Children Born Between January 2000 and December 2009
Reproductive Health Survey: Georgia, 2010

Characteristic	Infant Mortality			Child Mortality	Under-5 Mortality	No. of Cases
	Total	Neonatal	Postneonatal	1–4 Year	0–4 Years	
Total	23.8	17.5	6.3	2.2	26.0	4,015
Period of Exposure						
January 2000/December 2004	35.7	27.2	8.5	2.2	37.9	1,845
January 2005/December 2009	14.1	9.5	4.5	2.3	16.4	2,170
Residence						
Urban	21.8	16.3	5.6	0.5	22.4	1,772
Rural	25.7	18.6	7.0	3.9	29.4	2,243
Region						
Kakheti	27.0	16.0	10.9	5.9	32.8	345
Tbilisi	16.9	14.7	2.1	0.0	16.9	839
Shida Kartli	28.2	21.2	7.0	7.5	35.5	257
Kvemo Kartli	28.1	16.5	11.6	2.4	30.4	384
Samtskhe–Javakheti	21.8	13.6	8.3	3.1	24.9	329
Adjara	26.6	19.8	6.8	3.7	30.3	261
Guria	21.3	14.2	7.1	0.0	21.3	251
Samegrelo	34.1	31.0	3.1	0.0	34.1	293
Imereti	19.7	12.4	7.2	1.9	21.6	515
Mtskheta–Mtianeti	38.0	34.8	3.2	0.0	38.0	281
Racha–Svaneti	6.8	3.4	3.3	0.0	6.8	260
Age Group (at Birth)						
< 25	18.2	12.9	5.3	1.5	19.7	2,118
25–44	30.1	22.6	7.5	3.2	33.2	1,897
Education Level						
Secondary incomplete or less	22.8	16.6	6.3	1.6	24.4	730
Secondary complete	28.4	22.1	6.3	2.8	31.2	1,132
Technicum/university	21.8	15.4	6.4	2.2	23.9	2,153
Ethnic Group						
Georgian	23.8	17.5	6.4	2.1	25.9	3,395
Other	23.5	17.3	6.2	2.9	26.3	620
Socioeconomic Status						
Low	26.0	19.9	6.1	1.6	27.5	1,685
Medium/High	22.4	16.0	6.4	2.6	25.0	2,330
Birth Order						
First	20.4	14.9	5.5	0.7	21.2	1,978
Second	23.1	16.1	7.0	3.5	26.5	1,464
Third or more	36.7	29.3	7.4	3.9	40.4	573
Length of Birth Interval						
First Birth	20.4	14.9	5.5	0.7	21.2	1,978
<24 months	22.4	20.0	2.4	3.0	25.4	637
24–47 months	34.8	29.5	5.3	6.2	40.7	689
48 months or more	24.0	11.5	12.5	1.7	25.6	711
Sex of Child						
Boy	26.6	18.5	8.1	1.6	28.1	2,142
Girl	20.5	16.2	4.3	3.0	23.5	1,873

7 CHAPTER

CONTRACEPTIVE KNOWLEDGE

Contraceptive use is an important and direct determinant of variation in fertility and abortion rates. In Georgia, the availability of high quality contraceptive methods has been limited. Currently, Georgia does not have a stand-alone national family planning program, and neither state nor private health insurance packages include family planning provisions. However, family planning objectives are included in the national reproductive health strategy, and specific targets are set to increase the use of modern contraceptive methods and reduce unmet need for family planning (MoLHSA, 2007). All family planning activities are maintained through donor support, primarily from the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID). Since 1996–1999, both agencies have invested heavily in numerous advances: building capacity; providing free contraceptive supplies in government clinics; integrating contraceptive services into primary care; training family planning providers; providing services to remote areas, minorities and internally displaced families; and funding information, education and communication efforts. Supplied contraceptive methods are available, either at no cost, at subsidized prices via social marketing programs, or at market prices in pharmacies and the commercial for-profit sector. Most health facilities with family planning services—hospitals, polyclinics, and primary health centers—provide oral contraceptives, condoms, and spermicides free of charge; free contraceptives are also distributed by mobile units. For a fee, tubal ligations and intrauterine device (IUD) insertions can be obtained in facilities that have trained obstetricians/gynecologists on staff.

The survey questionnaire addressed many family planning topics such as knowledge of contraceptive methods, use of methods in the past and present, sources of supply, contraceptive counseling, discontinuation and failure rates, reasons for non-use, desire to use in the future, exposure to family planning messages, and attitudes toward family planning. Selected topics are included in the present chapter.

7.1 Contraceptive Awareness and Knowledge of Use

Limited knowledge about modern methods of contraception constitutes an important barrier to utilization of family planning services. To address this gap, the 2010 survey included questions on general awareness of specific contraceptive methods, knowledge of source(s) of supplied methods, perceived reliability (knowledge of contraceptive efficacy), and knowledge of how these methods are used.

At first glance, women of reproductive age in Georgia appeared to be well informed about contraception. Virtually all (97%) had heard of at least one modern method, though fewer were aware of at least one traditional method (64%) (Table 7.1.1). Levels of awareness of any method were lowest in the Kvemo Kartli region and highest in Tbilisi and Imereti. On average, women recognized 3.4 modern methods—ranging from 3.8 modern methods known by married women and 2.7 modern methods known by women who have never been married. As expected, awareness increased directly with the age of the respondent; young adults knew, on average 2.6 modern methods while women aged 35 or older knew of almost 4 modern methods (Table 7.1.2). Awareness of modern contraception also increased with the level of education, from knowing on average 2.4 methods among women with less than complete secondary education to 4.0 methods among women with the highest education attainment (Table 7.1.3). Condoms (94%), IUDs (87%), and oral contraceptives (81%) were the best known methods regardless of marital status, age or education.

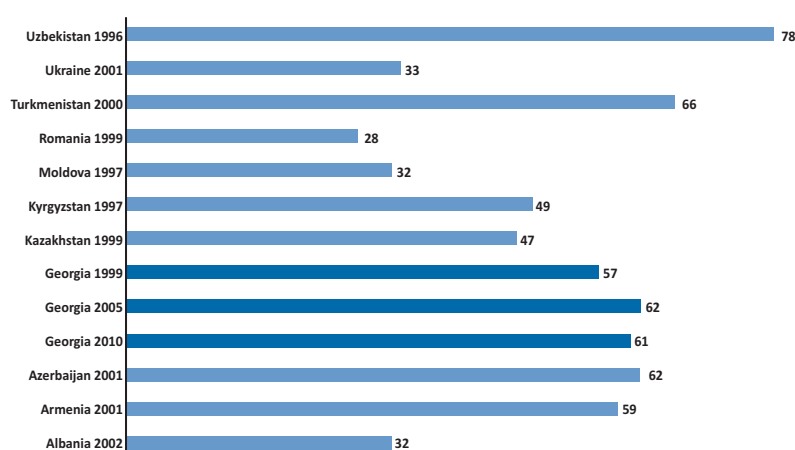
Low awareness of tubal ligation, vasectomy, and injectable methods was common in all subgroups. Only 39% of women had heard of tubal ligation and fewer (4%) had heard of vasectomy. This low level of awareness is common among all former Soviet-bloc countries (Figure 7.1.1), which often limited access to tubal ligation as a means of contraception. In most countries of Eastern Europe, including Georgia, tubal ligation is either specifically permitted by law or is not specifically prohibited (and is, therefore, implicitly allowed). However, most countries have set certain conditions or limitations on surgical contraception (e.g. age or/and parity requirements, medical com-

mittee approval, spousal consent) that are not always known by either providers or clients (EngenderHealth, 2002). For example, the USSR legalized tubal ligation in 1990 after a long period of prohibition (Ministry of Health of the USSR, Order No. 484 of December 14, 1990) and gave permission for tubal ligation only to women with 3 or more children or those over 30 years of age who already had 2 children (these restrictions were relaxed in 1993). After the dissolution of the Soviet Union in 1991 most successor states continued to regulate access to tubal ligation using the USSR legal statutes, although it was not clear that these restrictions should still apply.

Access to tubal ligation in Georgia is regulated by the Georgian Law on Health Care (Government of Georgia, 1997). Article 145 of the law stipulates that tubal ligation can be carried out only in certified medical facilities by certified physicians after written consent of the patient and after a mandatory waiting period of one month from the time of initial discussion of the issue with the patient. Although the legal statute of tubal ligation is permissive, few women have enough knowledge about the method to make a decision whether they want to use it or not. Limited awareness about the use of tubal ligation as a method of family planning seems to be the most important deterrent to its use in Georgia. Among women interviewed in 2010 who wanted no more children, almost two-thirds had only limited knowledge about the procedure—lack of awareness about the procedure, not knowing where it can be obtained, fear of surgery or complications after surgery—are the most important reasons for not being interested in tubal ligation (data not shown).

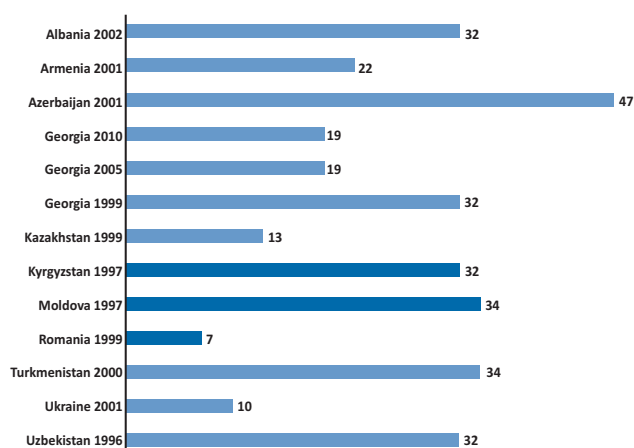
Lack of awareness and misconceptions about oral contraceptives are another legacy of the former So-

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



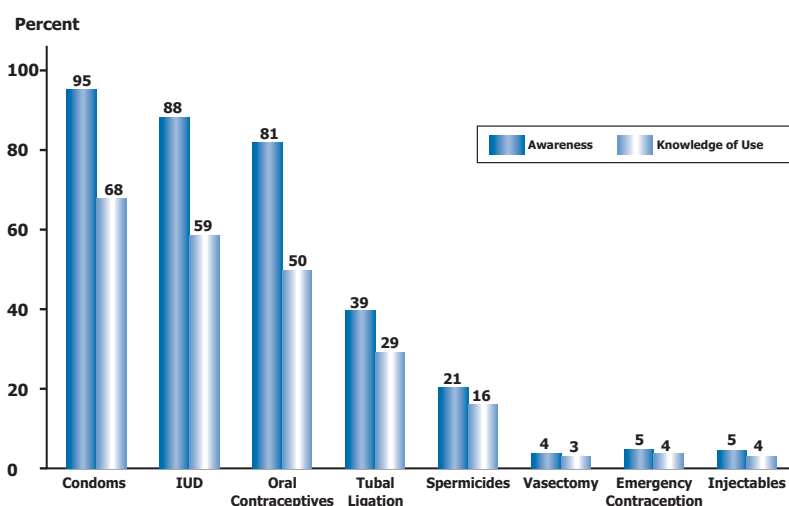
*Source: CDC and ORC/Macro, 2003. *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*

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



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

Figure 7.1.3 Awareness and Knowledge of How to Use Modern Contraceptive Methods among Women Aged 15–44 Years



viet regime, particularly among older women. Under the Soviet regime, hormonal methods were not actively promoted for family planning purposes and were usually prescribed for medical benefits. Further, potential health risks and side effects sometimes associated with hormonal methods were overstated. As a result, some women of childbearing age in the former Soviet-bloc countries continue to be unaware of oral contraceptives (Figure 7.1.2).

Awareness of contraception does not immediately translate into knowledge of how a contraceptive method should be used. Knowledge about how to use any modern method, or any traditional method, was much lower than the very high level of contraceptive awareness in Georgia (76% vs. 96% and 51% vs. 64%, respectively). For the most widely known modern contraceptive methods, there was a serious gap between awareness of the method and knowledge

about how the procedure or product should be used (compare Tables 7.1.2 and 7.1.4 and Figure 7.1.3). Although condom and IUD awareness were almost universal, only two thirds of women stated they knew how to use condoms and only 59% said they knew how the IUD is used. Knowledge about using oral contraceptives was much lower than awareness of it: 81% of women had heard of oral contraceptives, but only 50% had knowledge about how the method could be used. A considerable gap exists between awareness of other contraceptive methods and knowledge of how the procedures or products are used.

On average, women reported having knowledge about how contraceptives work for about two modern methods. The difference between awareness of, vs. knowledge about, use was greatest among never married women (93% vs. 58%) and young adults (94% vs. 63%); this difference diminished among married

Figure 7.1.4 Knowledge about a Source for Specific Modern Contraceptive Methods Women Aged 15–44 Years

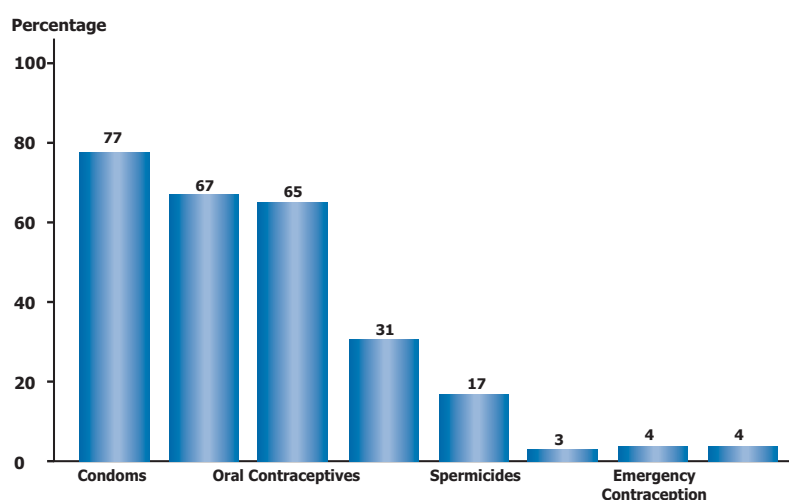
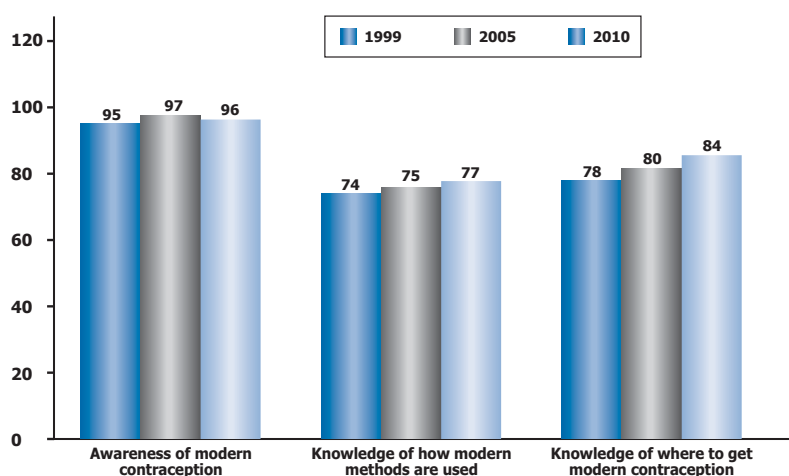


Figure 7.1.5 Trends in Awareness of Modern Contraception, Knowledge of How Modern Methods Are Used and Where to get Modern Contraception Among Women Aged 15–44 years; 1999, 2005 and 2010



women (99% vs. 92%) and among women aged 25–44 (98%–99% vs. 88%–92%). Never married and young adult women, on average, could identify how contraceptives work for 1.4–1.5 modern methods; women with marital experience and older women could identify up to 3 modern methods.

The low level of knowledge among never-married young women, often still in school, highlights the need to include information on contraceptive methods in nationwide, age-appropriate sexual health education programs.

The majority (84%) of women of reproductive age could name a source for at least one method of contraception (Table 7.1.5). On average, women were able to name sources for about two contraceptive methods. Respondents were more likely to know a source for the most commonly used modern methods. For instance, 77% of women knew a source for condoms, 67% knew where to obtain IUDs, and 65%

knew a source for pills. Figure 7.1.4 However, only 31% knew where tubal ligations were performed, and very few knew where vasectomies were performed or where to obtain injectables, spermicides, or emergency contraception.

Knowledge of a source was the higher among women living in Tbilisi (90%) and among those living in other urban areas (87%) than among rural residents (79%) (Table 7.1.5). As with other aspects of contraceptive knowledge, knowing a source for contraceptives increased with age.

Regarding overall trends for modern contraception, all three aspects of awareness, knowledge about correct use, and knowledge of sources improved by 2010 (Table 7.1.6 and Figure 7.1.5). These improvements may be a result of recent efforts to increase access to family planning information in remote areas of Georgia, either through primary health care or through mobile health units.

Figure 7.1.6 Trends in Awareness of Selected Modern Contraception Among All Women Aged 15-44 years; 1999, 2005 and 2010

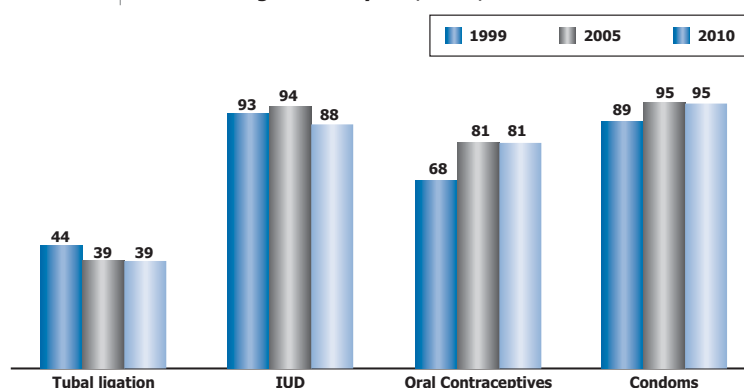
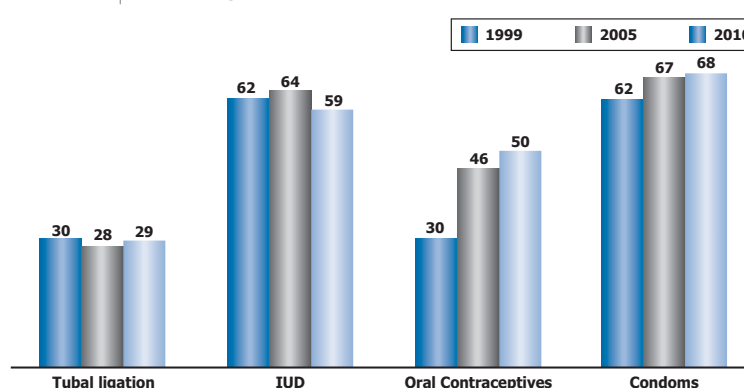


Figure 7.1.7 Trends in Knowledge of How Modern Methods Are Used Among Women Aged 15-44; 1999, 2005 and 2010



However there were differences in trends for the individual methods. Awareness of the IUD and tubal ligation declined after 1999, but rose for the pill and condom (Table 7.1.6 and Figure 7.1.6); Interestingly, the gap between rural and urban awareness narrowed over the eleven years, but remained substantial, depending on the particular method.

There were method differences also for knowledge about method use. Knowledge held steady (at a low level) for tubal ligation but fell for the IUD. After 1999 it rose for the pill and condom (Table 7.1.6 and Figure 7.1.7). Again, the rural-urban gap narrowed over time.

Finally, for knowledge of a source for obtaining a method, the results parallel those for knowledge about the methods themselves. Tubal ligation was flat at a low level; the IUD fell; and the pill and condom rose (Table 7.1.6 and Figure 7.1.8). The rural-urban difference persisted but diminished after 1999.

These improvements may result from efforts to increase access to family planning information and modern contraceptives, mostly pills and condoms, throughout Georgia, either through primary health care or through mobile health units.

7.2 Most Important Source of Information about Contraception

The 2010 survey found that for many women the main source of information about contraceptive methods was an acquaintance or a boy friend (32%), followed by a doctor (17%), a relative other than a parent (15%), a partner/husband (12%), and the TV, radio and internet (9%) (Table 7.2.1 and Figure 7.2.1). Parents and schools were seldom mentioned as important sources of contraceptive information (2% and 1%, respectively). Young women (those aged 15-24) reported somewhat different sources of information than older women did: 38% of young women found out about a contraceptive method in discussions with a friend or boy friend, 16% in discussions with relatives and 15% from audiovisual media. They were, however, less likely than women aged 25-34 or 35-44 to have learned about contraception from a health care provider (9% vs. 19% and 21%, respectively) and twice as likely to report television or radio or internet as their most important source of information about contraception (15% vs. 7% and 7%, respectively). Similar differences were found when never-married women were compared with ever-married women since the two groups differ so much in average age.

The source of contraceptive information varied also by method (Table 7.2.2). Condoms were unusual in

Figure 7.1.8 Trends in Knowledge of Where to Get Modern Contraception Among Women Aged 15-44; 1999, 2005 and 2010

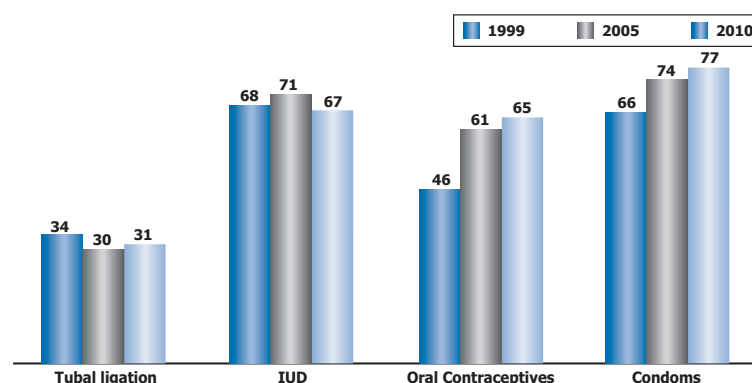
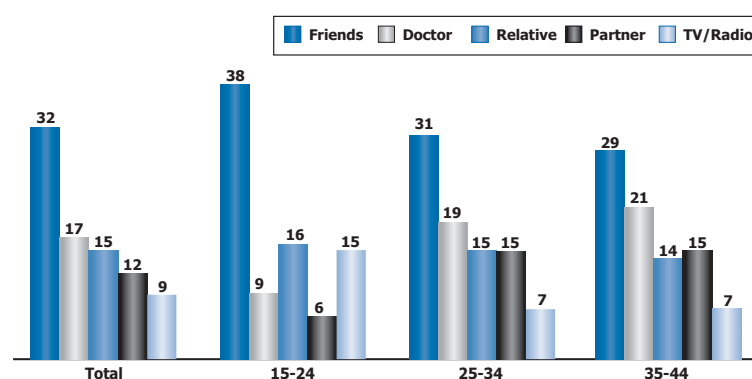


Figure 7.2.1 Main Source of Information about Contraception by Age Group Among Women Aged 15-44 Who Have Heard of Specific Methods



the dominance of the “grapevine” of friends, relatives, and the media, as opposed to doctors. However doctors ranked just below friends/boy friends for the pill, IUD, and tubal ligation as well as spermicides. Doctors and books came first however for vasectomy, injectables, and emergency contraception, all of which are not very well known at all. As for the withdrawal method, after partner/husband (39%), the second most important information source was a friend or boy friend (37%). An overview appears in Figure 7.2.2.

These findings explain, in part, the poor quality of contraceptive information among the public, and illustrate the need to increase public health efforts in educating women about the benefits of contraception, through the more reliable channels of schools, mass media, and health providers.

7.3 Knowledge about Contraceptive Effectiveness

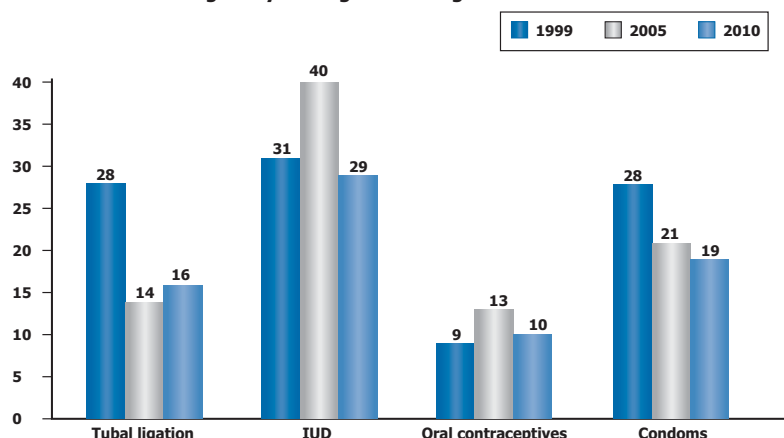
The 2010 survey addressed not only awareness of contraceptive methods and their sources, but also understanding of contraceptive effectiveness. Correct information about contraceptive effectiveness can greatly influence couples’ decisions about how to prevent unplanned pregnancies. Good knowledge by the public about the effectiveness of specific contraceptive methods is an indicator of the adequacy

of contraceptive counseling and of information and education programs. In the latest survey a majority of women did not recognize any modern method as very effective (Table 7.3 and Figure 7.3.1). While 29% of women correctly stated that the IUD is very effective in preventing pregnancy, only 16% believed that contraceptive sterilization is very effective. The majority of women incorrectly thought that pills were not very effective. In fact, the proportion of women who correctly said that pills were very effective was lower than the proportion who perceived the condoms as very effective (10% vs. 19%), although the documented use effectiveness of condoms is far lower than that of oral contraceptives (Hatcher et al., 2004).

Misperceptions among users of traditional methods of contraception constitute a striking example of how lack of knowledge about contraceptive effectiveness can impair informed choice and increase reliance on less effective methods. Overall, 38% and 27% of women, respectively, stated that the rhythm method and withdrawal are either very effective or effective. While the percentage of women who have heard of these methods declined from 2005 to 2010 (from 68% to 59% for rhythm and from 55% to 43% for withdrawal) (Table 7.1.6) belief in the high effectiveness of traditional methods is in fact the predominant view among women who are aware of these methods. That is, in

Figure 7.3

Percentage of Women Agreeing that Specified Contraceptive Methods* Are Very Effective in Preventing Pregnancy Among Women Aged 15-44



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

Table 7.3, 42% and 56% have never heard of the two methods and so when they are removed, most of the rest fall into the very effective and effective columns.

Further information regarding trends appears in Figure 7.3.1. The trends are rather erratic, and the reasons are not entirely clear. Between 1999 and 2005, the perceived effectiveness of the IUD and oral contraceptive increased (from 31% to 40% and from 9% to 13%, respectively). However, then the levels declined in 2010 close to the 1999 levels, reaching 29% and 10%, respectively. Belief that tubal ligation is very effective declined by half between 1999 and 2005 (from 28%

to 14%) and remained approximately constant from 2005 to 2010.

In summary, there are large deficits in public awareness of particular methods, as well as knowledge about how to use them and where to obtain them. Perceptions of method reliability are confused, and involve serious misunderstandings that tend to increase unplanned pregnancies and abortions. Clearly, programs are needed to address these widespread problems, to strengthen current efforts to educate both the public and the providers of modern contraception.

Table 7.1.1 Percentage of All Women Aged 15–44 Who Had Heard of Specific Methods of Contraception by Region
Reproductive Health Survey: Georgia, 2010

Awareness of Contraception	Total	Region										
		Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe-Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta-Mtianeti	Racha-Svaneti
Ever Heard of Any Method	96.6	95.7	98.9	97.0	90.6	95.0	95.4	99.2	98.3	96.8	97.5	96.3
Ever Heard of a Modern Method	96.2	95.3	98.9	97.0	88.7	94.4	95.0	98.6	98.3	96.5	97.5	96.1
Condoms	94.5	93.8	98.4	95.7	83.1	92.7	90.8	98.2	97.6	95.9	94.9	95.4
IUD	87.5	85.1	90.9	85.0	81.3	88.2	84.7	90.4	84.7	91.1	88.4	84.2
Pill	81.1	79.1	89.5	80.9	74.9	73.9	72.8	79.2	73.8	83.6	84.6	76.7
Tubal ligation	39.3	36.4	44.3	47.1	30.1	24.7	19.2	46.2	41.2	51.0	37.8	36.6
Spermicides	20.7	19.3	28.4	16.8	18.7	9.6	16.3	18.6	12.9	23.1	18.8	13.0
Emergency contraception	5.2	3.2	10.2	2.4	3.6	1.2	3.9	1.6	0.8	4.8	5.7	3.0
Injectables	4.8	2.8	9.3	3.4	3.4	1.7	3.2	4.6	2.5	3.2	4.9	3.6
Vasectomy	4.2	2.8	8.4	1.6	1.7	0.9	2.5	2.6	2.2	4.2	2.3	2.0
Average Number of Modern Methods	3.4	3.2	3.8	3.3	3.0	2.9	2.9	3.4	3.2	3.6	3.4	3.1
Ever Heard of a Traditional Method	63.7	62.2	67.9	63.1	60.4	66.6	59.0	61.2	55.6	67.0	65.6	59.5
Calendar (rhythm) method	58.5	57.4	64.7	60.4	48.1	55.6	51.3	51.6	51.6	64.4	62.4	54.9
Withdrawal	43.2	37.0	42.8	40.6	46.6	50.9	49.4	45.8	32.1	44.6	46.4	40.0
No. of Cases	6,292	498	1,426	392	546	481	419	401	477	805	393	454

Table 7.1.2 Percentage of All Women Aged 15–44 Who Had Heard of Specific Methods of Contraception by Marital Status and Age Group
Reproductive Health Survey: Georgia, 2010

Awareness of Contraception	Total	Marital Status			Age Group		
		Married	Previously Married	Never Married	15–24	25–34	35–44
Ever Heard of Any Method	96.6	98.6	96.8	93.0	93.8	97.9	98.6
Ever Heard of a Modern Method	96.2	98.1	96.3	93.0	93.7	97.7	97.7
Condoms	94.5	96.1	95.0	91.5	91.6	96.7	95.5
IUD	87.5	95.9	94.7	71.8	73.7	95.2	96.0
Pill	81.1	89.7	89.7	64.7	65.8	90.4	89.6
Tubal ligation	39.3	48.6	50.8	21.0	19.1	46.5	55.9
Spermicides	20.7	27.2	29.9	7.8	8.1	26.1	30.2
Emergency contraception	5.2	6.2	9.5	2.6	1.8	6.6	7.7
Injectables	4.8	5.6	7.3	3.0	2.1	5.2	7.8
Vasectomy	4.2	4.5	7.8	2.8	1.3	4.8	7.0
Average Number of Modern Methods	3.4	3.7	3.8	2.7	2.6	3.7	3.9
Ever Heard of a Traditional Method	63.7	83.0	74.9	28.5	34.0	77.4	85.1
Calendar (rhythm) method	58.5	75.3	71.6	27.0	30.3	70.6	79.5
Withdrawal	43.2	62.0	56.7	8.2	15.9	53.8	64.8
No. of Cases	6,292	4,098	389	1,805	1,960	2,359	1,973

Table 7.1.3 **Percentage of All Women Aged 15–44 Who Had Heard of Specific Methods of Contraception by Education**
Reproductive Health Survey: Georgia, 2010

Awareness of Contraception	Total	Education Level			
		Secondary Incomplete or Less	Secondary Complete	Technicum	University/ Postgraduate
Ever Heard Any Method	96.6	91.2	96.1	99.1	99.1
Ever Heard of a Modern Method	96.2	90.0	95.8	99.0	99.1
Condoms	94.5	87.4	93.2	97.2	98.5
IUD	87.5	69.5	86.7	97.4	95.1
Pill	81.1	59.2	77.5	90.8	92.7
Tubal ligation	39.3	19.9	30.6	51.6	51.6
Spermicides	20.7	6.7	12.5	28.0	31.5
Emergency contraception	5.2	0.5	2.1	7.1	9.1
Injectables	4.8	0.9	1.7	4.3	9.2
Vasectomy	4.2	0.2	1.2	5.5	7.9
Average Number of Modern Methods	3.4	2.4	3.1	3.8	4.0
Ever Heard of a Traditional Method	63.7	40.3	59.3	79.5	74.7
Calendar (rhythm) method	58.5	33.2	51.3	76.7	71.4
Withdrawal	43.2	27.9	41.1	51.1	50.6
No. of Cases	6,292	1,330	1,568	903	2,491

Table 7.1.4 Percentage of All Women Aged 15–44 Who Said They Know How Selected Methods of Contraception Are Used, by Marital Status and Age Group
Reproductive Health Survey: Georgia, 2010

Knowledge of Contraceptive Use	Total	Marital Status			Age Group		
		Married	Previously Married	Never Married	15–24	25–34	35–44
Know How to Use at Least One Method	79.9	92.0	87.9	57.5	62.9	87.9	91.8
At Least One Modern Method	76.5	87.3	85.5	56.2	61.1	84.3	86.8
Condoms	67.5	76.4	77.9	50.3	54.7	75.0	74.8
IUD	58.5	72.1	69.3	33.1	37.2	67.5	74.7
Pill	49.7	61.1	61.9	27.8	32.2	58.9	61.1
Tubal ligation	29.0	37.2	39.7	12.9	11.9	34.6	43.8
Spermicides	16.0	21.2	25.3	5.2	5.8	20.0	24.0
Emergency contraception	4.0	4.8	7.9	2.1	1.3	5.0	6.4
Injectables	3.5	3.9	6.8	2.2	1.3	3.5	6.3
Vasectomy	3.4	3.6	7.3	2.2	1.1	3.9	5.6
Average Number of Modern Methods	2.3	2.8	3.0	1.4	1.5	2.7	3.0
At Least One Traditional Method	50.5	69.3	62.0	15.9	22.5	61.9	72.0
Calendar (rhythm) method	41.9	56.2	55.2	14.8	18.2	50.4	61.4
Withdrawal	34.8	50.7	45.4	5.4	12.3	43.4	52.8
No. of Cases	6,292	4,098	389	1,805	1,960	2,359	1,973

Table 7.1.5 Percentage of All Women Aged 15–44 Who Said They Know Where to Get Selected Methods of Contraception, by Age Group and Residence
Reproductive Health Survey: Georgia, 2010

Knowledge of a Source of Contraception	Total	Residence			Age Group		
		Tbilisi	Other Urban	Rural	15–24	25–34	35–44
Know Where to Get at Least One Method	84.1	90.1	86.9	79.0	75.6	88.8	89.2
Condoms	77.4	85.1	80.2	71.4	70.5	82.0	80.9
IUD	66.5	68.9	69.8	63.2	48.0	75.2	79.4
Pill	64.7	73.3	67.6	58.2	50.2	73.6	72.8
Tubal ligation	30.6	33.9	32.7	27.5	13.0	36.8	45.2
Spermicides	17.1	21.8	20.6	12.5	6.4	21.1	25.7
Emergency contraception	4.1	8.0	3.3	2.3	1.3	5.2	6.5
Injectables	3.7	6.3	3.2	2.5	1.5	3.7	6.4
Vasectomy	3.4	6.7	2.7	2.0	1.1	3.9	5.8
Average Number of Modern Methods	2.3	2.7	2.5	2.0	1.5	2.7	3.0
No. of Cases	6,292	1,426	1,549	3,317	1,960	2,359	1,973

Table 7.1.6 Trends in Awareness of Contraceptive Methods, Knowledge of How Contraceptive Methods Are Used, and Knowledge of Where to Get Modern Methods, by Residence, Among All Women Aged 15–44
Reproductive Health Surveys, Georgia 1999, 2005 and 2010

Contraceptive Method	1999			2005			2010		
	Total	Residence		Total	Residence		Total	Residence	
		Urban	Rural		Urban	Rural		Urban	Rural
Awareness of Contraception									
Any Method	95.1	98.2	91.3	96.9	99.5	93.8	96.6	98.4	94.6
Any Modern Method	94.9	98.0	90.8	96.7	99.4	93.4	96.2	98.3	93.9
Condoms	88.5	95.5	79.3	95.2	99.2	90.3	94.5	97.3	91.3
IUD	92.6	95.9	88.3	93.9	96.8	90.3	87.5	90.0	84.8
Pill	67.5	77.7	54.4	81.3	88.4	72.7	81.1	87.2	74.2
Tubal ligation	43.5	48.5	37.0	38.5	47.7	27.4	39.3	42.6	35.5
Spermicides	11.3	14.6	6.9	18.4	23.6	12.1	20.7	25.8	15.0
Vasectomy	12.4	16.9	6.6	5.1	7.6	2.1	4.2	5.9	2.2
Emergency contraception	4.1	6.0	1.6	4.2	6.2	1.8	5.2	7.4	2.7
Injectables	4.3	5.8	2.5	3.3	5.2	1.1	4.8	6.6	2.8
Any Traditional Method	69.4	74.0	63.5	72.5	77.1	67.0	63.7	66.2	61.0
Calendar (rhythm) method	64.9	71.0	57.0	68.2	74.2	60.8	58.5	62.7	53.6
Withdrawal	50.3	53.6	46.1	54.9	58.0	51.0	43.2	42.6	43.9
Knowledge of How Contraceptive Methods Are Used									
Any Method	77.9	83.3	70.9	79.4	83.2	74.7	79.9	83.4	75.9
Any Modern Method	73.5	80.4	64.7	75.1	79.9	69.4	76.5	81.5	70.9
Condoms	62.2	71.3	50.4	66.6	72.8	59.2	67.5	73.7	60.4
IUD	61.8	67.0	55.2	64.0	67.6	59.6	58.5	62.1	54.5
Pill	30.1	36.9	21.4	45.9	50.2	40.6	49.7	54.7	44.2
Tubal ligation	30.1	35.2	23.6	28.3	35.4	19.5	29.0	32.5	25.1
Spermicides	7.0	9.6	3.6	11.5	14.8	7.6	16.0	20.3	11.0
Vasectomy	8.9	12.0	4.9	3.5	5.3	1.3	3.4	4.7	1.9
Emergency contraception	2.7	4.1	1.0	2.5	3.9	0.8	4.0	5.7	2.2
Injectables	2.6	3.8	1.0	1.7	2.5	0.7	3.5	4.8	2.1
Any Traditional Method	52.1	56.4	46.5	55.5	58.9	51.3	50.5	51.4	49.4
Calendar (rhythm) method	43.0	49.0	35.3	46.7	52.3	39.9	41.9	45.6	37.7
Withdrawal	37.9	40.0	35.1	41.3	43.0	39.2	34.8	33.0	36.8
Knowledge of Where to Get Modern Methods of Contraception									
Any Modern Method	77.5	83.8	69.4	80.4	84.2	75.7	84.1	88.5	79.0
Condoms	65.8	75.7	53.1	74.2	79.6	67.6	77.4	82.8	71.4
IUD	67.9	73.5	60.7	70.6	74.0	66.4	66.5	69.3	63.2
Pill	45.8	55.3	33.5	61.4	67.6	54.0	64.7	70.6	58.2
Tubal ligation	34.0	38.7	27.9	30.1	37.2	21.5	30.6	33.3	27.5
Spermicides	8.4	11.3	4.6	13.6	17.6	8.8	17.1	21.2	12.5
Vasectomy	9.4	12.7	5.2	4.1	5.8	1.9	3.4	4.7	2.0
Emergency contraception	2.9	4.5	0.8	3.0	4.6	1.1	4.1	5.8	2.3
Injectables	2.6	3.7	1.1	2.0	3.0	0.7	3.7	4.8	2.5
No. of Cases	7,798	4,759	3,039	6,376	3,196	3,180	6,292	2,975	3,317

Table 7.2.1 Most Important Source of Information About Contraception by Age Group and Marital Status Among Women Aged 15–44 Who Have Heard of at Least One Method of Contraception
Reproductive Health Survey: Georgia, 2010

Source	Total	Age Group			Marital Status		
		15–24	25–34	35–44	Married	Previously Married	Never Married
Friends, boyfriend	32.1	37.6	30.6	29.0	28.7	30.9	41.6
Doctor	17.0	8.9	19.5	21.2	22.3	17.2	2.6
Relative	15.3	16.5	15.3	14.4	14.7	14.0	17.4
Partner/husband	12.2	6.2	14.6	14.8	16.3	16.0	0.0
TV/Radio/internet	9.1	14.5	7.0	6.7	6.0	7.3	17.9
Co-worker, colleagues, peers	4.2	3.3	4.4	4.8	3.8	6.1	4.9
Mother or father	2.5	4.8	1.9	1.0	1.7	1.9	4.6
Books	2.2	2.1	1.8	2.8	1.8	3.6	3.0
Newspapers, magazines, brochures, flyers	1.8	1.6	1.5	2.2	1.6	1.2	2.5
Teacher	0.8	1.6	0.6	0.5	0.4	0.5	2.1
Nurse, midwife, field worker, CHW	0.2	0.1	0.2	0.3	0.3	0.0	0.1
Other	1.5	1.7	1.4	1.4	1.4	0.8	2.1
Does not remember	1.0	1.2	1.1	0.9	1.0	0.5	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,123	1,854	2,319	1,950	4,050	378	1,695

Table 7.3 Opinions Regarding Contraceptive Effectiveness of Specific Methods Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Contraceptive Method*	Contraceptive Effectiveness					Total	No. of Cases
	Very Effective	Effective	Not Effective	Does Not Know	Never Heard		
Tubal ligation	16.3	17.9	0.4	4.6	60.7	100.0	6,292
IUD	29.5	43.1	1.7	13.2	12.5	100.0	6,292
Pill	10.1	53.3	2.3	15.5	18.9	100.0	6,292
Condoms	19.2	59.1	1.5	14.7	5.5	100.0	6,292
Calendar (rhythm) method	4.7	33.5	10.0	10.2	41.5	100.0	6,292
Withdrawal	3.4	23.9	8.6	7.2	56.8	100.0	6,292

* Listed in the descending order of contraceptive effectiveness when the method is used correctly and consistently (Hatcher et al., 1998).

Table 7.2.2 Most Important Source of Information About Contraceptive Methods Among Women Aged 15–44 Who Have Heard of at Least One Method of Contraception
Reproductive Health Survey: Georgia, 2010

Source	Total	Method of Contraception									
		Pill	IUD	Condoms	Spermicides	Tubal Ligation	Vasectomy	Injectables	Emergency Contraception	Calendar (Rhythm) Method	Withdrawal
Friends, boyfriend	32.1	39.8	37.8	41.9	35.2	33.8	11.6	15.1	27.9	46.4	37.4
Doctor	17.0	25.3	32.2	8.7	28.8	25.1	22.6	25.3	25.2	13.2	3.6
Relative	15.3	12.2	15.6	6.9	9.0	17.4	3.2	5.0	4.5	25.2	11.3
Partner/husband	12.2	0.1	0.2	17.1	0.6	0.3	0.4	0.3	0.3	0.6	39.3
TV/Radio/Internet	9.1	8.7	2.5	14.6	4.7	5.5	10.0	11.1	6.4	0.6	0.3
Co-worker, colleagues,	4.2	3.5	3.8	4.1	6.3	4.0	6.8	8.9	9.0	4.5	4.0
Mother or father	2.5	1.4	2.6	0.8	0.2	1.2	0.4	0.6	0.0	3.2	0.2
Books	2.2	2.8	1.9	1.3	5.4	6.1	28.0	15.4	13.0	2.5	1.5
Newspapers, magazines,	1.8	1.7	0.9	1.5	2.9	2.6	7.4	7.5	4.3	0.9	0.4
Teacher	0.8	1.2	1.0	0.8	2.2	2.4	8.4	6.5	4.5	1.0	0.4
Nurse, midwife, fieldcher,	0.2	0.2	0.1	0.0	0.1	0.2	0.0	0.3	0.3	0.3	0.1
Other	1.5	2.3	0.9	1.6	4.2	0.4	1.1	1.9	3.2	0.7	0.2
Does not remember	1.0	0.7	0.6	0.8	0.3	1.0	0.4	2.0	1.3	0.9	1.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,123	5,237	5,652	6,006	1,346	2,614	259	306	326	3,906	2,958

8 CHAPTER

CONTRACEPTIVE USE

This chapter begins by examining ever use of contraception, among all women regardless of marital status. Most use is among currently married women, discussed later, and some use is among previously married women; very little use occurs among the never married. Therefore the percentages ever using among all women, just below, are considerably less than the percentages for currently married women.

8.1 Ever use of contraceptives

In Georgia the percentages for ever use are not high, indicating that adoption of contraceptive use, particularly of methods of high efficacy, is quite recent. Also, the percentages for all women are depressed by the inclusion of unmarried women. However the trend since 1999 is of interest (Figure 8.1.1.; see also Table 8.1.1). The use of modern methods has increased regularly while that for traditional methods has declined. The net result is an increase in the overall percent who have ever used a method.

Note that an overlap exists between modern and traditional methods since some women have used both. Therefore the two figures cannot be added. The bars to the right show that in 2010 46% of all women had ever used a method, up from 38% in 1999. These percentages are much higher for married women as shown in Table 8.1.2.

The highest figures for ever use among all women are for ages 30 and higher (67%-70%), especially high for two or more children (82%-86%), upper education 51%-56%), and the highest wealth quintile (52%). Surprisingly there is very little difference according to ethnicity for any method, but Georgian women use modern methods more and traditional method less than the Azeri or Armenian women do. In Figure 8.1.2 ever use of any method ranged from a high of 49% in Shida Kartli to a low of 41% in Racha-Svaneti.

Notably, ever use of modern methods is higher than for traditional methods in nearly every category shown in Table 8.1.2. That pattern holds true for every age group, as shown in Figure 8.1.3.

In Table 8.1.3 the most commonly used methods ever used were condoms (20%), calendar (rhythm) method (17%), IUDs (16%) and withdrawal (15%). Regarding trends (Figure 8.1.4) between 1999 and 2010, the percentage of women who reported that their partner had ever used a condom almost doubled (from 10%, to 13%, to 20%). As a result, condoms became the most ever-used method in 2010, followed by the

Figure 8.1.1 Changes in Contraceptive Status in Georgia Among All Women Aged 15-44; 1999, 2005 and 2010

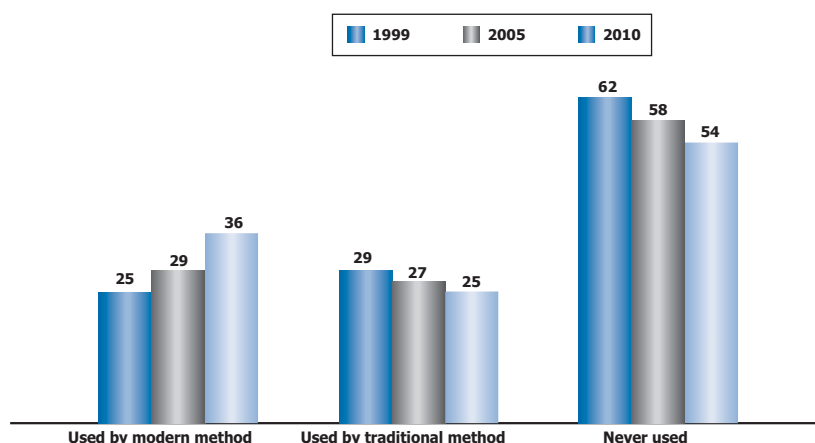


Figure 8.1.2 Ever-use of Any Contraception Among Women Aged 15-44 Years by Region

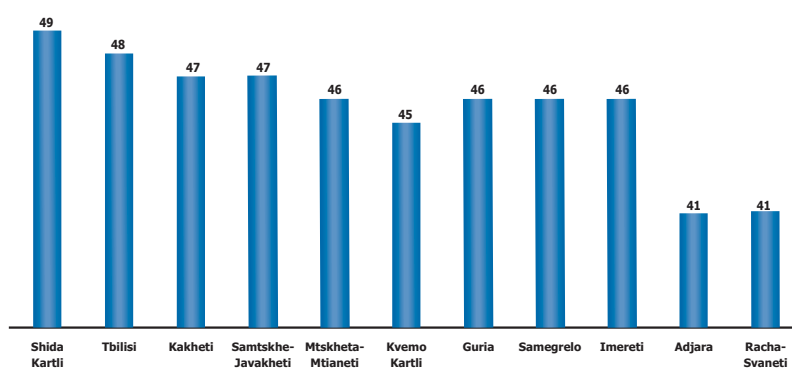
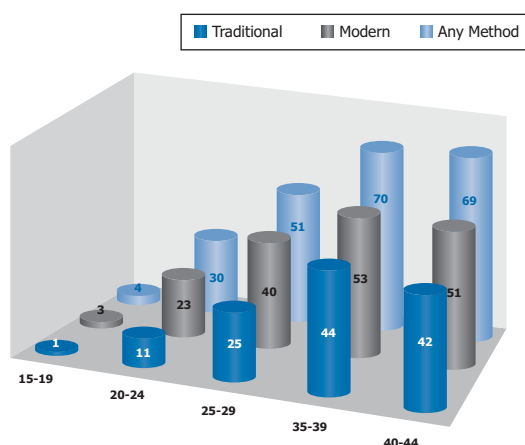


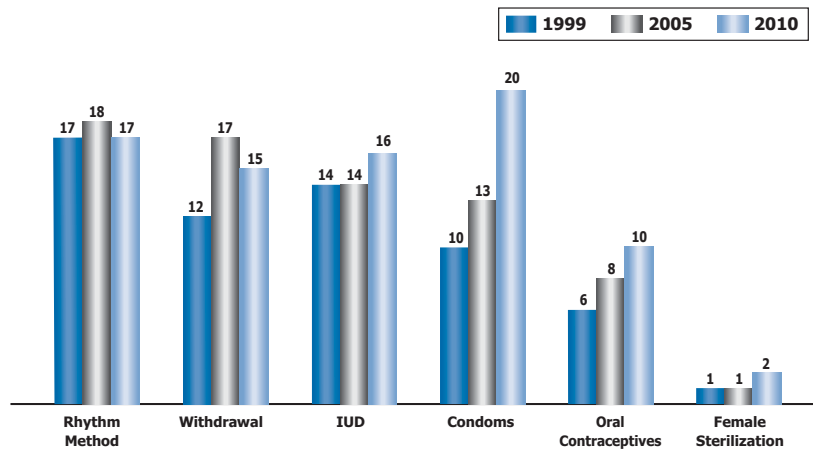
Figure 8.1.3 Ever-use of Contraception by Type of Method by Age Group Among All Women Aged 15-44



calendar (rhythm) method, which was reported as the leading method in the 1999 and 2005 surveys. The percentage of women who had ever used an IUD increased slightly (from 14% to 16%). Ever-use of the rhythm method appears to have plateaued between 1999 and 2010 at 17–18%. The percentage of women whose partner had ever used withdrawal decreased from 17% in 2005 to 15% in 2010, but was still higher

than the 1999 level of 12%. Ever use of oral contraceptives increased slightly but not significantly from 6% in 1999 to 8% in 2005 and 10% in 2010. The percentage who had ever used spermicide products, injectables, emergency contraception and tubal ligation did not increase or registered a small increase between 2005 and 2010. Only one woman reported that her partner had a vasectomy.

Figure 8.1.4 Ever-use of Specific Contraceptive Methods (%) Among All Women Aged 15-44:1999, 2005 and 2010



8.2 Current Use of Contraceptives

At the time of the survey, 32% of all women aged 15–44 years (or about 317,000 women) were currently using a contraceptive method including 21% (about 207,000 women) who were using modern methods (condoms, IUDs, pills, tubal ligation, and spermicides) (Table 8.2.1 and Figure 8.2.1). In general, the most commonly used method was the condom, followed by the IUD, withdrawal and the rhythm method (also known as the calendar method). Oral contraceptives were used by 2.4% of women and tubal ligation was used by 1.8%.

Contraceptive use by women in legal and consensual marriages is far higher than use by others because they represent the majority of sexually active women, have greater frequency of intercourse, and have higher fertility and risk of unplanned pregnancies. In Georgia, virtually all users of contraceptive methods are married, and currently 53% of married women

are currently using contraception, including 35% who were using modern methods. In contrast, use among those previously married is 6% and among those never married almost nonexistent. Virtually all previously married users employ modern methods (4% using condoms and 2% using long term or permanent methods of the IUD or tubal ligation).

These results may be explained by several factors. First, extramarital intercourse in Georgia is rare or denied by the majority of women as it is not acceptable by society. So unmarried women may deny not only use of contraception but also having sex at all. (Indirect evidence of this is in the male survey). Also, many women even subconsciously do not consider condom use by men as contraceptive use by themselves. And finally the higher figure of condom use reported by men than by women may be partially explained by a sharper physical memory by the male from using the method. All of these factors can help explain the differences between results obtained from the Male and

Figure 8.2.1 Current Use of Specific Contraceptive Methods by Marital Status

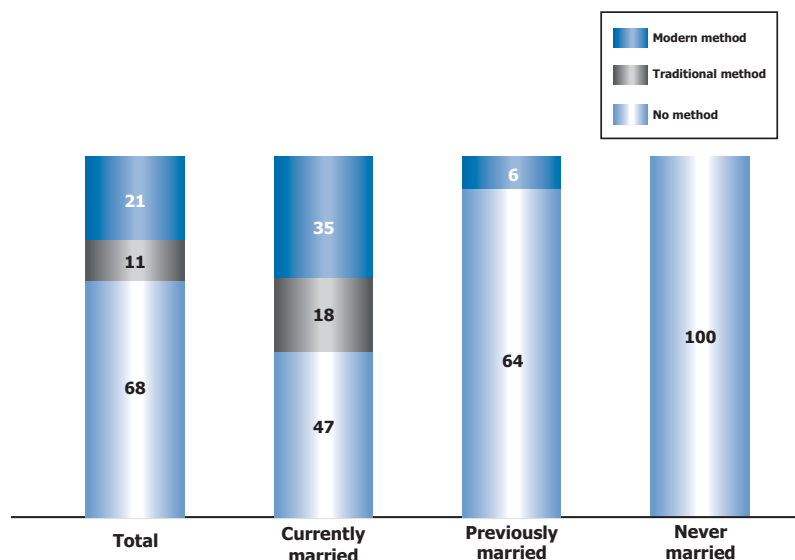


Figure 8.2.2 Current Contraceptive Prevalence Among Married Women Aged 15–44; Selected Countries in Eastern Europe and Eurasia

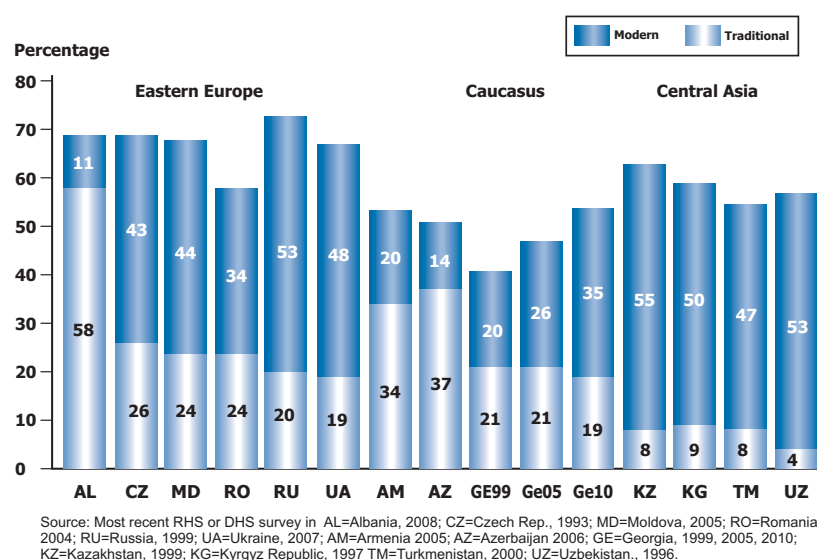
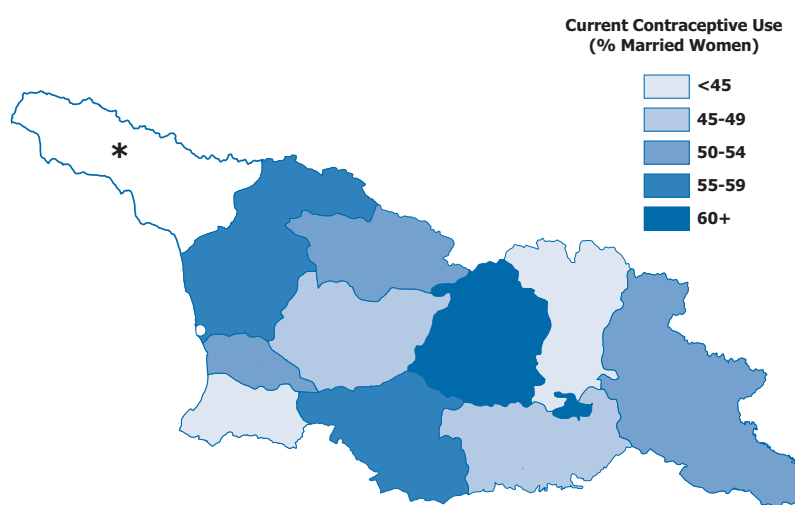


Figure 8.2.3 Current Use of Any Contraception by Region



* Abkhazia: Autonomous region not under government control

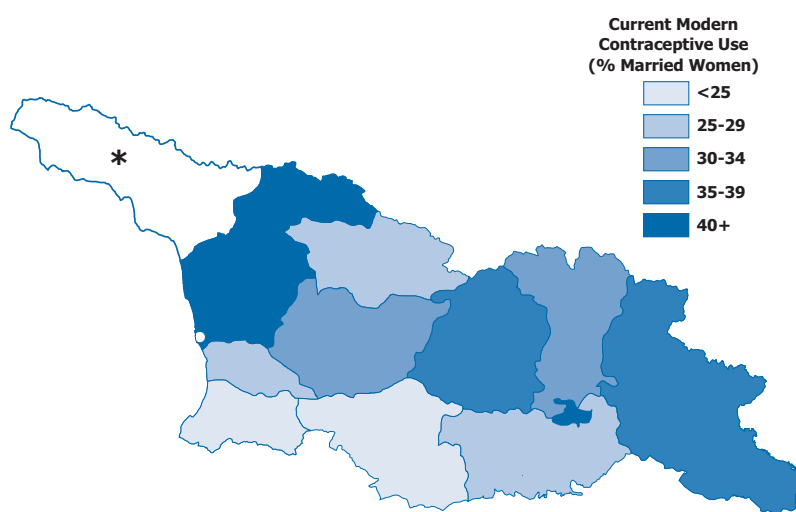
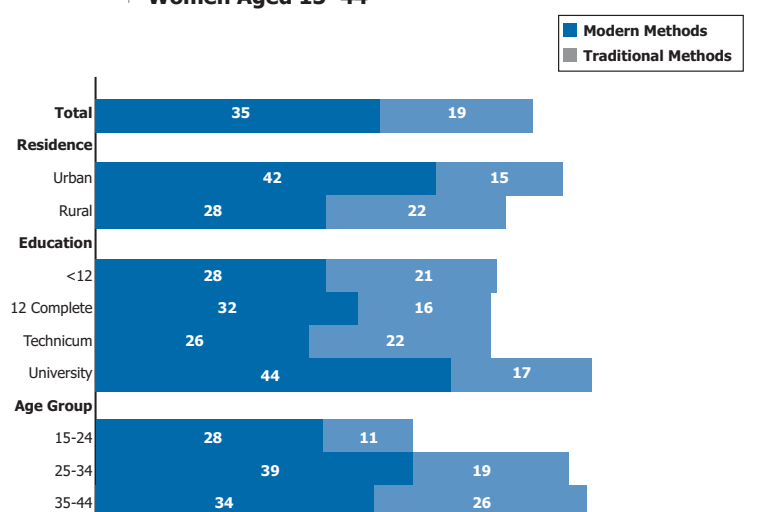
Women surveys, conducted nearly at the same time (2005): current use of modern methods as reported by men was 39.5% but by women only 27% due largely to differences for condom use: men 29% and women 5%. Usage of other methods by males is just 10%.

Despite the recent increase in current contraceptive use—from 41% in 1999 to 53% in 2010—Georgia continues to have one of the lowest contraceptive prevalence rates (CPR) in Eastern Europe and Eurasia (Figure 8.2.2).

In many Eastern European countries (i.e. Albania, Moldova, Russia, and Ukraine), around two-thirds of couples are using contraceptives, compared to Georgia's latest rate of 53%. The CPR in Georgia is comparable to the rates in Armenia in 2005 (54% of married women)

and Azerbaijan in 2006 (51% of married women), but the prevalence of modern methods is twice as high in Georgia. The use of modern methods in 2010 was comparable to the corresponding rate in Romania in 2004 (34%) but lower than the most recent available rates in Moldova, Ukraine, Russia, and Central Asia. The use of traditional methods in Georgia (19%) was higher in 2010 than in the Central Asian countries (ranging from 4% to 9%) and comparable to the rates in Ukraine and Russia.

Table 8.2.2 shows current use of modern and traditional contraception among married women aged 15–44, according to residence and region. As expected, urban women were more likely than their rural counterparts to be current users of contraceptives. In the urban areas, condoms were the most commonly used

Figure 8.2.4 Current Use of Modern Contraception, by Region**Figure 8.2.5** Current Use of Modern and Traditional Contraceptive Methods by Selected Characteristics Among Married Women Aged 15–44

method of contraception, surpassing rural use by 2.5 times.

Use of any method varied substantially by region, from lows of 44%–45% in Adjara and Mtskheta-Mtianeti to 61% in Tbilisi and Shida Kartli (Figure 8.2.3). Modern method use was especially high in Tbilisi at 46% (Table 8.2.2 and Figure 8.2.4). Excepting the regions of Samtskhe-Jahakheti and Adjara, couples in all other regions were more likely to use modern methods over traditional methods.

The most commonly used methods in most regions were the condom and IUD. Condom use was highest in Tbilisi (25%) and lowest in Adjara (5%). IUD use was highest in Shida Kartli, Samegrelo and Imereti (15%–16%). Use of oral contraceptives ranged from 1% in Samtskhe-Jahakheti to 9% in Samegrelo. Withdrawal

was most common in the Samtskhe-Jahakheti and Adjara regions (27% and 20%, respectively).

As shown in Table 8.2.3 and Figure 8.2.5, the highest rates of marital contraceptive use were among women aged 30–34, women with two children, women with a university-level education, and women of high socioeconomic status. Notably, women in each of these groups were more likely to be using a modern method of contraception than a traditional method. Childlessness and young adult age (15–24 years) were associated with the lowest contraceptive prevalence and lowest use of modern methods among married women. The use of any method increased substantially with the number of living children, from a low of 6% among childless women to over 60% among women with two or more children. Use of any method

Figure 8.2.6 Trends in Current Use of Contraception Among Married Women Aged 15-44: 1999, 2005 and 2010

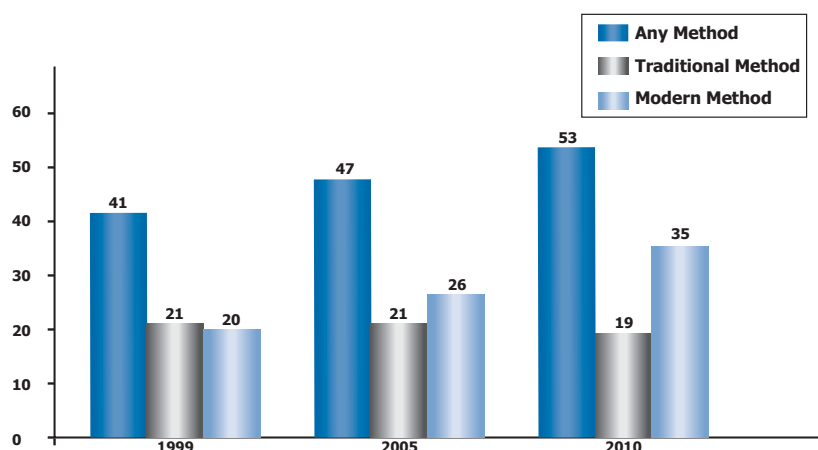
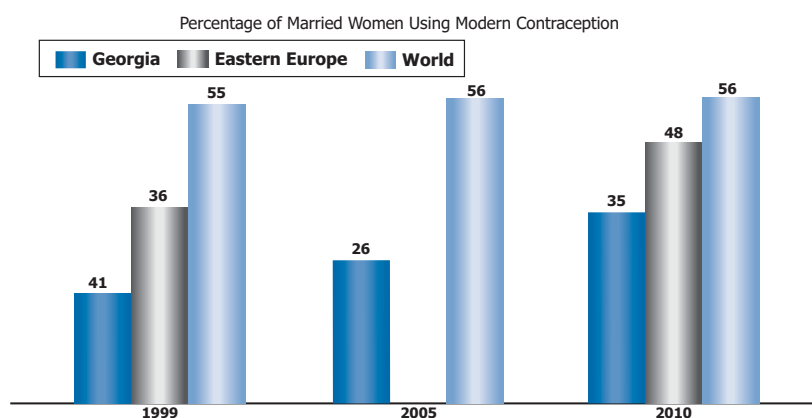


Figure 8.2.7 Trends in Current Use of Modern Contraception in Georgia Compared to Eastern Europe and World Average



Source: UN Department of Economics and Social Affairs, Population Division: World Contraceptive Use, 2010; SSSR Vestnik Statistiki, 1991; GERHS 1999, 2005 and 2010.

of contraception was slightly higher among Georgian women than among women of other ethnic backgrounds. The use of modern contraceptive methods was at least 50% higher among Georgians than among Azeri and Armenian women (37% vs. 23% and 20%, respectively).

The percentage of married women aged 15–44 years who were using contraception increased from 41% in 1999 to 45% in 2005 and 53% in 2010 (Table 8.2.4 and Figure 8.2.6). The use of modern contraceptive methods increased from 20% to 35% (a 75% increase). After 1999 the prevalence of modern methods exceeded the prevalence of traditional methods. As documented by the U.N., the adoption of modern methods of contraception in Georgia occurred at a much faster pace than elsewhere. In Figure 8.2.7, use of modern methods in Georgia increased by 75% (gain of 15% on base of 20%) compared to only 33% (gain of 12% on base of 36%) for the Eastern European region. At the same time, the world average remained unchanged.

According to the official Georgia figures for the population distribution by age and sex, the increase in modern contraceptive users after 1999 means that in 2010 there are almost 67,000 more women employing modern methods of contraception than there were in 1999. Such increases will mount year by year, with important implications for contraceptive forecasting and prevention of supply shortfalls, particularly at a time when donated contraceptive supplies are decreasing. Drawing upon the information in Table 8.2.2, Table 8.2.3, and Figure 8.2.8, differences in use can be described by method, for numerous subgroups of the population. There is an overall preference for condom use (14%), IUD (13%) and withdrawal (11%). Condom prevalence was much higher among urban than rural couples (20% vs. 8%) and it increased directly with education (from 7% of women with less than completed education to 21% of those with a university education) and with socioeconomic status (SES) of the household (from 7% of women living in low-SES households to 20% of women in high-SES households).

Figure 8.2.8 Current Use of Modern and Traditional Contraceptive Methods by Selected Characteristics Among Married Women Aged 15–44

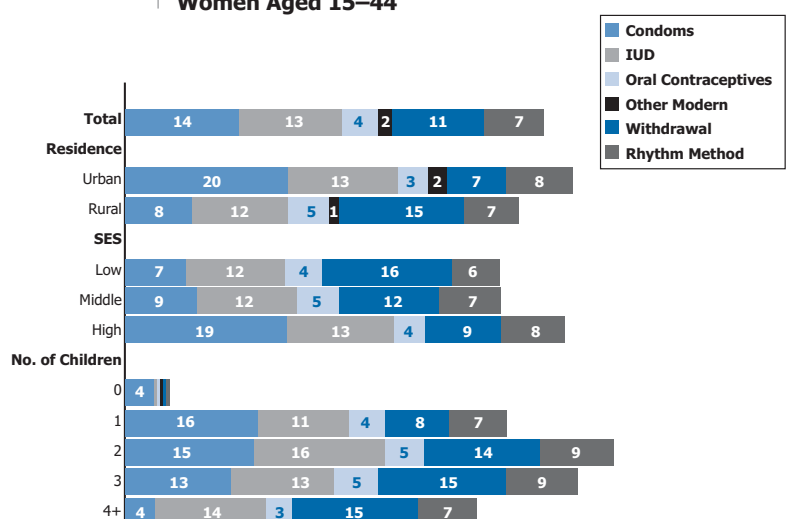
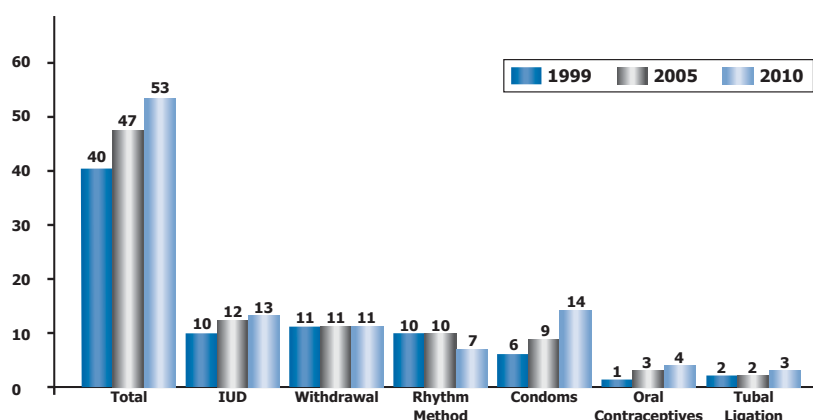


Figure 8.2.9 Trends in Contraceptive Prevalence, by Specific Methods among Married Women Aged 15–44 Years; 1999, 2005 and 2010



The only other modern method commonly used was the IUD; for which use was highest at 16% in Shida Kartli and 15% in Samegrelo and Imereti. IUD use increased somewhat though irregularly with age and number of living children. Use of withdrawal, the third most prevalent contraceptive method, was associated with rural residence (15%), incomplete secondary education (17%), low wealth quintile (18%), having two or more children (14%–15%) and being of Armenian or Azeri descent (26% and 20%, respectively). Popularity of withdrawal among Armenians was found also in the adolescent survey co-funded by the EU and UNFPA (RHIYC Project) in 2009. That comparative analysis of results from Adolescent Reproductive Health Surveys conducted in Armenia, Azerbaijan, and Georgia showed that both awareness and knowledge of withdrawal were highest among Armenian adolescents (96% and 95% respectively) and much less among Azeri (14% and 12%) and Georgian (35% and 10%) adolescents.

Prevalence of hormonal contraception remained low across all subgroups. The highest prevalence was reported by women in Samegrelo and Kakheti, probably due to recent regional family planning activities focused on increased use of hormonal methods, with support from donors. There was also an extremely low prevalence (3%) and lack of interest in tubal ligation, despite the fact that most married and fecund respondents reported that they wanted no more children. This is likely rooted in the lack of information about the method among family planning clients, as well as negative providers' attitudes, and limited provider training in modern sterilization techniques (i.e. mini-laparotomy for female sterilization and simpler vasectomy) (Tsertsvadze et al., 2010). Other modern methods (such as injectables, spermicides, and the diaphragm) were seldom used.

Data collected in the previous survey rounds in Georgia demonstrated a heavy reliance on traditional

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

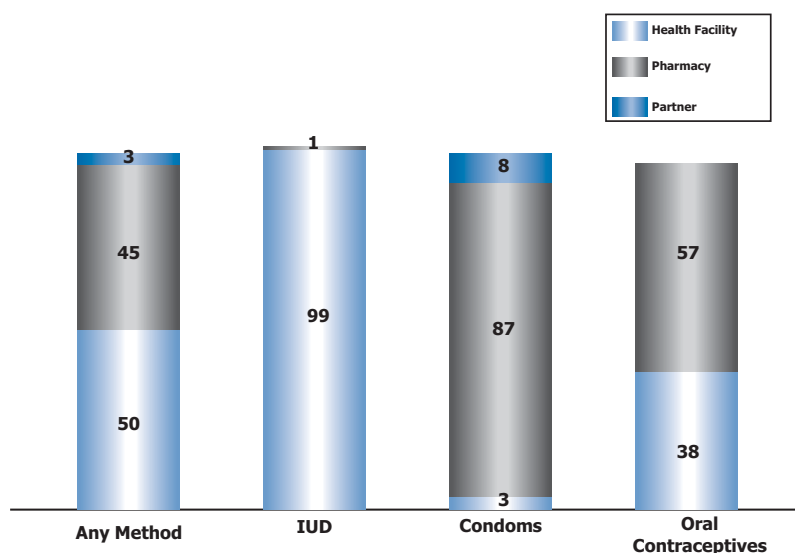
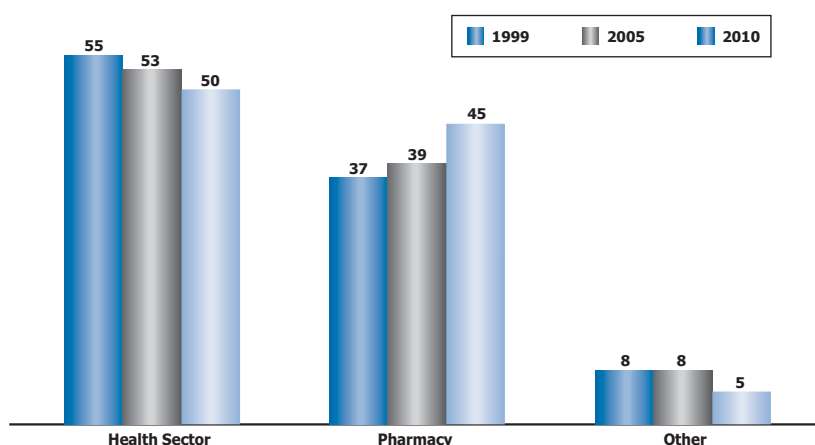


Figure 8.3.2 Source of Supply of Modern Contraceptive Methods Among Married Women Aged 15–44: 1999, 2005 and 2010



methods, especially withdrawal. However the 2010 survey showed a substantial increase in the use of modern methods while the use of traditional methods declined. Whereas withdrawal and the rhythm method were the leading methods in 1999, they were the second and third most prevalent methods in 2005 and the third and fourth most prevalent methods in 2010 (Figure 8.2.9).

From 1999 to 2010, condom use among couples increased 2.5 times (from 6% to 14%) and IUD use increased from 10% to 13%, becoming the first and second most used methods, respectively. Recent well-publicized upsurges in the prevalence of sexually transmitted infections and risk of HIV transmission may have contributed to the increase in condom use. The increase in IUD use is probably related to its cost-effectiveness and the desire to limit family size after having the intended number of children. Pill use, still very low, changed only from 3% in 2005 to 4% in 2010.

Increased use of condoms, IUDs, and oral contraceptives was solely responsible for the overall increase in contraceptive prevalence between 2005 and 2010. There were no noticeable changes in the use of other modern methods of contraception.

8.3 Source of contraception

Contraceptive supplies in Georgia are not subsidized by the government or by health insurance plans. Even the poorest segment of the population (800,000 persons, according to governmental estimates) does not benefit from subsidies for contraceptive services, although most other care is covered by the government via private insurance contributions. Through the concerted efforts of donors, primarily UNFPA and USAID, commodities are made available (either free of charge or for a small fee) in health clinics that provide family planning services.

Figure 8.4.1 Percentage of Women Who Desire to Switch to Another Contraceptive Method by Current Method Among Married Women Aged 15-44 Who Are Currently Using Contraceptives

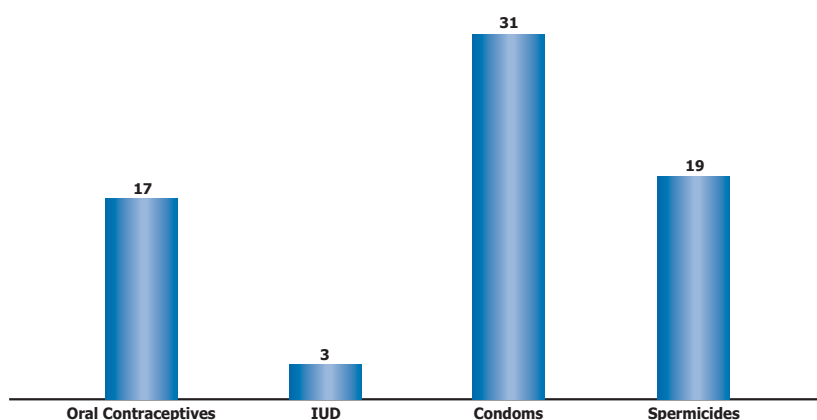


Figure 8.4.2 Most Commonly Cited Reasons for Not Currently Using Contraception, by Age Group Among Married Women Aged 15-44

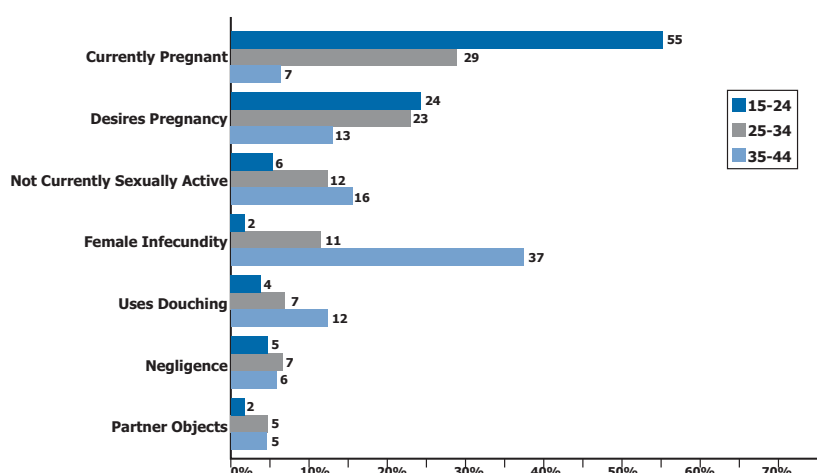


Table 8.3.1 presents the sources of contraception for currently married users of modern methods. The health care facilities were the principal source of modern contraceptives (50%). Commercial sales, specifically through pharmacies, were the second largest source of contraceptive supplies (45%), and "Other" sources covered 5%, to total 100% of all sources. Women's consultation clinics supplied 25% of contraceptive users while the hospital categories supplied 21%. The "Other" category included sources such as partners, friends and relatives, and the open market. Sources varied greatly according to the contraceptive method used. As shown in the bottom panel of the table, the medical sector was virtually the only source for IUDs (99%) and tubal ligation (97%). Pharmacies were the predominant source for methods which require periodic re-supply. They were the principal provider of condoms, supplying more than four fifths of women who reported their partners were using con-

doms. Pharmacies were also the leading source for spermicides (89%), other modern methods (73%), and over half of pill users (56%) (Figure 8.3.1).

Figure 8.3.2 shows changes in the sources of modern contraceptives between 1999, 2005 and 2010. In general, the changes are small. The participation of the medical sector declined from 55% (1999) to 53% (2005) and 50% (2010), while the participation of private pharmacies increased from 36% (1999) to 39% (2005) and 45% (2010).

It should be noted that sources of contraceptive supplies are not completely comparable with the data collected in the two previous surveys. In 2007 the Government of Georgia launched a comprehensive health care reform aimed at privatization of the system. The privatization of hospitals was regulated in the Hospital Development Master Plan (MoLHSA, Decree #11,

January 26, 2007), which called for complete replacement of the existing hospital infrastructure by a full transfer of ownership to the private sector. Primary health care services are also in various stages of privatization. The entire privatization process is planned to be completed by the end of 2012 (Chaturidze et al., 2009).

8.4 Desire to Use a Different Contraceptive Method

As shown in Table 8.4.1, only 16% of married users of modern methods (230 cases out of 1413) desired to use a different method, implying that 84% preferred their method to the available alternatives. A remarkable difference arose by method: only 3% of IUD users desired a change vs. a full 31% of condom users. Pill users were intermediate at 17% and spermicides at 19%. (Figure 8.4.1). The most frequently cited reasons (not shown) women gave for dissatisfaction with their current method included inconvenience, low effectiveness/method failure resulting in pregnancy, and proneness to forgetfulness.

The popularity of the IUD is reflected in the IUD column of Table 8.4.1, which shows it to be the most desired method among women who desired to switch methods (68%). Few women wanted to switch to tubal ligation (13%), pills (10%), or condoms (3%). No one wanted to change to the injectable, which is little known or available in Georgia.

The desire to change to the IUD was especially high in the lowest wealth quintile. It declined at older ages but was irregular with number of children. However the desire to use female sterilization rose sharply with number of children, reflecting an urgency for a reliable method to cease childbearing. Rural women also chose sterilization more than urban women.

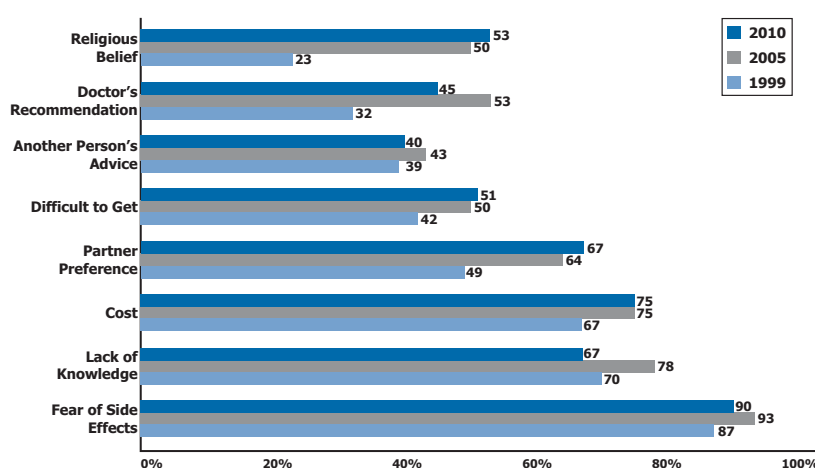
Nearly 77% of married women who were not using contraception at the time of the survey cited reasons related to pregnancy, fertility, or sexual activity. Most were currently pregnant (27%), desired pregnancy (20%), were infertile for medical (non contraceptive) or menopausal (19%) reasons, or had not had intercourse recently (12%). Additionally, 18% of the women gave “other” reasons for not using contraception at the time of the survey. Nearly 8% of women said they were using vaginal douching to avoid pregnancy, while another 6% declared that they just did not think about using a contraceptive method. Only 4% of the women stated that their husbands or partners objected to the use of contraception. These averages are shown by age in Figure 8.4.2. (Between 1999 and 2010 the percentage of married women who wanted to get pregnant soon increased by 50%, from 13% to 20%.)

Reasons for not using a method differed sharply by age group. Most young adult women were pregnant or seeking to become pregnant (79%), whereas women aged 35–44 years were not able to conceive because of either impaired fecundity (37%) or a lack of recent sexual activity (15%). It is worth mentioning that 13% of women aged 35–44 desired pregnancy, which is almost a three-fold increase compared to previous surveys, when only 4% and 5%, respectively, expressed such intentions.

8.5 Users of Traditional Methods

Of all current users of contraceptive methods, about a third (34%) use a traditional method, such as rhythm and/or withdrawal, which are the third and fourth most used of any contraceptive methods in Georgia. Among the various reasons that traditional users gave for preferring their methods to the alternative of mod-

Figure 8.5.1 Most Important Reasons for Not Using Modern Contraceptives Among Women Aged 15–44 Currently Using Traditional Methods: 1999, 2005 and 2010



ern methods, many cited fear of health problems or side effects associated with them. Others cited lack of knowledge about other methods; cost or poor availability of the methods; partner preferences; medical or other persons' advice against modern methods; and religious beliefs.

About 90% of respondents mentioned that fear of, or experience with, side effects from modern methods was an important or somewhat important factor (Table 8.5.1). Nearly 67% stated that they possessed little knowledge of modern methods, indicating the need for an information and education program on the advantages and disadvantages of using modern contraceptive methods. (Note that respondents could name multiple reasons, so they sum to over 100% in the table).

Cost was a factor for 75% of the respondents for not using a modern method, suggesting that the availability of subsidized contraception may help eliminate an important barrier to the use of modern methods. Difficulty in getting a modern method was mentioned by half (51%) of the users of traditional methods. This finding has programmatic implications in that it indicates that the geographic availability of modern methods in Georgia is not evenly distributed. A doctor's recommendation was a reason given by 45% of the women as to why they were using a traditional method, which suggests that modern methods may not always be brought up during the doctor-patient dialogue and that physicians may need professional updates on modern methods.

The husband's or partner's choice was given as a reason by 67% of respondents, indicating that information and education programs should focus on men as well as women. Religious beliefs were important

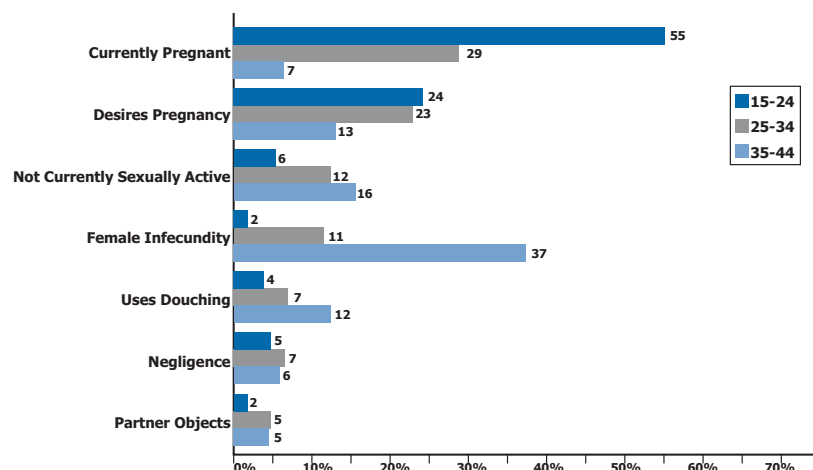
or somewhat important for 53% of these traditional method users.

Regarding subgroup differences, lack of knowledge of modern methods was a commonly cited reason for use of traditional methods among rural women, women aged 15-24 years, women with two children, women with a secondary or less education, and Armenian women. Similarly, the cost of modern methods was mentioned more often by rural women, as well as by women of least education and the lowest wealth quintile. Difficulty in getting a modern method was more frequently mentioned by women with least access to services in general: rural and low education women, and those in the low wealth quintiles, along with Armenian and Azeri women. Notably, nearly 50% of women aged 15-24 stated that they were using a traditional method on their doctor's recommendation; this is the same age group that mentioned lack of knowledge of modern methods as a reason for use of traditional methods. This suggests a need for doctors to talk to young women about the full range of contraceptive choices available to them.

Similar reasons for not using modern methods were cited by users of traditional methods in the 1999 and 2005 surveys (Figure 8.5.1). From 1999 to 2010, more women cited cost (from 67% to 75%), partner's preference (from 49% to 67%), religious beliefs (from 23% to 53%), doctor's recommendations (from 32% to 45%), and difficulty in getting a modern method (42% to 51%), as important reasons for not using modern contraceptives.

Users of traditional methods considered their current method more effective (29%) or equally effective (46%), compared with modern methods (Table 8.5.2). These are the same proportions as in 1999 and

Figure 8.6.1 Most Commonly Cited Reasons for Not Currently Using Contraception, by Age Group among Married Women Aged 15–44



2005. A response of “more effective” was given especially by women aged 35–44, women with secondary or less education, Georgian ethnicity, and women in the fourth highest wealth quintile. On the other hand, 16% considered their current method to be less effective than a modern method, and this did not vary much across the variables shown in Table 8.5.2, with the exceptions of the lower figures for the “other urban” group and the two top wealth quintiles, and the high figures for women with two children and Azeri women.

About 9% of respondents did not know or were unsure whether their current method was more or less effective than a modern method; this was much higher among the low education group and both Azeri and Armenian women, and tended to be higher at the lower wealth quintiles.

8.6 Reasons for Not Using Contraception

As shown in Table 8.6.1, nearly 77% of married women who were not using contraception at the time of the survey cited reasons related to pregnancy, fertility, or sexual activity. Most who were not using contraception were currently pregnant (27%), desired pregnancy (20%), were infertile for medical (non contraceptive) or menopausal (19%) reasons, or had not had intercourse recently (12%) (not shown). Additionally, almost 23% of the women gave “Other” reasons for not using contraception. Nearly 8% said they were using vaginal douching to avoid pregnancy, while another 6% declared that they just did not think about using a contraceptive method. Only 4% of the women stated that their husbands or partners objected to the use of contraception.

Table 8.6.1 shows the differences according to personal characteristics. The percent giving reasons relating

to pregnancy, fertility, or sexual activity was higher in urban than in rural areas, declined with age and number of children, but rose with education and wealth quintiles. It was very low in the Azeri group. All these patterns were reversed for “Other” reasons since the two totaled nearly 100% for each group.

Between 1999 and 2010 the percentage of all nonusers who wanted to get pregnant increased by about half, from 13% to 20%.

Reasons for not using a method differed sharply by age group (Figure 8.6.1). Most young adult women were pregnant or seeking to become pregnant (79%), whereas women aged 35–44 years were not able to conceive because of either impaired fecundity (37%) or a lack of recent sexual activity (16%). It is worth mentioning that 13% of women aged 35–44 desired pregnancy, which is almost a three-fold increase compared to 1999 and 2005, when only 4% and 5%, respectively, expressed that intention.

8.7 Intention to Use Contraceptives Among Non-users

As Table 8.7.1 shows, 30% of married respondents aged 15–44 who were not using any contraceptive method at the time of the survey said they planned to use a method in the next 12 months, while 17% planned to use a method sometime later. Thus, 47% plan to use a method, which is 9% higher than in 1999. As shown in Figure 8.7.1, planning to use a method in the next 12 months varied according to region, and was highest in the Adjara region and lowest in the Kvemo Kartli and Samtskhe-Javakheti regions.

Interestingly, about 22% of respondents were undecided as to whether they will use contraceptives in the

Figure 8.7.1 Intention to Use Contraception in the Next 12 Month Among Married Fecund Women Who Are Not Currently Using a Method, by Region

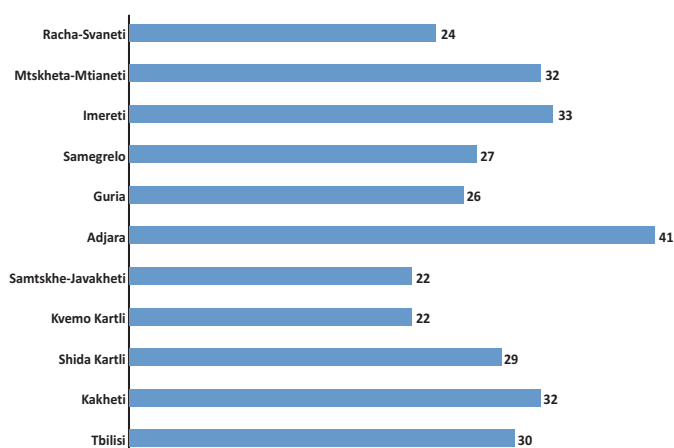
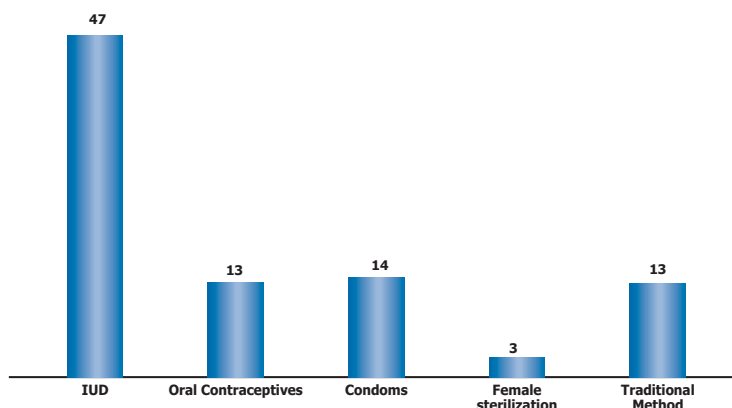


Figure 8.7.2 Preferred Method of Contraception Among Fecund Married Women Aged 15-44 Who Are Not Currently Using Contraception and Desire to Use in the Future



future, while a full third (32%) declared that they do not plan to use a method at any time. That is highest among women aged 35-44 years and women with three or more children (who include more infecund and sexually inactive women), and Azeri women.

In fact the desire to use a method in the next 12 months or at some point in the future was inversely associated with age and number of living children. Over three times more respondents aged 15-24 (72%) planned to use a method in the next 12 months or later than those aged 35-44 (21%). The percent planning to use fell regularly with the number of children from 50%-51% for 0-1 child to 44% for 2 children to only 37% for 3+ children. Further, for both age and number of children there was a decided shift toward using in the next 12 months rather than later, as age rose and number of children increased. These data suggest that the family planning program in Georgia should focus more promotion efforts on younger women and those with two or fewer children.

Among fecund married respondents who planned to use contraception in the future, the vast majority desired to use a modern method (Table 8.7.2). The method most desired was the IUD (47%), followed by condoms (14%), and pills (13%). An additional 3% preferred female sterilization. Regarding traditional methods, 6% of respondents planned to use the rhythm method, and 6.5% planned to use withdrawal.

Of the non-users who planned to use a modern method in the next 12 months or at some point in the future, 33% stated that they would obtain their method from a women's consultation clinic, while 37% would obtain their method from a pharmacy (Table 8.7.3). A women's consultation clinic is considered the best place to obtain an IUD (50%) but a pharmacy for getting pills (78%) and condoms/spermicides (92%).

8.8 Contraceptive Failure and Discontinuation

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

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

An estimated 10% of respondents became pregnant during the first year of using a method, 17% became

pregnant within 2 years, and 22% became pregnant within 3 years. Failure rates varied by type of contraceptive method - the IUD had the lowest failure rate at 1, 2, and 3 years: between 0.9% and 2.9% of IUD users became pregnant. Condom users reported failure rates of 5% during the first year, 10% within 2 years, and 14% within 3 years. Pill users reported failure rates of 7% during the first year, 10% within 2 years, and 16% within 3 years. The highest failure rates at 12, 24, and 36 months of use were reported by users of the rhythm method (21%, 33%, and 41%, respectively) and withdrawal (18%, 30%, and 37%, respectively), which highlights the need for increased information, education, and counseling efforts to promote correct use of more effective contraceptive methods.

Overall, 35% of respondents discontinued their method within 1 year, 53% within 2 years, and 64% within 3 years of use. The IUD was the only method with a low discontinuation rate at 1 year (9%), but 30% of IUD users had stopped using the method within 3 years (the lowest among all methods). Only 11% of IUD users (0.9/8.6 in the first year) discontinued the method because of method failure. In contrast, 52% of pill users discontinued their method during the first year and 81% within 3 years, despite the low failure rate of this method. As with the IUD, failure was a small proportion of the pill discontinuation rate at 14% during the first year (7.3/52.1). Condom discontinuation shows a similar pattern: 40% used the condom for less than 1 year and 69% for less than 3 years. Method failure accounted for 13% (5.2/40.4) of the reasons cited for

condom discontinuation. Withdrawal and the rhythm method were associated with very high discontinuation rates at one year (35%-37%), two years (54%-61%), and 3 years (66%-73%). Method failure was cited as the reason for more than one-half of those discontinuations (50%-57%). Of all those who discontinued a method, an unknown proportion became accidentally pregnant or switched to an alternative method.

In addition to method failure (13%), respondents discontinued a method for many other reasons (Table 8.8.2): the most cited reasons were desire to become pregnant (10%), partner's objections or temporary absence (8%), experienced or feared side effects (6%), negligence (4%) and switching to another method (4%). Note that the table gives "net" rates in the Total row but "gross" rates for all other rows, for the individual reasons.

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

**Table 8.1.1 Contraceptive Use Status Among All Women Aged 15-44
By Selected Characteristics
Reproductive Health Survey: Georgia, 2010**

Characteristic	Contraceptive Status			Total	No. of Cases
	Never Used	Previous User	Current User		
Total	53.5	14.5	32.0	100.0	6,292
Residence					
Urban	53.3	14.9	31.8	100.0	2,975
Rural	53.7	14.1	32.2	100.0	3,317
Region					
Kakheti	52.4	15.2	32.4	100.0	498
Tbilisi	51.9	16.2	31.9	100.0	1,426
Shida Kartli	50.3	11.6	38.1	100.0	392
Kvemo Kartli	55.3	13.1	31.6	100.0	546
Samtskhe-Javakheti	53.1	12.9	34.0	100.0	481
Adjara	55.8	15.3	29.0	100.0	419
Guria	54.8	11.2	34.0	100.0	401
Samegrelo	54.5	12.4	33.1	100.0	477
Imereti	54.5	14.7	30.7	100.0	805
Mtskheta-Mtianeti	53.6	17.9	28.5	100.0	393
Racha-Svaneti	58.3	11.5	30.2	100.0	454
Marital Status					
Legally married	27.1	19.4	53.5	100.0	4,011
Consensual union	41.8	10.3	47.9	100.0	87
Previously married	45.6	48.1	6.3	100.0	389
Never married	99.9	0.1	0.0	100.0	1,805
Age Group					
15-19	96.5	1.4	2.2	100.0	861
20-24	71.1	8.0	20.9	100.0	1,099
25-29	49.1	12.2	38.7	100.0	1,191
30-34	32.5	19.0	48.5	100.0	1,168
35-39	30.1	21.6	48.2	100.0	1,051
40-44	31.3	29.3	39.4	100.0	922
Number of Living Children					
0	97.0	1.9	1.1	100.0	2,276
1	36.0	23.4	40.6	100.0	1,286
2	17.3	22.1	60.6	100.0	2,069
3 or more	14.3	27.2	58.5	100.0	661
Education Level					
Secondary incomplete or less	66.4	10.0	23.6	100.0	1,330
Secondary complete	54.1	14.5	31.4	100.0	1,568
Technicum	44.3	21.0	34.7	100.0	903
University/postgraduate	48.8	15.0	36.2	100.0	2,491
Wealth Quintile					
Lowest	55.6	14.8	29.6	100.0	1,093
Second	53.8	13.6	32.6	100.0	1,385
Middle	53.2	13.2	33.5	100.0	1,413
Fourth	59.2	13.3	27.5	100.0	1,037
Highest	48.2	17.0	34.8	100.0	1,364
Ethnicity					
Georgian	53.3	14.6	32.1	100.0	5,488
Azeri	54.0	13.6	32.4	100.0	276
Armenian	55.2	14.7	30.1	100.0	364
Other	54.5	14.7	30.9	100.0	164

Table 8.1.2 **Ever-Use of Contraceptive Methods by Type of Method Used**
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Contraceptive Status			No. of Cases
	Any Method	Any Modern Method	Any Traditional Method	
Total	46.5	36.3	25.5	6,292
Residence				
Urban	46.9	39.7	22.9	2,975
Rural	46.1	32.6	28.4	3,317
Region				
Kakheti	47.3	38.6	26.4	498
Tbilisi	48.2	42.2	23.9	1,426
Shida Kartli	49.3	37.5	27.2	392
Kvemo Kartli	44.7	30.3	28.4	546
Samtskhe–Javakheti	46.7	26.9	39.3	481
Adjara	44.2	26.5	25.6	419
Guria	45.6	31.8	27.4	401
Samegrelo	45.9	40.0	19.2	477
Imereti	45.7	37.1	23.3	805
Mtskheta–Mtianeti	46.0	37.6	26.2	393
Racha–Svaneti	41.0	28.8	26.8	454
Marital Status				
Legally married	72.7	56.5	40.3	4,011
Consensual union	57.1	44.7	30.8	87
Previously married	53.8	44.5	26.8	389
Never married	0.6	0.5	0.1	1,805
Age Group				
15–19	3.6	3.1	0.7	861
20–24	29.3	23.5	11.4	1,099
25–29	51.0	39.7	25.2	1,191
30–34	67.4	55.1	37.0	1,168
35–39	69.6	53.5	43.8	1,051
40–44	68.5	50.7	41.9	922
Number of Living Children				
0	3.3	3.0	0.8	2,276
1	63.8	50.6	29.0	1,286
2	82.5	64.7	48.3	2,069
3 or more	85.7	62.6	53.0	661
Education Level				
Secondary incomplete or less	33.7	23.3	18.3	1,330
Secondary complete	45.9	32.7	26.5	1,568
Technicum	55.6	43.0	32.5	903
University/postgraduate	51.2	43.9	26.6	2,491
Wealth Quintile				
Lowest	44.4	27.2	30.1	1,093
Second	45.8	32.7	26.7	1,385
Middle	46.8	37.5	25.3	1,413
Fourth	41.3	32.7	21.4	1,037
Highest	51.7	45.8	25.0	1,364
Ethnicity				
Georgian	46.7	37.5	24.7	5,488
Azeri	45.8	26.3	29.1	276
Armenian	44.8	25.6	35.3	364
Other	45.5	37.5	24.2	164

Table 8.1.3 Ever-Use of Contraceptive Methods by Method and Age Group Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Age Group	Method of Contraception										No. of Cases
	Condom	Calendar (Rhythm) Method	IUD	Withdrawal	Pill	Spermicides	Tubal Ligation	Emergency Contraception	Injectables	Vasectomy	
15–19	2.0	0.3	0.7	0.5	0.8	0.2	0.0	0.0	0.0	0.0	861
20–24	13.9	5.9	7.0	7.3	6.1	1.7	0.3	0.2	0.1	0.0	1,099
25–29	21.3	14.9	15.6	15.8	11.1	3.6	0.9	0.0	0.0	0.1	1,191
30–34	30.6	24.1	23.0	19.9	17.5	6.9	2.5	0.6	0.4	0.0	1,168
35–39	29.3	30.6	25.4	26.1	15.7	4.8	3.4	0.3	0.5	0.0	1,051
40–44	23.4	30.5	30.2	23.6	12.7	4.5	4.9	0.6	0.1	0.0	922
Total	19.5	16.8	16.2	14.9	10.3	3.5	1.9	0.3	0.2	0.0	6,292

Table 8.2.1 Percent Using Contraception by Marital Status and Method
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Contraceptive Status	All Women	Marital Status		
		Married	Previously Married	Never Married
Any Method	32.0	53.4	6.3	0.0
Modern Methods	20.9	34.7	6.1	0.0
Pill	2.4	4.1	0.3	0.0
IUD	7.5	12.5	0.9	0.0
Condoms	8.3	13.6	3.8	0.0
Spermicides	0.9	1.5	0.0	0.0
Tubal ligation	1.8	2.9	1.1	0.0
Other modern methods	0.0	0.1	0.0	0.0
Traditional Methods	11.0	18.5	0.2	0.0
Calendar (Rhythm) method	4.4	7.4	0.2	0.0
Withdrawal	6.6	11.1	0.0	0.0
Not Currently Using	68.0	46.6	93.7	100.0
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	4,098	389	1,805

Table 8.2.2 Percent Using Modern and Traditional Contraception by Residence and Region
Among Married Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Any Method	Modern Method						Traditional Method			No. of Cases
		Condom	IUD	Pill	Tubal Ligation	Other	Any Modern Method	With-drawal	Calendar (Rhythm) Method	Any Traditional Method	
Total	53.4	13.6	12.5	4.1	2.9	1.7	34.8	11.1	7.4	18.6	4,098
Residence											
Urban	56.9	19.5	13.3	3.4	3.0	2.4	41.5	7.1	8.1	15.3	1,806
Rural	50.0	7.9	11.8	4.7	2.8	1.1	28.2	15.0	6.6	21.7	2,292
Region											
Kakheti	50.6	11.5	14.5	7.5	1.0	3.0	36.2	6.2	7.0	14.5	348
Tbilisi	60.9	25.4	13.3	2.5	2.0	2.7	46.0	5.9	9.0	14.9	815
Shida Kartli	61.3	13.2	15.8	1.9	3.2	1.9	36.1	10.6	14.5	25.2	266
Kvemo Kartli	48.9	9.5	10.1	2.5	2.3	1.1	25.5	15.1	8.3	23.4	375
Samtskhe–Javakheti	55.6	11.4	7.6	1.3	1.0	0.8	22.1	26.6	6.9	33.5	331
Adjara	44.4	5.0	9.4	3.6	3.6	0.3	21.8	19.8	2.8	22.6	292
Guria	53.5	9.4	9.7	6.0	2.8	1.9	29.9	17.0	6.6	23.6	276
Samegrelo	57.0	12.2	14.8	8.6	6.5	1.2	43.3	9.5	4.2	13.6	302
Imereti	49.0	9.1	14.8	4.7	4.4	1.5	34.4	8.3	6.3	14.6	540
Mtskheta–Mtianet	44.7	12.0	7.2	7.2	1.8	2.4	30.6	7.5	6.6	14.1	270
Racha–Svaneti	52.3	13.5	10.5	1.5	2.5	0.3	28.3	14.8	9.2	24.0	283

Table 8.2.3 Percent Using Modern and Traditional Contraception by Method and Selected Characteristics Among Married Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Any Method	Not Using	Modern Methods						Traditional Methods			No. of Cases
			Condom	IUD	Pill	Tubal Ligation	Other	Subtotal Modern	Withdrawal	Calendar (Rhythm) Method	Subtotal Traditional	
Total	53.4	46.6	13.6	12.5	4.1	2.9	1.7	34.8	11.1	7.4	18.6	4,098
Age Group												
15–19	20.4	79.6	6.5	5.3	3.7	0.0	0.7	16.2	2.6	1.5	4.2	124
20–24	42.7	57.3	13.0	11.1	4.3	0.5	1.3	30.2	8.6	4.0	12.5	610
25–29	53.9	46.1	16.9	12.7	5.3	1.3	1.7	37.9	10.2	5.8	16.0	863
30–34	61.0	39.0	15.8	12.9	5.2	3.0	2.7	39.4	11.9	9.5	21.6	948
35–39	59.8	40.2	12.5	14.5	3.8	3.8	1.6	36.0	14.5	9.2	23.8	836
40–44	51.3	48.7	10.6	12.1	1.7	6.2	1.5	31.8	11.0	8.3	19.4	717
Number of Living Children												
0	5.8	94.2	3.5	0.3	0.4	0.0	0.5	4.7	0.3	0.8	1.1	409
1	47.4	52.6	15.8	11.2	4.2	0.3	1.5	33.0	7.6	6.8	14.5	1,106
2	64.0	36.0	15.4	15.8	4.6	3.4	2.1	41.1	14.0	8.7	22.9	1,956
3 or more	61.7	38.3	11.0	12.8	4.6	7.8	1.8	37.9	15.4	8.3	23.7	627
Education Level												
Secondary incomplete or	50.7	49.3	4.7	15.4	5.0	2.2	1.1	28.4	17.0	5.3	22.3	726
Secondary	47.7	52.3	9.3	10.0	4.9	2.8	0.9	27.8	13.5	6.3	19.9	1,119
Technicum	48.4	51.6	12.7	9.6	2.8	4.9	2.4	32.2	7.7	8.4	16.2	673
University/postgraduate	60.5	39.5	20.9	14.2	3.7	2.5	2.4	43.5	8.3	8.5	17.0	1,580
Wealth Quintile												
Lowest	46.7	53.3	5.6	10.5	4.4	1.9	0.4	23.0	17.5	6.2	23.7	727
Second	50.4	49.6	7.8	13.3	4.4	2.4	1.0	28.6	14.1	7.5	21.9	966
Middle	53.8	46.2	11.3	12.4	5.5	4.4	2.1	35.6	11.5	6.6	18.3	952
Fourth	51.0	49.0	14.5	10.7	3.7	2.6	3.0	34.4	8.4	8.1	16.6	623
Highest	61.4	38.6	25.3	14.5	2.6	2.9	2.0	47.3	6.0	8.1	14.1	830
Ethnicity												
Georgian	54.3	45.7	14.6	13.1	4.0	3.2	1.8	36.5	9.8	8.0	17.9	3,521
Azeri	44.9	55.1	0.8	14.0	6.5	1.7	0.0	23.0	19.8	2.1	21.8	219
Armenian	50.7	49.3	11.4	4.5	1.0	1.6	2.0	20.4	25.8	4.4	30.2	249
Other	48.0	52.0	15.4	7.7	8.0	0.9	3.8	35.9	6.8	5.3	12.1	109

Table 8.2.4 **Percent Using Contraceptive Use by Year and Method**
Among Married Women Aged 15–44
Reproductive Health Surveys: Georgia, 1999, 2005 and 2010

Contraceptive Status	Survey Year		
	1999	2005	2010
Any Method	40.5	47.3	53.4
Modern Methods	19.8	26.6	34.7
Pill	1.0	3.2	4.1
IUD	9.7	11.6	12.5
Condom	6.3	8.7	13.6
Spermicides	0.1	0.9	1.5
Tubal Ligation	1.6	2.2	2.9
Injectables	0.0	0.0	0.0
Other modern methods	1.0	0.0	0.1
Traditional Methods	20.7	20.7	18.5
Calendar (Rhythm) method	10.2	9.5	7.4
Withdrawal	10.5	11.2	11.1
Not Currently Using	59.5	52.7	46.6
No. of Cases	5,177	4,119	4,098

Table 8.3.1 Source of Supply for Modern Methods by Selected Characteristics Among Married Women Aged 15–44 Who Are Currently Using Modern Methods
Reproductive Health Survey, Georgia, 2010

Characteristic	Health Sector						Pharmacy	Other						Total	No. of Cases
	Subtotal Health Sector	Women's Consultation Clinic	City Hospital	Regional Hospital	Primary Health Care Clinic/Center	Referral Hospital	Mobile Clinic	Subtotal Other	Partner/Husband	Friend	Relative	Open Market	Other	Does Not Know	
Total	50.0	24.6	11.6	9.1	4.0	0.6	0.2	44.8	3.3	0.4	0.3	0.2	1.0	0.0	1,413
Residence															
Tbilisi	34.7	23.5	6.8	0.5	1.8	1.6	0.5	59.8	4.6	0.7	0.0	0.0	0.2	0.0	379
Other Urban	51.9	32.1	11.5	5.2	2.8	0.2	0.0	44.2	2.9	0.2	0.2	0.0	0.5	0.0	373
Rural	60.4	20.4	15.2	18.2	6.4	0.1	0.1	33.7	2.6	0.3	0.6	0.6	1.9	0.1	661
Age Group															
15–24	43.8	24.2	12.3	4.5	2.8	0.0	0.0	48.3	5.6	0.0	0.9	0.0	1.3	0.3	211
25–34	46.2	22.6	9.1	7.8	5.5	1.0	0.3	49.8	3.1	0.3	0.3	0.0	0.3	0.0	687
35–44	56.8	27.1	14.2	12.4	2.6	0.4	0.1	37.5	2.6	0.6	0.1	0.6	1.8	0.0	515
Education Level															
Secondary incomplete or less	70.0	31.1	9.2	22.5	6.8	0.0	0.4	26.2	1.1	0.0	0.5	0.0	2.3	0.0	199
Secondary complete	52.6	24.5	12.9	9.7	3.9	1.3	0.3	40.6	3.6	0.0	0.2	1.0	1.7	0.2	324
Technicum	49.2	18.7	15.4	11.8	3.3	0.0	0.0	46.0	3.9	0.4	0.4	0.0	0.0	0.0	208
University/postgraduate	43.2	24.4	10.5	4.0	3.3	0.7	0.1	51.7	3.6	0.6	0.3	0.0	0.6	0.0	682
Wealth Quintile															
Lowest	58.7	22.0	9.8	22.0	5.0	0.0	0.0	30.8	1.9	0.6	1.8	2.2	3.8	0.0	168
Second	62.4	23.8	12.5	19.8	5.9	0.0	0.3	32.8	3.4	0.2	0.4	0.0	1.0	0.0	284
Middle	56.3	22.2	15.8	12.5	5.7	0.0	0.0	39.3	3.0	0.3	0.0	0.0	0.9	0.2	336
Fourth	45.8	28.5	10.2	2.7	3.8	0.5	0.0	50.5	3.7	0.0	0.4	0.0	0.9	0.0	227
Highest	38.4	25.4	9.3	0.2	1.5	1.6	0.4	56.4	4.3	0.7	0.0	0.0	0.2	0.0	398
Ethnicity															
Georgian	49.6	25.0	11.6	8.6	3.6	0.7	0.2	45.5	3.1	0.3	0.4	0.3	0.8	0.0	1,274
Azeri	82.9	28.6	15.9	23.4	15.0	0.0	0.0	10.2	0.0	0.0	0.0	0.0	6.8	0.0	52
Armenian	29.9	15.4	9.3	5.2	0.0	0.0	0.0	58.8	10.0	0.0	0.0	0.0	0.0	1.3	45
Other	34.0	14.5	7.4	6.8	3.5	0.0	1.7	58.8	4.8	2.4	0.0	0.0	0.0	0.0	42
Modern Method Used*															
Pill	37.5	15.9	5.1	5.7	10.7	0.0	0.0	56.3	0.0	0.6	1.2	0.0	4.4	0.0	176
IUD	99.0	60.0	14.5	18.2	5.2	1.1	0.0	0.4	0.0	0.0	0.2	0.0	0.4	0.0	498
Condoms	3.2	1.4	0.2	0.0	1.1	0.0	0.5	86.7	8.4	0.6	0.3	0.6	0.2	0.1	565
Spermicides	9.1	6.9	2.2	0.0	0.0	0.0	0.0	89.4	0.0	1.4	0.0	0.0	0.0	0.0	66
Tubal Ligation	97.0	1.9	65.9	21.7	4.8	2.8	0.0	0.0	0.0	0.0	0.0	0.0	3.0	0.0	103

* Excludes 5 women who were using other modern methods.

Table 8.4.1 Desire to Use a Different Contraceptive Method and Preferred Method by Selected Characteristics Among Married Women Aged 15–44 Who Are Currently Using Modern Methods
Reproductive Health Survey: Georgia, 2010

Characteristic	Desires to Use a Different Method		Preferred Method of Contraception								
	Percent	All Users	IUD	Tubal Ligation	Pill	Condoms	Spermicides	Calendar (Rhythm) Method	Others/Does Not Know	Total	No. of Cases
Total	15.8	1,413	68.3	12.5	10.4	2.5	2.2	2.3	1.8	100.0	230
Residence											
Tbilisi	19.6	379	68.6	11.6	9.3	2.3	1.2	4.7	2.3	100.0	77
Other Urban	13.6	373	72.1	5.7	12.1	4.1	2.1	1.7	2.1	100.0	56
Rural	14.4	661	65.6	17.6	10.4	1.7	3.4	0.3	1.0	100.0	97
Age Group											
15–24	17.6	211	84.2	2.7	6.5	2.9	0.0	0.0	3.7	100.0	42
25–34	17.9	687	68.7	13.1	10.5	2.0	2.6	1.8	1.2	100.0	126
35–44	12.6	515	59.0	16.7	12.3	3.1	2.7	4.4	1.7	100.0	62
Number of Living Children											
0–1	15.7	388	70.4	7.1	18.0	1.8	0.0	2.1	0.6	100.0	69
2	16.7	799	65.3	13.5	8.5	3.5	3.8	3.0	2.5	100.0	134
3 or more	13.3	226	76.1	18.3	4.5	0.0	0.0	0.0	1.1	100.0	27
Education Level											
Secondary incomplete or less	7.5	199	*	*	*	*	*	*	*	100.0	16
Secondary complete	13.0	324	70.5	13.5	2.8	8.0	5.3	0.0	0.0	100.0	43
Technicum	18.2	208	84.1	7.7	5.2	0.3	0.0	0.0	2.7	100.0	38
University/postgraduate	18.8	682	66.4	11.7	13.3	1.1	1.5	4.0	2.0	100.0	133
Wealth Quintile											
Lowest	17.3	168	87.8	7.4	3.3	0.0	0.0	0.0	1.5	100.0	27
Second	11.8	284	67.2	16.5	1.7	3.7	10.1	0.8	0.0	100.0	36
Middle	14.7	336	58.5	21.2	13.3	0.8	1.9	1.9	2.4	100.0	55
Fourth	17.6	227	70.8	5.2	10.3	5.2	2.7	5.0	0.9	100.0	37
Highest	17.4	398	67.1	11.3	14.0	2.6	0.0	2.5	2.6	100.0	75
Current Use of Contraception											
Pill	17.4	176	78.2	0.0	NA	11.0	7.3	3.1	0.4	100.0	29
IUD	2.6	498	NA	*	*	*	*	*	*	100.0	13
Condoms	30.6	565	71.5	11.4	11.5	NA	1.1	1.8	2.1	100.0	173
Spermicides	18.8	66	75.6	8.7	15.7	0.0	NA	0.0	0.0	100.0	13
Tubal Ligation	0.0	103	*	*	*	*	*	*	*	100.0	0
Other modern methods	21.6	5	*	*	*	*	*	*	*	100.0	2
Has Concerns About Current Method											
Yes	66.3	128	62.0	18.8	11.4	3.8	2.3	0.0	1.7	100.0	85
No	11.0	1,285	71.9	8.8	9.8	1.8	2.1	3.7	1.8	100.0	145

* Less than 25 cases.

NA: not applicable; same method as currently used.

Table 8.5.1 Selected Factors That Were Important or Somewhat Important in Deciding to Use a Traditional Method Instead of a Modern Method, by Selected Characteristics Among Married Women Aged 15–44 Who Currently Use Traditional Methods – Reproductive Health Survey: Georgia, 2010

Characteristic	Selected Factors								No. of Cases
	Fear of or Experience With Side Effects	Little Knowledge of Modern Methods	Cost	Husband/ Partner's Choice	Doctor's Recommendation	Religious Beliefs	Difficult to Get a Modern Method	Another Persons Advice	
Total	89.8	66.6	74.8	66.7	45.3	52.9	50.8	40.1	797
Residence									
Tbilisi	90.1	65.5	66.9	66.9	41.5	59.9	35.2	46.5	123
Other Urban	88.5	57.2	66.6	65.7	45.3	56.2	38.4	41.1	159
Rural	90.1	70.3	80.4	67.0	46.6	49.5	60.3	37.7	515
Age Group									
15–24	86.0	70.8	68.2	70.4	50.1	58.8	48.3	43.0	88
25–34	89.3	65.9	76.8	65.5	45.6	50.1	51.5	40.2	358
35–44	91.1	66.2	74.7	66.9	44.0	54.1	50.7	39.3	351
Number of Living Children									
0–1	84.1	61.6	66.7	64.6	42.3	47.5	44.3	39.1	166
2	91.0	68.5	76.8	63.3	44.1	52.7	52.5	40.7	472
3 or more	92.3	66.5	77.7	78.1	52.0	59.1	52.6	39.7	159
Education Level									
Secondary incomplete or less	88.8	69.2	80.4	72.5	50.0	51.1	59.3	44.0	169
Secondary	87.7	73.1	74.0	70.7	41.3	48.5	56.8	34.7	238
Technicum	89.6	59.3	75.5	52.9	35.1	42.8	48.0	41.0	128
University/ postgraduate	92.1	62.6	71.9	65.3	49.8	61.4	42.0	41.9	262
Wealth Quintile									
Lowest	88.1	69.9	86.6	63.4	47.8	47.6	59.4	33.1	179
Second	88.1	66.9	77.3	65.6	42.6	51.6	61.8	43.8	211
Middle	93.2	69.3	76.7	68.2	46.7	48.8	52.2	36.6	191
Fourth	89.0	61.5	71.2	67.9	45.5	57.9	45.6	40.0	105
Highest	90.3	63.5	59.5	68.7	44.7	61.4	29.0	47.1	111
Ethnicity									
Georgian	91.4	65.5	74.3	65.7	46.9	57.0	48.4	40.6	651
Azeri	66.3	66.3	70.2	58.9	32.3	43.8	62.5	41.9	46
Armenian	92.9	77.5	82.3	80.0	36.8	27.2	65.0	30.8	86
Other	*	*	*	*	*	*	*	*	14

* Less than 25 cases.

Table 8.5.2 Perceived Effectiveness of Traditional Methods Compared to Modern Methods by Selected Characteristics Among Married Women Aged 15–44 Who Currently Use Traditional Methods – Reproductive Health Survey: Georgia, 2010

Characteristic	Perceived Effectiveness				Total	No. of Cases
	Current Method More Effective	About Equally Effective	Current Method Less Effective	Does Not Know/Not Sure		
Total	28.9	46.1	16.2	8.8	100.0	797
Residence						
Tbilisi	32.4	43.7	16.9	7.0	100.0	123
Other Urban	31.6	51.2	9.9	7.3	100.0	159
Rural	26.8	45.0	18.3	10.0	100.0	515
Age Group						
15–24	24.2	50.7	14.2	10.9	100.0	88
25–34	26.2	46.4	18.4	9.0	100.0	358
35–44	32.5	44.6	14.8	8.2	100.0	351
Number of Living Children						
0–1	31.5	48.7	12.6	7.2	100.0	166
2	28.1	43.8	19.1	8.9	100.0	472
3 or more	28.2	49.5	12.0	10.2	100.0	159
Education Level						
Secondary incomplete or less	30.8	38.0	16.5	14.7	100.0	169
Secondary complete	30.1	42.2	17.8	9.9	100.0	238
Technicum	23.4	52.6	16.5	7.5	100.0	128
University/postgraduate	28.8	51.5	14.7	5.0	100.0	262
Wealth Quintile						
Lowest	26.9	43.9	18.7	10.5	100.0	179
Second	26.6	45.6	16.3	11.5	100.0	211
Middle	26.7	45.0	18.5	9.8	100.0	191
Fourth	37.9	47.6	12.0	2.5	100.0	105
Highest	29.4	49.0	14.2	7.4	100.0	111
Ethnicity						
Georgian	30.4	46.8	16.5	6.2	100.0	651
Azeri	18.2	32.8	20.8	28.1	100.0	46
Armenian	21.6	46.3	12.6	19.5	100.0	86
Other	*	*	*	*	100.0	14

* Less than 25 cases.

Table 8.6.1 **Reasons for Not Currently Using Contraception**
by Selected Characteristics Among Married Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Type of Reason			Total	No. of Cases
	Reasons Related to Pregnancy, Fertility or Sexual Activity	Other	Does Not Know		
Total	76.8	22.3	0.9	100.0	1,888
Residence					
Urban	81.0	18.7	0.2	100.0	772
Rural	73.2	25.3	1.5	100.0	1,116
Region					
Kakheti	74.2	21.7	4.0	100.0	166
Tbilisi	81.2	18.5	0.3	100.0	313
Shida Kartli	80.8	19.2	0.0	100.0	103
Kvemo Kartli	74.0	23.8	2.2	100.0	189
Samtskhe–Javakheti	84.0	16.0	0.0	100.0	146
Adjara	72.3	27.7	0.0	100.0	159
Guria	70.9	28.4	0.7	100.0	128
Samegrelo	70.3	29.0	0.7	100.0	130
Imereti	78.7	20.7	0.6	100.0	279
Mtskheta–Mtianeti	76.6	23.4	0.0	100.0	143
Racha–Svaneti	78.7	21.3	0.0	100.0	132
Age Group					
15–24	86.3	12.6	1.1	100.0	435
25–34	74.9	24.3	0.8	100.0	766
35–44	72.3	26.7	1.0	100.0	687
Number of Living Children					
0–1	90.6	9.1	0.3	100.0	961
2	63.7	34.8	1.5	100.0	685
3 or more	59.9	38.5	1.6	100.0	242
Education Level					
Secondary incomplete or less	68.8	28.0	3.1	100.0	358
Secondary complete	75.6	24.0	0.4	100.0	557
Technicum	76.3	23.7	0.0	100.0	337
University/postgraduate	82.4	16.9	0.6	100.0	636
Wealth Quintile					
Lowest	67.2	29.5	3.3	100.0	380
Second	74.9	24.1	1.0	100.0	471
Middle	77.3	22.7	0.0	100.0	425
Fourth	82.4	17.3	0.3	100.0	291
Highest	81.8	17.9	0.3	100.0	321
Ethnicity					
Georgian	77.8	21.9	0.3	100.0	1,596
Azeri	64.9	30.0	5.1	100.0	121
Armenian	81.2	18.8	0.0	100.0	118
Other	70.8	21.5	7.7	100.0	53

Table 8.7.1 **Desire to Use Contraception in the Future by Selected Characteristics Among Fecund Married Women Aged 15–44 Who Are Not Using Contraception**
Reproductive Health Survey: Georgia 2010

Characteristic	Desire to Use Contraception in the Future				Total	No. of Cases
	Desires to Use Within 12 Months	Desires to Use Later	Does Not Desire to Use	Undecided		
Total	30.2	16.5	31.8	21.5	100.0	2,046
Residence						
Urban	29.8	18.4	29.5	22.2	100.0	910
Rural	30.5	14.7	34.1	20.7	100.0	1,136
Region						
Kakheti	31.9	14.0	28.5	25.6	100.0	174
Tbilisi	29.9	19.1	25.6	25.4	100.0	403
Shida Kartli	28.9	16.4	41.4	13.3	100.0	105
Kvemo Kartli	22.4	18.0	35.7	23.9	100.0	211
Samtskhe–Javakheti	21.7	18.5	27.0	32.8	100.0	155
Adjara	41.0	12.4	36.7	10.0	100.0	165
Guria	26.1	17.4	39.9	16.7	100.0	119
Samegrelo	26.5	17.2	31.1	25.2	100.0	131
Imereti	32.7	15.6	32.7	19.0	100.0	291
Mtskheta–Mtianeti	32.5	15.2	33.5	18.8	100.0	154
Racha–Svaneti	23.5	15.4	37.0	24.1	100.0	138
Age Group						
15–24	42.3	29.7	9.1	18.9	100.0	468
25–34	36.7	18.7	19.2	25.3	100.0	829
35–44	15.7	5.7	59.3	19.3	100.0	749
Number of Living Children						
0	20.8	29.1	22.8	27.4	100.0	409
1	31.7	19.4	24.5	24.3	100.0	693
2	32.5	11.2	39.5	16.7	100.0	697
3 or more	34.7	2.7	45.7	16.8	100.0	247
Education Level						
Secondary incomplete or less	25.9	12.3	35.5	26.4	100.0	390
Secondary complete	36.5	18.6	27.8	17.1	100.0	573
Technicum	22.9	18.0	39.7	19.4	100.0	349
University/postgraduate	30.8	16.4	29.6	23.2	100.0	734
Wealth Quintile						
Lowest	28.9	11.5	39.0	20.6	100.0	393
Second	29.6	15.7	31.9	22.9	100.0	485
Middle	31.4	16.0	32.8	19.7	100.0	430
Fourth	29.2	19.3	30.4	21.1	100.0	343
Highest	31.5	19.2	26.7	22.6	100.0	395
Ethnicity						
Georgian	30.7	16.3	32.6	20.4	100.0	1,726
Azeri	27.0	17.7	35.5	19.9	100.0	120
Armenian	26.6	19.0	20.9	33.6	100.0	131
Other	29.1	16.6	25.1	29.2	100.0	69

Table 8.7.2 Preferred Method of Contraception by Selected Characteristics Among Fecund Married Women Aged 15–44 Who Are Not Currently Using Contraception and Desire to Use Contraception in the Future
Reproductive Health Survey: Georgia, 2010

Characteristic	Preferred Method of Contraception								Total	No. of Cases
	IUD	Condoms	Pill	Tubal Ligation	Injectables	Withdrawal	Rhythm	Does Not Know		
Total	46.7	14.3	13.5	2.5	0.1	6.5	6.2	8.4	100.0	940
Residence										
Tbilisi	36.8	26.8	15.5	0.8	0.0	2.9	6.7	9.2	100.0	191
Other Urban	46.6	14.9	13.5	2.7	0.0	3.4	7.7	9.2	100.0	243
Rural	51.8	7.6	12.5	3.2	0.2	10.0	5.3	7.5	100.0	506
Age Group										
15–24	45.2	14.3	15.4	2.6	0.3	1.9	4.5	15.1	100.0	331
25–34	55.6	13.3	12.6	2.6	0.0	4.9	3.6	5.5	100.0	456
35–44	26.9	17.0	11.6	1.8	0.0	20.6	17.0	0.9	100.0	153
Number of Living Children										
0	40.3	22.1	12.0	0.0	0.0	0.5	3.2	21.9	100.0	184
1	47.1	12.1	17.4	3.9	0.0	5.1	5.0	8.2	100.0	356
2	51.6	13.5	11.9	1.8	0.4	8.5	7.7	1.8	100.0	312
3 or more	43.2	8.9	7.2	4.2	0.0	18.0	12.7	0.7	100.0	88
Education Level										
Secondary incomplete or less	53.9	7.3	12.9	3.4	0.0	12.1	2.6	6.8	100.0	148
Secondary complete	46.3	11.3	13.3	1.9	0.3	7.4	5.4	11.3	100.0	300
Technicum	42.4	11.1	19.8	4.9	0.0	6.3	7.2	8.2	100.0	137
University/postgraduate	45.6	21.4	11.6	1.6	0.0	3.2	8.2	6.3	100.0	355
Wealth Quintile										
Lowest	50.4	6.7	11.7	5.4	0.0	13.1	2.4	7.5	100.0	155
Second	53.7	6.9	13.7	3.4	0.5	8.7	5.3	7.4	100.0	216
Middle	43.3	15.3	12.6	2.4	0.0	5.4	9.2	9.0	100.0	208
Fourth	48.1	11.6	14.1	0.7	0.0	5.1	7.5	9.4	100.0	165
Highest	40.3	26.4	14.7	1.3	0.0	2.7	5.9	8.3	100.0	196

Table 8.7.3 Preferred Source of Contraceptive Methods by Selected Characteristics Among Fecund Married Women Aged 15–44 Who Are Not Currently Using Contraception and Desire to Use Contraception in the Future
Reproductive Health Survey: Georgia, 2010

Characteristic	Health Sector							Pharmacy	Other				Total	No. of Cases	
	Women's Consultation Clinic	City Hospital	Regional Hospital	Primary Health Care Clinic/ Center	Policlinic	Family Medicine Center	Referral Hospital		Mobile Clinic	Partner/ Husband	Relative	Other			Do Not Know
Total	32.5	13.0	8.9	3.8	2.1	0.8	0.3	0.1	36.5	0.3	0.1	0.0	1.4	100.0	756
Residence															
Tbilisi	32.0	7.7	0.0	2.6	2.1	1.0	0.0	0.0	53.6	0.5	0.0	0.0	0.5	100.0	156
Other Urban	37.1	11.5	6.0	2.8	1.7	1.0	1.1	0.0	37.5	0.0	0.0	0.0	1.5	100.0	194
Rural	30.3	16.6	15.3	5.1	2.4	0.7	0.1	0.3	26.8	0.3	0.3	0.0	1.9	100.0	406
Age Group															
15–24	30.0	13.5	7.6	4.6	1.7	0.7	0.7	0.3	38.7	0.4	0.4	0.0	1.4	100.0	262
25–34	36.0	14.3	10.8	3.0	2.8	0.6	0.1	0.0	30.7	0.0	0.0	0.0	1.8	100.0	393
35–44	27.3	6.7	5.8	4.6	1.0	1.9	0.0	0.0	51.7	1.0	0.0	0.0	0.0	100.0	101
Number of Living Children															
0	27.7	13.9	8.3	1.8	0.9	0.7	0.0	0.0	46.1	0.0	0.0	0.0	0.7	100.0	139
1	33.2	13.4	6.1	5.3	3.1	0.8	0.4	0.3	34.4	0.7	0.4	0.0	2.1	100.0	295
2	35.1	14.0	9.9	4.0	2.0	0.9	0.1	0.0	32.5	0.0	0.0	0.0	1.4	100.0	258
3 or more	31.1	5.3	19.3	1.3	0.6	1.3	1.6	0.0	39.5	0.0	0.0	0.0	0.0	100.0	64
Education Level															
Secondary incomplete or less	31.2	11.3	15.8	5.9	4.6	0.8	0.0	0.0	27.7	0.9	0.0	0.0	1.8	100.0	114
Secondary complete	28.5	14.0	13.3	2.8	1.1	0.0	0.1	0.0	37.9	0.0	0.4	0.0	1.8	100.0	236
Technicum	29.1	13.1	9.6	5.9	0.3	1.8	1.0	0.9	37.1	0.0	0.0	0.0	1.0	100.0	109
University/postgraduate	37.8	12.7	2.0	3.1	2.6	1.2	0.4	0.0	38.7	0.4	0.0	0.0	1.1	100.0	297
Wealth Quintile															
Lowest	22.6	16.1	23.8	3.8	1.9	0.3	0.0	0.9	28.5	0.0	0.0	0.0	2.2	100.0	124
Second	29.5	19.0	12.6	8.9	3.2	0.7	0.9	0.0	22.4	0.0	0.0	0.1	2.8	100.0	175
Middle	35.6	9.2	11.5	1.9	1.6	1.3	0.0	0.0	36.8	1.4	0.7	0.0	0.0	100.0	161
Fourth	40.6	11.2	2.3	3.7	0.7	0.7	0.0	0.0	39.5	0.0	0.0	0.0	1.3	100.0	132
Highest	32.1	10.8	0.6	1.5	2.8	1.0	0.5	0.0	49.6	0.0	0.0	0.0	1.1	100.0	164
Preferred Method															
Pill	9.8	3.1	2.5	3.1	1.2	1.5	0.0	0.0	77.9	0.0	0.0	0.1	0.7	100.0	127
IUD	49.7	18.8	13.7	5.1	2.9	0.4	0.3	0.0	7.2	0.0	0.2	0.0	1.7	100.0	448
Condoms/spermicides	3.9	0.0	0.0	0.0	0.9	0.7	0.0	0.0	91.8	1.3	0.0	0.0	1.4	100.0	150
Other	20.9	40.9	11.4	9.0	0.0	5.8	4.3	4.0	3.8	0.0	0.0	0.0	0.0	100.0	31

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 2005
Reproductive Health Survey: Georgia, 2010

Duration	Failure Rates						
	All Methods	Method of Contraception					
		IUD	Condom	Pill	Other Modern Methods	Calendar (Rhythm) Method	Withdrawal
One Year	10.3	0.9	5.2	7.3	8.5	20.9	17.7
Two Years	17.2	1.7	10.0	10.0	13.1	33.2	30.2
Three Years	21.9	2.9	14.3	16.4	15.0	40.6	37.2
No. of Segments	3,981	545	1,183	542	255	663	793
Duration	Discontinuation Rates						
	All Methods	Method of Contraception					
		IUD	Condoms	Pill	Other Modern Methods	Calendar (Rhythm) Method	Withdrawal
One Year	35.4	8.6	40.4	52.1	33.7	36.8	35.4
Two Years	53.4	18.7	59.3	69.3	48.8	61.1	53.8
Three Years	64.0	30.2	69.1	80.5	56.0	72.6	65.6
No. of Segments	3,981	545	1,183	542	255	663	793
% Discontinuation Due to Method Failure (12 months)	29.2	10.6	12.9	14.0	25.1	57.0	50.0

Table 8.8.2 Contraceptive Discontinuation Rates As of One Year by Primary Reason for Discontinuing Contraception. For Selected Methods of Contraception; All Segments of Contraceptive Use Initiated Since January 2005
Reproductive Health Survey: Georgia, 2010

Main Reason for Discontinuing Contraception	All Methods	Method of Contraception					
		IUD	Condoms	Pill	Other Modern Methods	Calendar (Rhythm) Method	Withdrawal
Total, for Net Rates [†] Gross Rates*	35.4	8.6	40.4	52.1	33.7	36.8	35.4
Got pregnant while using contraception	13.1	2.1	6.7	6.9	9.9	27.3	24.7
Partner's objections or absence	8.0	0.2	14.3	2.5	5.0	4.2	12.4
Negligence	4.3	0.0	4.7	2.9	1.8	11.2	2.4
Desired to become pregnant	9.6	6.4	12.4	9.9	8.7	7.1	9.7
Experienced or feared side effects	6.1	11.2	0.6	29.8	5.5	0.2	0.1
Switched to other method	4.1	0.2	4.9	1.6	4.8	7.5	4.2
Cost/Availability	3.2	0.0	6.3	6.1	6.8	0.2	0.1
Stopped to rest body/Physician Advice	3.5	7.9	2.2	9.6	2.3	1.2	0.2
Difficult or inconvenient to use	1.8	0.2	3.4	0.6	1.7	1.8	1.2
Other	2.1	1.7	2.8	0.8	3.0	2.3	1.6
No. of Cases	3,981	545	1,183	542	255	663	793

† Net discontinuation rates in this row.

* Gross discontinuation rates in rest of table; they sum to more than the net rate in the "Total" row; see text footnote.

9 CHAPTER

NEED FOR CONTRACEPTIVE SERVICES

The concepts of potential demand and unmet need for contraception have been around since the 1960s, when researchers first demonstrated a gap in the developing world between women's fertility preferences and their use of contraception. The total potential demand for contraception is generally defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to eliminate unwanted or mistimed childbearing (unmet need). Thus, unmet need for contraception is a specific estimate that shows the gap between desired fertility and current contraceptive practices.

Monitoring the "need" for contraception has been increasingly recognized as central to family planning efforts. By providing evidence about women whose contraceptive demand is not fully satisfied, data on unmet need can demonstrate the work left to be done in assisting women and couples to prevent unintended pregnancies. In addition, such data can help assess whether national financial and political support is adequate for rectifying this problem. With the addition in 2006 of a new target of universal access to reproductive health services to help assess progress in meeting the Millennium Development Goals (MDGs Target 5b), UN panels have also recommended "unmet need for contraception" as one of the indicators to be monitored globally. A second measure, unmet need for a modern contraceptive method, which excludes less effective traditional methods such as periodic abstinence and withdrawal, has been recommended as a supplement. These measures are based on data collected through large-scale, nationally representative surveys of women conducted periodically in both developing and developed worlds.

Among those the Reproductive Health Surveys (RHS) in Georgia play an essential role in describing the current need and potential future demand for contraceptive services, by assessing respondent fecundity and reproductive preferences. The surveys have employed the definition of unmet need (Bongaarts, 1991; Westoff, 2006) that includes women currently married or in consensual unions who are currently sexually active (within the past month); who are currently exposed to the risk of pregnancy (excluding women not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea); who are fecund (neither they nor their partners have any subfecundity conditions); who do not want to become pregnant (at the time of the interview); and who are not using any method of contraception. In addition, the formulation of unmet need was extended to cover all

women, to more accurately reflect the total number of women with an unfulfilled need for contraception. By documenting periodically the additional contraceptive use that would be required to eliminate the risk of unintended pregnancies in Georgia, the surveys have helped with sharpen the family planning agenda and monitor and evaluate the effectiveness of ongoing programs, including the introduction of contraceptive logistics management, and the assessment of progress toward universal access to reproductive health services. The time trends over the 1999 to 2010 period are a special strength.

9.1 Potential Demand and Unmet Need for Contraception

Overall, the 2010 survey found that 39% of all women had a potential demand for contraception. Among married women, who are much more sexually active and at risk of unplanned pregnancies, the potential demand for contraception was much higher (65%),

including 34% of current users of modern methods, 18% of current users of traditional methods, and 12% of nonusers (Table 9.1.1 and Figure 9.1.1). In Table 9.1.1 18.2% of married women are using traditional methods, and they are included along with the 12.3% of nonusers at risk, to total 30.5% having unmet need. About one in every three (35.3%) married women had no need for contraception because they were currently pregnant, trying to become pregnant, infecund, or had not had intercourse recently. In addition to the unmet need for any contraception (12.3%), the need for modern contraception (30.5%) is emphasized. It is always larger since it includes all traditional method users. It is particularly useful in countries where the use of traditional, high-failure methods is high.

(It should be noted that these percentages are conservative, since some pregnant women do not want either this pregnancy or any future ones, and action programs should provide postpartum contraception to address their needs as well.)

Figure 9.1.2 Unmet Need for Any Contraception by Region Among Married Women Aged 15-44

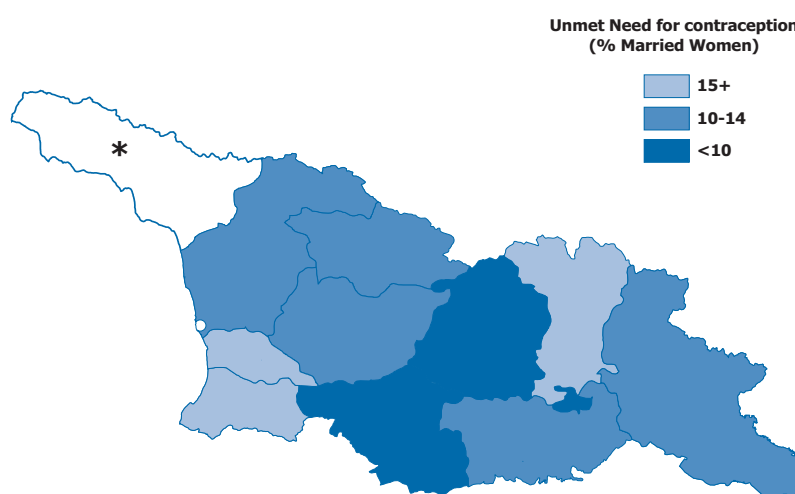


Figure 9.1.1 Potential Demand and Unmet Need for Any Contraception by Marital Status Among Women Aged 15-44

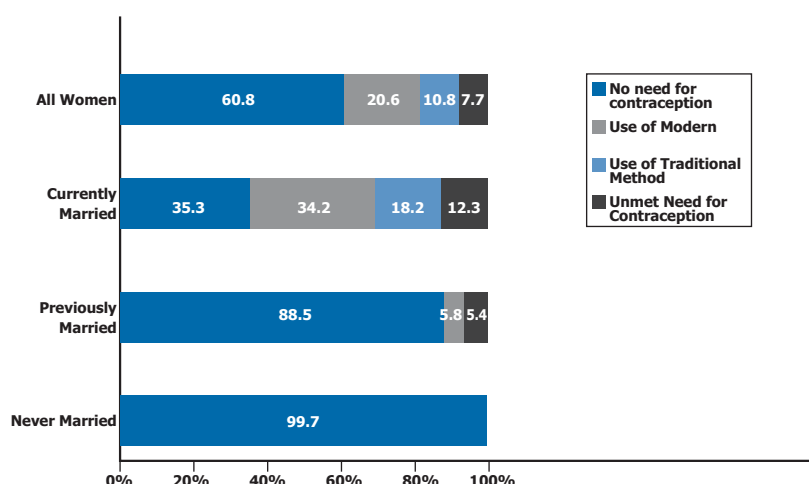


Figure 9.1.3 | **Unmet Need for Modern Contraception by Region Among Married Women Aged 15-44**

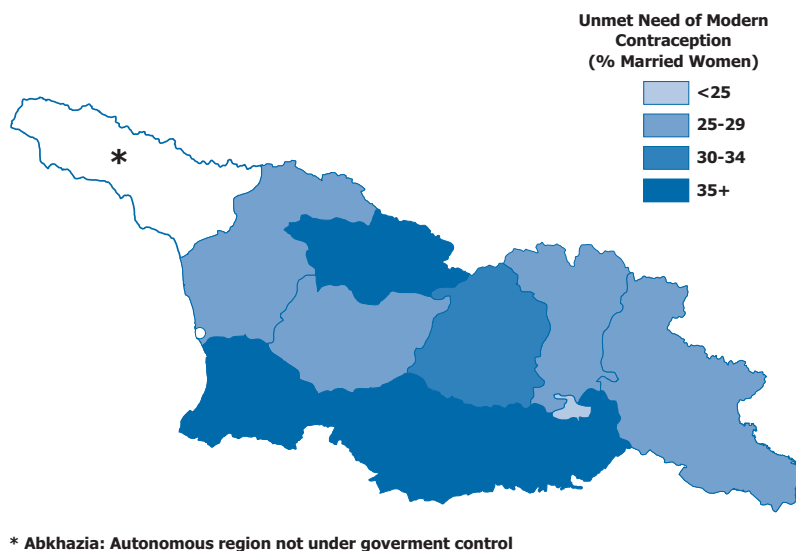
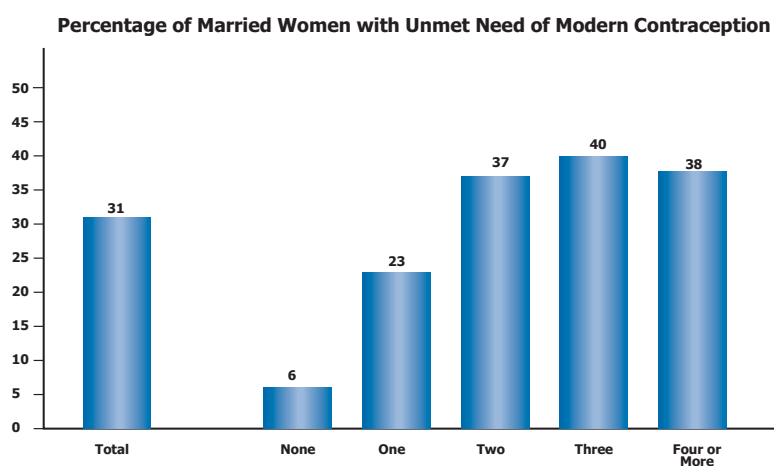


Figure 9.1.4 | **Current Unmet Need for Modern Contraception by Number of Living Children Among Married Women Aged 15-44**



Some subgroups of married women exhibited much higher levels of unmet need than others (Table 9.1.2). Regional levels of unmet need for any contraception ranged from a high of 15%–16% in Adjara, Guria and Mtskheta-Mtianeti to 8%–9% in Tbilisi, Samtskhe-Javakheti, and Shida Kartli (Figure 9.1.2).

Unmet need for modern contraception is much greater and ranged from a high of 38%–40% in Samstkhe-Javakheti, Adjara, Guria, Racha-Svaneti and Kvemo Kartli to 23%–27% in Tbilisi, Samegrelo and Imereti (Figure 9.1.3).

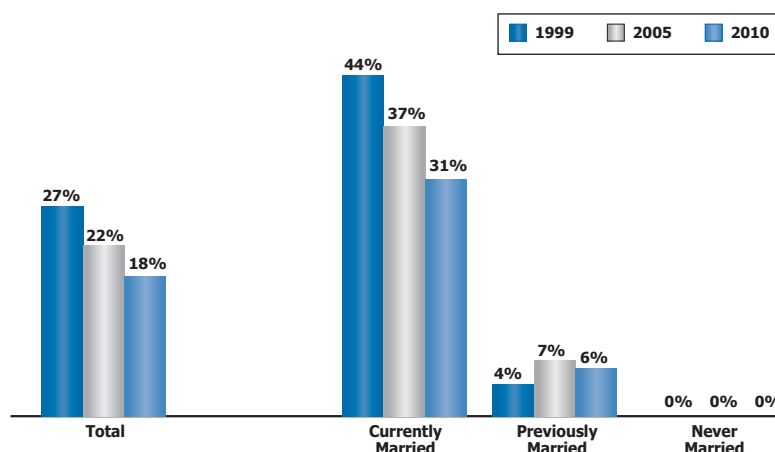
Generally, levels of unmet need, particularly levels of unmet need for modern contraception, were higher among rural women than urban women and increased with the number of living children (Figure 9.1.4). Respondents with secondary education or less had higher levels of unmet need than those with post-secondary education (Table 9.1.2).

Georgia's unmet need for modern contraception among married women was 30%, down from 44% in 1999 and 37% in 2005. That is nearly a one-third decline from 1999 (Figure 9.1.5). The unmet need for modern contraception among all women decreased from 27% to 18%, also a one-third decline. Practically all this decline resulted from increased use of modern methods among couples, while unmet need among never married and previously married women remained constant and very low.

In absolute numbers, this decline represents an apparent decrease of approximately 75,000 women aged 15–44 with unmet need for modern contraception between 2005 and 2010 and could account for the observed substantial reduction in unplanned pregnancies and induced abortions.

In Table 9.1.2, for modern methods, there is still a gap of 18% of all Georgian women aged 15–44 (31%

Figure 9.1.5 | Unmet Need for Modern Contraception by Marital Status Among Women Aged 15-44: 1999, 2005 and 2010



of married women), however, with an unmet need. They have an unfulfilled desire to plan and space their childbearing and continue to be at risk of unplanned pregnancy. This translates into almost 180,000 couples whose modern contraceptive needs are unmet. In order to reduce this gap, policymakers and programs can target subgroups where unmet need is most concentrated, according to characteristics such as age, income, education, and ethnicity.

9.2 Potential Demand for Family Planning by Fertility Preferences

Comparing the most recent data from population-based surveys in Eastern Europe and the Caucasus region countries, Armenia (52%, 2000) and Azerbaijan (53%, 2001) had the highest unmet need for modern contraception, followed by Ukraine (47%, 1999), Czech Republic (39%, 1993), Romania (39%, 1999) and Georgia (31%, 2010) (CDC and ORC Macro, 2003).

Table 9.2.1 and Figure 9.2.1 give details; they also separate unmet need by whether it relates to “spacing” or “limiting.” That is, in addition to measuring the overall demand for family planning services, the survey data also allow for estimates of both met and unmet need based on respondents’ fertility preferences (Table 9.2.2). Among respondents with potential demand for any contraceptive method or for a modern method, women who did not want to get pregnant right away but wanted to have children sometime in the future (including those who were undecided as to whether to have children or not) were classified as having unmet need for spacing births. Respondents who did not want (any) more children but were not doing anything to prevent pregnancy (or were using less effective traditional methods) were considered to have an unmet need for limiting births. Similarly, respondents whose contraception needs were met (users of any methods

or modern methods) were classified as having their needs met for both for spacing and limiting births.

The final two columns of Table 9.2.1 show the percent of all unmet need due to limiting. For example, for Georgia in 2010, 68% of all unmet need for “any contraception” is due to limiting (8.4/12.3) and 67% of unmet need for “modern contraception” is due to limiting (20.5/30.4). In nearly all countries limiting needs clearly dominate. Only in Turkmenistan and Uzbekistan is the limiting percentage as low as 50% or below. Generally, in Table 9.2.2 and Figure 9.2.2 unmet need for limiting births is higher than unmet need for spacing births, regardless of region or whether the standard or expanded definition is used. Among women currently in union the unmet need for limiting births is two to three times higher than the unmet need for spacing births, a finding that is concordant with the low ideal family size and future reproductive intentions that are typical in this region. The unmet need for limiting births in Georgia declined between 1999 and 2010 by 14%, while the unmet need for spacing births remains the same (10%).

The most common reasons for unmet need in Georgia are lack of information, fears about contraceptive side effects, and inconvenience of services. Women with unmet need typically have low awareness of effective contraceptive methods, lack knowledge about how methods are used, and are less likely to believe that family planning services are readily accessible to them.

In order to meet their needs, considerably more effort should be made to increase contraceptive awareness through Information Education and Communication (IEC) and Behavior Change Communication (BCC) programs and to expand the availability of a wide array of effective, high quality, affordable contraceptive methods, including long-term and permanent methods. In conclusion, policy makers and donors need to be

Figure 9.2.1 Unmet Need for Any Contraception and Unmet Need for Modern Contraception Among Married Women in Selected Countries in Eastern Europe and Eurasia

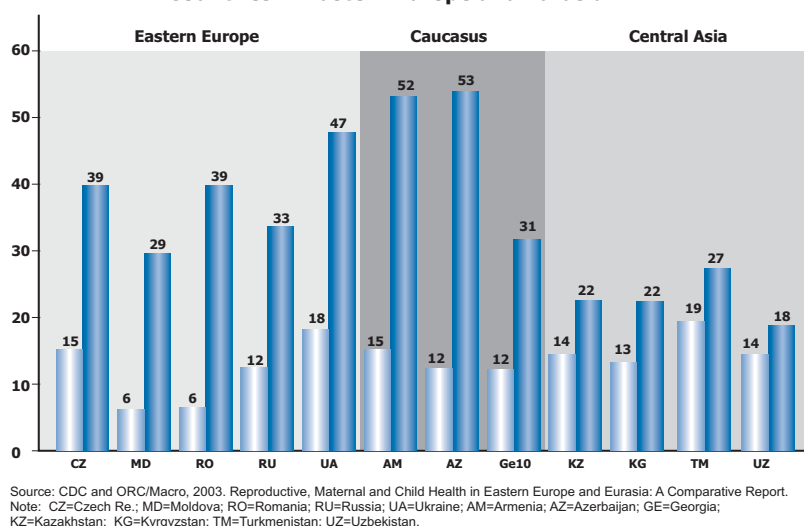
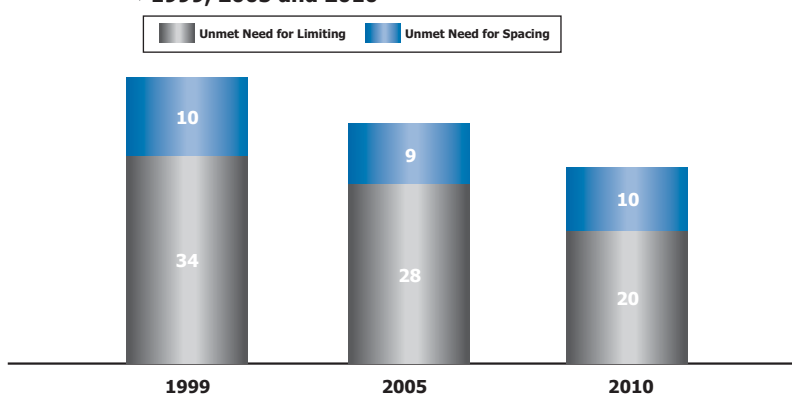


Figure 9.2.2 Unmet Need for Modern Methods Among Married Women by Future Fertility Preferences; Reproductive Health Surveys 1999, 2005 and 2010



aware of the quantity of family planning commodities needed to satisfy the needs of all Georgian women who currently use modern methods (21% in Table 9.1.1 or around 207,000 users); in addition, they need to account for a potential increase in contraceptive commodities when users of traditional methods and those not currently using any method adopt modern methods. On the basis of just satisfying unmet alone, supply requirements may increase dramatically even if population growth is held constant. Further, changes in fertility preferences and in the timing of childbearing may also generate more users.

Currently, all family planning activities are organized with donor support (chiefly from UNFPA and USAID) and are implemented by local governmental institutions and international or local NGOs. Donors support three key functions aimed at strengthening family planning services: 1) availability of a range of effective and acceptable contraceptive methods in family planning outlets; 2) training for family planning health personnel through general training programs; and 3)

information dissemination and community-based education and outreach activities.

Satisfying the unmet need for modern contraception in Georgia will require a substantial increase in programmatic and financial support. Currently, the majority of contraceptive services are paid for through donor contributions and consumer payments, while government family planning subsidies remain limited. To better meet the demand for family planning services, the government needs to scale up its partnership with the donor community to make services affordable and accessible to all couples in need of services. The national reproductive health strategy should provide free or low-cost contraceptive supplies, educate women about what methods and services are available, and disseminate accurate information to counter incorrect beliefs about modern contraceptives. The national strategy should give high priority to making contraception practice more acceptable, in line with the MDG goal of universal access to reproductive health services.

Table 9.1.1 Demand for Family Planning (FP) Services by Marital Status and Age Group Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Demand for Family Planning	Total	Marital Status			Age Group		
		Married	Previously Married	Never Married	15–24	25–34	35–44
No Demand	60.8	35.3	88.5	99.7	85.3	49.1	44.1
Never had sexual intercourse	34.2	0.0	0.0	99.7	67.7	19.0	10.2
Not currently sexually active*	8.7	5.6	82.2	0.0	2.7	9.0	15.6
Currently pregnant or post-partum	7.6	12.8	1.3	0.0	10.4	9.4	2.3
Seeking to get pregnant†	4.9	8.2	1.1	0.0	4.1	6.8	3.8
Infecund/subfecund‡	5.4	8.7	3.9	0.0	0.4	4.9	12.2
Potential Demand	39.1	64.7	11.4	0.2	14.8	51.0	55.8
Met Need	31.4	52.4	6.0	0.0	11.5	42.7	43.5
Current users of a modern method	20.6	34.2	5.8	0.0	8.3	28.9	26.7
Current users of a traditional method	10.8	18.2	0.2	0.0	3.2	13.8	16.8
Unmet need for any contraception (Nonusers at risk of unintended pregnancy)	7.7	12.3	5.4	0.2	3.3	8.3	12.3
Unmet Need for Modern Contraception§	18.5	30.5	5.6	0.2	6.5	22.1	29.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,292	4,098	389	1,805	1,960	2,359	1,973

* Within the past month.

† Want to get pregnant right away; includes 115 respondents who answered "when God wants."

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

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

**Table 9.1.2 Unmet Need for Family Planning (FP) Services by Marital Status and Age Group
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010**

Characteristic	All Women		No. of Cases	Married Women		No. of Cases
	Any Method	Modern Method		Any Method	Modern Method	
Total	7.7	18.5	6,292	12.3	30.5	4,098
Residence						
Urban	6.1	14.2	2,975	10.1	24.8	1,806
Rural	9.5	23.2	3,317	14.5	36.0	2,292
Region						
Kakheti	9.5	18.2	498	14.2	27.9	348
Tbilisi	5.3	12.7	1,426	8.9	23.2	815
Shida Kartli	5.7	21.1	392	9.0	34.2	266
Kvemo Kartli	9.7	24.6	546	14.4	37.6	375
Samtskhe–Javakheti	5.0	24.7	481	7.6	39.8	331
Adjara	10.5	25.0	419	15.7	38.3	292
Guria	10.2	25.0	401	15.1	38.4	276
Samegrelo	7.4	15.1	477	13.1	26.7	302
Imereti	8.5	17.4	805	13.5	27.8	540
Mtskheta–Mtianeti	10.8	19.4	393	16.2	29.7	270
Racha–Svaneti	8.2	21.8	454	14.2	37.8	283
Age Group						
15–19	1.0	1.4	861	9.0	13.1	124
20–24	5.5	11.3	1,099	10.7	22.6	610
25–29	7.7	18.8	1,191	10.7	26.4	863
30–34	9.0	25.5	1,168	10.7	31.9	948
35–39	11.1	29.6	1,051	13.1	36.3	836
40–44	13.7	28.5	922	16.8	36.2	717
No. of Living Children						
0	0.9	1.0	2,276	4.6	5.8	409
1	8.2	19.9	1,286	8.9	23.0	1,106
2	14.0	34.9	2,069	14.6	36.9	1,956
3 or more	16.0	38.5	661	15.8	39.5	627
Education Level						
Secondary incomplete or less	8.4	18.7	1,330	17.6	39.9	726
Secondary complete	9.2	21.9	1,568	13.9	33.4	1,119
Technicum	11.2	22.4	903	14.7	30.5	673
University/postgraduate	5.2	14.9	2,491	7.8	24.2	1,580
Wealth Quintile						
Lowest	12.4	27.2	1,093	18.6	42.1	727
Second	9.0	22.9	1,385	13.9	35.7	966
Middle	6.4	17.4	1,413	10.4	28.1	952
Fourth	6.9	15.5	1,037	11.3	27.3	623
Highest	5.6	13.2	1,364	9.3	22.9	830
Ethnicity						
Georgian	7.0	17.2	5,488	11.4	28.8	3,521
Azeri	16.3	32.1	276	22.5	44.4	219
Armenian	7.5	24.9	364	11.8	41.3	249
Other	12.1	20.1	164	18.0	30.1	109

**Table 9.2.1 Percentage of Currently Married Women of Reproductive Age*
With Unmet Need for Contraception by Future Fertility Preferences
Selected Countries in Eastern Europe and Eurasia**

Region and Country	Unmet Need for Any Contraception†			Unmet Need for Modern Contraception			% of Unmet Need due to Limiting	
	Total	For Spacing	For Limiting	Total	For Spacing	For Limiting	Any Method	Modern Method
Eastern Europe								
Czech Rep., 1993	14.6	3.9	10.7	38.9	11.9	27.0	73	69
Moldova, 1997	5.9	2.5	3.4	28.9	9.3	19.6	58	68
Romania, 1999	5.6	1.7	3.9	39.2	9.4	29.8	70	76
Russia, 1999‡	11.5	2.4	9.1	32.5	7.0	25.5	79	78
Ukraine, 1999	17.5	3.4	14.1	47.2	8.1	39.1	81	83
Caucasus								
Armenia, 2000	15.0	4.0	11.0	52.0	10.0	42.0	73	81
Azerbaijan, 2001	11.5	1.8	9.7	53.3	8.2	45.1	84	85
Georgia, 1999	23.8	5.7	18.1	44.1	9.9	34.2	76	78
Georgia, 2005	16.3	4.3	12.0	36.9	8.6	28.3	74	77
Georgia, 2010	12.3	3.9	8.4	30.4	9.9	20.5	68	67
Central Asia								
Kazakhstan, 1999	15.0	6.0	9.0	22.0	9.0	13.0	60	59
Kyrgyz Rep., 1997	13.0	5.0	8.0	22.0	9.0	13.0	62	59
Turkmenistan, 2000	19.0	11.0	8.0	27.0	14.0	13.0	42	48
Uzbekistan, 1996	14.0	7.0	7.0	18.0	8.0	10.0	50	56

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

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

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

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

**Table 9.2.2 Met and Unmet Need for Family Planning (FP) Services
Among All Women and Among Women in Union Aged 15–44
According to Their Future Fertility Preferences
Reproductive Health Survey: Georgia, 2010**

Characteristic	All Women		Women In Union	
	Any Method %	Any Modern Method %	Any Method %	Any Modern Method %
Total Demand for FP	39.1	39.1	64.7	64.6
Demand for spacing	13.6	13.6	22.3	22.3
Demand for limiting	25.5	25.5	42.4	42.3
Met Need For FP (Users)	31.4	20.6	52.4	34.2
For spacing	11.1	7.5	18.4	12.4
For limiting	20.3	13.1	34.0	21.8
Unmet Need For FP (Non-Users)	7.7	18.5	12.3	30.4
For spacing	2.5	6.1	3.9	9.9
For limiting	5.2	12.4	8.4	20.5
% of Demand Satisfied	80.3	52.7	81.0	52.9
For spacing	81.6	55.1	82.5	55.6
For limiting	79.6	51.4	80.2	51.5
No. of Cases	6,292	6,292	4,098	4,098

10

CHAPTER

CONTRACEPTIVE COUNSELING

The choice of a contraceptive method should take into account the patient's personal history, her life stage as to whether a short term or long term method is appropriate, the contraindications of particular methods, and her past experience if any with modern contraception. Without proper information and reassurance on side effects, for example on anxieties about menstruation disorders patients may soon discontinue and risk unplanned pregnancies.

Instructions need to be clear and given in the language that the patient can understand. So far there is only limited evidence about what works to help users choose a method that they understand and will continue to use. For example despite their high effectiveness, hormonal contraceptives suffer from poor adherence to the required regimen and suffer low rates for long-term continuation. Nevertheless for most methods there is a definite increase in contraceptive uptake when women are provided with educational materials and counseling sessions, and they often then prefer the more reliable modern methods. Furthermore, training for high quality counseling is needed to avoid careless prescriptions that go contrary to client expectations, leading to high discontinuation rates and general dissatisfaction (Moreau et al., 2007).

10.1 Client-Provider Communications Regarding Family Planning

Family planning counseling and services in Georgia are provided by obstetricians, gynecologists and "reproductologists" (a concept unique to Georgia that includes other physicians who have received extra training related to reproductive issues). The Georgian Law on Medical Activities (Government of Georgia, 2001) specifies that physicians already licensed in closely related specialties can be licensed as "reproductologists" after a short post-graduate course; physicians specialized in other areas must complete the full post-graduate course and residency before being licensed to as a reproductologist. An important component of the newly implemented reproductive health strategy is to train health professionals to provide family planning counseling at all levels of medical care, including primary care. Both UNFPA and USAID have supported physician post-graduate training in contraceptive technology. A waiver issued by the MoLHSA for the USAID-funded project Healthy Women in Georgia (HWG) allowed for the first time primary care doctors, pediatricians, and nurses to be trained in family planning counseling and services under the project (JSI, 2009). Through UNFPA and USAID support, the number of family planning (FP) providers in Georgia

has increased substantially, particularly in the last five years. A recent survey of a sample of reproductologists and general physicians in four regions conducted with UNFPA support documented that the majority (77%) of respondents received family planning training, mostly after 2005. About two-thirds of providers were classified as having correct knowledge about FP methods, though fewer correctly answered questions related to the side effects of the IUD and oral contraceptives (Tsertsvadze et al., 2010).

As in previous surveys, the 2010 survey included a series of questions to assess typical interactions between family planning providers and their clients. Specifically, the survey asked about the extent to which health professionals had provided basic family planning information and services to women who had used a modern contraceptive method or had an abortion or a birth during the five years prior to the interview.

Women who had used at least one modern contraceptive method in the previous five years were asked who had advised them to use their most recent method. If the advice came from a health care provider (e.g., a physician, nurse or midwife), they were also asked about the content of the family planning counseling. Most respondents were advised by a gynecologist to use their current or most recent modern method (55%) and an additional 1% were advised by a nurse, midwife or general practitioner (Table 10.1. and Figure 10.1.1). Most women who did not receive medical advice started using their last method at the partner's suggestion (24%), at their own counsel (9%), at the suggestion of friend (6%), or at the suggestion of a relative (4%), bypassing any family planning counseling. Only 1% chose a method at the suggestion of a pharmacist.

The source of advice varied widely by the last modern method used (Figure 10.1.2). Almost all IUD users and women sterilized had chosen their method based on

the advice of a health care provider (94% and 90%, respectively), while 78% of pill and 51% of other modern contraceptive users did so. Only 12% of condom users were advised by a physician, nurse, or midwife. Most women who had used condoms did so because their partners suggested it (57%) or because they decided to do so themselves (20%) or because of a friend's advice (7%). For "Other" users most non-medical advice came from friends and relatives (36%).

During provider-client interactions, 64% of women received general information about other contraceptive methods (Figure 10.1.3); 59% were counseled about the effectiveness of the chosen method compared with other methods; 82% were told of possible side effects of the chosen method; and 77% were told what to do if they experienced side effects (Table 10.1). Overall, 52% of women received comprehensive counseling; this was only slightly higher in rural (53%) than in urban (51%) areas.

The content of counseling is very important since interactions between family planning providers and their clients, and the messages conveyed during those interactions, can affect continued and correct use of the method as well as client satisfaction with the service.

Regarding trends, between 1999 and 2010 there was very little change in the percentage of women who were advised by a health provider about their most recent method. However, the content of these interactions had improved significantly. By 2010 as noted above, during provider-client interactions, 64% of women received general information about other contraceptive methods, doubling from only 34% in 1999; 59% were counseled about the effectiveness of the chosen method in 2010 compared to only 31% in 1999, also a near doubling; and 82% reported that the provider had explained possible side effects of the method chosen, compared to 70% in 1999.

Figure 10.1.1 Source of Contraceptive Advice for Most Recently Used Contraceptive Method Among All Women Aged 15-44 Who Had Used Modern Contraceptives in the Last 5 Years

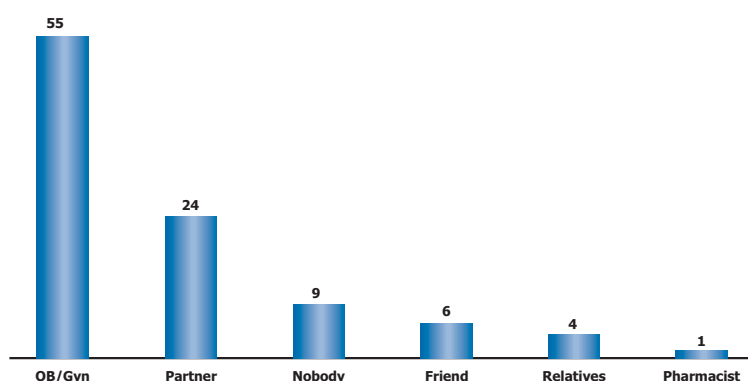


Figure 10.1.2 Source of Contraceptive Advice By Type of Modern Method of Contraception Used Among All Women Aged 15–44 Who Had Used Modern Contraceptives in the Last 5 Years

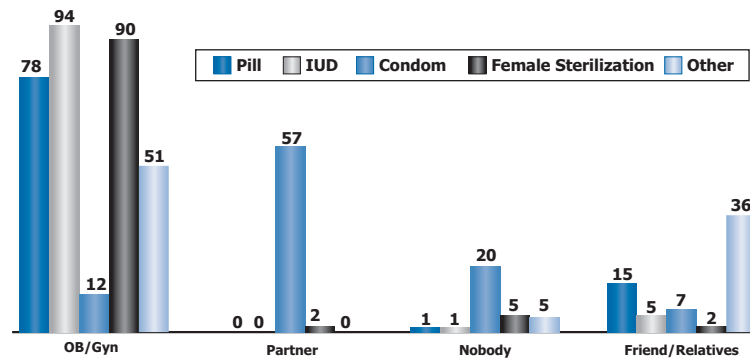
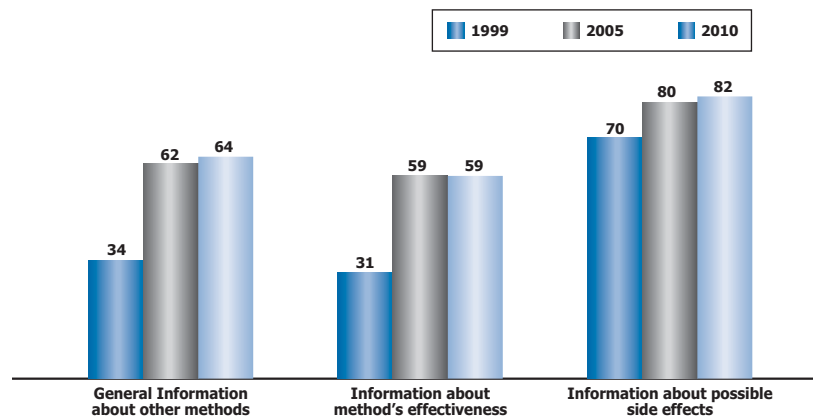


Figure 10.1.3 Trends in Type of Counseling Received Among Women Aged 15–44 Who Had Used a Modern Method Within the Last 5 Years; 1999, 2005 and 2010



The content of contraceptive counseling differed among the various methods. The content of contraceptive counseling varied also by the method chosen. For example IUD users were more likely to be counseled about side effects (91%) and what to do if they occur (86%) than were users of other contraceptive methods (Table 10.1). Sterilization users were the least likely to receive any counseling, particularly information about other methods (49%) and contraceptive effectiveness (48%). Women who used pills were the most likely to have received medical advice about other methods (73%) and contraceptive effectiveness (67%). Overall, condom and “Other” users were the least likely to receive comprehensive counseling (41% and 39%, respectively), whereas users of pills were the most likely (60%).

Good communication between clients and family planning providers during counseling is a key to informed choice. When counseling is a partnership, in which clients and providers communicate openly, share information, express emotion, and ask and answer questions freely, clients are more satisfied, understand and recall information better, use contraception more effectively, and live healthier lives.

The process of making informed family planning choices begins long before people visit a provider, and many people make informed choices without face-to-face communication with a provider. When clients do seek services, however, there is substantial evidence on what clients and providers can do together to ensure that family planning decisions are based on the principle of informed choice.

Client and health provider interactions offer important opportunities to promote counseling on risk behaviors. Therefore integration of family planning counseling and services with primary health care (PHC) services is definitely recognized by MoLHSA and other concerned government agencies and partner organizations as a priority strategy. Integration is the combination of different kinds of services or operational programs to maximize reproductive health outcomes, including referrals from one service to another, as well as services provided in the same setting or by the same provider. Improved access to FP counseling and low cost or free contraceptives at the primary health care level and in hard to reach geographical locations (via mobile clinics) have been a priority among government agencies and donors. To pursue this priority,

Figure 10.2.1 Percentage of Women Aged 15–44 Who Were Very Satisfied or Satisfied with Specific Types of Counseling Received Among Women Who Had Used a Modern Method Within the Last 5 Years

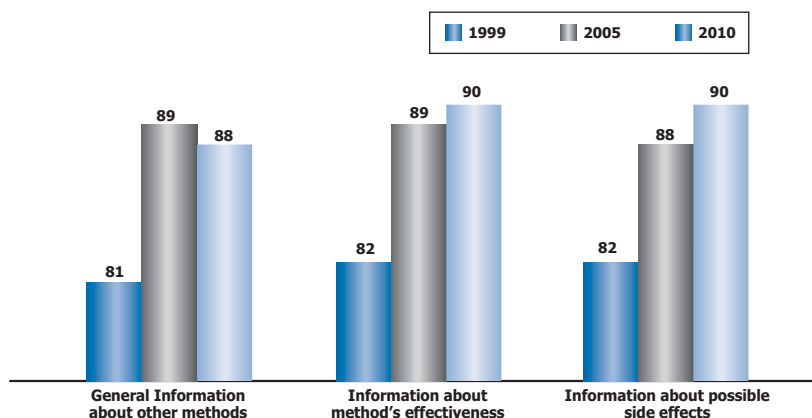
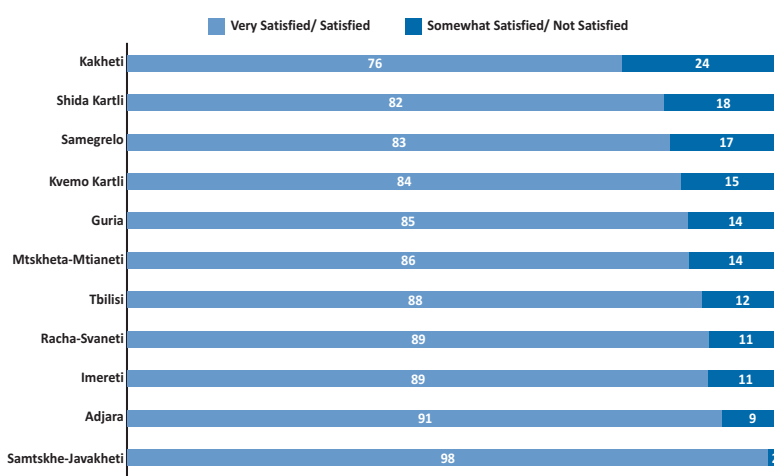


Figure 10.2.2 Satisfaction with Family Planning Services Among Women Aged 15–44 Who Have Received Contraceptive Counseling in the Last 5 Years



more primary care doctors, pediatricians, and nurses need to be trained in techniques for family planning counseling and services. Beside training efforts, regulations must be changed to allow PHC doctors and nurses to provide those services, probably with the exception of IUD insertion.

10.2 Satisfaction with Counseling Services

Family planning clients and providers both have responsibilities to ensure that the counseling process reflects the principle of informed choice and leads to family planning decisions that clients make for themselves. A number of obstacles often stand in the way of good client-provider communication. These include unnecessary medical barriers and other restrictions that providers place on services, providers' own preferences about contraception and biases toward or against certain methods, both providers' and clients' discomfort with discussing sexuality, the differences in status and knowledge between providers and clients, and gender bias. Finding ways to surmount these obstacles helps foster informed choice.

Respondents who used a modern method in the last five years were asked about their satisfaction with the service provider (Table 10.2). Only 41% were "very satisfied" and 45%, "satisfied;" 11% were "somewhat satisfied," while 3% were "dissatisfied." Satisfaction varied little by respondent background characteristics. However satisfaction varied sharply by method: ratings were highest by IUD and sterilization users, but for all other methods the ratings were similar to each other, at much lower levels.

Women who were counseled about all birth control methods at the time of making their contraceptive decision were more likely to be "very" satisfied with counseling than those who did not receive complete information (44% vs. 36%). Similarly, women who received counseling about method effectiveness were more likely to be very satisfied than those that did not (46% vs. 34%), as were women who received counseling about side effects (45% vs. 23%); similarly for counseling on what to do if side effects occur (43% vs. 32%); and for the receipt of comprehensive counseling (47% vs. 34%).

Compared to 1999, the percentage of women who were very satisfied or satisfied with specific counseling information changed as shown in the three categories in Figure 10.2.1.

Satisfaction with specific types of counseling ranged from a high of 98% in the region of Samtskhe-Javakheti to a low of 76% in the region of Kakheti (Figure 10.2.2).

10.3 Postabortion and Postpartum Counseling

Meeting the contraceptive needs of clients at all stages of their reproductive lives is a vital aspect of quality reproductive health care. During the postpartum and postabortion phases, special considerations govern the provision of care.

Postpartum contraception is the initiation and use of a contraceptive method in the first six weeks after delivery to prevent unintended pregnancy, particularly in the first 1-2 years after childbirth, when another pregnancy can be harmful to the mother or to a breastfeeding baby. Postabortion contraception is the initiation and use of a contraceptive method, most often immediately after treatment for abortion: within 48 hours, or before fecundity returns (2 weeks postabortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief interval. The majority of women receiving postabortion care do not want to become pregnant again in the near future, and it is important that the contraceptive needs of women during this critical period are met.

Unfortunately, a large number of women who wish to delay or prevent future pregnancies receive little or no

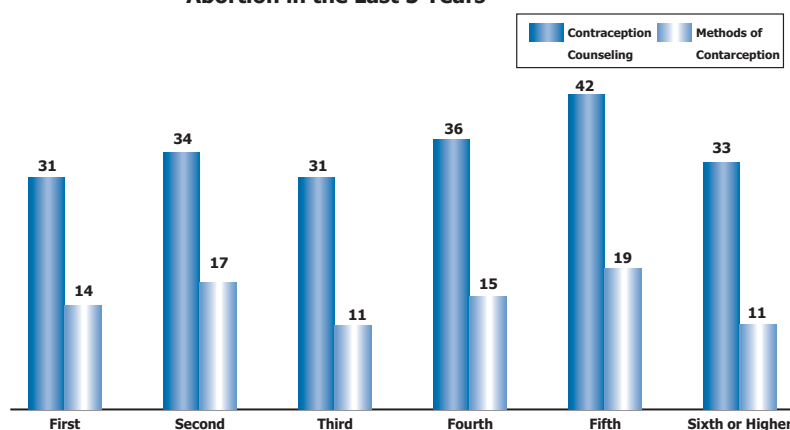
information on safe, available, effective contraception for postpartum or postabortion use, including how and where to obtain a method, and how soon after childbirth and abortion use of a method should be initiated. Good counseling should address their fears as well, as women often have valid concerns that certain methods may affect breastfeeding, reducing their breast milk or harming the growth and development of their infant.

All respondents who had an abortion in the last five years were asked if they received any family planning advice either before or after the abortion procedure; if they received any contraceptive method or a prescription for any method; and if they were referred to a family planning facility following the procedure. Although 33% of respondents with a history of at least one abortion in the last five years reported receiving contraceptive counseling around the time of the abortion, only 7% received a contraceptive method, prescription, or referral. Women in urban areas (36%) were more likely than rural residents (31%) to receive pre- or post- abortion information about contraception. (Table 10.3.1; rows can sum to more than the total figure due to use of multiple services). Receipt of contraception counseling or methods varied rather irregularly by abortion order (Figure 10.3.1; the “methods” bars show the sum of “method distributed” and “prescription given” in Table 10.3.1).

Compared to 1999, more women reported receipt of contraceptive information in 2010 (33%), and more women had received a contraceptive method or prescription as well (14%) (Figure 10.3.2).

These levels of services are all quite low. They demonstrate that even if there is an increase in counseling, referrals, and provision of contraceptives there will remain a great need to improve and expand services at the time of abortion and birth.

Figure 10.3.1 Selected Family Planning Services Received at the Time of Legally Performed Abortions by Abortion Order Among Women Aged 15–44 Years Who Have Had at Least One Abortion in the Last 5 Years



Equally defective is the level of contraceptive counseling during perinatal health care visits (Table 10.3.2). Only 39% of women who gave birth in the last five years and had at least one prenatal care visit reported receiving family planning information as a component of the prenatal consultation. Similarly, only 43% of women who received postpartum care in the last five years reported contraceptive counseling on that occasion. These levels were not uniform across subgroups: counseling was directly correlated with residence, age, education and wealth quintile, so more counseling was received by urban, older, better educated, and wealthier women.

Average levels of counseling are low but they improved considerably between 1999 and 2005, and again from 2005 to 2010. Compared to 1999, contraceptive counseling during prenatal care increased from 20% to 39%, as did counseling during postnatal care visits, from 20% to 43% (Figure 10.3.3).

One of the major advantages of postabortion and postpartum family planning services is that they do not require a separate clinical infrastructure or staff. The initiation of contraception during the immediate postabortion and postpartum periods can lead to short-term and long-term cost savings for both the client and the provider. Once postabortion and postpartum family planning education and services become a routine part of the activities conducted at a maternity care center, they are easily institutionalized and sustained.

Decisions about reproductive health and contraceptive use are among the most crucial that people of childbearing age make. With widespread endorsement of informed choice for family planning, people can have better information, a wider range of options, and more support to make appropriate decisions themselves. Ensuring informed choice in family planning should be the goal of donor agencies, governments, family planning programs, and providers everywhere.

Figure 10.3.2 Receipt of Contraceptive Counseling at the Time of an Abortion on Request; 1999, 2005 and 2010

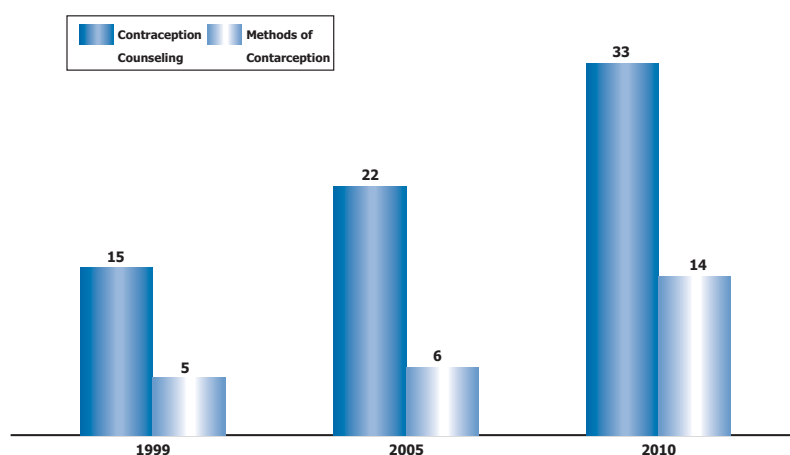


Figure 10.3.3 Receipt of Contraceptive Counseling at the Time of Prenatal or Postnatal Care; 1999, 2005 and 2010

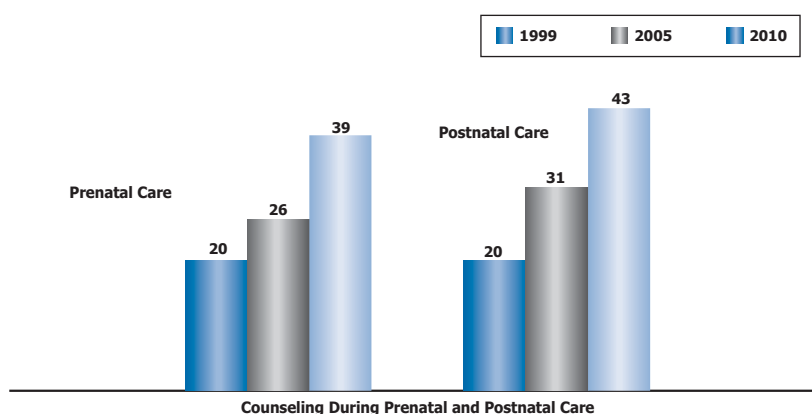


Table 10.1 Source of Contraceptive Advice and Type of Contraceptive Counseling,
by Residence and By Type of Modern Method of Contraception Used Among All
Women Aged 15–44 Who Have Used Modern Contraceptives in the Last 5 Years
Reproductive Health Survey: Georgia, 2010

Primary Person Who Advised User of Method	Total	Residence		Modern Method of Contraception				
		Urban	Rural	Pill	IUD	Condom	Female Sterilization	Other
Ob/Gyn	54.6	48.4	63.6	78.3	93.6	11.6	90.1	51.4
Partner/husband	24.2	28.0	18.6	0.0	0.0	56.6	1.7	0.4
Nobody	9.4	12.6	4.9	1.3	1.1	19.6	5.1	5.0
Friend	5.6	5.6	5.7	8.7	0.9	7.3	0.0	22.8
Relative	4.2	3.8	4.9	6.6	4.0	3.1	1.6	13.5
Pharmacist	1.1	1.2	0.8	2.7	0.0	1.1	0.0	5.3
Nurse/midwife	0.5	0.2	0.9	1.6	0.4	0.3	0.0	1.1
Other	0.4	0.3	0.6	0.8	0.0	0.4	1.5	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,871	1,010	861	271	612	792	107	89
Type of Counseling	Total	Urban	Rural	Pill	IUD	Condom	Female Sterilization	Other
General information about other methods	64.0	63.8	64.3	72.7	63.1	63.6	48.6	76.0
Information about method effectiveness	59.1	59.2	58.9	67.4	58.0	56.4	47.6	68.6
Information about possible side effects	81.9	81.7	82.2	78.2	91.1	53.2	70.7	67.9
What to do if side effects occur	77.3	75.9	78.8	78.9	85.9	47.5	60.9	61.1
Comprehensive	52.0	51.2	52.9	60.2	52.9	40.7	57.9	39.3
No. of Cases	1,015	480	535	212	572	88	95	48

Table 10.2 Satisfaction with Family Planning Services Among Women Aged 15–44
Who Have Received Contraceptive Counseling in the Last 5 Years
Reproductive Health Survey: Georgia, 2010

Characteristic	Degree of Satisfaction				Total	No. of Cases
	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied		
Total	40.7	45.3	10.7	3.3	100.0	1,015
Residence						
Urban	42.7	43.9	10.7	2.6	100.0	480
Rural	38.6	46.8	10.6	4.0	100.0	535
Age Group						
15–24	34.2	47.6	13.0	5.3	100.0	135
25–34	40.9	45.3	10.2	3.5	100.0	499
35–44	42.8	44.5	10.4	2.3	100.0	381
Region						
Kakheti	29.4	47.1	19.3	4.2	100.0	110
Tbilisi	45.5	42.2	8.6	3.7	100.0	207
Shida Kartli	34.9	47.0	16.9	1.2	100.0	70
Kvemo Kartli	41.6	42.7	12.4	3.4	100.0	79
Samtskhe–Javakheti	28.3	69.6	0.0	2.2	100.0	37
Adjara	46.3	45.1	6.1	2.4	100.0	66
Guria	32.4	52.9	10.3	4.4	100.0	62
Samegrelo	47.5	35.6	14.4	2.5	100.0	104
Imereti	38.7	50.3	6.8	4.2	100.0	164
Mtskheta–Mtianeti	40.3	45.8	12.5	1.4	100.0	58
Racha–Svaneti	41.5	47.7	7.7	3.1	100.0	58
Education Level						
Secondary incomplete or less	36.9	44.0	16.1	3.0	100.0	180
Secondary complete	34.4	51.6	10.1	3.9	100.0	259
Technicum	48.3	41.7	6.2	3.8	100.0	152
University/postgraduate	43.3	43.5	10.4	2.9	100.0	424
Wealth Quintile						
Lowest	43.6	44.8	8.2	3.5	100.0	141
Second	39.5	46.8	10.1	3.5	100.0	226
Middle	35.8	45.5	14.2	4.5	100.0	250
Fourth	37.9	49.6	11.3	1.1	100.0	169
Highest	46.5	41.6	8.6	3.3	100.0	229
Method Used						
Pill	28.7	48.8	17.0	5.5	100.0	212
IUD	44.5	45.6	7.5	2.5	100.0	572
Condom	26.4	48.3	19.7	5.6	100.0	88
Other	28.5	44.8	19.9	6.8	100.0	48
Female sterilization	59.9	35.4	4.7	0.0	100.0	95
Counseled About All Methods						
No	35.8	46.6	12.9	4.7	100.0	371
Yes	43.5	44.6	9.4	2.5	100.0	644
Counseled About Method Effectiveness						
No	33.8	46.9	14.2	5.1	100.0	420
Yes	45.5	44.2	8.3	2.1	100.0	595
Counseled About Possible Side Effects						
No	22.5	46.0	23.6	7.9	100.0	187
Yes	44.7	45.2	7.8	2.3	100.0	828
Counseled for Knowledge About What to Do If Side Effects Occur						
No	31.8	44.9	18.1	5.2	100.0	238
Yes	43.3	45.4	8.5	2.8	100.0	777
Comprehensive Counseling						
No	34.4	46.5	14.2	5.0	100.0	499
Yes	46.5	44.2	7.5	1.8	100.0	516

**Table 10.3.1 Selected Family Planning Services Received at the Time of Legally Performed Abortions
By Selected Characteristics Among Women Aged 15–44
Who Have Had at Least One Abortion in the Last 5 Years
Reproductive Health Survey: Georgia, 2010**

Characteristic	Contraception Counseling			Distribution of Methods of Contraception, Prescriptions for Methods, or Referrals			No. of Cases
	Total	Before Abortion	After Abortion	Method Distributed	Prescription Given	Referral Given	
Total	33.1*	9.9	13.2	6.6	7.4	1.0	2,054
Residence							
Urban	35.6	10.5	13.6	6.1	9.2	1.2	768
Rural	31.3	9.4	12.8	6.9	6.1	0.9	1,286
Residence							
Tbilisi	36.3	9.7	11.8	4.1	9.7	1.8	333
Other Urban	35.0	11.2	15.3	8.0	8.6	0.7	435
Rural	31.3	9.4	12.8	6.9	6.1	0.9	1,286
Age Group							
15–24	31.0	10.8	10.1	9.3	7.1	1.0	226
25–34	36.1	9.2	15.4	7.4	8.1	0.8	1,188
35–44	28.8	10.5	10.5	4.4	6.3	1.4	640
Education Level							
Secondary incomplete or less	30.6	6.5	14.7	6.1	6.5	1.9	456
Secondary complete	33.5	11.4	12.8	6.6	7.8	0.6	668
Technicum	27.1	7.7	8.1	3.7	7.5	0.4	286
University/ postgraduate	36.8	11.7	14.5	8.2	7.7	1.1	644
Socioeconomic Status							
Low	28.7	14.7	9.1	3.9	9.2	0.0	286
Middle	33.3	8.6	14.4	7.5	6.5	1.3	982
High	34.3	9.6	13.2	6.6	7.8	1.1	786
Ethnicity							
Georgian	34.9	10.5	13.4	7.6	6.9	0.7	1,661
Azeri	28.4	7.7	13.7	3.7	9.7	0.0	181
Armenian	26.3	9.0	13.7	1.9	8.9	6.1	141
Other	21.2	4.2	7.2	1.1	8.6	3.6	71
Order of Abortion							
First	30.5	10.5	12.1	7.4	7.0	0.6	576
Second	34.4	12.4	12.7	7.5	9.6	1.2	417
Third	30.6	9.0	11.9	5.6	5.2	0.4	291
Fourth	35.6	12.2	12.8	7.3	7.3	1.2	185
Fifth	41.8	10.4	17.4	10.8	8.1	1.3	135
Sixth or Higher	33.2	6.4	14.6	4.1	7.3	1.7	450

*Percent receiving any counseling or service. Rows can sum to more than the total figure due to use of multiple services

Table 10.3.2 Family Planning Counseling Received During Prenatal and Postnatal Care
By Selected Characteristics Among Women Aged 15–44
Who Received Perinatal Health Services in the Last 5 Years
Reproductive Health Survey: Georgia, 2010

Characteristic	Contraception Counseling During Prenatal Care		Contraception Counseling During Postnatal Care	
	%	No. of Cases	%	No. of Cases
Total	39.2	2,575	43.0	611
Residence				
Urban	42.1	1,184	46.9	332
Rural	36.1	1,391	37.0	279
Residence				
Tbilisi	37.3	563	46.1	160
Other Urban	47.3	621	47.7	172
Rural	36.1	1,391	37.0	279
Age Group				
15–24	36.2	722	36.0	147
25–34	39.0	1,473	43.1	375
35–44	45.7	380	55.5	89
Education Level				
Secondary incomplete or less	30.9	400	32.2	76
Secondary complete	36.2	724	33.7	134
Technicum	41.5	332	43.1	69
University/postgraduate	43.2	1,119	48.8	332
Wealth Quintile				
Lowest	28.1	410	36.2	69
Second	39.4	619	35.9	110
Middle	39.0	579	41.8	143
Fourth	41.9	406	41.4	118
Highest	43.0	561	49.9	171
Birth Order				
First	39.2	1,285	38.6	335
Second	38.5	924	46.0	206
Third or more	40.5	366	56.8	70

11 CHAPTER

OPINIONS ABOUT CONTRACEPTION

Use of contraceptives remains relatively low in Georgia. Slightly more than half of married women (53%) use any method of contraceptive. Since contraceptive practice is correlated with awareness and information about it, improved usage of methods and especially modern methods requires reliable data about what reproductive aged women think about specific details. According to GERHS10 survey results, practically all Georgian women have heard of at least one method of contraception. However, knowledge about the concrete characteristics of the different contraceptives, such as advantages, disadvantages and use-effectiveness, is low. Unfortunately, some indicators related to attitudes and knowledge about contraception that had improved between the 1999 and 2005 surveys, do not show further gains in the 2010 survey.

11.1 Opinions on Method Effectiveness

To assess awareness concerning the effectiveness of contraceptive methods all respondents were shown a list of 12 different methods and were asked to identify the most effective method for preventing pregnancy (Table 11.1 and Figure 11.1). International research shows female sterilization to have the highest use-effectiveness, while withdrawal has the lowest; however, only seven percent mentioned female sterilization. Three other methods were mentioned more frequently by the respondents, including the condom, which is subject to substantial failures in ordinary practice. Previously married women, older women, women with two or more children, and women with a high level of education, compared to other groups of respondents, were most likely to rank female sterilization first, but the percentages were small in all subgroups around the seven percent average. In Table 11.1, contraceptive methods are listed from left to right according to their actual use-effectiveness in preventing pregnancy, but as the results show, respondents' opinions do not correspond with this sequence.

The IUD, which is considered second in terms of actual use-effectiveness, was ranked first in effectiveness by 35% of the respondents, more than for any other method. However while condoms are ranked fourth in actual use-effectiveness, they were ranked first by 20% of respondents, second only to the IUD. Next, the pill came out third in terms of both actual effectiveness and respondent-rated effectiveness. It was followed by female sterilization, in fourth place as noted. With use-effectiveness that is in fact poor, the rhythm method was ranked fifth. As for the "other" category which included Norplant, emergency contraception, injectable contraceptives, and vasectomy,

Figure 11.1 Figure Opinions Regarding Which is the Most Effective Contraceptive Method, by Residence, Among Women Aged 15-44

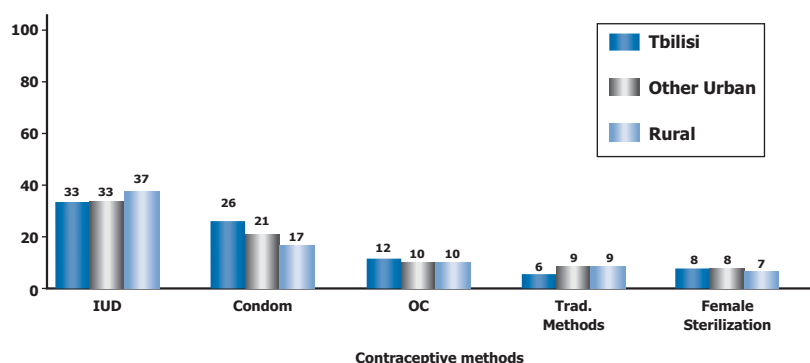


Figure 11.2.1 Opinions Regarding the Advantages of Using the Pill, Among Women Who Have Heard of it, for Women Aged 15-44, in 1999, 2005, 2010

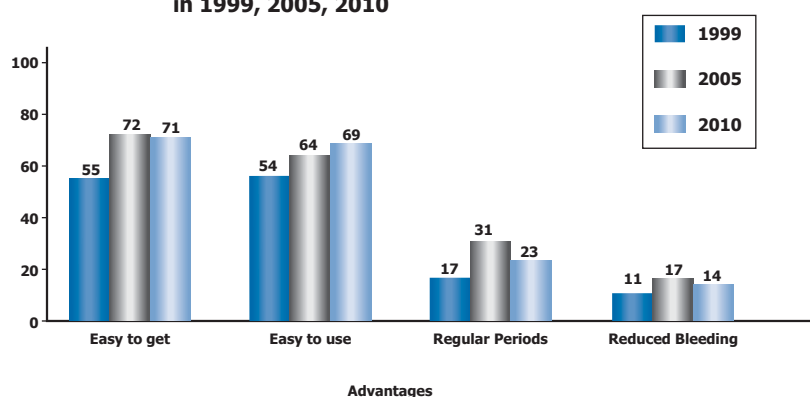
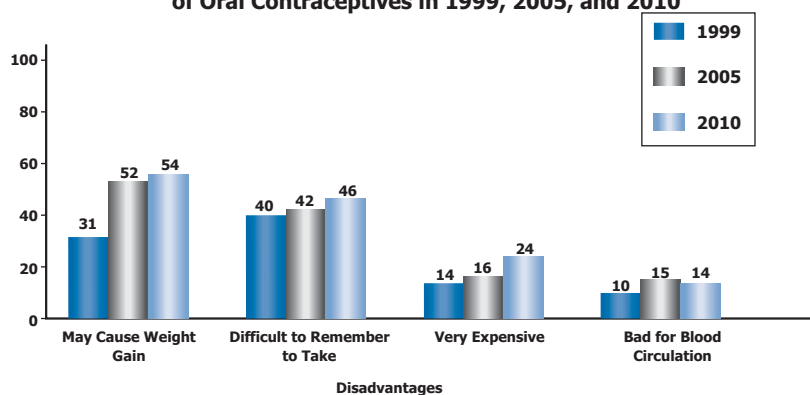


Figure 11.2.2 Opinions Regarding the Disadvantages Associated with Using OC Among Women Aged 15-44 Who Have Heard of Oral Contraceptives in 1999, 2005, and 2010



all very highly effective methods, only 1.3% of the respondents considered this category of methods as most effective.

Sterilization and the IUD were ranked first more often by women who were older and had more children, quite systematically, at the expense of the condom. Otherwise the accuracy of the rankings of the various methods did not improve significantly as respondent's education or wealth quintile increased. Unfortunately, the most effective methods are relatively less popular in Georgia, as confirmed by the 1999 and 2005 surveys as well as other Reproductive Health (RH) surveys carried out in Georgia (Khomasuridze, Kristesashvili,

and Tsuladze, 2004; Kristesashvili and Tsuladze, 2002; and Kristesashvili et al. 2009).

Overall, 16% of the women did not have an opinion on which method is most effective. That "no opinion" percentage varied greatly, and was very high among women aged 15-19 (42%), never married women (34%), and women with no children yet (32%). Most other groups had much lower percentages, showing that interest about contraception increases sharply as it becomes relevant to a woman's circumstances.

The percentage was also high for Azeri women (38%), and those with low educational attainment (29%).

Compared to the 2005 results, the percent of women who chose female sterilization as the most effective method hardly increased at all (from 6% to 7%), while the proportion of women who chose the IUD as the most effective actually declined (from 45% to 35%). Additionally, the percent of women having no opinion on the use-effectiveness of the methods increased (from 11% to 16%).

In sum, lack of information, in addition to incorrect information, about the various contraceptive methods appears to be widespread among women of reproductive age, indicating the need for improved information and education programs in the country.

11.2 Opinions on Advantages and Disadvantages of the Pill and the IUD

To assess women's information about the advantages and disadvantages of certain contraceptive methods, respondents who had heard of oral contraceptives and the IUD were asked to agree or disagree with several statements referring to their positive and negative effects. Seventy-one percent of respondents agreed that the "Pill is easy to get, while 69% agreed that "It is easy to use." They were less likely to agree that the pill makes menstrual periods more regular (23%) and reduces menstrual bleeding (14%) (Figure 11.2.1). The trend from 1999 to 2010 is sharply up for "easy to get" and "easy to use." In general, the percentage of women correctly identifying the advantages of the pill was higher as place of residence became more urban and as age, educational attainment, and wealth quartile increased (Table 11.2.1).

About 54% of respondents agreed with the statement that the pill may cause weight gain, while 46% stated that remembering to take the pill every day is difficult. A fourth (24%) agreed that the pill is very expensive, and 14% said that the use of the pill is "bad for blood circulation" (Figure 11.2.2.). Interestingly, the trend of opinion is up since 1999 for disadvantages

as well as for advantages, suggesting that the pill is becoming better known by the public. However with about half of women who have heard of the pill saying it can cause weight gain and is difficult to remember to take, and a fourth seeing it as very expensive, it is not surprising that its use is low in the country. Accurate information concerning the pros and cons of the pill should come primarily from physicians; this once again reflects the need to improve their own knowledge and to enhance their role in counseling and as educators.

For the IUD, three fifths (61%) of women who had heard of it said it is "Easy to use," and half (51%) said it is "Relatively inexpensive." As to disadvantages, a third (32%) said that it increases the risk of PID, and nearly a fourth (23%) said it could increase blood loss. The trend is up for "easy to use" and down for the two disadvantages of PID risk and blood loss, which points to an increasingly favorable image of the IUD and may encourage its adoption. All these percentages were higher among ever-married women and women aged 25-44, once again indicating that a woman's life stage affects the relevance of contraception to her and her opinions about particular methods. Percentages were also higher with educational attainment and, generally, with wealth quintile. Slightly more than one-third (32%) of respondents agreed that IUD use increases the risk of pelvic inflammatory disease, while 23% agreed that the IUD increases blood loss during menses. (Table 11.2.2. and Figure 11.2.3).

Overall women's knowledge about the advantages, disadvantages, and use-effectiveness of contraceptives is poor and presumably is not obtained from a reliable source such as a physician. However we can assume that the low level of counseling by physicians itself plays a serious role and again reflects the need to improve their educational role.

Figure 11.2.3 Opinions Regarding the Advantages and Disadvantages Associated with Using the IUD among Women Aged 15-44 Who Have Heard of the IUD in 1999, 2005, and 2010

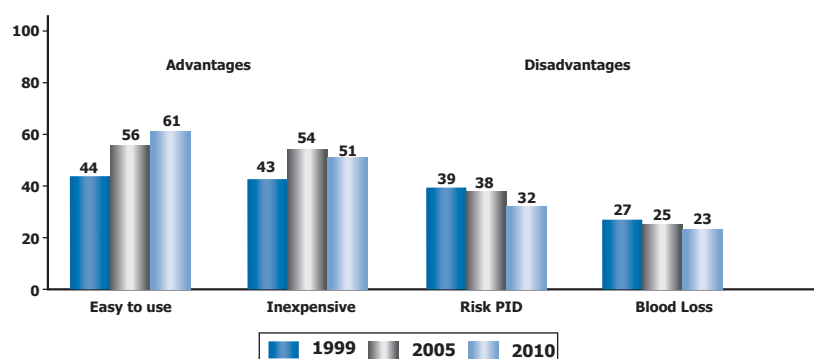


Figure 11.3.1 Perceived Risk Levels for Abortion, by Education, with “Don’t knows” Removed. The Former Gradient Nearly Disappears, and the Perceived Risk Levels are Higher

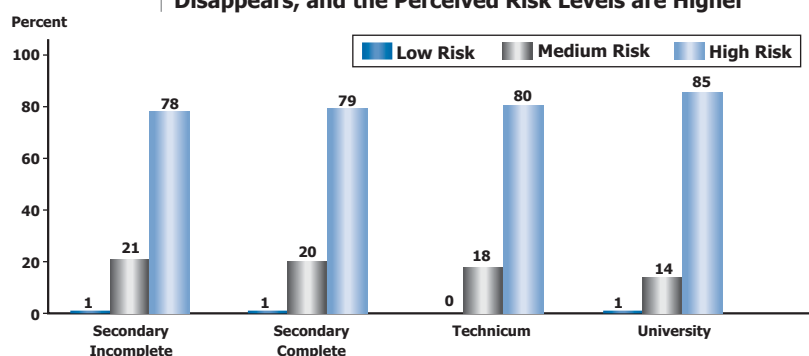
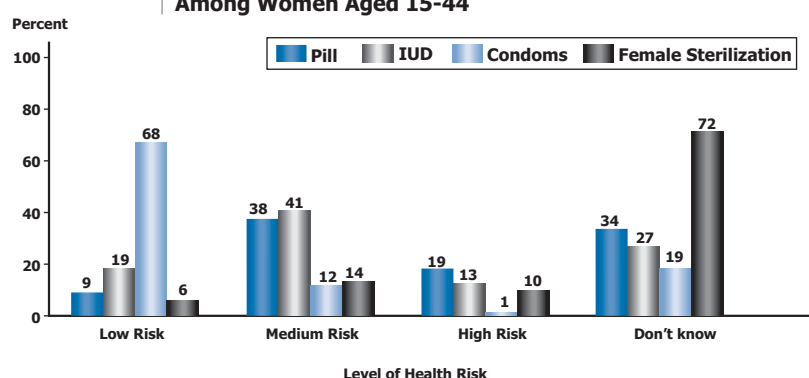


Figure 11.3.2 Opinions Regarding the Level of Health Risk Associated with Using Selected Contraceptive Methods Among Women Aged 15-44



11.3 Opinions on the Risks of Contraceptive Use

One of the determinants of modern contraceptive use is popular opinion regarding its risks to women's health. All respondents were asked to evaluate the degree of risk to a woman's health associated with the use of five modern contraceptive methods and abortion on request (Table 11.3.1, and Figures 11.3.1 to 11.3.5.) The series of tables from 11.3.2 through 11.3.6 gives details for each of the methods except the injectable, which is very little known in Georgia.

In Table 11.3.1 the perceived risk was lowest for condoms and highest for abortion. More than half of respondents believed that there is medium to high risk associated with oral contraceptive and IUD use; merely 9% of respondents considered the risk to be low for oral contraceptives; 19% thought so for the IUD.

High proportions of women “did not know” in Table 11.3.1 whether certain contraceptive methods posed a risk to a woman's health. This was the lowest for condoms and abortion, at 19% each, and the highest for injectables (97%), which is related to the limited accessibility of injectables in the country. The percentage not knowing was also very high also for female sterilization (70%), which is little used. The low “don't know” percentage for abortion is clearly related to its extensive use.

In Tables 11.3.2 through 11.3.6 each method is considered in turn, except the injectable, which is so little known. These tables all show perceptions of risk according to the various subgroups in the population. The oral contraceptive is considered first, and abortion last. The patterns across the subgroups vary according to the method, but the risk figures cannot be interpreted without attention to the “don't know” percentages.

The essential problem is that the “don't know” percentages remove many women from the other three columns in each table. In Table 11.3.2 for example, 41% of rural respondents said they didn't know; consequently their other percentages for risk must be low. On the other hand, only 24% of Tbilisi respondents said they didn't know, so their risk percentages are higher. That can be misleading, so the perception of risk must be judged carefully. Of the rural women, about 60% had an opinion and of these, 32% are in the medium risk column, for a ratio of about half (32%/60%). But among Tbilisi women the same calculation uses 47%/76%, giving 62% who perceive medium risk. Thus among women with an opinion, far more Tbilisi women see the pill as risky than rural women do. The same problem affects the interpretations for the other groups. The never-married group shows low percentages for risk, but most are in the don't know column.

Figure 11.3.3 Opinions Regarding the Level of Health Risk Associated with Using Abortion on Request by Education Among Women Aged 15-44

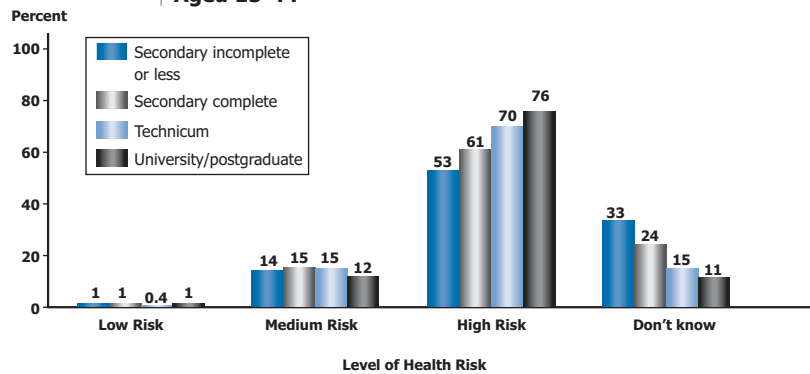
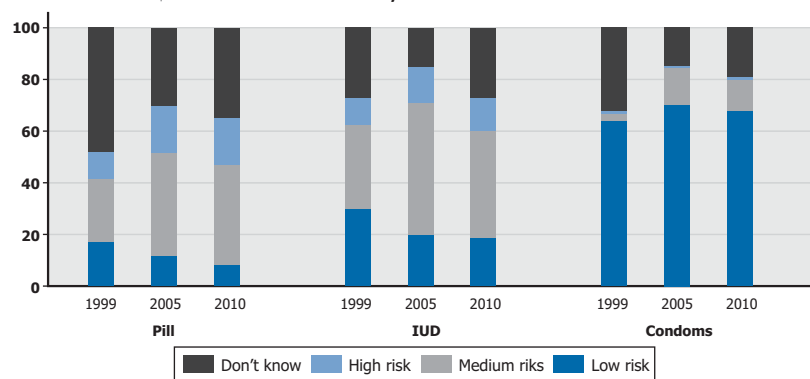


Figure 11.3.4 Opinions Regarding the Level of Health Risk Associated with Using Selected Contraceptive Methods Among Women Aged 15-44 Years in 1999, 2005 and 2010



The picture according to education is entirely reversed with this kind of correction. For abortion Table 11.3.6 shows a sharp gradient, with high risk rising with higher education, from 53% to 76%, but the “don’t know” percentage drops from 33% to 11%. With a correction to remove the “don’t know” group, as Figure 11.3.1 shows, instead of the percentage for high risk rising it is nearly level at 79% to 85% in all groups.

There are actually two groups in each of the Tables 11.3.2 to 11.3.6: one that has very little information about a method, which is of interest by itself, and the group that perceives some level of risk for the method. For education, the first key message is that having an opinion increases steadily with education, but second, for those with an opinion, all education groups may turn out to agree on the degree of risk.

The following Figures 11.3.2 to 11.3.5 retain all information in the tables, including the “don’t know” percentages, since they gauge the lack of public information and the need for program actions to improve it. As Table 11.3.1 demonstrated, a full one-fifth (19%) of all women interviewed say they do not know the risk levels of abortion or condoms.

However, to assess the perceived risks among those with an opinion, all figures must be adjusted to re-

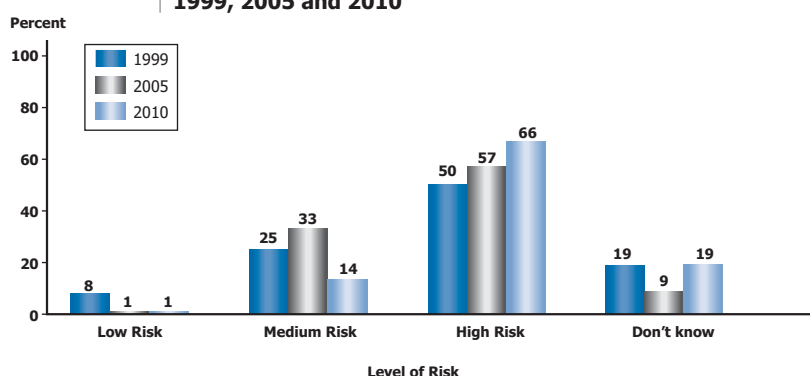
move the “don’t know” group, as illustrated above. Otherwise there is a distortion of the picture of perceived risk among those who have thought about it.

11.4 Desire for More Information on Contraceptive Methods

The 2010 survey data confirm that women want to know more about contraception. Over half (53%) of respondents want more information. The percentage rises among young adult women, never-married women, those with no living children, groups that currently have least information. The percentage also rose with higher wealth quintiles. Women who had never used oral contraceptives were more interested in receiving additional information on contraception than ever-users were. Interestingly, as age and the number of living children increased the desire for more information decreased, perhaps because those groups already possessed more information than others (Table 11.4.1 and Figure 11.4.1).

Respondents were asked what they considered to be the “best” source of information on contraception. The sources mentioned can be grouped into two different categories: medical sources (e.g., gynecologists), and nonmedical sources (e.g., radio/TV, friends/peers, and mother). Ever married women, older wom-

Figure 11.3.5 Opinions Regarding the Level of Risk Associated with Using Abortion on Request Among Women Aged 15-44 Years in 1999, 2005 and 2010



en, women with more education, and urban residents most frequently named gynecologists as the best source of information. Overall, among women who expressed an interest in receiving more information, 52% considered a gynecologist to be the best source of information; the other 48% preferred nonmedical sources of information. About 20% of women in this group identified TV/radio as the best source, followed by 10% who thought that newspapers and magazines to be the best source (Table 11.4.2 and Figure 11.4.2). These two sources (TV/radio and newspapers) make up a single category of information, “mass media,” so nearly one-third of respondents chose “mass media” as the best source of information on contraception.

An additional nine percent mentioned books, three percent friends, and another three percent the Internet. Not surprisingly, the role of the internet has increased for obtaining information on contraception. About 4-6 % of young women, women with more education, those at the highest wealth quintile, and women residing in Tbilisi believed the Internet to be the best source of information.

Interestingly, only two percent of all respondents mentioned their mothers as the best source. The percent was a little higher, up to six percent, among the never married, the young, and the less educated.

In the 2010 survey, for half (52%) of reproductive age women the best source of information is the gynecologist. Compared to adolescent girls, reproductive age women have more trust in the mass media. Thus, it is clear that gynecologists should pay more attention to their educational role in communicating with their patients, and representatives of the mass media should take into consideration that 30% of women rely on them as their best source of information and that they have a societal duty.

The 2010 survey results show the desire for more information to be the same (53 %) as in 1999 and slightly lower (55%) than in 2005 (Figure 11.4.1). In the 2005

and 2010 surveys, a greater percentage of women under the age of 35 indicated a desire for more information on contraceptives, compared to those aged 30 and older in both surveys. However, in 2010, fewer women aged 15-34 were interested in receiving information about contraceptives than women of the same age group in 2005, whereas the interest among older women aged 35-44 had increased by 10 percentage points.

The sensitivity of the public to contraceptive information in the mass media is assessed in Table 11.4.3. The results are somewhat mixed: a full two-thirds of women favored this, but one fourth did not. The more conservative position appeared among the rural and less educated groups, as well as the lower wealth quintiles. It was unusual among the Azeri, 29% of whom did not know with the rest split evenly between “yes” and “no” replies.

In general, contrary to the opinion of many among the more disadvantaged groups in the society, survey data clearly show the need for the majority of women of reproductive age to obtain more information on contraception, including some from the mass media.. At the same time it is also clear that obstetrician-gynecologists should be considered as the primary source of correct information. The data obtained in these surveys should be taken into account in planning public information in future RH programs.

Table 11.1 Opinions Regarding Which Contraceptive Method Is the Most Effective by Selected Characteristics
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Method of Contraception										Total	No. of Cases
	Female Sterilization	IUD (Spiral)	Pill	Condom	Spermicides	Other Modern*	Rhythm	Withdrawal	None of Them	Does Not Know		
Total	7.3	34.9	10.6	20.4	1.3	0.2	4.8	3.4	1.0	16.3	100.0	6,292
Residence												
Tbilisi	7.6	33.4	11.5	26.0	1.9	0.2	5.1	1.0	1.0	12.2	100.0	1,426
Other Urban	7.6	33.2	10.2	21.2	1.5	0.2	6.0	3.1	0.6	16.4	100.0	1,549
Rural	7.0	36.6	10.3	16.6	0.8	0.1	4.0	5.0	1.2	18.6	100.0	3,317
Marital Status												
Married	8.9	41.7	11.3	16.5	1.8	0.1	6.7	5.5	1.1	6.3	100.0	4,098
Previously married	9.1	38.5	8.0	22.0	1.4	0.6	6.4	1.1	1.6	11.3	100.0	389
Never married	4.3	22.3	9.9	26.7	0.3	0.1	1.3	0.1	0.7	34.4	100.0	1,805
Age Group												
15–19	1.7	17.4	8.5	29.3	0.0	0.0	0.3	0.1	0.7	42.0	100.0	861
20–24	4.3	32.6	13.5	22.1	0.8	0.2	3.2	1.8	0.6	20.8	100.0	1,099
25–34	8.1	40.5	11.9	18.6	2.0	0.1	4.6	4.6	0.8	8.7	100.0	2,359
35–44	11.7	40.5	8.5	15.9	1.5	0.3	8.7	5.1	1.5	6.4	100.0	1,973
Number of Living Children												
0	4.8	24.4	10.1	26.0	0.4	0.2	1.4	0.2	0.7	31.9	100.0	2,276
1	7.4	40.1	12.6	20.6	1.5	0.2	6.2	4.0	0.7	6.6	100.0	1,286
2	9.2	43.2	10.9	15.1	2.3	0.1	7.8	5.5	1.3	4.5	100.0	2,069
3 or more	12.0	43.2	7.7	12.2	1.6	0.1	7.3	9.1	1.7	5.2	100.0	661
Education Level												
Secondary incomplete or less	3.0	29.5	8.5	21.1	0.6	0.0	2.7	4.6	1.3	28.6	100.0	1,330
Secondary complete	6.3	35.7	10.4	17.7	0.8	0.0	4.1	4.4	1.0	19.5	100.0	1,568
Technicum	11.1	40.8	10.5	14.7	1.9	0.1	7.2	3.2	0.5	10.1	100.0	903
University/postgraduate	9.2	35.4	11.9	23.5	1.8	0.4	5.7	2.1	0.9	9.3	100.0	2,491
Wealth Quintile												
Lowest	6.6	35.5	10.0	16.6	0.4	0.1	3.7	6.4	1.4	19.3	100.0	1,093
Second	7.0	37.4	9.8	15.8	0.5	0.0	4.7	4.7	1.0	19.1	100.0	1,385
Middle	7.2	32.8	10.6	20.0	1.6	0.1	4.9	3.5	0.9	18.3	100.0	1,413
Fourth	6.8	35.4	10.3	21.4	1.3	0.1	6.0	2.7	1.4	14.6	100.0	1,037
Highest	8.5	33.9	11.6	25.4	2.1	0.3	4.6	1.1	0.5	12.0	100.0	1,364
Ethnicity												
Georgian	8.0	34.9	11.1	21.5	1.4	0.2	5.1	2.7	0.9	14.4	100.0	5,488
Azeri	1.8	34.2	5.8	5.3	0.3	0.0	3.0	10.7	1.2	37.7	100.0	276
Armenian	3.1	35.4	5.1	15.2	0.3	0.0	2.3	8.3	1.3	29.0	100.0	364
Other	5.9	34.3	14.8	23.0	2.3	0.0	2.7	2.9	2.5	11.6	100.0	164

* Other modern methods include: Norplant, emergency contraception, injectables, and vasectomy.

Table 11.2.1 Opinions Regarding the Advantages and Disadvantages of Using Oral Contraceptives by Selected Characteristics Among All Women Aged 15–44 Who Have Ever Heard of Oral Contraceptives
Reproductive Health Survey: Georgia, 2010

Characteristic	Advantages				Disadvantages				No. of Cases
	Easy to Get	Easy to Use	Regular Periods	Reduced Bleeding	May Cause Weight Gain	Difficult to Remember to Take	Very Expensive	Bad for Blood Circulation	
Total	71.1	69.1	23.2	14.4	53.8	46.0	24.0	13.5	5,237
Residence									
Tbilisi	76.3	73.5	26.6	17.8	57.9	46.7	24.1	14.7	1,304
Other Urban	71.5	70.0	22.3	11.8	53.3	45.5	23.4	11.9	1,352
Rural	67.3	65.5	21.4	13.6	51.3	45.8	24.4	13.7	2,581
Marital Status									
Married	74.6	73.3	26.8	17.2	58.0	49.8	27.6	15.7	3,686
Previously married	74.3	71.1	29.7	16.5	57.2	48.9	26.3	15.4	347
Never married	62.0	58.6	13.0	7.3	43.0	36.1	15.0	7.9	1,204
Age Group									
15–19	56.7	55.6	7.6	4.8	33.7	29.6	10.1	5.5	449
20–24	68.1	63.7	18.8	12.2	46.6	37.1	18.8	9.8	884
25–34	75.0	72.4	27.3	16.2	56.7	49.4	27.1	15.4	2,125
35–44	73.5	73.1	26.5	17.0	61.6	52.8	28.3	16.3	1,779
Education Level									
Secondary incomplete or less	58.2	60.9	14.6	7.4	40.3	37.4	19.4	7.2	833
Secondary complete	67.6	65.8	21.1	13.9	49.7	44.4	28.4	10.9	1,257
Technicum	74.4	71.2	26.0	15.2	59.7	49.7	25.5	19.4	827
University/postgraduate	76.7	73.1	26.6	17.0	59.1	48.8	23.0	15.3	2,320
Wealth Quintile									
Lowest	63.7	63.2	20.2	11.9	49.6	44.5	28.4	11.0	824
Second	66.4	64.6	20.6	12.5	49.7	45.7	24.6	14.8	1,077
Middle	69.5	68.7	22.1	12.4	54.3	46.6	23.3	13.0	1,160
Fourth	71.7	69.6	22.4	15.4	52.8	46.8	23.1	10.0	925
Highest	78.2	74.5	27.5	17.5	58.6	45.8	22.9	16.6	1,251
Ethnicity									
Georgian	72.7	70.2	23.8	14.9	56.2	47.3	24.4	14.3	4,709
Azeri	54.2	53.2	16.4	10.8	27.8	37.3	15.2	6.0	160
Armenian	51.5	53.6	12.6	8.8	29.9	31.5	25.5	7.0	237
Other	71.0	75.7	28.2	12.1	43.8	33.6	20.2	7.4	131

Table 11.2.2 Options Regarding the Advantages and Disadvantages of Using the IUD
by Selected Characteristics Among All Women Aged 15–44
Who Have Ever Heard of the IUD
Reproductive Health Survey: Georgia, 2010

Characteristic	Advantages		Disadvantages		No. of Cases
	Easy to Use	Relatively Inexpensive	Increases the Risk of Pelvic Inflammatory Disease	May Increase Blood Loss	
Total	60.6	50.8	32.2	23.0	5,652
Residence					
Tbilisi	64.4	51.4	35.5	25.3	1,328
Other Urban	62.4	52.8	29.6	20.6	1,415
Rural	57.1	49.2	31.7	22.9	2,909
Marital Status					
Married	68.6	59.3	36.5	27.0	3,938
Previously married	63.1	52.3	41.9	29.0	369
Never married	41.6	30.8	20.1	12.2	1,345
Age Group					
15–19	38.2	26.4	13.0	9.2	513
20–24	54.0	41.1	23.8	16.4	986
25–34	65.7	56.4	32.8	23.7	2,251
35–44	66.9	59.1	43.4	31.1	1,902
Education Level					
Secondary incomplete or less	52.6	41.6	20.7	15.2	982
Secondary complete	56.9	48.5	30.0	20.1	1,401
Technicum	64.1	59.1	38.6	29.1	884
University/postgraduate	64.8	53.1	36.2	25.8	2,385
Wealth Quintile					
Lowest	55.5	48.7	26.8	19.6	935
Second	56.3	46.4	30.9	20.9	1,221
Middle	59.5	52.5	33.7	22.5	1,261
Fourth	62.5	50.2	29.7	23.2	952
Highest	65.6	53.9	36.6	26.5	1,283
Ethnicity					
Georgian	61.3	51.7	33.4	24.1	5,005
Azeri	50.0	45.7	17.4	15.2	191
Armenian	53.3	41.1	22.7	10.3	308
Other	63.7	46.0	32.0	21.1	148

Table 11.3.1 Opinions Regarding the Level of Health Risk From Using Selected Family Planning Methods Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Degree of Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Pill	9.3	38.3	18.6	33.7	100.0	6,292
IUD	19.0	40.8	13.2	27.0	100.0	6,292
Condom	68.1	11.9	0.7	19.3	100.0	6,292
Female Sterilization	6.1	13.7	10.0	70.2	100.0	6,292
Injectables	0.4	1.8	1.1	96.8	100.0	6,292
Abortion on Request	1.0	13.5	66.2	19.4	100.0	6,292

Table 11.3.2 Opinions Regarding the Level of Health Risk From Using Oral Contraceptives by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Level of Health Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Total	9.3	38.3	18.6	33.7	100.0	6,292
Residence						
Tbilisi	8.5	47.4	20.5	23.6	100.0	1,426
Other Urban	10.4	39.8	18.0	31.8	100.0	1,549
Rural	9.3	32.2	17.9	40.6	100.0	3,317
Marital Status						
Married	10.7	44.4	22.6	22.3	100.0	4,098
Previously married	9.6	43.3	23.3	23.8	100.0	389
Never married	7.0	27.0	10.8	55.2	100.0	1,805
Age Group						
15–19	5.8	17.9	6.3	69.9	100.0	861
20–24	10.1	36.6	14.4	38.9	100.0	1,099
25–34	11.1	43.5	22.6	22.8	100.0	2,359
35–44	9.1	45.9	24.2	20.8	100.0	1,973
Education Level						
Secondary incomplete or less	6.1	24.4	10.2	59.3	100.0	1,330
Secondary complete	9.9	32.9	16.6	40.6	100.0	1,568
Technicum	9.9	45.9	23.9	20.3	100.0	903
University/postgraduate	10.7	47.2	23.0	19.2	100.0	2,491
Wealth Quintile						
Lowest	10.5	28.8	15.5	45.1	100.0	1,093
Second	9.4	31.6	17.7	41.3	100.0	1,385
Middle	8.1	35.4	19.6	36.9	100.0	1,413
Fourth	9.9	44.3	18.6	27.3	100.0	1,037
Highest	9.3	46.9	20.3	23.4	100.0	1,364
Ethnicity						
Georgian	10.0	40.6	19.4	30.0	100.0	5,488
Azeri	5.0	19.8	7.1	68.1	100.0	276
Armenian	2.4	23.9	16.7	57.1	100.0	364
Other	10.1	28.0	19.3	42.5	100.0	164
Ever Used Oral Contraceptives						
Yes	25.8	44.1	26.8	3.3	100.0	716
No	7.5	37.7	17.7	37.2	100.0	5,576

Table 11.3.3 Opinions Regarding the Level of Health Risk From Using the IUD
by Selected Characteristics, Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Level of Health Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Total	19.0	40.8	13.2	27.0	100.0	6,292
Residence						
Tbilisi	20.7	44.8	14.0	20.5	100.0	1,426
Other Urban	18.1	43.5	12.5	25.9	100.0	1,549
Rural	18.6	36.9	13.0	31.4	100.0	3,317
Marital Status						
Married	23.3	47.0	15.2	14.4	100.0	4,098
Previously married	19.5	46.7	17.0	16.9	100.0	389
Never married	11.6	28.9	8.9	50.6	100.0	1,805
Age Group						
15–19	10.5	18.7	5.7	65.0	100.0	861
20–24	18.8	37.9	10.2	33.1	100.0	1,099
25–34	22.9	46.5	15.1	15.5	100.0	2,359
35–44	20.0	49.4	17.4	13.2	100.0	1,973
Education Level						
Secondary incomplete or less	15.2	27.2	8.4	49.2	100.0	1,330
Secondary complete	18.9	36.8	12.3	32.1	100.0	1,568
Technicum	21.1	50.2	15.5	13.2	100.0	903
University/postgraduate	20.7	47.9	15.7	15.8	100.0	2,491
Wealth Quintile						
Lowest	19.3	33.8	10.8	36.1	100.0	1,093
Second	19.3	36.3	13.1	31.3	100.0	1,385
Middle	16.7	41.2	14.2	27.9	100.0	1,413
Fourth	19.4	42.8	14.5	23.3	100.0	1,037
Highest	20.3	46.2	12.7	20.7	100.0	1,364
Ethnicity						
Georgian	19.6	42.3	13.7	24.4	100.0	5,488
Azeri	19.2	19.5	3.6	57.7	100.0	276
Armenian	10.0	34.6	14.8	40.6	100.0	364
Other	18.2	43.3	10.4	28.1	100.0	164
Ever Used IUD						
Yes	45.1	41.7	11.5	1.7	100.0	1,048
No	14.0	40.6	13.5	31.9	100.0	5,244

Table 11.3.4 Opinions Regarding the Level of Health Risk From Using Condoms by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Level of Health Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Total	68.1	11.9	0.7	19.3	100.0	6,292
Residence						
Tbilisi	76.5	11.4	0.3	11.8	100.0	1,426
Other Urban	69.0	12.2	1.3	17.6	100.0	1,549
Rural	62.7	12.1	0.6	24.6	100.0	3,317
Marital Status						
Married	73.4	12.3	0.8	13.5	100.0	4,098
Previously married	74.5	12.8	1.1	11.6	100.0	389
Never married	57.7	11.1	0.5	30.7	100.0	1,805
Age Group						
15–19	51.6	9.4	0.6	38.4	100.0	861
20–24	65.5	12.0	0.3	22.2	100.0	1,099
25–34	73.7	12.3	0.8	13.1	100.0	2,359
35–44	73.4	13.0	0.9	12.8	100.0	1,973
Education Level						
Secondary incomplete or less	51.9	12.8	0.6	34.7	100.0	1,330
Secondary complete	64.7	10.8	0.6	23.9	100.0	1,568
Technicum	76.3	9.7	1.2	12.8	100.0	903
University/postgraduate	76.8	12.9	0.6	9.7	100.0	2,491
Wealth Quintile						
Lowest	59.4	11.9	0.5	28.1	100.0	1,093
Second	62.1	12.0	0.7	25.2	100.0	1,385
Middle	67.4	11.6	0.6	20.4	100.0	1,413
Fourth	69.4	14.5	1.4	14.7	100.0	1,037
Highest	77.1	10.2	0.4	12.2	100.0	1,364
Ethnicity						
Georgian	71.3	12.2	0.7	15.8	100.0	5,488
Azeri	36.1	8.4	1.1	54.4	100.0	276
Armenian	49.6	10.4	0.4	39.5	100.0	364
Other	61.4	13.0	1.5	24.1	100.0	164
Ever Used Condoms						
Yes	90.5	5.9	0.8	2.8	100.0	1,316
No	62.6	13.4	0.7	23.3	100.0	4,976

Table 11.3.5 Opinions Regarding the Level of Health Risk From Using Female Sterilization by Selected Characteristics Among All Women Aged 15–44 Reproductive Health Survey: Georgia, 2010

Characteristic	Level of Health Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Total	6.1	13.7	10.0	70.2	100.0	6,292
Residence						
Tbilisi	8.1	15.2	11.9	64.8	100.0	1,426
Other Urban	5.4	15.1	10.0	69.4	100.0	1,549
Rural	5.3	12.1	8.9	73.7	100.0	3,317
Marital Status						
Married	7.8	17.2	12.6	62.4	100.0	4,098
Previously married	6.0	18.7	12.5	62.9	100.0	389
Never married	3.3	6.7	5.0	85.0	100.0	1,805
Age Group						
15–19	1.1	2.4	2.1	94.3	100.0	861
20–24	4.3	9.8	6.6	79.3	100.0	1,099
25–34	6.3	15.6	12.7	65.4	100.0	2,359
35–44	10.0	20.8	13.8	55.3	100.0	1,973
Education Level						
Secondary incomplete or less	2.0	6.9	5.1	86.0	100.0	1,330
Secondary complete	5.5	9.7	7.7	77.1	100.0	1,568
Technicum	8.8	18.6	11.0	61.5	100.0	903
University/postgraduate	8.0	18.5	13.9	59.6	100.0	2,491
Wealth Quintile						
Lowest	6.0	9.1	8.6	76.3	100.0	1,093
Second	4.7	11.4	9.0	74.9	100.0	1,385
Middle	5.3	14.6	9.7	70.4	100.0	1,413
Fourth	5.9	12.9	8.5	72.7	100.0	1,037
Highest	8.2	17.9	12.8	61.1	100.0	1,364
Ethnicity						
Georgian	6.6	14.9	10.8	67.7	100.0	5,488
Azeri	2.1	4.3	2.8	90.8	100.0	276
Armenian	3.3	3.4	4.1	89.2	100.0	364
Other	2.6	14.6	9.2	73.7	100.0	164
Ever Used Female Sterilization						
Yes	51.8	42.4	1.7	4.2	100.0	112
No	5.3	13.2	10.2	71.4	100.0	6,180

Table 11.3.6 Opinions Regarding the Level of Health Risk From Using Abortion on Request by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Level of Health Risk				Total	No. of Cases
	Low Risk	Medium Risk	High Risk	Does Not Know		
Total	1.0	13.5	66.2	19.4	100.0	6,292
Residence						
Tbilisi	1.2	12.5	70.8	15.5	100.0	1,426
Other Urban	0.7	10.7	69.5	19.1	100.0	1,549
Rural	1.0	15.6	61.7	21.8	100.0	3,317
Marital Status						
Married	1.2	15.5	70.8	12.4	100.0	4,098
Previously married	1.4	14.9	68.3	15.4	100.0	389
Never married	0.6	9.7	57.8	32.0	100.0	1,805
Age Group						
15–19	0.5	10.4	49.1	40.0	100.0	861
20–24	0.8	11.9	64.6	22.7	100.0	1,099
25–34	1.1	14.2	71.1	13.6	100.0	2,359
35–44	1.2	15.5	71.9	11.4	100.0	1,973
Education Level						
Secondary incomplete or less	0.9	13.8	52.6	32.7	100.0	1,330
Secondary complete	0.7	14.5	61.2	23.5	100.0	1,568
Technicum	0.4	14.8	70.0	14.7	100.0	903
University/postgraduate	1.4	12.2	75.8	10.6	100.0	2,491
Wealth Quintile						
Lowest	1.2	18.5	56.5	23.9	100.0	1,093
Second	0.8	14.3	63.0	21.8	100.0	1,385
Middle	1.0	14.1	65.9	19.0	100.0	1,413
Fourth	1.3	11.4	69.1	18.2	100.0	1,037
Highest	0.8	11.0	72.1	16.1	100.0	1,364
Ethnicity						
Georgian	0.9	12.9	69.2	17.0	100.0	5,488
Azeri	2.4	17.7	37.3	42.6	100.0	276
Armenian	0.8	17.1	51.7	30.4	100.0	364
Other	0.2	16.6	52.7	30.5	100.0	164
Used Any Method						
Yes	1.1	17.1	73.5	8.3	100.0	3,170
No	0.9	10.3	59.8	29.0	100.0	3,122

Table 11.4.1 Desire for More Information About Methods of Contraception
By Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Desired More Information			Total	No. of Cases
	Yes	No	Does Not Know		
Total	53.2	42.9	3.9	100.0	6,292
Residence					
Tbilisi	54.2	43.2	2.5	100.0	1,426
Other Urban	55.9	41.3	2.8	100.0	1,549
Rural	51.2	43.5	5.3	100.0	3,317
Marital Status					
Married	53.9	43.4	2.7	100.0	4,098
Previously married	28.9	67.6	3.5	100.0	389
Never married	56.7	37.2	6.1	100.0	1,805
Age Group					
15–19	62.0	29.8	8.2	100.0	861
20–24	66.8	28.8	4.4	100.0	1,099
25–34	56.7	40.2	3.1	100.0	2,359
35–44	35.6	62.4	2.0	100.0	1,973
Number of Living Children					
0	56.8	37.5	5.8	100.0	2,276
1	58.2	39.4	2.4	100.0	1,286
2	48.7	48.8	2.6	100.0	2,069
3 or more	42.7	54.2	3.1	100.0	661
Education Level					
Secondary incomplete or less	46.6	45.2	8.2	100.0	1,330
Secondary complete	56.0	39.7	4.3	100.0	1,568
Technicum	52.8	45.6	1.6	100.0	903
University/postgraduate	55.4	42.6	1.9	100.0	2,491
Wealth Quintile					
Lowest	48.6	46.2	5.2	100.0	1,093
Second	51.5	42.8	5.8	100.0	1,385
Middle	53.1	42.5	4.4	100.0	1,413
Fourth	52.4	45.2	2.4	100.0	1,037
Highest	57.8	39.8	2.4	100.0	1,364
Ethnicity					
Georgian	54.2	42.7	3.1	100.0	5,488
Azeri	33.3	51.2	15.5	100.0	276
Armenian	60.1	33.5	6.4	100.0	364
Other	47.0	49.8	3.2	100.0	164
Ever Used Oral Contraceptives					
Yes	58.7	39.3	1.9	100.0	716
No	52.6	43.3	4.1	100.0	5,576

Table 11.4.2 Opinions Regarding the Best Source of Information about Methods of Contraception
By Selected Characteristics Among All Women Aged 15–44 Who Desire More Information
Reproductive Health Survey: Georgia, 2010

Characteristic	Best Source of Information about Methods of Contraception								Total	No. of Cases
	Gynecologist	Radio/TV	Newspapers/Magazines	Books	Friends, Peers, Contraceptive User	Internet	Mother	Other or Unknown		
Total	51.5	19.8	9.6	8.9	2.6	2.6	1.9	3.2	100.0	3,441
Residence										
Tbilisi	54.6	15.9	7.7	10.5	2.4	4.6	2.1	2.3	100.0	776
Other Urban	51.0	20.5	11.8	6.6	2.1	3.6	1.7	2.5	100.0	893
Rural	49.9	21.8	9.4	9.2	2.9	0.7	1.8	4.2	100.0	1,772
Marital Status										
Married	61.1	17.6	8.4	7.0	1.7	1.4	0.1	2.6	100.0	2,277
Previously married	59.0	14.0	4.9	12.3	5.0	3.2	0.0	1.6	100.0	108
Never married	35.1	24.1	11.9	11.7	3.7	4.3	5.0	4.4	100.0	1,056
Age Group										
15–19	36.6	22.6	10.4	9.8	4.8	4.1	6.4	5.4	100.0	549
20–24	51.5	20.3	9.5	8.6	2.1	3.8	1.4	2.9	100.0	767
25–34	60.4	18.1	8.5	6.8	1.6	1.7	0.6	2.4	100.0	1,383
35–44	51.6	19.4	10.6	11.9	2.5	1.1	0.2	2.7	100.0	742
Education Level										
Secondary incomplete or less	41.0	23.6	7.5	9.5	4.0	2.7	5.0	6.8	100.0	620
Secondary complete	52.8	21.4	11.0	6.6	3.6	1.3	1.3	1.9	100.0	895
Technicum	53.6	22.0	8.9	10.8	2.1	0.2	0.6	1.7	100.0	496
University/postgraduate	55.1	16.3	9.9	9.4	1.3	4.1	1.2	2.7	100.0	1,430
Wealth Quintile										
Lowest	43.4	23.2	11.5	8.9	3.7	0.1	2.7	6.4	100.0	542
Second	51.2	22.8	7.4	9.2	3.0	1.2	1.8	3.6	100.0	747
Middle	54.0	20.8	10.4	8.3	2.4	0.9	0.6	2.7	100.0	792
Fourth	53.6	19.5	10.7	7.2	1.8	2.6	2.2	2.5	100.0	572
Highest	52.4	15.7	8.7	10.2	2.4	5.9	2.4	2.3	100.0	788
Employment										
Working	49.3	18.7	11.1	13.0	2.3	3.2	0.4	2.1	100.0	763
Not working	52.1	20.1	9.2	7.8	2.6	2.4	2.3	3.5	100.0	2,678
Ethnicity										
Georgian	51.5	19.4	9.9	9.1	2.4	2.8	2.0	3.0	100.0	3,036
Azeri	56.1	24.6	4.4	0.9	2.6	0.0	0.9	10.4	100.0	93
Armenian	51.1	22.4	7.6	10.4	3.7	0.5	1.9	2.5	100.0	235
Other	48.3	21.7	9.9	7.6	6.4	3.4	0.0	2.7	100.0	77
Used Any Method										
Yes	60.9	17.2	9.0	7.1	1.8	1.8	0.1	2.1	100.0	1,736
No	43.6	22.1	10.0	10.4	3.2	3.2	3.4	4.1	100.0	1,705

Table 11.4.3 Opinions Regarding Whether Information about Methods of Contraception Should be Broadcast on Radio or Television by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	"Should Information about Methods of Contraception Be Broadcast?"			Total	No. of Cases
	Yes	No	Does Not Know		
Total	67.1	26.7	6.1	100.0	6,292
Residence					
Tbilisi	71.9	24.6	3.5	100.0	1,426
Other Urban	72.3	23.5	4.2	100.0	1,549
Rural	61.6	29.7	8.7	100.0	3,317
Marital Status					
Married	68.5	25.1	6.4	100.0	4,098
Previously married	59.5	34.6	5.9	100.0	389
Never married	66.3	27.9	5.8	100.0	1,805
Age Group					
15–19	65.2	27.0	7.8	100.0	861
20–24	71.8	21.9	6.3	100.0	1,099
25–34	69.2	24.8	6.1	100.0	2,359
35–44	63.2	31.7	5.1	100.0	1,973
Education Level					
Secondary incomplete or less	55.9	32.0	12.1	100.0	1,330
Secondary complete	67.3	26.7	6.0	100.0	1,568
Technicum	69.4	26.6	4.0	100.0	903
University/postgraduate	72.8	23.8	3.5	100.0	2,491
Wealth Quintile					
Lowest	56.1	31.7	12.2	100.0	1,093
Second	61.6	30.4	8.0	100.0	1,385
Middle	69.2	25.4	5.4	100.0	1,413
Fourth	68.9	26.7	4.4	100.0	1,037
Highest	74.5	22.3	3.2	100.0	1,364
Employment					
Working	72.1	24.8	3.0	100.0	1,410
Not working	65.8	27.2	7.0	100.0	4,882
Ethnicity					
Georgian	69.0	26.7	4.3	100.0	5,488
Azeri	34.5	36.6	29.0	100.0	276
Armenian	72.0	16.2	11.9	100.0	364
Other	59.9	29.4	10.7	100.0	164
Ever used Oral Contraceptives					
Yes	71.7	24.7	3.6	100.0	716
No	66.6	26.9	6.4	100.0	5,576

12

CHAPTER

REPRODUCTIVE HEALTH KNOWLEDGE AND OPINIONS

The reproductive health survey of Georgia incorporated questions that describe women's knowledge, attitudes, and opinions on certain reproductive health topics. According to the study results, women's opinion on the ideal number of children during 11 years (from 1999 to 2010) has been remained stable at three. Correct knowledge on the contraceptive effect of breastfeeding increased after 1999, while the percentage of women correctly knowing when the highest risk for getting pregnant is during the menstrual cycle slightly declined. Women's attitudes on the acceptability of abortion are very important, since for a long time period in Georgia abortion has been considered as a main opportunity to resolve an unwanted pregnancy. Acceptance of a woman's own right to decide about her pregnancy, including abortion, is still high in Georgia, as well as in the former Soviet Union countries. According to Georgian law abortion is still allowed if the pregnancy does not exceed 12 weeks. On January first, 2011, a new regulation was established, according to which gynecologists must have a conversation concerning abortion with a pregnant women who desires an abortion; then after three days she can proceed with the abortion if she wishes. The regulation prohibits abortion after 12 weeks, as well as the advertising of abortion.

12.1 Ideal Family Size

All respondents were asked about their opinion concerning the "ideal" number of children for a young family in Georgia. Nearly two-third (67%) of respondents stated that a young couple should have two or three children, with 47% favoring three children. About 10% of surveyed women responded that a young couple should have as many children as possible, and 6% said that a young couple should have as many as God gives (Table 12.1). These figures did not vary greatly across subgroups, except that a high 17% of the Azeri group said "As Many as Possible" while the Armenian group seldom said that and instead had a high 30% favoring an ideal of only two children.

In addition, the ideal size was elevated among women with three or more children already, which may reflect their own lifetime experiences. Only seven percent favored an ideal of two children whereas 77% favored ideals of three to five or more and another 14% chose responses of "as many as God Gives" or "As Many as Possible." The same figures were only 64% and 13% respectively among women with two living children currently.

12.2 Knowledge of the Menstrual Cycle

Respondents were asked their opinion as to when a woman is most likely to get pregnant during the menstrual cycle. Approximately 19% of married women use a traditional method of contraception, such as withdrawal and the rhythm method (Table 8.2.1). To use the rhythm method successfully, women should know when during the menstrual cycle they are most likely to get pregnant. According to the results, only 41% of the respondents correctly answered that the highest risk of becoming pregnant is halfway between two menstrual periods. Accuracy was highest in urban areas and among ever-married women, and was directly correlated with educational attainment, wealth quintile, and age. It was remarkably low in the three groups of the youngest women, those with no children yet, and those never married, all of which had menstruated for years but for whom the rhythm method was not yet relevant. Notably, even among the best educated women only about half gave an accurate answer.

Overall, 29% answered that they did not know when the risk is highest, but with significant variations. Again, the youngest women, those never-married women, and those children gave high “Don’t Know” replies, as did women with less education and Azeri

women; half of all these groups said they did not now (Table 12.2). These results are dramatic in reflecting a need for improvement in sex education efforts.

The time trends are discouraging for correct knowledge of when the risk of getting pregnant is the highest. The percent giving the correct answer declined between 2005 and 2010 at every educational level, even though it had increased between 1999 and 2005 (Figure 12.2.1). It also declined from 1999 to 2010 for every age group, and most sharply for young women, at ages 15-19 and 20-24 (Figure 12.2.2). It is reasonable that correct knowledge about the menstrual cycle correlates positively with education, age, living children, marital status, wealth quintile, and urban residence, but the levels are too low and the trend is negative. Some of this explained because educational activities for reproductive health face barriers from the conservative elements of the society, and perhaps also because traditional methods of contraception are being replaced by modern methods and women are paying less attention to the chances of becoming pregnant during the menstrual cycle. (Among married women aged 15-44 the percentage using modern methods rose, from 1999 to 2005 to 2010, from 19.8% to 26.6% to 34.7%, while the percentage using traditional methods was 20.7%, 20.7%, 18.5% respectively.)

Figure 12.2.1 Correct Knowledge of When a Women is Most Likely to Become Pregnant During the menstrual Cycle by Education: 1999, 2005 and 2010

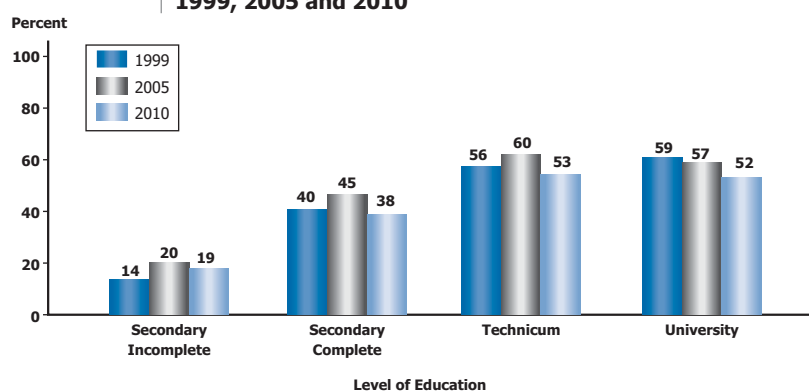
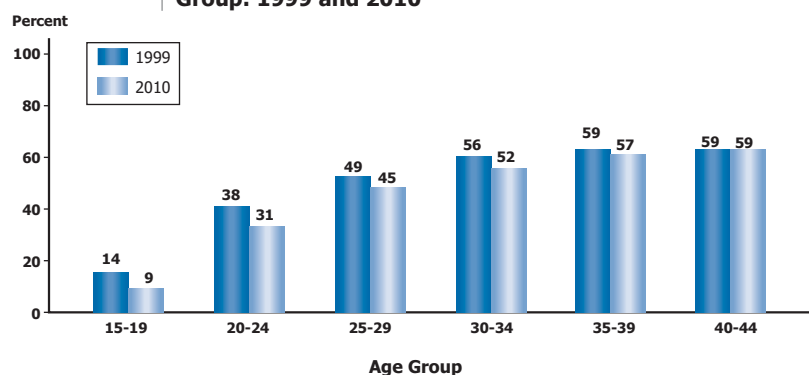


Figure 12.2.2 Correct Knowledge of When a Women is Most Likely to Become Pregnant During the menstrual Cycle by Age Group: 1999 and 2010



12.3 Knowledge of the Contraceptive Effect of Breastfeeding

Women were asked if in their opinion breastfeeding increases, decreases, or has no effect on a woman's chance of becoming pregnant. Nearly two-thirds (59%) of women correctly answered that the risk of pregnancy is lower during breastfeeding (Table 12.3). Another 17% said it has no effect, and essentially no-one said it increases the risk. However 23% said they did not know what kind of effect breastfeeding has on fertility, and that percentage was far higher among the never married, the youngest women, those with no children, those with least education, and those in the Azeri group. On the other hand, the "Don't Know" percentage was least (8%) and the correct reply (73%) was best among the group for which breastfeeding is most relevant, the currently married group.

Accuracy was remarkably better above age 25 (Figure 12.3) and in the two higher education groups. Little difference was found among women according to residence and wealth quintile.

Compared to 1999, in 2010 the percentage of women correctly reporting the contraceptive effect of breastfeeding increased from 56% to 60%, but it is three percentage points lower than in 2005. In addition, the proportion of women who did not know whether breastfeeding influences women's fertility changed from 25% in 1999 to 19% in 2005 and back up to 23% in 2010. This is the same time trend pattern as observed for knowledge of high-risk during menstruation (above), first increasing from 1999 to 2005 and then declining by 2010. Some of this can probably be explained by the intensive and effective information campaign on the advantages of breastfeeding conducted from 1995 to 2004. Currently, both Table 12.2 and Table 12.3 show that sex education efforts must be targeted more energetically toward women aged 15-24 years old, Azeri women, and women with low educational attainment (secondary incomplete or less).

12.4 Opinions on the Acceptability of Abortion

The respondents' positions on abortion were explored by asking if "a woman should always have the right to decide about her pregnancy, including whether or not to have an abortion." Respondents who said "No" were then asked under what specific circumstances it would be acceptable to have an abortion (Table 12.4.1). Overall, 72% of respondents agreed that a woman should always have the right to decide about her pregnancy, including resorting to abortion. Less than three percent of women opposed pregnancy termination under any circumstance whatever, while 24% considered abortion acceptable under certain circumstances.

The acceptability of abortion "always" increased with age and number of living children. The pattern is irregular according to educational attainment and wealth quintile, as well as by residence. All subgroups had high percentages on this item, but those who were less likely to agree with "always" included those aged 15-19 years (65%), never-married women (66%), those living in Tbilisi (66%) and women with no living children (66%). The opposite percentage, for those saying abortion was never acceptable, was below four percent in all subgroups, and the "don't know" percentages were nearly trivial.

The percentage saying that abortion was acceptable only under certain circumstances varied around the average of 24%, being highest in the same three groups that often in these analyses show a common pattern: the youngest age group, those never-married, and those with no children yet. About 30% in each group favored abortion only under certain circumstances. Tbilisi residents were also at 31%. The percentage increased generally with wealth quintile except at the next to highest level.

Those respondents who said that abortion is acceptable only under certain circumstances were read a list of possible circumstances and asked to judge each on

Figure 12.2.3 Correct Knowledge That Breastfeeding Decreases a Women's Chance of Becoming Pregnant by Age Group: 1999 and 2010

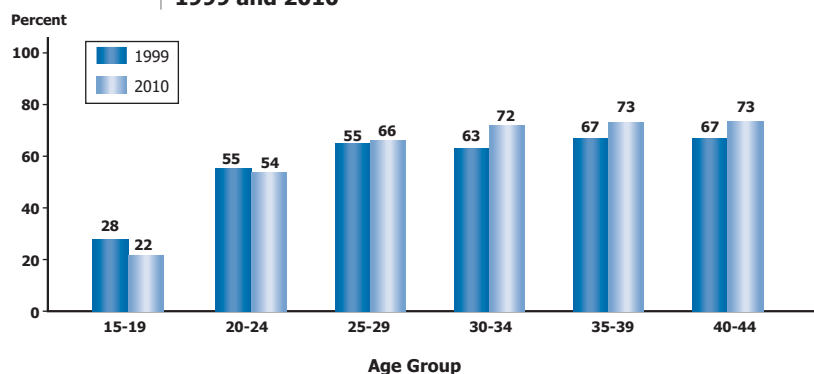


Figure 12.4.1 Percentage of All Women Aged 15-44 Who Believe That Abortion is Always acceptable by Age Group: 1999 and 2010

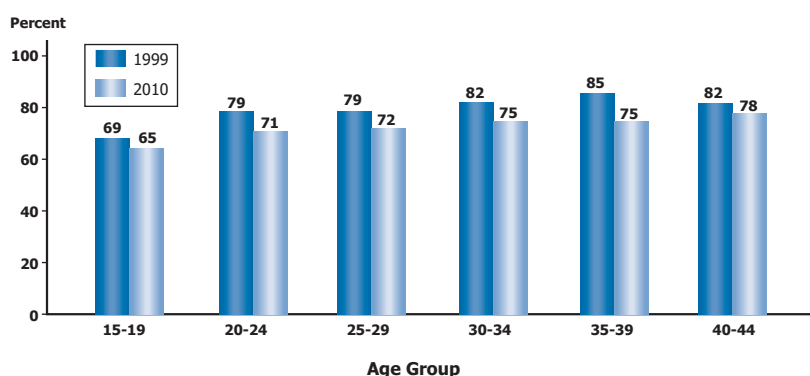
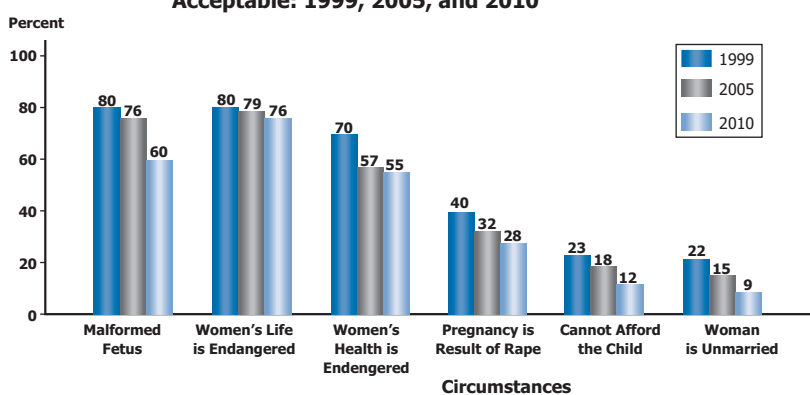


Figure 12.4.2 Circumstances Under Which Abortion is Acceptable among Women Aged 15-44 Who Said That Abortion is not Always Acceptable: 1999, 2005, and 2010



acceptability by responding by “yes,” “no,” “depends,” or “don’t know.” Three main reasons were mentioned under which a pregnant woman could have an abortion (Table 12.4.2). The highest “yes” percentage (77%) was when the pregnancy endangers the life of the mother, followed by 60% if the fetus has a physical deformity, and 55% if the pregnancy would endanger the woman’s health. Less than a one-third (29%) considered abortion acceptable when the pregnancy resulted from rape. Smaller percentages were recorded for cases in which the couple cannot afford a(nother) child (11%) or where they desire no more children (7%), or if the woman is not married (9%). In general the reverse of all these percentages fell into the “not acceptable” category, since the percentages saying “depends” were only 5% to 8% and the “don’t know” percentages were all below 4% with one exception.

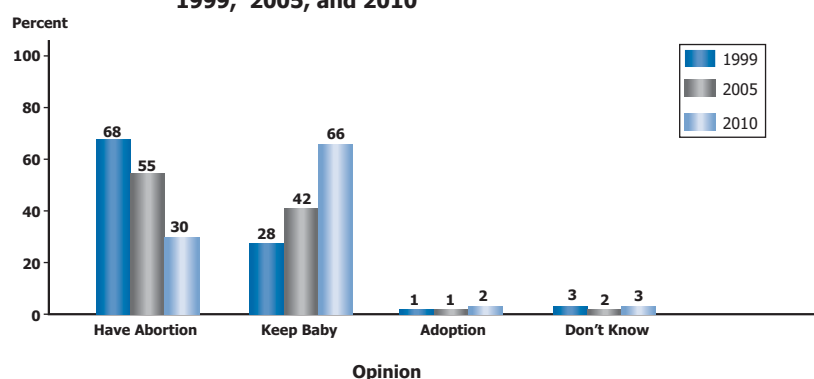
Thus it is clear that for the majority of women abortion is acceptable if the pregnancy endangers the woman’s life, no matter what subgroup is considered (Table 12.4.3). That is also true for the percentage concerning a fetus with physical deformities, for which the average was 60% and the lowest percentage was 56%-57% for such groups as the youngest women, the never married, and those with either no children or three or more children. Compared to Georgian wom-

en, Azeri and Armenian women are twice as likely to consider abortion acceptable when the woman is unmarried. Probably this reflects the influences of traditional views on the subject.

All respondents, regardless of their opinion about a woman’s right to decide about her pregnancy, were asked, “If a woman has an unwanted pregnancy, should she keep the baby, give the baby up to adoption, or have an abortion?” As shown in Table 12.4.4, about one-third of respondents said that the woman should have an abortion, while two-thirds said the woman should give birth and keep the baby. Only two percent said that the woman should have the baby and give it up for adoption. This confirms that in Georgia, for unwanted pregnancies, most women of child-bearing age feel that most should be carried to birth (two thirds) and most of the rest should be terminated by abortion. Those less likely to favor abortion as an option were again the usual threesome of never-married women, young women aged 15-19, and women with no living children, groups that of course overlap considerably. High education women were also less likely to favor the abortion outcome.

The most remarkable result however was the very high percentages favoring abortion among the Azeri,

Figure 12.4.3 Opinions Regarding What a Women Should Do if a Pregnancy is Unwanted Among Women Aged 15-44: 1999, 2005, and 2010



Armenian, and “other” ethnic groups, at 52%, 39%, and 49% respectively. That again must somehow reflect traditional cultural effects, perhaps along with greater poverty.

The trend since 2005 shows that the percentage of women who believe that abortion is always acceptable is ten percentage points lower than in 2005 (72.4% vs. 81.7% in 2005). That is balanced by an increase of eight percentage points in those saying it is acceptable only under certain circumstances (24.2% vs. 15.9% in 2005).

The decline in the percentage favoring abortion as always acceptable is displayed in Figure 12.4.1. It shows the decline in every age group that occurred between the 1999 and 2010 surveys. The decline varied between 4 to 10 percentage points depending upon the age group.

Marked declines also occurred in the percentage viewing each circumstance as justifying an abortion (Figure 12.4.2). It shows the systematic, large declines for every justification, from 1999 to 2005 to 2010 in the percentage of respondents in 1999, 2005 and in 2010 who agreed that abortion is acceptable under certain circumstances.

The most remarkable change however is in Figure 12.4.3. A decline of a full 38 points (68% to 30%) occurred in the percentage feeling that a woman with an unwanted pregnancy should have an abortion. A parallel increase of 38 points (28% to 66%) occurred in the percentage saying she should keep the baby. Those are truly historic shifts in public opinion and are more believable since the declines occurred in each five-year period. These should undoubtedly be regarded as positive trends.

12.5 Attitudes and Opinions toward Family and Reproductive Roles

All respondents were asked if they agreed with some statements reflecting reproductive roles and women’s

rights and responsibilities within the family. Overall, 74% of respondents agreed that “all people should marry” (Table 12.5.1). Among ethnic groups, Azeri women showed the highest endorsement (89%). Previously married women were less likely to endorse universal marriage (65%), compared to married women (76%) and never-married women (74%). A significant difference in endorsement occurred between women living in Tbilisi (65%) versus those outside Tbilisi (over 74%). Endorsement rose regularly by number of children, but fell regularly with higher education and higher wealth quintiles. About four-fifth of respondents (78%) agreed that “a woman must be a virgin at marriage.” This conservative view is more prevalent among women living outside Tbilisi, young women aged 15-24 years, women with three or more children, those with less education, and those in the low and middle wealth quintiles, as well as among Azeri and Armenian women.

In general, 72% of respondents agreed that “child care is a women’s job” (Figure 12.5.1). The subgroup patterns are largely similar to those just above regarding virginity. Rural women, women with more children, those with lower educational attainments and wealth quintiles, as well as Azeri and Armenian women were most likely to endorse this statement. On another topic, 74% of respondents agreed that “women should have as many children as God gives them.” The high rates of endorsement of this traditional attitude were among never-married women, women aged 15-24 years, women with no living children, women with the highest level of education, and those in the fourth highest quintile. Azeri, Armenian, and “other” ethnic groups are notable for the low endorsements they gave to this item, which is consistent with their greater endorsement of abortion seen above. Other patterns are somewhat irregular, and are somewhat difficult to explain. It can be assumed that in the recent period religious women are equally represented in all layers of society.

Four additional questions (on risk of pregnancy at first intercourse, refusal of sex if a husband has an STI, ac-

ceptability of asking a husband to use a condom if he has an STI, and whether a good wife obeys her husband) were asked of all respondents. The vast majority (84%) agreed that a woman can become pregnant during first sexual intercourse. The subgroups of women least likely (73% and less) to agree with this statement were women aged 15-24 years, never married women, women with no children and those with a secondary incomplete or lower education (Table 12.5.1).

A majority (76%) also agreed that “a woman can refuse sex with her husband if he has an STI” and that “a woman can ask her husband to use a condom when they have sex if he has an STI” (74%). Never-married women, women aged 15-24 years, women with secondary incomplete or less education, and Azeri women were the least likely to agree with these two statements. By far, most women residing in Tbilisi (81%) agreed that “a woman can ask her husband to use a condom...”, whereas only 68% of women from rural areas agreed with this statement. Agreement for both questions was least among the unmarried, youngest, and childless groups, and the Azeri and Armenian groups. It declined systematically toward less education and toward the poorest quintiles. In general, knowledge regarding sexual and reproductive health correlates with less education and to some extent with life experience and the related groups should be considered as a focus for conducting educational activities. They also appear to need special programs aimed at improving communication with sexual partners.

Respondents were asked about agreement with the statement that “A good wife obeys her husband.” Only 42% agreed, the lowest concurrence among all items in Table 12.5.1. A mere 26% of Tbilisi women agreed, only 34% in the top education group did so, and only 28% in the top wealth quintile did so. The expected patterns also by age and number of children appeared, all along the lines of greater independence for women during social change in Georgia.

Finally, all study participants were asked, “Who do you think should decide how many children a couple should have?” The vast majority of respondents (94%) said that a man and a woman should make that decision together. All other percentages were low (3% to 6%), with little variation among subgroups. Less than 2% of the women stated that the man should make the decision, except for about 6% in the Azeri group (Table 12.5.2).

The trends are interesting for some of the above findings, and they reflect the social changes underway in Georgia (Figure 12.5.1). Between 1999 and 2010 the percentage of women who agreed that “child care is a women’s job” declined, as did the percentage insisting on virginity at marriage, or that every individual should get married, although all percentages remained at high levels. In contrast there was a very sharp increase, of 23 points, in the percentage saying women must have the children that God gives to them. That seems consistent with the declines in the percentage favoring abortion on demand.

Clearly, an emancipation process is underway in Georgia. At the same time, human values are strengthening, while a dislike of abortion is increasing. During these processes a positive influence of religion in the post-soviet period should play an important role. The surveys show that the foundation of the family and having children are the most significant values for women living in Georgia. It is worth noting that various awareness-raising and educational projects implemented by the UNFPA during the last decade could have had greater effects if not hindered by the reactionary groups during negative TV talk-shows, while constructive health-related informational and educational programs on TV including those on reproductive health are minimized.

Figure 12.5.1 Agreement with Various Statements on Reproductive Norms Among Women Aged 15-44: 1999, 2005, and 2010

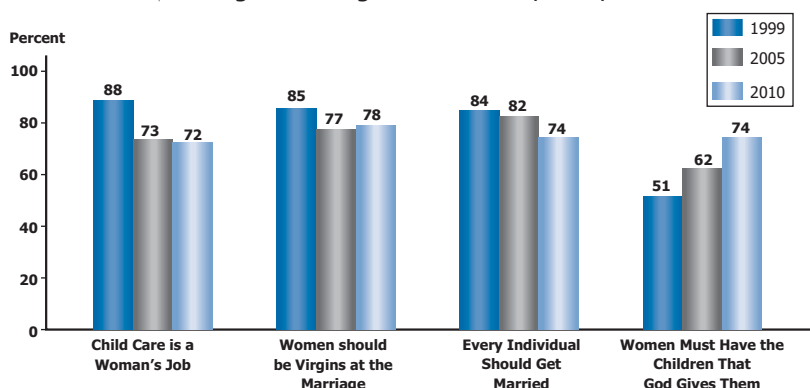


Table 12.1 Opinions Regarding the Ideal Number of Children for a Young Family in Georgia by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Ideal Number of Children								Total	No. of Cases	Mean No. of Children	
	0–1	2	3	4	5 or More	As Many as God Gives	As Many as Possible	Not Sure			Mean	No. of Cases *
Total	0.7	19.8	47.1	12.3	2.3	5.8	9.9	2.1	100.0	6,292	3.0	5,159
Residence												
Tbilisi	0.8	19.5	49.0	13.1	1.8	5.6	8.8	1.4	100.0	1,426	3.0	1,203
Other Urban	1.0	22.0	45.1	11.3	2.6	6.1	10.4	1.6	100.0	1,549	2.9	1,255
Rural	0.4	18.8	47.0	12.3	2.4	5.9	10.4	2.9	100.0	3,317	3.0	2,701
Marital Status												
Married	0.6	18.6	49.5	13.0	2.2	4.4	10.1	1.5	100.0	4,098	3.0	3,416
Previously married	0.8	23.4	40.0	10.5	2.4	6.6	13.0	3.3	100.0	389	2.9	304
Never married	0.9	21.1	44.1	11.3	2.4	8.1	9.1	2.9	100.0	1,805	2.9	1,439
Age Group												
15–19	0.6	21.8	44.8	10.6	2.2	7.3	8.9	3.8	100.0	861	2.9	691
20–24	0.8	21.2	49.6	10.1	2.2	4.9	8.4	2.7	100.0	1,099	2.9	929
25–34	0.6	19.5	47.0	12.6	2.1	5.4	11.4	1.5	100.0	2,359	3.0	1,927
35–44	0.7	18.1	46.8	14.3	2.6	6.1	9.9	1.5	100.0	1,973	3.0	1,612
Number of Living Children												
0	0.8	20.9	44.4	11.3	2.3	8.6	9.0	2.7	100.0	2,276	2.9	1,805
1	0.9	23.0	47.3	9.6	1.2	4.8	11.2	1.9	100.0	1,286	2.8	1,063
2	0.3	20.7	48.1	13.7	1.8	2.8	10.8	1.7	100.0	2,069	3.0	1,744
3 or more	0.6	6.8	54.2	17.0	5.8	5.3	9.0	1.3	100.0	661	3.3	547
Education Level												
Secondary incomplete or less	0.6	22.2	43.2	11.7	2.4	5.6	9.4	4.9	100.0	1,330	2.9	1,070
Secondary complete	1.1	19.0	46.6	13.0	2.5	5.6	9.8	2.5	100.0	1,568	3.0	1,284
Technicum	0.3	20.4	49.4	11.1	1.7	5.2	10.7	1.3	100.0	903	3.0	746
University/postgraduate	0.6	18.8	48.7	12.6	2.2	6.4	10.1	0.6	100.0	2,491	3.0	2,059
Wealth Quintile												
Lowest	0.4	19.2	41.0	14.2	2.9	5.8	11.9	4.7	100.0	1,093	3.0	839
Second	0.5	18.9	49.5	10.7	2.0	5.1	10.6	2.7	100.0	1,385	3.0	1,148
Middle	0.7	19.4	47.4	12.5	2.2	6.8	9.6	1.5	100.0	1,413	3.0	1,164
Fourth	0.9	23.7	43.5	11.6	2.5	6.3	9.9	1.7	100.0	1,037	2.9	850
Highest	0.9	18.4	50.9	12.8	2.0	5.4	8.7	1.1	100.0	1,364	3.0	1,158
Ethnicity												
Georgian	0.7	19.2	47.7	12.7	2.4	6.4	9.9	1.1	100.0	5,488	3.0	4,519
Azeri	0.3	19.4	39.0	7.5	1.6	3.0	17.3	11.9	100.0	276	2.9	186
Armenian	1.5	30.1	48.1	9.3	1.4	0.9	3.1	5.7	100.0	364	2.8	328
Other	0.0	20.3	38.6	14.8	2.6	4.0	10.7	9.0	100.0	164	3.0	126

* Excludes 1,133 women who gave non-numeric answers.

Table 12.2 Opinions Regarding When a Woman is Most Likely to Become Pregnant During Her Menstrual Cycle by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	When is a Women Most Likely to Became Pregnant?						Total	No. of Cases
	Just Before Her Period Starts	During Her Period	Right After Her Period Ends	Halfway Between Her Periods	Anytime	Don't Know		
Total	3.1	0.3	18.5	41.1	7.6	29.4	100.0	6,292
Residence								
Tbilisi	3.6	0.4	19.0	46.2	6.8	24.0	100.0	1,426
Other Urban	2.1	0.4	18.3	44.7	7.8	26.7	100.0	1,549
Rural	3.4	0.3	18.3	36.1	8.0	34.0	100.0	3,317
Marital Status								
Married	3.3	0.2	21.3	54.5	6.5	14.2	100.0	4,098
Previously married	1.6	0.9	18.5	57.1	6.8	15.0	100.0	389
Never married	3.1	0.5	13.6	14.8	9.7	58.2	100.0	1,805
Age Group								
15–19	3.0	0.2	9.1	9.3	10.2	68.2	100.0	861
20–24	2.9	0.4	19.9	31.3	9.1	36.5	100.0	1,099
25–34	3.5	0.3	21.6	48.5	7.2	18.9	100.0	2,359
35–44	3.0	0.5	19.9	57.9	5.7	13.1	100.0	1,973
Number of Living Children								
0	3.0	0.5	14.5	19.8	9.3	52.9	100.0	2,276
1	2.6	0.2	21.8	55.2	6.7	13.5	100.0	1,286
2	3.5	0.1	21.7	56.5	5.8	12.4	100.0	2,069
3 or more	3.5	0.7	19.6	55.9	7.6	12.7	100.0	661
Education Level								
Secondary incomplete or less	2.4	0.6	15.4	19.3	9.5	52.8	100.0	1,330
Secondary complete	5.4	0.2	16.8	37.6	8.2	31.7	100.0	1,568
Technicum	2.5	0.4	23.4	53.0	5.6	15.0	100.0	903
University/postgraduate	2.3	0.2	19.7	51.7	6.8	19.2	100.0	2,491
Wealth Quintile								
Lowest	2.9	0.4	17.3	32.8	5.8	40.8	100.0	1,093
Second	4.2	0.2	20.1	35.0	8.2	32.3	100.0	1,385
Middle	3.1	0.3	18.2	37.6	9.9	30.9	100.0	1,413
Fourth	3.0	0.6	17.1	45.4	7.2	26.6	100.0	1,037
Highest	2.5	0.3	19.2	50.0	6.6	21.4	100.0	1,364
Ethnicity								
Georgian	3.2	0.4	19.3	42.7	7.0	27.4	100.0	5,488
Azeri	1.7	0.0	11.4	20.8	12.3	53.8	100.0	276
Armenian	3.1	0.0	13.7	34.0	11.1	38.1	100.0	364
Other	3.3	0.0	16.5	40.4	10.5	29.3	100.0	164

Table 12.3 Opinions Regarding Whether Breastfeeding Increases, Decreases, or Has No Effect on a Woman's Chances of Becoming Pregnant by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	How Does Breastfeeding Affect a Woman's Chance of Getting Pregnant?				Total	No. of Cases
	Increases the Chance	Decreases the Chance	Has No Effect	Don't Know		
Total	0.6	59.0	17.3	23.1	100.0	6,292
Residence						
Tbilisi	0.9	59.5	20.2	19.4	100.0	1,426
Other Urban	0.2	61.1	17.8	21.0	100.0	1,549
Rural	0.7	57.6	15.3	26.3	100.0	3,317
Marital Status						
Married	0.7	73.3	18.0	8.0	100.0	4,098
Previously married	0.4	68.1	18.7	12.9	100.0	389
Never married	0.6	32.6	15.8	50.9	100.0	1,805
Age Group						
15–19	0.5	22.0	14.7	62.7	100.0	861
20–24	0.6	54.0	16.8	28.6	100.0	1,099
25–34	0.7	69.3	18.4	11.6	100.0	2,359
35–44	0.6	72.9	18.0	8.5	100.0	1,973
Number of Living Children						
0	0.7	36.2	16.5	46.7	100.0	2,276
1	0.7	74.5	17.8	7.0	100.0	1,286
2	0.6	75.2	18.1	6.0	100.0	2,069
3 or more	0.5	75.6	17.4	6.5	100.0	661
Education Level						
Secondary incomplete or less	0.6	42.6	14.8	42.0	100.0	1,330
Secondary complete	0.6	56.5	16.6	26.3	100.0	1,568
Technicum	0.6	70.9	19.4	9.1	100.0	903
University/postgraduate	0.7	66.0	18.4	14.8	100.0	2,491
Wealth Quintile						
Lowest	0.5	55.2	15.5	28.8	100.0	1,093
Second	0.6	58.7	14.6	26.0	100.0	1,385
Middle	1.0	57.0	16.9	25.1	100.0	1,413
Fourth	0.2	62.3	17.3	20.1	100.0	1,037
Highest	0.7	60.6	20.7	18.0	100.0	1,364
Ethnicity						
Georgian	0.6	60.7	17.6	21.2	100.0	5,488
Azeri	0.0	41.5	15.5	43.0	100.0	276
Armenian	1.6	48.0	14.6	35.8	100.0	364
Other	2.1	59.3	17.8	20.8	100.0	164

Table 12.4.1 Opinions Regarding the Acceptability of Abortion by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Acceptability of Abortion				Total	No. of Cases
	Always Acceptable	Acceptable Under Certain Circumstances	Never Acceptable	Does Not Know		
Total	72.4	24.2	2.9	0.5	100.0	6,292
Residence						
Tbilisi	65.5	30.9	3.2	0.4	100.0	1,426
Other Urban	75.1	21.1	3.6	0.2	100.0	1,549
Rural	75.0	22.0	2.2	0.7	100.0	3,317
Age Group						
15–19	64.5	31.4	3.0	1.2	100.0	861
20–24	71.4	24.1	3.8	0.7	100.0	1,099
25–34	73.7	22.8	3.0	0.4	100.0	2,359
35–44	76.4	21.5	2.0	0.1	100.0	1,973
Marital Status						
Married	75.6	21.4	2.6	0.3	100.0	4,098
Previously married	77.7	19.4	2.7	0.2	100.0	389
Never married	65.9	29.9	3.3	0.9	100.0	1,805
Number of Living Children						
0	65.6	30.3	3.3	0.8	100.0	2,276
1	74.9	21.7	3.2	0.2	100.0	1,286
2	77.9	19.4	2.4	0.3	100.0	2,069
3 or more	79.3	18.3	1.7	0.7	100.0	661
Education Level						
Secondary incomplete or less	75.7	21.2	2.0	1.2	100.0	1,330
Secondary complete	71.8	24.0	3.7	0.5	100.0	1,568
Technicum	74.9	22.5	2.1	0.4	100.0	903
University/postgraduate	70.1	26.7	3.1	0.2	100.0	2,491
Wealth Quintile						
Lowest	76.2	20.6	2.2	1.0	100.0	1,093
Second	76.9	20.6	2.0	0.5	100.0	1,385
Middle	71.2	25.0	3.1	0.7	100.0	1,413
Fourth	72.8	23.1	3.7	0.3	100.0	1,037
Highest	67.7	29.1	3.1	0.2	100.0	1,364
Ethnicity						
Georgian	71.6	25.0	2.9	0.4	100.0	5,488
Azeri	77.1	19.3	2.0	1.7	100.0	276
Armenian	78.9	18.1	1.8	1.2	100.0	364
Other	75.9	20.1	3.5	0.5	100.0	164

Table 12.4.2

Acceptability of Abortion Under Selected Circumstances Among Women Aged 15–44 Who Do Not Believe That Abortion Is Always Acceptable
Reproductive Health Survey: Georgia, 2010

Circumstance	Acceptability of Abortion				Total	No. of Cases
	Acceptable	Not Acceptable	Depends	Don't Know		
If pregnancy endangers woman's life	77.2	16.1	4.4	2.4	100.0	1,689
If the fetus has a physical deformity	60.4	27.6	8.1	4.0	100.0	1,689
If pregnancy endangers women's health	55.2	34.8	6.8	3.1	100.0	1,689
If pregnancy resulted from rape	29.4	55.5	7.7	7.4	100.0	1,689
If the couple cannot afford to have a(nother) child	10.8	80.2	5.4	3.7	100.0	1,689
If the women is not married	8.8	80.1	7.2	4.0	100.0	1,689
If the couple desire no (more) children	7.2	84.6	4.9	3.3	100.0	1,689

Table 12.4.3

Circumstances Under Which It Is Acceptable to Have an Abortion by Selected Characteristics
Among Women Aged 15–44 Who Do Not Believe That Abortion Is Always Acceptable
Reproductive Health Survey: Georgia, 2010

Characteristic	Circumstances Under Which It Is Acceptable to Have an Abortion							No. of Cases
	Women's Life Endangered	Fetus Deformed	Women's Health Endangered	Pregnancy Resulted from Rape	Cannot Afford Child	Women Unmarried	Desires No (More) Children	
Total	77.2	60.4	55.2	29.4	10.8	8.8	7.2	1,689
Residence								
Tbilisi	81.2	57.7	56.3	26.6	10.2	4.7	6.6	483
Other Urban	71.9	57.3	51.1	29.3	9.3	10.5	3.7	381
Rural	76.8	64.2	56.7	31.6	12.0	11.1	9.6	825
Age Group								
15–24	76.9	56.4	55.5	29.1	7.8	8.8	4.8	615
25–34	77.3	62.2	56.2	28.3	11.4	10.3	7.4	598
35–44	77.6	64.6	53.7	31.1	14.7	6.8	11.0	476
Marital Status								
Married	77.4	64.2	56.1	31.9	14.1	9.2	9.2	998
Previously married	74.3	59.9	49.0	24.3	12.0	6.1	8.0	83
Never married	77.3	55.7	55.0	26.9	6.5	8.5	4.6	608
Number of Living Children								
0	77.1	56.8	54.4	27.3	6.6	7.9	4.6	773
1	74.9	64.5	59.0	27.1	14.4	8.0	8.1	334
2	80.6	66.5	57.7	34.1	16.7	10.8	11.5	446
3 or more	72.3	55.9	45.0	34.1	12.0	9.9	9.2	136
Education Level								
Secondary incomplete or less	77.4	60.5	59.4	34.9	11.8	13.6	9.7	319
Secondary complete	72.8	60.7	52.0	31.8	11.7	9.3	6.4	409
Technicum	80.4	69.4	60.5	35.4	16.2	11.7	10.7	217
University/postgraduate	78.7	57.5	53.8	23.6	8.2	5.4	5.5	744
Wealth Quintile								
Lowest	78.6	62.7	59.0	32.7	15.3	9.6	8.3	260
Second	79.3	66.7	59.2	29.3	13.2	15.0	10.0	324
Middle	75.0	58.4	48.0	29.0	8.8	9.2	6.7	391
Fourth	75.7	60.2	56.2	25.0	5.8	5.9	3.9	282
Highest	78.0	57.5	56.4	30.9	12.1	6.5	7.6	432
Ethnicity								
Georgian	77.7	59.7	55.2	28.6	10.3	8.1	6.5	1,520
Azeri	68.5	67.6	53.9	47.2	16.6	16.8	18.1	60
Armenian	73.2	71.2	60.8	30.4	9.3	14.2	9.9	67
Other	78.2	54.8	49.8	25.1	17.7	10.7	11.5	42

Table 12.4.4 Opinions Regarding What a Woman Should Do If She Has an Unwanted Pregnancy
by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	What Should a Woman Do If She Has an Unwanted Pregnancy?				Total	No. of Cases
	Give Birth and Keep the Baby	Have an Abortion	Give Birth and Give the Baby Up for Adoption	Does Not Know		
Total	65.5	29.5	2.1	2.9	100.0	6,292
Residence						
Tbilisi	66.1	29.4	2.5	2.0	100.0	1,426
Other Urban	70.5	25.0	1.8	2.7	100.0	1,549
Rural	62.4	32.0	2.0	3.6	100.0	3,317
Marital Status						
Married	60.1	35.3	1.9	2.7	100.0	4,098
Previously married	64.4	32.4	1.8	1.4	100.0	389
Never married	74.9	18.9	2.5	3.7	100.0	1,805
Age Group						
15–19	72.8	19.7	2.4	5.1	100.0	861
20–24	69.2	26.1	1.8	2.8	100.0	1,099
25–34	63.4	32.1	2.0	2.5	100.0	2,359
35–44	61.0	34.6	2.2	2.2	100.0	1,973
Number of Living Children						
0	75.2	18.9	2.4	3.5	100.0	2,276
1	66.2	30.9	1.5	1.5	100.0	1,286
2	55.7	38.5	2.3	3.5	100.0	2,069
3 or more	53.1	43.6	1.4	1.9	100.0	661
Education Level						
Secondary incomplete or less	61.5	32.4	1.7	4.4	100.0	1,330
Secondary complete	60.5	33.8	2.3	3.4	100.0	1,568
Technicum	62.6	33.1	2.3	2.0	100.0	903
University/postgraduate	71.8	23.9	2.1	2.1	100.0	2,491
Wealth Quintile						
Lowest	60.3	34.2	1.4	4.1	100.0	1,093
Second	64.3	30.7	1.9	3.1	100.0	1,385
Middle	64.9	29.2	2.2	3.7	100.0	1,413
Fourth	67.2	28.3	2.5	2.0	100.0	1,037
Highest	68.6	27.1	2.3	2.1	100.0	1,364
Ethnicity						
Georgian	68.3	26.9	2.2	2.6	100.0	5,488
Azeri	39.2	52.3	0.9	7.6	100.0	276
Armenian	55.3	39.2	1.4	4.0	100.0	364
Other	45.6	48.8	2.4	3.1	100.0	164

Table 12.5.1 Agreement with Selected Statements on Gender and Reproductive Norms by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Agreement with Selected Statements on Gender and Reproductive Norms								No. of Cases
	All people Should Marry %	Women Must be Virgins at Marriage %	Child Care is a Women's Job %	Women Must have the Children That God Gives Them %	A women Can Get Pregnant at First Sex %	A women Can Refuse Sex if Her Husband Has an STI %	A women Can Ask Her Husband to Use a Condom if He Has an STI %	A Good Wife Obeys Her Husband %	
Total	74.3	77.5	72.2	73.9	84.1	76.5	73.8	42.5	6,292
Residence									
Tbilisi	64.6	60.8	62.1	73.1	85.4	82.8	81.1	26.5	1,426
Other Urban	74.7	80.5	71.1	76.4	86.3	78.2	76.5	41.8	1,549
Rural	79.8	85.7	78.6	72.9	82.1	71.8	68.1	52.1	3,317
Age Group									
15–24	76.0	80.0	72.6	77.6	72.9	70.3	67.6	40.1	1,960
25–34	73.1	75.2	71.9	70.8	89.7	80.2	78.1	43.4	2,359
35–44	73.6	77.0	71.9	72.6	91.6	80.1	76.7	44.3	1,973
Marital Status									
Married	75.8	78.7	72.6	70.8	91.0	79.8	77.2	47.3	4,098
Previously married	64.7	59.1	68.1	70.4	91.4	86.5	84.4	28.5	389
Never married	73.5	78.8	72.2	79.8	70.7	68.9	66.1	36.7	1,805
Number of Living Children									
0	73.8	78.3	71.9	80.1	72.8	70.9	68.0	37.9	2,276
1	72.3	71.1	69.7	72.3	91.1	83.4	82.0	41.9	1,286
2	74.7	77.5	72.2	67.0	92.5	80.5	76.9	44.9	2,069
3 or more	79.1	86.0	77.7	71.1	92.2	75.0	73.2	54.9	661
Education Level									
Secondary incomplete or less	81.1	84.8	80.3	72.8	71.5	65.5	63.3	51.6	1,330
Secondary complete	75.7	83.4	77.1	71.3	83.5	73.6	69.8	49.5	1,568
Technicum	75.7	79.8	73.2	72.4	90.9	81.3	78.2	39.1	903
University/postgraduate	69.1	68.9	64.0	76.6	89.4	83.1	80.9	33.9	2,491
Wealth Quintile									
Lowest	79.6	85.8	79.4	73.8	78.3	73.0	69.4	56.4	1,093
Second	80.5	87.2	79.0	71.9	85.0	71.4	67.5	50.9	1,385
Middle	78.5	82.7	74.3	72.0	84.0	75.7	72.4	46.3	1,413
Fourth	70.2	76.5	73.5	77.5	84.9	77.2	75.4	38.2	1,037
Highest	66.1	61.9	60.2	74.3	86.1	82.5	81.1	28.1	1,364
Ethnicity									
Georgian	73.6	76.6	70.7	75.8	85.3	78.8	76.8	38.8	5,488
Azeri	88.5	92.4	87.9	60.3	73.4	52.6	44.9	84.9	276
Armenian	73.0	82.3	81.5	59.4	75.1	60.2	49.5	55.8	364
Other	72.8	67.9	70.1	65.4	83.5	78.2	79.3	51.6	164

Table 12.5.2 Opinions Regarding Who Should Decide How Many Children a Couple Will Have by Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Who Should Decide How Many Children a Couple Will Have?				Total	No. of Cases
	The Woman	The Man	Both	Does Not Know		
Total	4.0	0.8	94.1	1.1	100.0	6,292
Residence						
Tbilisi	4.9	0.4	94.0	0.7	100.0	1,426
Other Urban	2.9	0.4	95.9	0.8	100.0	1,549
Rural	4.1	1.2	93.2	1.5	100.0	3,317
Marital Status						
Married	3.9	1.0	94.5	0.7	100.0	4,098
Previously married	6.3	0.2	92.5	1.0	100.0	389
Never married	3.8	0.6	93.7	1.9	100.0	1,805
Age Group						
15–19	4.1	0.8	93.1	2.0	100.0	861
20–24	3.0	0.8	94.4	1.8	100.0	1,099
25–34	4.0	1.0	94.4	0.6	100.0	2,359
35–44	4.6	0.6	94.2	0.6	100.0	1,973
Number of Living Children						
0	3.5	0.7	94.3	1.6	100.0	2,276
1	4.7	0.5	94.1	0.7	100.0	1,286
2	4.3	0.7	94.1	0.9	100.0	2,069
3 or more	4.1	2.1	93.2	0.7	100.0	661
Education Level						
Secondary incomplete or less	4.3	1.8	91.2	2.7	100.0	1,330
Secondary complete	5.0	0.8	93.4	0.8	100.0	1,568
Technicum	3.5	0.5	95.5	0.5	100.0	903
University/postgraduate	3.4	0.3	95.7	0.6	100.0	2,491
Wealth Quintile						
Lowest	3.3	1.0	93.9	1.7	100.0	1,093
Second	4.4	1.4	93.1	1.1	100.0	1,385
Middle	3.5	0.9	93.9	1.7	100.0	1,413
Fourth	3.9	0.3	94.9	0.9	100.0	1,037
Highest	4.6	0.4	94.5	0.5	100.0	1,364
Ethnicity						
Georgian	3.8	0.4	94.9	0.9	100.0	5,488
Azeri	2.9	5.5	89.2	2.5	100.0	276
Armenian	5.2	2.0	89.5	3.2	100.0	364
Other	8.9	1.9	87.0	2.2	100.0	164

13 CHAPTER

HEALTH BEHAVIORS

The right health-promoting behaviors can greatly enhance personal health and can complement formal health care. Behaviors such as getting regular exams, avoiding cigarette smoking, and drinking alcohol only in moderation are instrumental in protecting health and preventing chronic diseases. This chapter reports on important health behaviors and knowledge among women of reproductive age in Georgia. In particular, the Georgian 2010 survey explores health care utilization, breast and cervical cancer screening, tuberculosis, smoking, and alcohol use. These issues are examined with attention to women's demographic characteristics, to help explain the changing and varied health care needs of the various subgroups in the population.

Particular attention was given to documenting preventive practices that help lower the risk of breast and cervical cancer. Despite recent advances in prevention, diagnosis, and treatment, gynecologic malignancies continue to be a leading cause of death in women of reproductive age in both the developed and developing world. Among reproductive system cancers, breast and cervical cancer are the most common. Early diagnosis and treatment are essential for cancer therapy to be highly effective. Unfortunately, a substantial proportion of these cancers in Eastern Europe are detected at an advanced and incurable stage as a result of several factors: women's lack of awareness or reluctance to access preventive care services; provider's lack of interest, time, or expertise for health promotion; and a health system that allocates more of its limited resources to curative care than to prevention. Breast cancer accounted for most deaths among women aged 15-44 in Georgia in 2006 (14%) and cervical cancer ranked fourth, accounting for 5% of deaths. Crude case-specific mortality rates for breast cancer among these women was higher than the European average (7.9 per 100,000 vs. 5.4 per 100,000 women aged 15-44) (Serbanescu et al., 2009).

13.1 Utilization of Health Care Services

Interactions between clients and health providers constitute an important opportunity for health promotion and disease prevention. During patient encounters, providers can give general health counseling and advice to lessen high-risk behaviors. Patients' attitudes and behaviors regarding health care visits are important determinant of whether they receive health counseling and routine screening, including cervical and breast cancer screening. Therefore respondents were asked a series of questions that explored health care-seeking behaviors and barriers to health care.

Having a “usual place” for care, a location or source where one regularly receives health care, is associated with fewer delays in getting care, better preventive care, and better treatment. The majority of respondents (79%) reported having a usual place where they obtain their health care (Table 13.1.1).

This was more often the case for women who had health insurance (85%) and those employed (83%). There appears to be a direct correlation between having a usual place of care and educational attainment. The proportion of women with a usual place for care increased with education from 73% of women who had no completed secondary school to 83% of women with university or postgraduate education. Having a consistent place for care was less common for adolescents aged 15-19 (71%), young adults aged 20-24 (76%), women residing in households in the lowest wealth quintile (74%), and ethnic minorities (70%). Women who reported they had a usual place for care obtained most of the care in hospitals (38%) and ambulatory clinics (i.e. polyclinics and women’s consultation clinics) (26%). Only a minority obtained usual care in primary health care (PHC) facilities (14%). In rural areas the most common place for usual care was a regional/city hospital (46%), while in urban areas, substantial proportions of women attended polyclinics and women’s consultation clinics or regional/city hospitals (33% and 31% respectively) (Figure 13.1.1).

Over a third of women (37%) reported that they had visited a health care facility (either for treatment or for preventive services, including family planning) during the 12 months before the interview (Table 13.1.2). That is an increase from the previous, 2005, survey, in which only a quarter (25%) of women had visited a health care facility in the past year (data not shown). Health care visits were more common among urban residents (39%), residents of Tbilisi (41%) and Imereti (43%).

Of those who had at least one health visit (2353 cases in Table 13.1.2), one half (51%) were seen for acute care, 41% were seen for preventive care, and 20% were seen for care of a chronic condition (summing to over 100% due to multiple visits). Compared to their rural counterparts, a higher proportion in urban areas had preventive health visits (43% vs. 39%) and a lower proportion had acute care visits (49% vs. 53%) (Figure 13.1.2). There was no urban/rural difference in the proportion who received care for chronic conditions.

When asked if they had to delay getting medical care in the last 12 months, either for prevention or for an illness, a quarter (25%) of respondents reported delays (Table 13.1.3). The overwhelming majority of women (82%) who had delayed care reported that the cost of health care services was the most important deterrent. This was particularly true for women with multiple children (84% and higher), women with the

Figure 13.1.1 Usual Place of Health Care by Residence Among Women Aged 15-44 Years

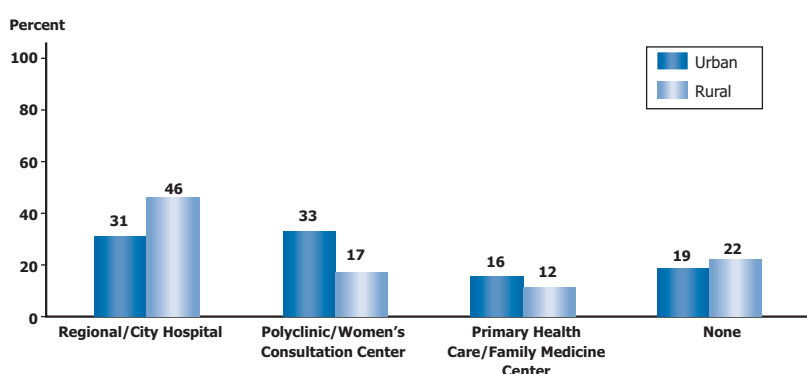


Figure 13.1.2 Type of Health Care Received by Residence Among Women Aged 15-44 Who Had Used Medical Care in the Past 12 Months

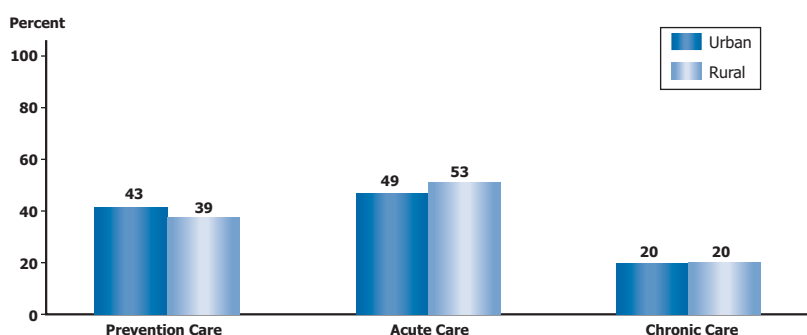
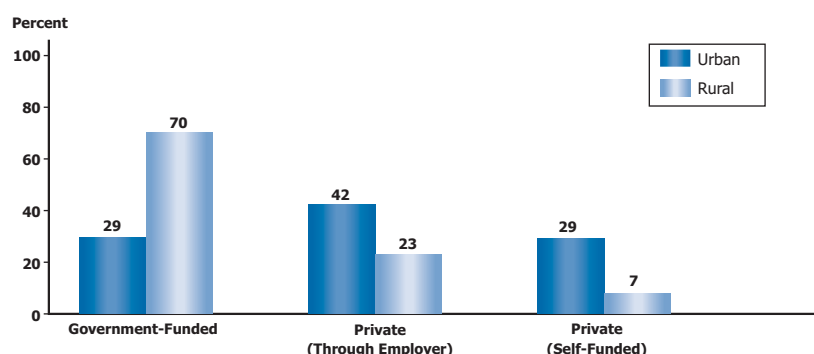


Figure 13.1.3 Main Source of Health Insurance by Residence Among Women Aged 15-44 with Health Insurance



Note: Rates are age-standardized, so they permit international comparisons regardless of varying age structures. Source: Ferlay J, et al., *Cancer Incidence and Mortality Worldwide: IARC Cancer Base No 10, 2010*

least education (91%) or in the poorest wealth quintile (90%), and ethnic minority women (91%).

In this context, GERHS10 examined the health insurance coverage among women of reproductive age at the time of interview. A woman was defined as insured if either directly or through a spouse or parent she had any government-paid insurance (e.g. insurance for vulnerable populations --- “5 Lari” insurance), other government-sponsored health plan, or private health insurance through an employer (i.e. insurance for civil servants and governmental employees; private insurance partially funded), or self-insurance.

Only 22% of women had any health insurance at the time of the interview (Table 13.1.4). This proportion varied little by urban or rural residence and was the lowest among residents of Kvemo Kartli (14%).

Given the unequal geographic distribution of the population under the poverty level, insured women in rural areas were much more likely to have government-supported health insurance than urban women (70% vs. 29%) and less likely to have private insurance (Figure 13.1.3). Women aged 35 or older were slightly more likely to report being insured and more likely to have private insurance than younger women. Health insurance coverage was higher among women with post graduate education (27%), who were mostly covered by private insurance, than among women with lower education (18-19%). Women residing in households within the lowest wealth quintile reported higher coverage (28%) than women in other wealth groups; virtually all of them had government-funded insurance for the vulnerable population. Employed women were more than twice as likely as unemployed women to have insurance (39% vs. 18%); more than half of those with insurance had an insurance plan partially or fully supported by the employer. Twenty-four percent of Georgian women compared to only 11% of women belonging to ethnic minorities had

health insurance; among insured women the source of insurance did not differ by ethnic background.

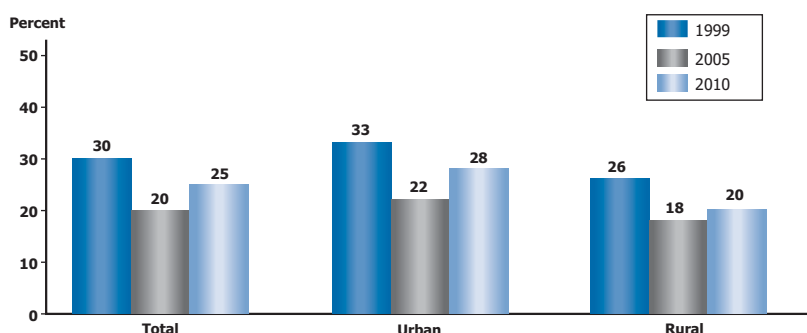
13.2 Prevalence of Routine Gynecologic Visits

The American college of Obstetricians and Gynecology has recently updated its guidelines to recommend that women have a routine gynecologic examination every year after age 21; however other guidelines vary throughout the world. The Georgia 2010 survey shows an increase in the proportion of women who have had routine gynecologic exams in the last year (25%, up from 20% in 2005); however, this is still lower than in 1999 when 30% of women reported having had an exam in the last year (Table 13.2 and Figure 13.2). There was an inverse correlation between age and having had a gynecologist exam in the past 12 months, ranging from 32% of 15-24 year-olds to only 17% of 40-44 year-olds. In fact, 38% of women aged 40-44 years had their last routine gynecological exam more than three years prior to the interview and 19% had never had a routine exam. A direct relationship existed between wealth quintiles and gynecologic exams, with more women in the lowest quintile never having had an exam (39%) and fewer women in the highest quintiles never having had one (21%). Since screenings for cervical and breast cancer are generally provided or prescribed during routine gynecologic visits, a low prevalence of routine gynecologic exams inevitably has an impact on early detection and treatment of gynecologic cancers. It also has a substantial negative effect on family planning counseling and dissemination of other health messages.

13.3 Breast Cancer Screening

Breast cancer far exceeds all other cancer diagnoses among women, with an estimated 1.38 million new cancer cases globally diagnosed in 2008 (23% of all cancers), and it ranks second overall (10.9% of all cancers). Breast cancer has become the most common

Figure 13.2 Prevalence of Routine Gynecologic Visits during the Past Year by Residence among Sexually Experienced Women Aged 15-44 Years: 1999, 2005, and 2010



cancer both in developed and developing regions with approximately 690,000 new cases estimated in each region (population ratio 1:4) (Ferlay et al., 2010). The age-standardized incidence rate of reported new cases of breast cancer in Georgia (38.5 new cases per 100,000 women) is higher than elsewhere in Western Asia (as categorized in GLOBOCAN 2008 cancer registry) but it is lower than the averages in Central and Eastern Europe, North America, and Western Europe, which is the region with the highest incidence rate in the world (Ferlay et al., 2010) (Figure 13.3.1). Crude cause-specific mortality due to breast cancer in Georgia in 2006 (7.9 deaths from cancer per 100,000 women aged 15-44) was slightly higher than the European average, perhaps reflecting late detection and treatment.

Recently, Georgia has been aggressively seeking to increase the screening of reproductive tract cancers. Through the new national screening program and under patronage of the First Lady of Georgia, early breast and cervical cancer detection has been promoted through free access to screening, by education of clinicians, and by increased public awareness. In 2006 the Georgian National Screening Center was opened in Tbilisi through collaboration between the MoLHSA, Tbilisi municipality, and UNFPA. While the Center initially targeted women in Tbilisi, the success of the program prompted the government to scale it up to the national level. The Center was awarded the “Pearl of Wisdom” Award in 2009 at the European Parliament Cervical Cancer Prevention Summit Meeting in Brussels. The Center also promoted the formation of the Black Sea Countries Coalition on Breast and Cervical Cancer Prevention, with support from the UNFPA and the First Lady. Efforts to increase awareness of breast and cervical cancer and promote screening practices were also the focus of USAID-supported projects, starting with the Healthy Women in Georgia project. Through these efforts, several “Race for the Cure” awareness campaigns were organized in Tbilisi. The current project, implemented by JSI (SUSTAIN), covers a broad range of social mobilization activities and breast cancer clinical training for health providers.

Currently available practices for detecting breast cancer include breast self-examination (BSE), clinical breast examination (CBE), and mammography. Guidelines for the early detection of breast cancer in average-risk women consist of a combination of regular clinical breast examination and counseling to raise awareness of breast symptoms beginning at age 20, and annual mammography beginning at age 40 (American Cancer Society, 2005). BSE is a very simple self-care procedure that can detect changes in the breast over time and can be performed by women in the privacy of their homes after minimal instruction. BSE is recommended as a supportive detection system to be used in conjunction with CBE and mammography. Women should be told about the benefits and limitations of BSE and the importance of prompt reporting of any new breast symptoms to a health care professional. Women who choose to do BSE should receive instruction and have their technique reviewed on the occasion of a periodic health examination. Appropriate follow-up by a physician should be available for women who detect breast changes through self-examination. At that point, CBE and, when indicated, mammography should be conducted.

The Georgia 2010 RHS explored the level of experience with BSE and how often the exam was performed. Overall, 42% of sexually experienced women had ever performed BSE (Table 13.3.1) which is higher than in 2005 (29%). In terms of BSE frequency, 17% of sexually experienced women reported having one every month, 12% every 2-5 months, 12% every 6-12 months or less often, and 58% never. Levels of BSE usage were lower among women in rural areas, younger women, the two poorest quintiles, and ethnic minority women. Also, having ever conducted a BSE was correlated with having the experience of a routine gynecological exam. This is likely because a gynecological exam is an important opportunity for a clinician to encourage and instruct a woman on how to perform a BSE.

As mentioned above, BSE is not adequate on its own; consequently, women were also asked about the uti-

Figure 13.3.1 Breast Cancer Incidence and Mortality, by Region, 2008
Rates per 100,000 women

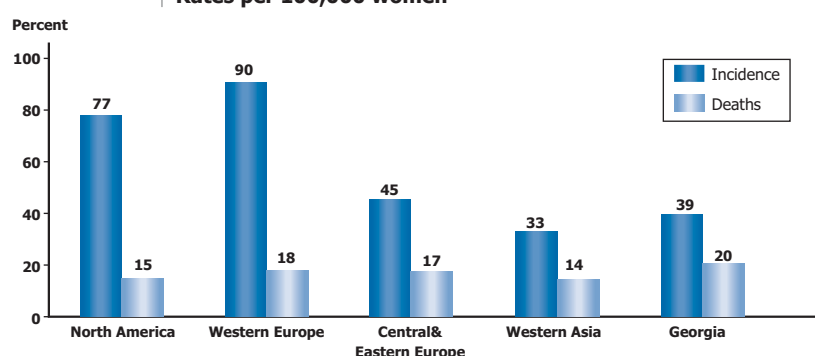
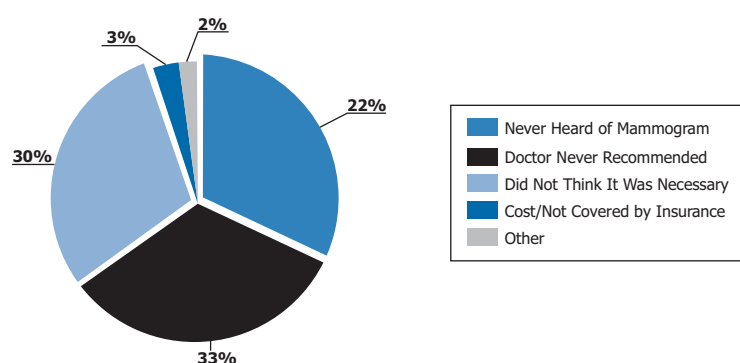


Figure 13.3.2 Most Commonly Cited Reasons for Never Having Had a Mammogram Among Sexually Experienced Women Aged 15-44



lization of CBE and mammography. A CBE – a physical examination of the breast done by a health professional to detect abnormalities – can be part of a routine health examination. Table 13.3.2 shows that less than fifth (18%) of sexually experienced women had ever had a CBE, and that a disparity exists between urban and rural women (22% vs. 13%, respectively). The proportion of women who had ever had a CBE increased with age, educational attainment, and wealth, both for all women and for those with sexual experience. Among sexually experienced women, almost twice as many ethnic Georgian women as those of other ethnic backgrounds had a CBE in their lifetime (19% vs. 10%).

Because breast cancer risk increases with age, mammography screening is primarily targeted to older women. Therefore women in the oldest age group surveyed (40-44) were more likely to report mammography screening compared to their younger counterparts. In Tbilisi, where the Georgian cancer screening program was initially focused, the utilization of mammography was at least double that in other regions. Thirteen percent of sexually experienced women in Tbilisi had ever had mammography, whereas the proportion in all other regions ranged from 3% in Samtskhe-Javakheti to a little over 6% in Mtskheta-Mtianeti.

Women who had never had a mammogram were asked the main reason why not. In Table 13.3.3 and Figure 13.3.2 responses were divided almost evenly

into three categories: no doctor had ever recommended it (33%), they had never heard of mammography (32%), and they did not think it was necessary (30%). Awareness of mammography was greater in Tbilisi, where only 22% of women had never heard of it. A fifth of women aged 35-44, a group who are in or soon will be in the target group for mammogram screening in Georgia, still had never heard of this screening practice.

13.4 Cervical Cancer Screening and HPV Awareness

Cervical cancer is the third most common cancer of women, with an estimated 530,000 new cases globally in 2008 (Ferlay et al., 2010). Both the age-adjusted incidence (9.4 new cases of cervical cancer per 100,000) and the age-adjusted mortality (4.7 deaths due to cervical cancer per 100,000) reported in Georgia for 2008 were higher than those in industrialized countries and other Western Asia Countries, but lower than those in Central and Eastern Europe (Figure 13.4.1). The Georgian study of the main causes of death among women of reproductive age found that cervical cancer was the fourth leading cause of death among these women in 2006 (Serbanescu et al., 2009).

The Papanicolaou (Pap) smear is the primary method of screening for cervical cancer and while guidelines vary by country, being often dependent upon available recourses, most recommend that women who are sexually active should have a Pap smear test at least

once every three to five years. In industrialized nations screenings are recommended as early as age 18 but in resource-poor settings the core group that should be targeted is usually women aged 30-60 years. The age group targeted for cervical cancer screening by the Georgian screening program mentioned in the prior section is age 25-60 and the recommended frequency of the screening test is every three years.

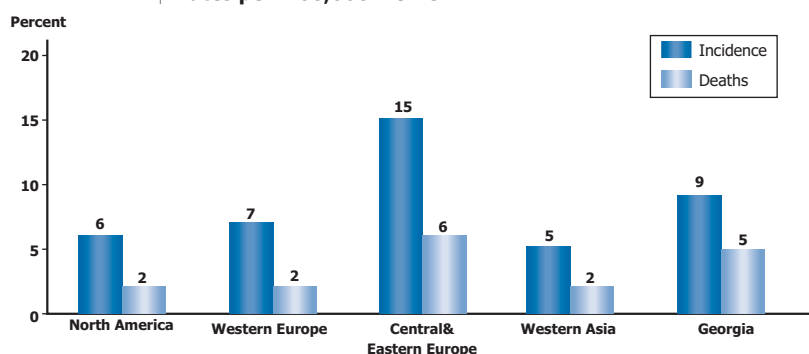
Survey reports are a useful way to estimate the extent of cervical screening in the general population. All of the reproductive health surveys in Georgia have included a series of questions regarding Pap test history to determine if the respondents had ever had a Pap smear test and, if so, when they had their most recent test. In the current survey, 12% of sexually experienced women aged 15-44 reported ever having had a Pap smear test (Table 13.4.1); that is very low, but it is a sizeable increase from the 4% reported in both 2005 and 1999 (Figure 13.4.2). Five percent have had a test in the past 12 months, and that is also an improvement over the last two surveys. The low prevalence of cervical cancer screening does not allow subgroup breakdowns to study the potential determinants of that preventive practice. However as shown for Pap tests in Table 13.4.2, the higher prevalence of tests in Tbilisi in the 25-34 and 35-44 age groups (15% and 22%, respectively) suggest that the targeted screening campaign there for reproductive cancers had a posi-

tive impact. As it expands nationally cervical cancer screening should be more widely practiced in other regions as well.

One of the major risk factors for cervical cancer is infection with human papilloma virus (HPV). The development of HPV vaccines in the last decade has provided a safe and effective tool for the prevention of cervical cancer. For the first time, GERHS10 explored the level of awareness and use of the HPV vaccine in Georgia. Women were asked a series of questions about their awareness of HPV, their knowledge that a vaccine to prevent cervical cancer exists, and their interest (or lack of it) in getting the vaccine.

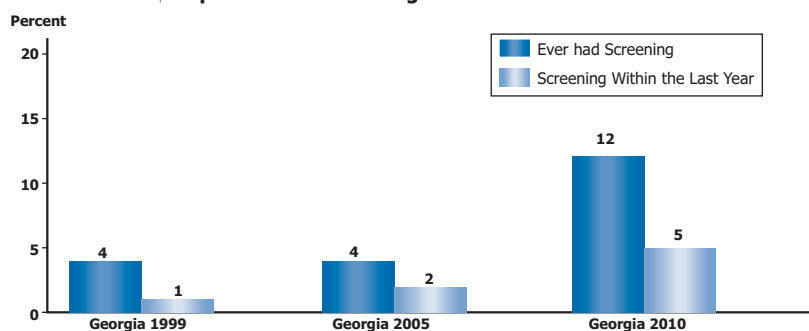
Among all women aged 15-44 only 21% had ever heard of HPV infection, and only 18% had heard of the vaccine for it (Table 13.4.3). Once told about the vaccine's effectiveness in preventing cervical cancer 29% expressed an interest in receiving it. Awareness of HPV infection was twice as high in Tbilisi (34%) as in most other regions. Awareness of the vaccine for it was also highest in Tbilisi. While awareness increased with age, interest in receiving the vaccine was inversely correlated with age, perhaps because the vaccine is recommended for use in young girls, who are less likely to be sexually experienced or to have been infected. Both awareness and interest increased with education. Awareness of HPV and of the vaccine were

Figure 13.4.1 Cervical Cancer Incidence and Mortality, by Region, 2008
Rates per 100,000 women



Note: Rates are age-standardized, so they permit international comparisons regardless of varying age structures. Source: Ferlay J, et al., *Cancer Incidence and Mortality Worldwide: IARC Cancer Base No 10*, 2010

Figure 13.4.2 Prevalence of Cervical Cancer Screening Tests Among Sexually Experienced Women Aged 15-44



Source: CDC and ORC/MACRO, 2003.

far lower among ethnic minorities (7%), pointing to an important area for improvement in outreach efforts. Once informed, many women in these groups expressed an interest in getting vaccinated (20%).

13.5 Tuberculosis Awareness and Exposure

According to WHO, 1.7 million people died from TB in 2009, equal to 4,700 deaths a day. Of these 380,000 were women, and another 380,000 were people with HIV, (WHO, 2010). In 2009 there were an estimated 9.4 million incident cases of TB globally (equivalent to 137 cases per 100,000 population). The deterioration of health systems in the early 1990s, including TB control efforts, contributed to a major TB problem in Georgia specifically and elsewhere in the former Soviet Union. WHO estimates that in 2009, Georgia had an incidence rate of 107 cases per 100,000 population. Multidrug resistant TB (MDR-TB) is particularly problematic in Georgia, accounting for 10% of all new cases and 31% of retreatment cases. Georgia has been identified as one of the 27 high MDR-TB burden countries and has been included in the EXPAND-TB (expanding Access to New Diagnostics for TB) project within the global STOP TB Partnership. After identifying TB as one of the nation's greatest public health threats in the early 1990s, the Ministry of Labor, Health, and Social affairs established the National TB Control Program (NTCP) in 1995. In 1997, pilot sites for Directly Observed Therapy short-course (DOTS) implementation were created, and gradually the DOTS strategy was introduced countrywide. Since 2003, USAID Georgia has supported the NTCP to improve the DOTS coverage; increase treatment success rates and reduce treatment default rates; strengthen clinical and laboratory services for TB patients; and promote linkages between HIV/AIDS and TB treatment efforts (USAID Georgia, 2009).

Almost all women surveyed (95%) were aware of tuberculosis (Table 13.5.1, left panel). Over two-thirds (67%) correctly indicated that it is transmitted through the air when coughing. Correct knowledge of transmission was higher among urban women and increased directly with the wealth quintile (SES) of the household (Figure 13.5). Women aged 15-19 (53%), those with less than complete secondary education (50%), and minority women (45%) were the least likely to know that TB is transmitted through coughing. Over half of respondents (57%) mentioned other ways of TB transmission. Almost one in eight women (12%) had no knowledge about how TB can spread. A substantial proportion of women had been exposed to TB either from a family member who has had TB (12%) (Table 13.5.1). Residents of Kvemo-Kartli (17%) and Kakheti (15%), women with the lowest education (17%), and minority women (23%) were the most likely to report they had been exposed to TB in their households.

When asked their knowledge of specific symptoms of TB, most women knew of prolonged and severe coughing (71%). Fewer women were aware of fever (28%), blood in sputum (27%), weight loss (24%), or other items (Table 13.5.2). Knowledge of various symptoms was consistently lower in rural parts of the country than in urban areas. Knowledge generally increased with age and education.

Despite the nearly universal awareness of TB, only three-quarters (75%) of women were aware that TB can be completely cured (Table 13.5.3). The women who were most frequently aware that TB is curable included those with technicum or university/postgraduate education (83% and 85% respectively), those aged 30 to 44 (83%), those who were employed (87%), and those residing in households with the wealthiest quintiles (85%). When asked the most appropriate treat-

Figure 13.5 Correct Knowledge of Tuberculosis Transmission by Residence and SES

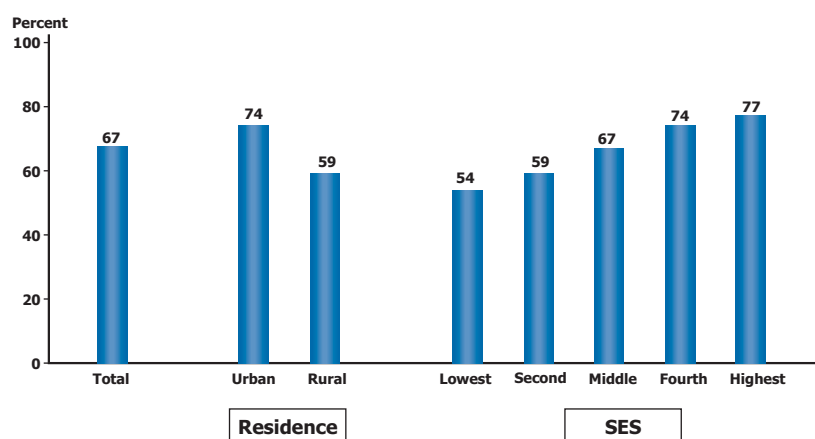
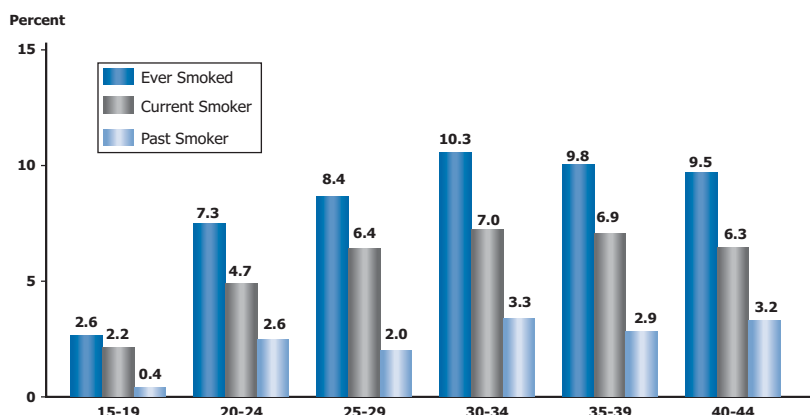


Figure 13.6 Lifetime, Current, and Past Smoking Prevalence by Age Group among Women Aged 15-44



ment for TB-infected people the vast majority (78%) said they should be hospitalized, 13% said they should be hospitalized initially and then treated at home, and 1% said they should be treated entirely at home. These perceptions were roughly similar across demographic groups but should be examined closely for specialized TB studies.

13.6 Cigarette Smoking

Tobacco contains potent human carcinogens that have been shown to be related to many cancers including those of respiratory and digestive tracts, bladder, cervix, and kidney. Worldwide approximately 5 million deaths are attributable to tobacco use; a number expected to double by 2020 (WHO, 2003). Tobacco smoking accounts for an estimated 22% of cancer deaths per year, including 70% of lung cancer deaths. Aside from cancer, smoking can also be linked to a variety of other health issues such as atherosclerosis, asthma, emphysema, pneumonia, and osteoporosis. Maternal smoking has been linked to low birth-weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome, and infant respiratory problems (DiFranza and Lew, 1996).

Several questions were posed to women to assess their cigarette-smoking status. Only a very small percentage of women aged 15-44 were current tobacco smokers (6%) (Table 13.6.1). Five percent of them were daily smokers and 1% were occasional smokers. Not only did 94% of women indicate that they were not current smokers, 92% stated that they had never smoked.

Overall, reports of ever, current, and past smoking were low with only 8% of women having smoked, 6% being current smokers and 2% being past smokers (Table 13.6.2). Ever-smoking was correlated with age up through age 34; however above that age patterns of smoking experience were quite similar (Figure 13.6).

There was also a higher prevalence of smoking among women in urban areas. Almost a tenth (9%) of urban women reported being current smokers, and 13% of Tbilisi women in particular, compared to only 2% of women in rural areas. A full 98% of women in rural areas had never smoked at all.

For individuals who do not use tobacco themselves, there are still the risks associated with second hand smoke (SHS). There is no safe level of exposure to SHS and it can still cause lung cancer in nonsmokers. It has also been associated with heart disease in adults and sudden infant death syndrome, ear infections, and asthma attacks in children (US DHHS, 2006; US DHHS, 2010). A recent study showed that worldwide, over 600,000 deaths each year are attributable to SHS, 165,000 of which are children (Oberg et al., 2011). It also found that Eastern Europe is one of the regions with the highest exposures to SHS, and the Georgia RHS 2010 confirms high numbers. Although the majority of women surveyed did not smoke, one in two reported high levels of current (in the past 30 days) SHS both at home and at work. The level of SHS in the home was high for everyone, reported by 52% of women aged 15-44 and 50% of non-smokers (Table 13.6.3).

Georgia has taken steps to combat second hand smoke, by developing and recently updating national tobacco control legislation, and by signing on to the WHO Framework Convention on Tobacco Control (FCTC) in 2006 (WHO, 2003).

The WHO FCTC calls for the protection of all people from exposure to tobacco smoke and stresses the importance of demand reduction strategies as well as supply issues.

13.7 Alcohol Use

As a result of gender differences in absorption and metabolism of alcohol, women experience higher concentrations of alcohol in the blood and become more impaired than men do after drinking equivalent amounts of alcohol, making them more vulnerable to alcohol's long term health effects.

Heavy drinking is associated with a number of chronic health conditions, including liver disease, cancer, cardio-vascular disease, and neurological damage, as well as a variety of psychiatric problems. Binge drinking in particular has been most commonly associated with unintentional injuries, violence, alcohol poisoning, hypertension, myocardial infarction, sexually transmitted diseases, meningitis and poor control of diabetes (Naimi et al., 2003). Alcohol abuse among pregnant women has additional significance because of its potential harm to the fetus. No amount of alcohol is safe to drink during pregnancy, nor is there a safe period during pregnancy for alcohol consumption. Drinking during pregnancy can risk birth defects (fetal alcohol spectrum disorders), physical and mental developmental problems and even miscarriage, stillbirth, and premature delivery (Wilsnack et al., 1984; Kesmodel et al., 2002).

The Georgia survey measured alcohol use by asking respondents about the frequency and quantity of their drinking in the past three months. Having at least one drink daily or almost every day was considered current drinking; consuming in excess of one drink per day, on average, was considered current frequent drinking, and the consumption of five or more drinks in a row at a given time was defined as episodic heavy drinking or "binge" drinking. Because data are based on self-reports, they might be subject to reporting bias, especially among pregnant respondents who may have been aware that alcohol use in pregnancy is discouraged.

On average, 31% of women have ever drunk alcohol and 17% are current drinkers, but 2% are current frequent drinkers (Table 13.7). Eight percent of women reported binge drinking in the three months preceding the survey. As in the 2005 survey, drinking correlated somewhat with age, except for binge drinking (Figure 13.7). Of note is the relatively higher prevalence of current, frequent, and binge drinking (22%, 6% and 14%, respectively) among women who were previously married. Binge drinking in particular was more common among urban women (9%), especially in Tbilisi (12%), and women in the wealthiest quintile (12%). Frequent and binge drinking were rarely reported by Azeri women (0% and 1%, respectively) suggesting that there may be protective factors against alcohol abuse in this population.

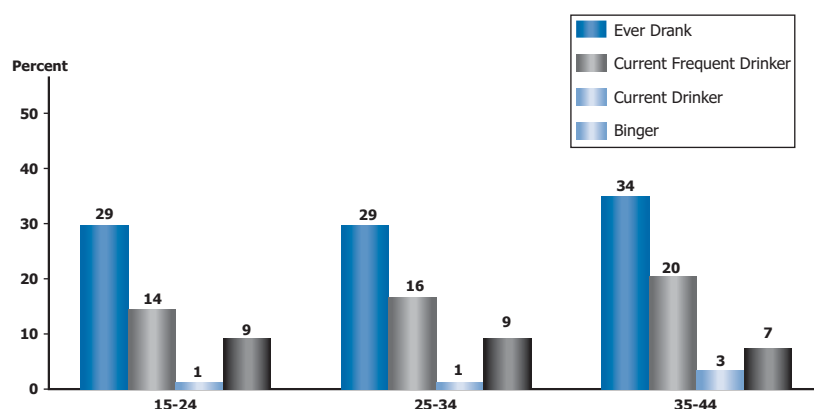
13.8 Prevalence of Selected Health Problems

To explore selected health problems among women of reproductive age, all study participants were asked: "Has a doctor or other health care provider ever told you that you have (below listed) health problems?" The health problems listed in the questionnaire were: diabetes, anemia, high blood pressure, and heart disease. The prevalence of pelvic inflammatory diseases (PID) was assessed by asking respondents an additional question, whether they "Had ever been treated for an infection of the fallopian tubes, uterus, or ovaries, also called pelvic infection?"

The most commonly reported health problem among women of reproductive age was PID: 19% of all respondents, 29% of married women, and 32% of those aged 35-44 had been told by a doctor that they had PID. Few (7%) young woman aged 19-24 reported PID; it was rare among the somewhat overlapping group of never married women (Table 13.8).

The second most common condition was high blood pressure: overall about 6% of respondents and 11% of older women aged 35-44 reported hypertension. Other health problems included anemia, heart dis-

Figure 13.7 Current Drinking Percentages by Age Group Among Women Aged 15-44



ease, and diabetes: about 4% of study participants had been diagnosed with anemia, 3% reported heart disease, and 1% had been told that they had diabetes. In general, survey data are imperfect regarding these selected health problems. No lab testing was done; all data are based on self-reports, and many respondents did not know or could not specify their problems. Therefore the true rates of the diseases are much higher than reported. In addition, the various region-

al distributions of the health conditions are impacted by the availability of medical facilities in the regions. Furthermore, the questionnaire collected information about the lifetime occurrence of diseases and did not estimate new cases. For all these reasons, the study could not provide fully accurate data on women's health problems, and the results should be considered as minimum estimates of the true prevalence of these conditions among women of childbearing age.

Characteristic	Had a Usual Place of Care		Usual Place for Health Care						
	%	No. of Cases	Regional/ City Hospital %	Policlinic/ Women's Consultation Clinic %	Primary Health Care/ Family Medicine Center %	Other %	None %	Total	No. of Cases
Total	79.4	6,292	37.9	25.6	14.4	1.4	20.6	100.0	6,292
Residence									
Urban	80.7	2,975	30.5	32.9	16.2	1.1	19.3	100.0	2,975
Rural	77.9	3,317	46.3	17.4	12.4	1.7	22.1	100.0	3,317
Region									
Kakheti	79.7	498	39.4	20.9	17.1	2.4	20.3	100.0	498
Tbilisi	78.0	1,426	20.2	34.8	21.6	1.3	22.0	100.0	1,426
Shida Kartli	86.8	392	60.4	18.7	7.7	0.0	13.2	100.0	392
Kvemo Kartli	73.7	546	40.0	23.1	10.1	0.4	26.3	100.0	546
Samtskhe–Javakheti	78.3	481	49.4	17.9	10.4	0.6	21.7	100.0	481
Adjara	75.8	419	37.5	29.3	8.5	0.5	24.2	100.0	419
Guria	74.4	401	40.0	26.4	7.8	0.2	25.6	100.0	401
Samegrelo	89.2	477	60.0	23.9	3.9	1.5	10.8	100.0	477
Imereti	80.2	805	40.2	19.3	17.8	2.9	19.8	100.0	805
Mtskheta–Mtianeti	78.9	393	34.0	23.4	20.5	1.0	21.1	100.0	393
Racha–Svaneti	84.7	454	62.9	9.4	6.9	5.5	15.3	100.0	454
Age Group									
15–19	71.0	861	31.0	26.4	12.6	1.0	29.0	100.0	861
20–24	76.0	1,099	35.2	26.1	13.2	1.5	24.0	100.0	1,099
25–29	81.5	1,191	40.1	25.6	14.5	1.2	18.5	100.0	1,191
30–34	82.4	1,168	42.0	25.3	13.6	1.4	17.6	100.0	1,168
35–39	85.0	1,051	40.1	25.9	17.1	1.8	15.0	100.0	1,051
40–44	82.2	922	40.7	24.0	16.2	1.2	17.8	100.0	922
Number of Living Children									
0	75.0	2,276	33.8	26.3	13.6	1.2	25.0	100.0	2,276
1	82.6	1,286	37.5	27.3	16.3	1.5	17.4	100.0	1,286
2	82.7	2,069	42.2	25.2	13.9	1.4	17.3	100.0	2,069
3 or more	81.4	661	42.9	21.3	15.6	1.5	18.6	100.0	661
Education Level									
Secondary incomplete or less	73.1	1,330	37.4	23.7	11.2	0.9	26.9	100.0	1,330
Secondary complete	77.6	1,568	40.1	24.9	11.4	1.2	22.4	100.0	1,568
Technicum	82.3	903	45.3	24.8	10.8	1.4	17.7	100.0	903
University/postgraduate	83.1	2,491	34.4	27.5	19.4	1.8	16.9	100.0	2,491
Wealth Quintile									
Lowest	73.7	1,093	47.8	17.2	7.3	1.5	26.3	100.0	1,093
Second	78.9	1,385	46.6	18.4	12.2	1.7	21.1	100.0	1,385
Middle	80.7	1,413	44.2	22.0	13.0	1.5	19.3	100.0	1,413
Fourth	79.5	1,037	31.1	32.8	14.6	0.9	20.5	100.0	1,037
Highest	81.7	1,364	25.5	33.8	21.2	1.3	18.3	100.0	1,364
Employment									
Working	82.5	1,410	36.1	25.2	19.1	2.1	17.5	100.0	1,410
Not working	78.5	4,882	38.4	25.8	13.2	1.2	21.5	100.0	4,882
Ethnicity									
Georgian	80.8	5,488	37.7	26.5	15.1	1.5	19.2	100.0	5,488
Other	69.8	804	39.3	20.1	9.7	0.7	30.2	100.0	804
Has Health Insurance									
Yes	85.1	1,548	35.3	23.2	24.2	2.4	14.9	100.0	1,548
No	77.7	4,744	38.7	26.3	11.7	1.1	22.3	100.0	4,744

Table 13.1.2 Receipt of Any Medical Care in the Last 12 Months and Type of Care by Selected Characteristics
Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Any Medical Care in the Last 12 Months		Type of Medical Care			
	%	No. of Cases	Preventive Care	Acute Care	Care for Chronic Conditions	No. of Cases
Total	36.6	6,292	41.1	50.7	20.0	2,353
Residence						
Urban	38.7	2,975	42.6	49.4	20.1	1,172
Rural	34.3	3,317	39.1	52.5	20.0	1,181
Region						
Kakheti	39.2	498	46.8	46.4	27.0	205
Tbilisi	40.7	1,426	43.1	51.6	18.0	580
Shida Kartli	34.9	392	36.7	56.5	19.8	142
Kvemo Kartli	32.7	546	43.7	48.0	20.1	187
Samtskhe–Javakheti	30.9	481	34.7	58.3	13.6	159
Adjara	25.9	419	31.5	47.9	26.7	119
Guria	33.0	401	57.0	50.3	7.9	139
Samegrelo	35.0	477	41.3	51.0	16.8	174
Imereti	43.0	805	39.0	50.9	20.9	352
Mtskheta–Mtianeti	29.7	393	39.7	44.2	25.6	124
Racha–Svaneti	38.9	454	30.6	53.4	24.7	172
Age Group						
15–19	30.6	861	27.1	61.3	16.3	273
20–24	36.6	1,099	47.8	45.7	14.3	428
25–29	40.1	1,191	45.8	43.7	18.5	475
30–34	38.6	1,168	44.7	51.3	17.4	454
35–39	36.0	1,051	42.4	51.1	25.5	379
40–44	38.6	922	35.5	54.0	30.0	344
Number of Living Children						
0	32.6	2,276	32.9	56.0	19.5	776
1	42.1	1,286	54.5	39.8	16.2	541
2	39.9	2,069	40.6	53.4	21.2	807
3 or more	33.1	661	44.0	46.6	27.1	229
Education Level						
Secondary incomplete or less	30.3	1,330	32.9	55.0	19.7	427
Secondary complete	35.5	1,568	43.0	46.8	21.6	563
Technicum	38.8	903	34.6	57.8	23.7	348
University/postgraduate	40.2	2,491	45.7	48.8	18.1	1,015
Wealth Quintile						
Lowest	31.7	1,093	37.6	54.7	23.3	367
Second	34.0	1,385	42.0	49.5	18.5	483
Middle	37.7	1,413	37.4	52.1	20.1	547
Fourth	39.4	1,037	42.7	44.6	23.9	411
Highest	38.5	1,364	44.0	53.1	16.6	545
Employment						
Working	40.7	1,410	45.0	46.7	18.3	572
Not working	35.5	4,882	39.9	52.0	20.5	1,781
Ethnicity						
Georgian	37.4	5,488	41.5	50.4	19.9	2,092
Other	31.2	804	37.8	53.9	20.9	261
Has Health Insurance						
Yes	48.7	1,548	42.0	52.2	19.6	736
No	33.2	4,744	40.7	50.1	20.2	1,617

Table 13.1.3 Delayed Medical Care and Main Reason for Delay in the Last 12 Months
by Selected Characteristics among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Delayed Medical Care in the Last 12 Months		Main Reason to Delay Care			Total	No. of Cases
	%	No. of Cases	Cost Related	Other Reasons	Does not Remember		
Total	25.2	6,292	82.0	17.8	0.2	100.0	1,672
Residence							
Urban	22.3	2,975	75.5	24.2	0.4	100.0	682
Rural	28.6	3,317	87.7	12.2	0.1	100.0	990
Region							
Kakheti	21.2	498	84.3	15.7	0.0	100.0	109
Tbilisi	23.4	1,426	67.6	31.7	0.7	100.0	339
Shida Kartli	29.6	392	94.7	5.3	0.0	100.0	118
Kvemo Kartli	30.1	546	85.3	14.7	0.0	100.0	168
Samtskhe–Javakheti	25.5	481	89.0	10.4	0.6	100.0	130
Adjara	22.6	419	89.0	11.0	0.0	100.0	93
Guria	24.8	401	87.1	12.9	0.0	100.0	100
Samegrelo	26.9	477	87.5	12.5	0.0	100.0	135
Imereti	24.0	805	84.9	15.1	0.0	100.0	193
Mtskheta–Mtianeti	35.4	393	82.3	17.2	0.5	100.0	140
Racha–Svaneti	31.4	454	79.1	20.9	0.0	100.0	147
Age Group							
15–19	10.1	861	80.6	19.4	0.0	100.0	88
20–24	16.8	1,099	77.1	22.9	0.0	100.0	186
25–29	22.0	1,191	80.0	19.8	0.2	100.0	272
30–34	32.1	1,168	82.5	17.2	0.3	100.0	383
35–39	33.2	1,051	83.3	16.0	0.7	100.0	352
40–44	42.3	922	84.5	15.5	0.0	100.0	391
Number of Living Children							
0	16.4	2,276	76.9	23.0	0.1	100.0	391
1	23.8	1,286	81.1	18.8	0.1	100.0	313
2	33.2	2,069	84.0	15.6	0.5	100.0	701
3 or more	40.8	661	86.6	13.4	.	100.0	267
Education Level							
Secondary incomplete or less	25.4	1,330	91.1	8.9	0.0	100.0	351
Secondary complete	26.4	1,568	88.1	11.8	0.1	100.0	437
Technicum	31.7	903	86.9	13.1	0.0	100.0	294
University/postgraduate	22.2	2,491	69.1	30.3	0.6	100.0	590
Wealth Quintile							
Lowest	33.0	1,093	90.1	9.9	0.0	100.0	373
Second	27.7	1,385	88.6	11.4	0.0	100.0	400
Middle	26.6	1,413	86.9	12.9	0.1	100.0	382
Fourth	22.4	1,037	80.4	19.2	0.4	100.0	237
Highest	19.9	1,364	63.2	36.1	0.7	100.0	280
Employment							
Working	26.3	1,410	65.2	34.3	0.5	100.0	386
Not working	24.9	4,882	86.8	13.1	0.1	100.0	1,286
Ethnicity							
Georgian	25.1	5,488	80.6	19.2	0.2	100.0	1,462
Other	25.8	804	91.0	8.7	0.2	100.0	210
Has Health Insurance							
Yes	29.0	1,548	69.3	30.4	0.2	100.0	462
No	24.2	4,744	86.3	13.5	0.2	100.0	1,210

Table 13.1.4 Percentage of Women Aged 15–44 with Health Insurance Coverage at the Time of the Interview and Main Sources of Health Insurance by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Has Health Insurance		Source of Health Insurance			Total	No. of Cases *
	%	No. of Cases	Government-funded	Private (Through Employer)	Private (Self-funded)		
Total	22.1	6,292	49.1	32.6	18.3	100.0	1,542
Residence							
Urban	21.4	2,975	28.8	42.1	29.0	100.0	659
Rural	23.0	3,317	70.4	22.7	6.9	100.0	883
Region							
Kakheti	20.1	498	69.3	19.7	11.0	100.0	110
Tbilisi	23.3	1,426	19.7	45.8	34.5	100.0	333
Shida Kartli	24.9	392	71.4	19.8	8.7	100.0	101
Kvemo Kartli	14.1	546	49.0	22.9	28.1	100.0	77
Samtskhe–Javakheti	19.1	481	34.1	61.8	4.1	100.0	98
Adjara	25.4	419	55.9	26.6	17.5	100.0	105
Guria	26.6	401	75.2	18.0	6.8	100.0	109
Samegrelo	21.2	477	66.7	26.2	7.1	100.0	98
Imereti	21.1	805	56.0	34.4	9.6	100.0	181
Mtskheta–Mtianeti	33.7	393	74.6	16.9	8.5	100.0	132
Racha–Svaneti	42.1	454	81.4	15.7	3.0	100.0	198
Age Group							
15–19	16.8	861	73.8	13.1	13.1	100.0	150
20–24	18.2	1,099	51.1	30.1	18.9	100.0	212
25–29	23.2	1,191	47.3	34.1	18.6	100.0	307
30–34	22.5	1,168	45.9	36.1	18.0	100.0	298
35–39	24.5	1,051	43.7	37.1	19.3	100.0	298
40–44	29.7	922	39.5	40.0	20.4	100.0	277
Number of Living Children							
0	18.8	2,276	51.6	27.7	20.7	100.0	472
1	23.4	1,286	40.4	37.9	21.7	100.0	316
2	24.0	2,069	47.3	35.9	16.8	100.0	547
3 or more	27.9	661	60.0	29.8	10.3	100.0	207
Education Level							
Secondary incomplete or less	19.3	1,330	81.9	9.5	8.6	100.0	294
Secondary complete	18.2	1,568	80.6	10.4	9.0	100.0	333
Technicum	19.8	903	56.3	29.2	14.5	100.0	204
University/postgraduate	27.0	2,491	20.5	52.4	27.1	100.0	711
Wealth Quintile							
Lowest	27.7	1,093	91.0	5.6	3.4	100.0	345
Second	22.7	1,385	67.2	25.5	7.2	100.0	356
Middle	20.0	1,413	54.0	34.5	11.5	100.0	321
Fourth	16.7	1,037	36.7	37.4	25.9	100.0	186
Highest	24.3	1,364	12.0	51.5	36.6	100.0	334
Employment							
Working	38.6	1,410	13.4	59.2	27.4	100.0	571
Not working	17.7	4,882	70.3	16.9	12.8	100.0	971
Ethnicity							
Georgian	23.9	5,488	48.5	32.8	18.7	100.0	1,442
Other	10.6	804	58.0	29.7	12.3	100.0	100

* Excludes 6 women who did not know the type of health insurance coverage.

Table 13.2 Time of Last Routine Gynecologic Exam by Selected Characteristics
Among Women Aged 15–44 Who Had Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

Characteristic	Timing of Last Routine Gynecologic Exam				Total	No. of Cases [*]
	During the Past 12 Months	Within 1–3 Years	More than 3 Years Ago	Never Had		
Total	24.6	26.1	20.1	29.3	100.0	4,473
Residence						
Urban	28.2	27.6	19.8	24.5	100.0	2,039
Rural	20.8	24.5	20.4	34.3	100.0	2,434
Region						
Kakheti	19.8	29.6	20.7	29.8	100.0	377
Tbilisi	30.8	28.3	19.6	21.4	100.0	941
Shida Kartli	23.1	24.6	26.0	26.3	100.0	285
Kvemo Kartli	23.7	21.9	16.8	37.7	100.0	416
Samtskhe–Javakheti	21.8	19.9	18.4	40.0	100.0	349
Adjara	20.7	30.4	16.6	32.2	100.0	314
Guria	16.9	24.4	19.0	39.8	100.0	288
Samegrelo	21.9	24.9	22.4	30.9	100.0	325
Imereti	26.8	24.4	22.1	26.8	100.0	584
Mtskheta–Mtianeti	15.6	26.7	20.0	37.8	100.0	290
Racha–Svaneti	20.6	22.1	22.3	35.0	100.0	304
Age Group						
15–24	31.8	19.6	3.2	45.3	100.0	770
25–29	28.5	27.4	10.5	33.6	100.0	908
30–34	25.5	27.1	18.5	29.0	100.0	1,027
35–39	20.7	29.4	28.4	21.5	100.0	941
40–44	17.2	26.0	37.5	19.3	100.0	827
Number of Living Children						
0	38.3	13.2	9.9	38.6	100.0	477
1	26.0	26.1	15.7	32.1	100.0	1,283
2	22.9	28.4	22.5	26.2	100.0	2,057
3 or more	17.1	28.1	28.2	26.6	100.0	656
Education Level						
Secondary incomplete or less	18.3	25.3	19.6	36.9	100.0	794
Secondary complete	22.6	23.2	19.3	34.9	100.0	1,192
Technicum	24.9	26.3	23.3	25.4	100.0	738
University/postgraduate	28.5	28.2	19.6	23.8	100.0	1,749
Wealth Quintile						
Lowest	17.6	24.2	19.7	38.5	100.0	786
Second	21.4	24.1	21.1	33.4	100.0	1,025
Middle	23.5	24.0	20.7	31.8	100.0	1,013
Fourth	28.4	27.7	18.4	25.5	100.0	706
Highest	29.6	29.4	20.1	20.8	100.0	943
Ethnicity						
Georgian	24.9	26.2	21.1	27.8	100.0	3,847
Other	22.5	25.3	14.2	38.0	100.0	626
Current Use of Contraception						
Modern	25.3	31.5	20.4	22.8	100.0	1,429
Traditional	20.0	26.9	21.2	31.9	100.0	797
No method	25.6	22.4	19.5	32.4	100.0	2,247

* Excludes 20 women who did not remember when they had the last routine gynecologic examination.

Table 13.3.1 Frequency of Breast Self-Examination (BSE) by Selected Characteristics
Among Women Aged 15–44 Who Had Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

Characteristic	Frequency of BSE				Total	No. of Cases
	Every Month	Every 2–5 Months	Every 6–12 Months or Less	Never Had		
Total	17.1	12.4	12.4	58.1	100.0	4,493
Residence						
Urban	19.9	14.1	14.4	51.6	100.0	2,048
Rural	14.3	10.6	10.3	64.9	100.0	2,445
Region						
Kakheti	17.9	13.8	12.9	55.4	100.0	380
Tbilisi	22.8	13.4	14.8	49.0	100.0	943
Shida Kartli	15.1	14.8	10.9	59.2	100.0	285
Kvemo Kartli	13.4	8.4	12.0	66.1	100.0	420
Samtskhe–Javakheti	7.4	5.7	11.7	75.2	100.0	350
Adjara	9.6	11.7	11.7	67.0	100.0	317
Guria	15.6	10.2	8.1	66.2	100.0	290
Samegrelo	15.8	15.3	9.3	59.7	100.0	326
Imereti	20.4	13.3	11.8	54.5	100.0	586
Mtskheta–Mtianeti	18.8	11.9	16.0	53.3	100.0	292
Racha–Svaneti	11.5	14.3	10.3	63.9	100.0	304
Age Group						
15–19	10.1	2.2	3.5	84.2	100.0	130
20–24	9.4	8.9	8.7	73.0	100.0	642
25–29	12.9	11.3	10.7	65.1	100.0	910
30–34	17.7	10.8	13.0	58.5	100.0	1,036
35–39	20.0	15.9	15.7	48.4	100.0	946
40–44	24.4	15.5	14.0	46.1	100.0	829
Number of Living Children						
0	12.5	7.9	6.3	73.3	100.0	477
1	17.3	13.0	11.7	58.1	100.0	1,286
2	18.1	13.1	13.8	55.1	100.0	2,069
3 or more	17.2	12.4	14.1	56.3	100.0	661
Education Level						
Secondary incomplete or less	8.5	7.5	7.6	76.4	100.0	802
Secondary complete	13.4	11.7	10.9	63.9	100.0	1,196
Technicum	19.9	13.8	15.4	50.9	100.0	740
University/postgraduate	22.3	14.4	14.4	49.0	100.0	1,755
Wealth Quintile						
Lowest	12.5	9.6	9.6	68.3	100.0	788
Second	11.9	10.9	9.9	67.3	100.0	1,032
Middle	18.6	11.8	13.4	56.2	100.0	1,018
Fourth	17.7	11.9	12.4	58.0	100.0	710
Highest	22.5	16.1	15.3	46.1	100.0	945
Employment						
Working	24.8	17.4	14.6	43.2	100.0	1,013
Not working	14.9	10.9	11.8	62.4	100.0	3,480
Ethnicity						
Georgian	18.8	13.3	13.0	55.0	100.0	3,859
Other	7.3	7.0	9.1	76.6	100.0	634
Current Use of Contraception						
Modern	19.3	14.7	14.8	51.3	100.0	1,436
Traditional	18.9	12.8	10.2	58.2	100.0	798
No method	15.2	10.8	11.7	62.4	100.0	2,259
Ever Had a Routine Gynecologic Exam						
Yes	19.5	14.2	13.8	52.5	100.0	3,099
No	11.3	8.0	9.1	71.6	100.0	1,394

Table 13.3.2 Prevalence of BSE, CBE and Mammography Screening by Selected Characteristics
Among All Women and Sexually Experienced Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Ever Had BSE		Ever Had CBE		Ever Had a Mammogram		Number of Cases	
	All Women	Sexually Experienced	All Women	Sexually Experienced	All Women	Sexually Experienced	All Women	Sexually Experienced
Total	32.1	41.9	13.1	17.7	4.9	6.8	6,292	4,493
Residence								
Urban	36.2	48.4	15.8	21.9	6.9	9.7	2,975	2,048
Rural	27.5	35.1	10.1	13.4	2.8	3.8	3,317	2,445
Region								
Kakheti	35.0	44.6	13.4	18.3	4.1	5.9	498	380
Tbilisi	37.0	51.0	19.0	26.7	8.8	12.6	1,426	943
Shida Kartli	31.8	40.8	9.9	13.9	3.2	4.7	392	285
Kvemo Kartli	27.3	33.9	11.3	14.4	4.6	6.0	546	420
Samtskhe–Javakheti	17.2	24.8	6.5	10.0	2.2	3.3	481	350
Adjara	25.0	33.0	9.4	13.5	2.8	4.1	419	317
Guria	29.0	33.8	8.4	11.4	3.2	4.2	401	290
Samegrelo	29.9	40.3	8.1	10.1	2.7	3.8	477	326
Imereti	36.4	45.5	13.6	17.9	3.6	4.8	805	586
Mtskheta–Mtianeti	34.4	46.7	12.4	16.9	4.8	6.4	393	292
Racha–Svaneti	29.3	36.1	10.8	14.6	2.7	4.0	454	304
Age Group								
15–19	5.4	15.8	3.0	7.2	0.4	0.0	861	130
20–24	19.4	27.0	7.6	11.2	1.7	2.6	1,099	642
25–29	31.6	34.9	10.5	12.7	3.3	3.8	1,191	910
30–34	40.2	41.5	16.2	17.2	6.5	6.9	1,168	1,036
35–39	51.0	51.6	22.3	23.3	9.3	9.4	1,051	946
40–44	52.6	53.9	22.4	23.7	10.2	11.0	922	829
Number of Living Children								
0	15.6	26.7	5.8	13.4	1.8	4.3	2,276	477
1	41.9	41.9	18.9	18.9	7.1	7.1	1,286	1,286
2	44.9	44.9	18.8	18.8	8.1	8.1	2,069	2,069
3 or more	43.7	43.7	15.3	15.3	4.2	4.2	661	661
Education Level								
Secondary incomplete or less	14.2	23.6	5.7	8.7	1.9	3.2	1,330	802
Secondary complete	28.0	36.1	9.1	11.9	2.7	3.7	1,568	1,196
Technicum	41.8	49.1	17.4	20.6	6.5	7.9	903	740
University/postgraduate	41.7	51.0	18.4	24.4	7.5	10.0	2,491	1,755
Wealth Quintile								
Lowest	24.5	31.7	7.8	10.5	1.9	2.6	1,093	788
Second	25.5	32.7	9.4	12.1	3.1	4.3	1,385	1,032
Middle	33.5	43.8	11.6	15.9	3.0	4.4	1,413	1,018
Fourth	31.0	42.0	12.6	18.0	4.7	6.6	1,037	710
Highest	40.9	53.9	20.6	28.1	9.8	13.6	1,364	945
Ethnicity								
Georgian	34.2	45.0	14.0	19.1	5.4	7.5	5,488	3,859
Other	18.1	23.4	7.3	9.8	2.0	2.7	804	634
Current Use of Contraception								
Modern	48.7	48.7	20.0	20.0	8.3	8.3	1,436	1,436
Traditional	41.8	41.8	14.3	14.3	6.2	6.2	798	798
No method	25.4	37.6	10.8	17.4	3.7	6.1	4,058	2,259
Ever Had a Routine Gynecologic Exam								
Yes	45.9	47.5	21.7	22.0	8.4	8.6	3,322	3,099
No	18.0	28.4	4.3	7.4	1.4	2.3	2,970	1,394

Table 13.3.3 Most Commonly Cited Reasons for Never Having Had a Mammography by Selected Characteristics
Among Women Aged 15–44 Who Had Never Had a Mammography
Reproductive Health Survey: Georgia, 2010

Characteristic	Main Reason for Never Having Had a Mammography					Total	No. of Cases
	Doctor Never Recommended it	Never Heard of Such Exam	Did Not Think it Was Necessary/ Too Young	Cost/ No Insurance/ Not Covered by Insurance	Other*		
Total	33.4	31.7	29.8	3.0	2.1	100.0	5,984
Residence							
Urban	35.0	24.6	35.8	2.9	1.8	100.0	2,768
Rural	31.6	39.5	23.4	3.2	2.4	100.0	3,216
Region							
Kakheti	37.6	38.3	20.5	0.8	2.8	100.0	475
Tbilisi	34.5	21.9	39.0	2.2	2.4	100.0	1,300
Shida Kartli	33.0	36.7	25.1	4.1	1.2	100.0	381
Kvemo Kartli	31.9	35.9	25.6	3.7	2.8	100.0	519
Samtskhe–Javakheti	18.7	56.3	24.1	0.5	0.3	100.0	470
Adjara	30.5	29.6	29.3	9.3	1.3	100.0	404
Guria	23.6	26.9	39.0	6.2	4.3	100.0	389
Samegrelo	30.1	45.9	22.1	1.0	0.9	100.0	462
Imereti	41.4	25.8	29.1	1.6	2.1	100.0	772
Mtskheta–Mtianeti	28.7	24.8	36.3	5.6	4.6	100.0	372
Racha–Svaneti	33.6	44.2	19.7	1.3	1.3	100.0	440
Age Group							
15–24	19.4	45.8	33.1	0.6	1.1	100.0	1,938
25–34	39.0	25.1	31.4	2.4	2.1	100.0	2,256
35–44	45.6	20.5	23.6	6.9	3.4	100.0	1,790
Number of Living Children							
0	19.1	42.5	36.4	0.8	1.2	100.0	2,229
1	43.6	22.7	28.0	3.7	2.0	100.0	1,203
2	45.0	22.8	24.7	4.7	2.7	100.0	1,919
3 or more	41.5	28.1	19.9	6.4	4.1	100.0	633
Education Level							
Secondary incomplete or less	20.4	51.5	23.9	2.5	1.6	100.0	1,303
Secondary complete	31.0	36.3	26.8	4.1	1.8	100.0	1,525
Technicum	39.6	21.8	31.5	5.5	1.6	100.0	847
University/postgraduate	40.7	20.0	34.9	1.7	2.7	100.0	2,309
Wealth Quintile							
Lowest	28.5	45.8	20.0	3.4	2.3	100.0	1,072
Second	33.2	38.3	24.6	2.3	1.6	100.0	1,342
Middle	32.2	35.9	25.2	4.4	2.3	100.0	1,360
Fourth	35.4	25.5	34.8	2.5	1.8	100.0	983
Highest	36.0	18.7	40.3	2.5	2.4	100.0	1,227
Ethnicity							
Georgian	34.8	28.5	31.5	3.1	2.1	100.0	5,197
Other	24.1	52.2	19.3	2.3	2.2	100.0	787
Current Use of Contraception							
Modern	48.1	18.0	27.2	3.9	2.9	100.0	1,323
Traditional	40.0	26.8	27.6	3.7	1.9	100.0	752
No method	28.0	36.5	30.9	2.6	1.9	100.0	3,909

* Includes negligence, not knowing where the test is offered and fear of results.

Table 13.4.1 History of Cervical Cancer Screening by Selected Characteristics
Among Women Aged 15–44 Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

Characteristic	Timing of Last Cervical Cancer Screening				Total	No. of Cases*
	During the Past 12 Months	Within 1–3 Years	More than 3 Years Ago	Never Had		
Total	5.0	4.0	3.1	87.8	100.0	4,491
Residence						
Urban	7.1	5.1	3.1	84.8	100.0	2,047
Rural	2.9	3.0	3.2	91.0	100.0	2,444
Region						
Kakheti	3.9	3.4	3.6	89.1	100.0	379
Tbilisi	10.0	7.0	3.3	79.7	100.0	942
Shida Kartli	3.0	1.5	4.4	91.1	100.0	285
Kvemo Kartli	3.2	3.4	3.0	90.4	100.0	420
Samtskhe–Javakheti	1.9	1.4	2.6	94.0	100.0	350
Adjara	4.3	4.6	2.8	88.3	100.0	317
Guria	4.8	5.4	4.5	85.3	100.0	290
Samegrelo	1.6	0.8	0.0	97.5	100.0	326
Imereti	3.7	3.4	4.2	88.7	100.0	586
Mtskheta–Mtianeti	4.4	2.5	1.1	92.0	100.0	292
Racha–Svaneti	2.3	3.7	2.9	91.1	100.0	304
Age Group						
15–24	6.5	3.1	0.8	89.5	100.0	772
25–29	4.7	4.4	2.9	88.1	100.0	910
30–34	3.9	3.5	3.2	89.4	100.0	1,035
35–39	5.4	4.1	4.2	86.2	100.0	946
40–44	4.8	5.0	4.2	86.0	100.0	828
Number of Living Children						
0	6.5	3.3	1.9	88.2	100.0	477
1	6.0	4.3	2.6	87.1	100.0	1,285
2	4.8	4.1	3.5	87.6	100.0	2,069
3 or more	2.9	3.6	3.8	89.7	100.0	660
Education Level						
Secondary incomplete or less	2.0	1.3	1.7	95.0	100.0	802
Secondary complete	3.6	2.4	2.6	91.4	100.0	1,196
Technicum	5.6	4.9	3.5	86.0	100.0	739
University/postgraduate	7.1	6.0	4.0	83.0	100.0	1,754
Wealth Quintile						
Lowest	1.2	1.7	2.8	94.4	100.0	788
Second	3.7	2.8	3.8	89.6	100.0	1,032
Middle	3.0	3.4	2.4	91.2	100.0	1,017
Fourth	5.4	4.9	2.1	87.6	100.0	710
Highest	10.0	6.3	4.1	79.6	100.0	944
Ethnicity						
Georgian	5.6	4.1	3.5	86.8	100.0	3,857
Other	1.9	3.5	0.8	93.9	100.0	634
Current Use of Contraception						
Modern	5.0	4.1	3.3	87.5	100.0	1,436
Traditional	3.4	3.9	2.8	89.9	100.0	798
No method	5.6	4.0	3.1	87.4	100.0	2,257
Ever Had a Routine Gynecologic Exam						
Yes	6.3	4.9	3.6	85.2	100.0	3,097
No	1.9	2.0	1.9	94.1	100.0	1,394

* Excludes 2 women who did not remember if they had cervical cancer screening.

Table 13.4.2 Receipt of Cervical Cancer Screening in the Last 3 Years by Selected Characteristics and Age among Women Aged 15–44 Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

Characteristic	Had Cervical Cancer Screening in the Last 3 Years			No. of Cases*
	15–24	25–34	35–44	
Total	9.6	8.1	9.7	4,491
Residence				
Urban	10.4	11.0	14.0	2,047
Rural	8.8	5.2	5.1	2,444
Region				
Kakheti	7.7	5.7	8.4	379
Tbilisi	11.1	14.8	21.6	942
Shida Kartli	7.1	5.2	2.7	285
Kvemo Kartli	9.4	7.1	4.9	420
Samtskhe–Javakheti	2.3	2.9	4.4	350
Adjara	16.7	4.2	9.3	317
Guria	15.7	11.2	7.1	290
Samegrelo	0.0	3.3	2.2	326
Imereti	10.7	7.7	5.1	586
Mtskheta–Mtianeti	6.6	5.5	8.3	292
Racha–Svaneti	12.8	7.1	3.4	304
Education Level				
Secondary incomplete or less	3.7	1.4	5.0	802
Secondary complete	8.2	6.1	3.9	1,196
Technicum	17.9	10.4	8.8	739
University/postgraduate	12.7	11.4	14.8	1,754
Wealth Quintile				
Lowest	4.0	3.7	1.7	788
Second	12.5	4.0	5.9	1,032
Middle	3.9	6.9	6.9	1,017
Fourth	8.5	10.8	10.7	710
Highest	15.9	13.3	19.2	944
Ethnicity				
Georgian	10.6	8.6	10.3	3,857
Other	5.7	5.5	4.8	634
Current Use of Contraception				
Modern	11.0	7.5	10.4	1,436
Traditional	4.3	6.3	9.0	798
No method	9.9	9.3	9.6	2,257
Ever Had a Routine Gynecologic Exam				
Yes	12.5	10.4	11.4	3,097
No	6.2	3.1	3.0	1,394

* Excludes 2 women who did not remember if they had cervical cancer screening.

Table 13.4.3

Awareness of Human Papilloma Virus (HPV) and HPV Vaccine and Interest in the HPV Vaccine by Selected Characteristics Among Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Awareness		Interest	No. of Cases
	Of the Human Papilloma Virus (HPV)	Of the HPV Vaccine	In Getting the HPV Vaccine	
Total	20.8	18.3	29.3	6,292
Residence				
Urban	28.3	24.1	29.7	2,975
Rural	12.3	11.8	28.8	3,317
Region				
Kakheti	19.1	19.1	30.9	498
Tbilisi	34.3	28.8	30.3	1,426
Shida Kartli	16.4	11.4	29.4	392
Kvemo Kartli	15.0	12.6	30.4	546
Samtskhe–Javakheti	7.6	8.7	13.5	481
Adjara	14.9	17.4	34.8	419
Guria	13.6	11.4	34.6	401
Samegrelo	10.3	6.9	22.7	477
Imereti	20.3	18.2	30.9	805
Mtskheta–Mtianeti	18.4	18.4	26.6	393
Racha–Svaneti	9.8	11.5	25.4	454
Age Group				
15–19	5.7	8.9	31.9	861
20–24	15.1	14.7	30.7	1,099
25–29	21.5	18.2	29.7	1,191
30–34	27.7	21.0	29.1	1,168
35–39	28.5	25.0	28.4	1,051
40–44	29.9	24.6	25.0	922
Number of Living Children				
0	15.0	15.2	29.5	2,276
1	26.8	22.8	31.9	1,286
2	24.8	19.9	28.3	2,069
3 or more	21.2	18.4	26.1	661
Education Level				
Secondary incomplete or less	4.7	6.7	27.5	1,330
Secondary complete	12.0	12.1	25.3	1,568
Technicum	26.5	20.2	28.1	903
University/postgraduate	33.6	28.3	33.2	2,491
Wealth Quintile				
Lowest	7.6	7.8	24.2	1,093
Second	13.1	11.5	28.1	1,385
Middle	14.1	13.9	29.8	1,413
Fourth	21.7	19.3	31.4	1,037
Highest	38.9	32.5	31.1	1,364
Ethnicity				
Georgian	22.8	20.1	30.7	5,488
Other	7.2	6.9	19.8	804
Current Use of Contraception				
Modern	30.4	24.5	32.3	1,436
Traditional	22.4	18.5	29.6	798
No method	17.5	16.4	28.3	4,058
Ever Had a Routine Gynecologic Exam				
Yes	27.7	21.7	30.2	3,322
No	13.8	14.9	28.3	2,970

Table 13.5.1 Knowledge of Tuberculosis (TB) and the Way TB Is Transmitted and Exposure to TB
By Selected Characteristics among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Have Heard of TB	Knowledge of Transmission			Exposure to TB		No. of Cases
	%	Through the Air When Coughing	Other Ways	Does not Know How TB Spreads	From a Family Member Who Has Had TB*	From Frequent Contact with Someone Who Has Had TB	
Total	94.5	67.3	56.6	12.1	8.7	11.8	6,292
Residence							
Urban	96.9	74.3	59.2	7.9	6.0	12.3	2,975
Rural	91.7	59.4	53.7	16.8	11.7	11.2	3,317
Region							
Kakheti	87.0	61.2	46.5	22.0	15.3	12.2	498
Tbilisi	97.1	77.3	63.3	6.9	5.8	13.1	1,426
Shida Kartli	97.0	71.6	65.1	5.7	8.1	7.7	392
Kvemo Kartli	86.1	57.6	45.3	24.6	17.7	11.4	546
Samtskhe–Javakheti	90.2	44.9	39.3	23.6	12.1	9.0	481
Adjara	98.6	73.9	43.9	4.6	4.1	14.9	419
Guria	97.2	72.4	62.4	7.2	6.6	16.0	401
Samegrelo	96.0	74.3	72.6	6.1	6.7	9.4	477
Imereti	95.6	57.1	57.9	15.3	7.5	10.4	805
Mtskheta–Mtianeti	97.5	65.8	58.7	10.3	7.6	12.9	393
Racha–Svaneti	96.4	63.8	67.9	10.1	6.9	12.3	454
Age Group							
15–19	89.2	52.9	40.0	23.5	13.3	8.3	861
20–24	92.4	61.7	51.4	16.1	10.7	10.4	1,099
25–29	95.5	70.2	59.1	10.1	6.9	13.9	1,191
30–34	96.6	72.4	63.6	6.9	6.1	11.6	1,168
35–39	97.4	75.0	64.0	7.3	5.9	13.1	1,051
40–44	97.1	75.0	65.3	6.0	8.3	14.2	922
Number of Living Children	92.7	63.4	51.1		9.7	11.1	2,276
0				15.6			
1	95.5	71.2	62.6	9.6	8.4	12.8	1,286
2	96.4	69.8	60.2	8.9	6.7	11.9	2,069
3 or more	94.3	68.6	57.4	11.6	10.8	12.4	661
Education Level							
Secondary incomplete or less	86.3	49.6	41.0	25.1	17.1	7.6	1,330
Secondary complete	94.9	62.2	54.0	13.6	8.5	11.7	1,568
Technicum	97.6	75.8	65.5	5.6	6.4	13.0	903
University/postgraduate	97.9	77.9	64.2	5.8	4.7	13.8	2,491
Wealth Quintile							
Lowest	90.7	54.3	55.1	17.9	13.6	13.8	1,093
Second	91.4	59.0	50.0	17.2	11.7	9.6	1,385
Middle	94.6	66.8	56.7	12.6	8.7	10.0	1,413
Fourth	97.1	73.5	55.6	8.3	6.4	13.5	1,037
Highest	97.1	76.9	63.1	7.2	5.3	12.5	1,364
Ethnicity							
Georgian	96.7	70.6	60.1	9.0	6.6	12.1	5,488
Other	79.7	45.2	33.4	32.5	22.6	9.6	804

* Includes 36 women who were not sure if they were exposed to TB from a family member.

Table 13.5.2 Awareness of Symptoms of TB by Selected Characteristics among Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Symptoms of TB Spontaneously Mentioned												No. of Cases
	Prolonged and Severe Cough	Fever	Blood in Sputum	Weight Loss	Tiredness/ Fatigue	Night Sweating	Coughing More Than 3 Weeks	Loss of Appetite	Pain in Chest	Lethargy	Other	Does Not Know	
Total	70.5	28.0	27.2	24.3	20.4	13.6	13.1	12.8	4.6	1.5	1.2	11.7	6,292
Residence													
Urban	75.7	30.4	32.1	27.2	21.6	15.3	16.0	14.7	5.4	1.9	0.8	7.4	2,975
Rural	64.6	25.2	21.7	21.0	19.1	11.7	9.9	10.6	3.7	1.1	1.6	16.6	3,317
Region													
Kakheti	57.8	17.7	22.3	15.7	16.3	8.9	8.9	8.5	3.3	1.4	0.2	22.9	498
Tbilisi	79.7	32.0	34.7	29.4	23.4	15.6	14.8	15.6	6.3	2.7	0.6	6.3	1,426
Shida Kartli	77.7	34.1	17.0	22.3	23.7	13.6	7.7	7.9	5.3	0.6	3.0	6.3	392
Kvemo Kartli	58.9	19.3	19.4	20.9	12.6	10.9	11.0	8.4	3.1	1.1	1.6	24.7	546
Samtskhe–Javakheti	53.9	17.2	15.7	12.4	21.1	5.6	1.7	5.7	2.2	0.3	2.2	22.4	481
Adjara	75.0	26.5	30.2	29.3	13.0	16.3	30.4	20.8	8.5	1.6	0.7	3.7	419
Guria	79.0	20.8	36.8	32.0	12.2	21.8	7.6	18.6	4.6	1.2	0.4	6.6	401
Samegrelo	74.1	42.4	35.0	25.9	22.7	12.3	11.4	10.9	1.5	1.7	1.3	5.9	477
Imereti	65.2	28.2	23.3	22.1	26.0	15.7	11.0	12.7	3.7	0.5	1.7	15.1	805
Mtskheta–Mtianeti	72.1	22.6	24.0	24.1	20.5	8.6	13.9	11.0	2.9	0.6	0.6	5.9	393
Racha–Svaneti	74.2	37.1	25.4	21.8	27.5	14.6	10.8	12.8	2.8	1.6	1.8	8.9	454
Age Group													
15–19	58.0	17.8	17.8	15.6	10.9	6.0	8.4	7.4	2.6	1.0	0.3	23.2	861
20–24	65.3	22.2	23.8	21.6	18.0	10.3	11.7	10.4	3.2	0.7	1.4	15.3	1,099
25–29	70.8	29.7	30.7	26.8	22.0	15.3	13.2	12.5	5.6	2.3	0.9	9.7	1,191
30–34	74.7	33.3	30.1	25.5	22.6	14.6	13.6	13.0	4.8	0.8	1.4	7.3	1,168
35–39	76.6	33.4	33.0	27.5	24.1	17.7	17.3	16.2	5.7	1.7	1.7	7.1	1,051
40–44	80.9	34.3	29.6	31.0	27.3	19.8	15.8	18.7	6.6	2.7	1.5	5.0	922
Number of Living Children													
0	65.6	24.9	24.9	21.9	17.9	10.1	11.4	10.2	3.4	1.3	1.0	15.6	2,276
1	74.5	32.1	32.3	26.1	23.4	16.7	14.6	16.0	5.6	2.2	0.5	9.2	1,286
2	74.3	29.5	28.0	25.1	21.6	15.6	13.6	14.2	5.4	1.1	2.0	8.6	2,069
3 or more	71.6	28.1	24.7	28.2	22.0	16.3	16.2	13.2	5.8	2.0	1.0	9.6	661
Education Level													
Secondary incomplete or less	55.7	18.7	15.7	14.9	11.5	7.0	8.0	7.3	2.4	0.9	0.5	25.3	1,330
Secondary complete	66.0	22.7	23.1	22.1	15.8	11.4	12.9	11.4	4.5	1.3	1.7	13.4	1,568
Technicum	74.7	33.9	31.6	31.5	27.7	16.8	16.2	17.5	7.4	1.5	2.2	5.2	903
University/postgraduate	80.4	34.5	34.9	28.7	26.1	17.7	15.3	15.2	5.1	2.0	0.9	5.1	2,491
Wealth Quintile													
Lowest	62.3	25.8	21.7	17.3	14.8	11.0	10.6	7.4	3.2	1.3	1.8	17.2	1,093
Second	62.2	24.4	19.5	19.1	16.7	9.0	9.2	9.0	2.9	0.6	2.2	18.3	1,385
Middle	69.3	24.0	23.9	25.1	24.0	13.7	11.3	13.3	4.0	1.3	1.2	12.0	1,413
Fourth	74.4	28.8	30.6	25.7	18.6	16.4	17.4	16.3	5.7	1.5	0.3	7.7	1,037
Highest	79.6	34.6	36.4	30.5	24.9	16.4	16.1	15.7	6.6	2.4	0.7	6.3	1,364
Ethnicity													
Georgian	73.8	30.3	29.1	25.7	21.7	14.8	14.4	13.8	4.8	1.7	1.2	8.5	5,488
Other	48.5	12.6	14.7	15.4	12.1	5.9	5.0	6.1	3.7	0.3	1.2	32.6	804

Table 13.5.3 Awareness That TB Can Be Completely Cured and Perception About the Most Appropriate Treatment Approach for a Person with TB by Selected Characteristics among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Awareness That TB Can Be Completely Cured		Perception About the Most Appropriate Treatment Approach for a Person with TB					
	%	No. of Cases	Hospitalization	Treatment at Home	Hospitalization Followed by Home Treatment	Does Not Know	Total	No. of Cases
Total	75.2	6,292	77.8	1.4	12.8	8.0	100.0	6,292
Residence								
Urban	81.7	2,975	80.7	1.2	13.6	4.5	100.0	2,975
Rural	67.9	3,317	74.5	1.6	11.9	12.0	100.0	3,317
Region								
Kakheti	60.0	498	68.8	2.1	10.8	18.4	100.0	498
Tbilisi	82.3	1,426	81.9	1.0	13.1	4.0	100.0	1,426
Shida Kartli	83.2	392	83.0	1.6	11.6	3.7	100.0	392
Kvemo Kartli	61.7	546	71.4	1.4	9.7	17.4	100.0	546
Samtskhe–Javakheti	58.9	481	66.6	1.2	11.0	21.1	100.0	481
Adjara	74.2	419	78.3	2.1	17.6	2.0	100.0	419
Guria	86.6	401	78.4	0.4	17.0	4.2	100.0	401
Samegrelo	78.8	477	80.7	1.0	13.3	5.0	100.0	477
Imereti	79.4	805	79.2	1.4	12.0	7.4	100.0	805
Mtskheta–Mtianeti	76.0	393	78.7	1.5	14.8	4.9	100.0	393
Racha–Svaneti	77.3	454	80.8	1.1	13.7	4.4	100.0	454
Age Group								
15–19	58.5	861	72.5	2.0	8.9	16.6	100.0	861
20–24	69.8	1,099	75.9	1.3	12.4	10.4	100.0	1,099
25–29	78.8	1,191	78.3	1.1	13.9	6.7	100.0	1,191
30–34	82.6	1,168	82.2	0.8	12.5	4.5	100.0	1,168
35–39	82.6	1,051	80.3	1.2	14.3	4.2	100.0	1,051
40–44	82.7	922	78.7	1.8	15.4	4.1	100.0	922
Number of Living Children								
0	69.0	2,276	74.4	1.7	13.4	10.4	100.0	2,276
1	80.4	1,286	80.3	1.2	11.8	6.7	100.0	1,286
2	79.6	2,069	80.1	1.1	13.2	5.6	100.0	2,069
3 or more	78.1	661	80.0	1.4	10.7	8.0	100.0	661
Education Level								
Secondary incomplete or less	56.7	1,330	72.5	1.1	7.7	18.7	100.0	1,330
Secondary complete	72.1	1,568	77.2	1.9	12.3	8.6	100.0	1,568
Technicum	83.1	903	82.0	1.5	13.6	2.9	100.0	903
University/postgraduate	85.3	2,491	79.8	1.2	15.7	3.3	100.0	2,491
Wealth Quintile								
Lowest	65.0	1,093	71.7	1.9	13.4	12.9	100.0	1,093
Second	67.2	1,385	75.7	1.9	10.5	11.9	100.0	1,385
Middle	73.7	1,413	77.1	1.3	12.5	9.1	100.0	1,413
Fourth	80.4	1,037	80.3	1.1	14.1	4.5	100.0	1,037
Highest	84.7	1,364	81.7	0.9	13.4	4.1	100.0	1,364
Employment								
Working	86.6	1,410	77.0	1.2	18.6	3.2	100.0	1,410
Not working	72.2	4,882	78.0	1.4	11.2	9.4	100.0	4,882
Ethnicity								
Georgian	79.6	5,488	79.9	1.4	13.6	5.1	100.0	5,488
Other	46.4	804	63.6	1.3	7.6	27.5	100.0	804

Table 13.6.1 Percentage of Women Aged 15–44 by Current Smoking Status and by Residence. Reproductive Health Survey: Georgia, 2010

Smoking Status	Total	Residence		
		Tbilisi	Other Urban	Rural
Current tobacco smoker	5.5	13.4	4.1	1.7
Daily smoker	4.6	11.3	3.5	1.2
Occasional smoker	0.9	2.1	0.6	0.4
Non-smoker	94.5	86.6	95.9	98.3
Former daily smoker	1.3	3.5	0.8	0.2
Never daily smoker	1.1	2.4	0.8	0.5
Never smoker	92.2	80.7	94.3	97.6
Total	100.0	100.0	100.0	100.0
No. of Cases *	6,279	1,417	1,547	3,315

* Exclude 13 women who refused to answer.

Table 13.6.2

Percentage of Women Aged 15–44 Who Have Ever Smoked
and Who Currently Smoke by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Ever Smoked	Current Status		No. of Cases
		Current Smoker	Past Smoker	
Total	7.8	5.5	2.3	6,292
Residence				
Urban	12.7	8.9	3.8	2,975
Rural	2.4	1.7	0.7	3,317
Region				
Kakheti	4.5	3.6	0.9	498
Tbilisi	19.2	13.3	5.9	1,426
Shida Kartli	2.8	1.4	1.4	392
Kvemo Kartli	3.1	2.1	1.0	546
Samtskhe–Javakheti	1.4	1.1	0.3	481
Adjara	6.1	4.3	1.8	419
Guria	1.0	0.6	0.4	401
Samegrelo	2.8	1.8	1.0	477
Imereti	3.0	2.6	0.4	805
Mtskheta–Mtianeti	5.7	3.2	2.5	393
Racha–Svaneti	2.5	0.9	1.6	454
Age Group				
15–19	2.6	2.2	0.4	861
20–24	7.3	4.7	2.6	1,099
25–29	8.4	6.4	2.0	1,191
30–34	10.3	7.0	3.3	1,168
35–39	9.8	6.9	2.9	1,051
40–44	9.5	6.3	3.2	922
Number of Living Children				
0	7.0	5.6	1.4	2,276
1	13.0	8.4	4.6	1,286
2	6.5	4.2	2.3	2,069
3 or more	5.4	3.2	2.2	661
Education Level				
Secondary incomplete or less	2.5	2.3	0.2	1,330
Secondary complete	5.7	3.8	1.9	1,568
Technicum	5.6	3.9	1.7	903
University/postgraduate	13.0	8.9	4.1	2,491
Wealth Quintile				
Lowest	2.1	1.6	0.5	1,093
Second	2.5	1.8	0.7	1,385
Middle	4.0	2.5	1.5	1,413
Fourth	9.6	6.7	2.9	1,037
Highest	16.9	12.0	4.9	1,364
Ethnicity				
Georgian	8.4	5.8	2.6	5,488
Other	4.0	3.3	0.8	804
Current Use of Contraception				
Modern	9.3	5.9	3.4	1,436
Traditional	4.5	3.2	1.3	798
No method	7.9	5.7	2.2	4,058

Table 13.6.3 Secondhand Smoking at Home and at Work (Indoors) by Selected Characteristics
Among All Women and Women Not Currently Smoking Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	All Women				Non-Smoker			
	Exposed to Tobacco Smoke at Home	No. of Cases	Exposed to Tobacco Smoke at Work	No. of Cases	Exposed to Tobacco Smoke at Home	No. of Cases	Exposed to Tobacco Smoke at Work	No. of Cases
Total	51.6	6,292	43.6	1,352	49.6	5,823	40.3	1,167
Residence								
Urban	48.9	2,975	47.0	872	45.4	2,588	43.4	703
Rural	54.5	3,317	35.3	480	53.9	3,235	33.9	464
Age Group								
15–24	51.0	1,960	47.3	169	49.8	1,871	43.9	154
25–29	56.0	1,191	40.8	250	54.0	1,102	36.3	217
30–34	52.2	1,168	45.9	260	48.9	1,057	43.2	222
35–39	49.3	1,051	40.8	352	47.5	955	36.2	298
40–44	49.7	922	44.7	321	47.3	838	42.9	276
Education Level								
Secondary incomplete or less	52.9	1,330	59.4	48	52.1	1,295	56.0	41
Secondary complete	55.7	1,568	55.7	108	54.3	1,493	52.9	95
Technicum	54.4	903	44.4	199	53.0	850	42.6	182
University/postgraduate	47.2	2,491	41.2	997	43.7	2,185	37.4	849
Wealth Quintile								
Lowest	52.9	1,093	39.3	87	52.1	1,063	37.2	84
Second	56.3	1,385	33.1	200	55.7	1,353	31.0	194
Middle	51.7	1,413	39.9	314	50.5	1,356	37.5	296
Fourth	51.0	1,037	47.9	280	48.6	936	46.3	246
Highest	47.5	1,364	46.5	471	42.6	1,115	41.9	347
Ethnicity								
Georgian	51.7	5,488	43.7	1,252	49.7	5,054	40.2	1,072
Other	50.4	804	41.5	100	49.1	769	41.6	95

Table 13.7 Percentage of Women Aged 15–44 Who Used Alcohol During the Previous Three Months by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Alcohol Use During the Past Three Months				No. of Cases
	Ever Drank	Current Drinkers	Current Frequent Drinkers	Binger	
Total	30.5	16.6	1.8	8.0	6,292
Residence					
Urban	33.9	18.5	2.3	9.2	2,975
Rural	26.7	14.5	1.2	6.7	3,317
Region					
Kakheti	32.8	21.8	3.2	8.2	498
Tbilisi	40.9	23.2	3.1	12.3	1,426
Shida Kartli	36.5	15.8	1.4	9.5	392
Kvemo Kartli	19.3	8.9	0.7	5.7	546
Samtskhe–Javakheti	18.6	7.6	0.3	3.1	481
Adjara	13.7	7.3	0.9	3.4	419
Guria	19.8	10.4	0.4	6.2	401
Samegrelo	33.4	19.2	2.2	8.6	477
Imereti	30.7	16.8	0.8	6.4	805
Mtskheta–Mtianeti	34.2	16.5	1.9	6.8	393
Racha–Svaneti	33.2	16.9	2.3	8.5	454
Age Group					
15–24	29.0	14.4	1.0	8.6	1,960
25–34	29.4	16.4	1.4	8.6	2,359
35–44	33.7	19.6	3.3	6.9	1,973
Marital Status					
Married	26.9	14.8	1.4	6.3	4,098
Previously married	36.6	21.7	5.6	14.0	389
Never married	35.7	18.8	1.7	9.9	1,805
Education Level					
Secondary incomplete or less	24.5	12.0	1.0	6.0	1,330
Secondary complete	26.7	16.2	2.0	8.1	1,568
Technicum	31.1	16.9	1.6	8.8	903
University/postgraduate	36.2	19.4	2.2	9.0	2,491
Wealth Quintile					
Lowest	26.8	12.9	0.6	6.5	1,093
Second	24.7	14.3	1.0	5.6	1,385
Middle	28.5	16.0	2.2	7.3	1,413
Fourth	28.1	14.8	1.4	7.7	1,037
Highest	40.4	22.2	3.0	11.6	1,364
Ethnicity					
Georgian	32.6	17.6	2.0	8.8	5,488
Other	16.7	9.8	0.7	3.1	804
Employment					
Working	39.6	22.5	2.4	8.7	1,410
Not working	28.1	15.0	1.6	7.9	4,882

Table 13.8 Percentage of Women Aged 15–44 Who Have Ever Been Told by a Doctor That They Have Selected Health Problems by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Selected Health Problems					No. of Cases
	PID	High Blood Pressure	Anemia	Heart Disease	Diabetes	
Total	19.4	5.5	4.2	2.8	0.6	6,292
Residence						
Urban	18.6	5.1	4.4	2.4	0.7	2,975
Rural	20.2	6.1	3.9	3.4	0.5	3,317
Region						
Kakheti	22.6	8.5	5.2	1.1	0.2	498
Tbilisi	18.1	5.4	5.2	2.0	0.8	1,426
Shida Kartli	22.3	7.1	4.3	2.6	0.4	392
Kvemo Kartli	19.3	3.6	4.0	3.1	0.3	546
Samtskhe–Javakheti	17.7	2.8	1.1	2.3	0.0	481
Adjara	16.2	5.9	0.7	5.5	0.2	419
Guria	11.8	5.2	3.0	2.2	0.4	401
Samegrelo	19.3	5.5	2.5	3.9	0.3	477
Imereti	21.7	5.4	5.8	2.8	1.6	805
Mtskheta–Mtianeti	21.9	7.2	5.9	4.6	0.8	393
Racha–Svaneti	22.6	6.4	4.3	3.4	0.4	454
Age Group						
15–24	6.5	2.3	2.7	1.4	0.5	1,960
25–34	22.4	4.0	5.3	1.8	0.4	2,359
35–44	31.6	11.2	4.7	5.8	1.0	1,973
Marital Status						
Married	29.2	7.1	5.2	3.2	0.6	4,098
Previously married	31.6	9.1	5.7	6.4	1.0	389
Never married	0.1	2.2	2.2	1.6	0.6	1,805
Education Level						
Secondary incomplete or less	13.1	4.8	2.8	3.2	0.4	1,330
Secondary complete	20.8	5.1	3.5	2.7	0.8	1,568
Technicum	26.1	9.3	3.9	5.3	0.8	903
University/postgraduate	19.8	5.0	5.5	1.9	0.6	2,491
Wealth Quintile						
Lowest	16.6	7.7	3.3	5.5	0.9	1,093
Second	21.7	5.1	2.7	2.4	0.7	1,385
Middle	20.5	6.1	4.8	2.9	0.3	1,413
Fourth	16.8	4.2	3.8	2.1	0.7	1,037
Highest	20.0	5.2	5.5	2.2	0.6	1,364
Ethnicity						
Georgian	19.5	5.7	4.6	2.9	0.7	5,488
Other	18.6	4.6	1.6	2.7	0.2	804
Employment						
Working	21.8	6.2	5.1	2.2	0.7	1,410
Not working	18.7	5.4	3.9	3.0	0.6	4,882

14

CHAPTER

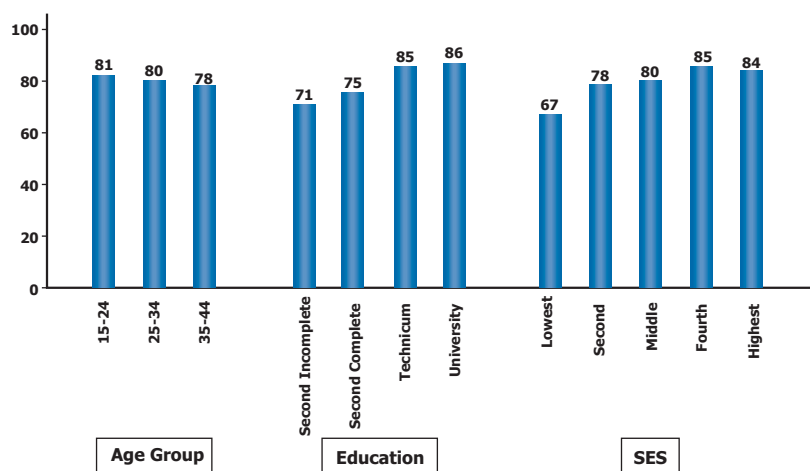
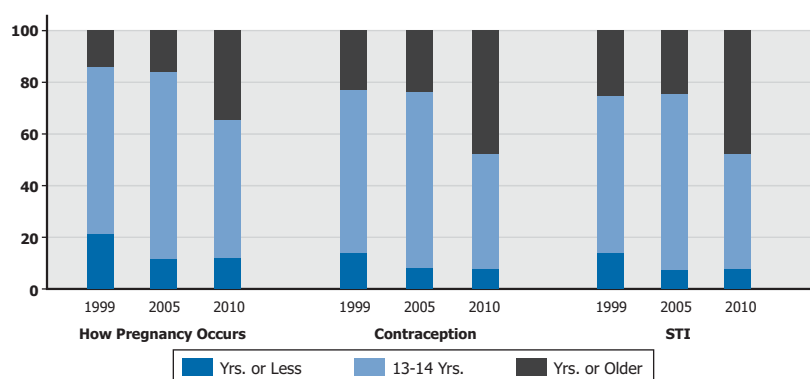
FAMILY LIFE EDUCATION

Interests in teenage sexuality, adolescent pregnancy, and sexual health have been increasing worldwide in recent years. It has become clear that complex approaches are required for prevention activities meant to reduce the rates of sexually transmitted infections and early pregnancies among adolescents. For example, school-based sex education should be an important component of a wider effort. Health education interventions at school, with a family-based exposure to sex education, are appropriate for promoting teenage sexual and reproductive health. Various studies from different countries have demonstrated that high-quality sex education programs in school can lead to enhanced understanding of personal hygiene, health, and reproductive issues. In the countries with well-established family life education curricula, age-appropriate topics from the first to 12th grade are included as a component of the health and physical curriculum. Recently, in Georgia, elements of reproductive biology have been incorporated in high school biology and human anatomy classes, but the curriculum still needs improvement and enhancement.

14.1 Opinions about Family Life Education at Schools

Adolescents' health knowledge and behavior can be improved by providing high quality family life education in schools. One of the objectives of the GERHS10, as well as of the previous surveys, was to examine whether reproductive-age women in Georgia favor school-based sex education (termed "family life education" in the region) and to explore their opinions about the best age to start such education. Survey information on exposure to family life education as experienced by young respondents can be used for establishing school curricula and for planning training courses of teachers. In 2010, the large majority of respondents (80%) supported sex education at schools. Teaching specific sex education topics, concerning "how pregnancy occurs," sexually transmitted infections, and contraception, was supported by 80%, 78%, and 76% of respondents respectively (Table 14.1.1, Figure 14.1.1). Support for any sex education at schools was the strongest among women who are employed (86%), have high SES (84%), live in urban areas (83%), have no or one child (82%), are more educated (85%), and are young (81% at ages 15-24). It was the weakest among Azeri women (50%), those with three or more children (69%), and those with lowest SES (lowest wealth quintile) (67%).

Those respondents who favored family life education at schools were asked the best age to start teaching the above mentioned topics (Tables 14.1.2 and

Figure 14.1.1 Support for family Life Education in Schools by Age, Education and SES**Figure 14.1.2** Perceived Best Age to Start family Life Education About Specific Topics in 1999, 2005 and 2010

14.1.3). Only 12% felt that this should start before the age of 14; 52% felt it should start between 14-15 years of age, and 35% felt it should start only at age 16 or older. The women from certain regions tended to be more conservative about the best age to introduce sex education topics. Slightly more than 40% of respondents from Shida Kartli, Adjara, Samtskhe-Javakheti, and Mtskheta-Mtianeti mentioned that waiting until the age of 16 or later was the most appropriate for introducing courses on “how pregnancy occurs” and on contraception. Other subgroups also rose above 40% favoring age 16 or later on that topic: women with three or more children, those with a technicum education, those in the second quintile, and the Armenian and “Other” ethnic groups.

These patterns were mirrored by responses about the best age to start courses on contraception: the same regions were conservative on this as were the subgroups mentioned.

Conservative views were found for other topics as well. Only 8% of respondents believed the topic of sexually transmitted infections should be introduced

at the age of 13 or earlier; the rest were split evenly between ages 14-15 and 16 or later, at 44% to 48% each. Regarding the regions, more than half of respondents from Shida Kartli, Samtskhe-Javakheti, Adjara, and Mtskheta-Mtianeti favored the age of 16 or older as best for introducing the course on STIs.

Trends on three of these topics appear in Figure 14.1.2. It compares respondents’ opinions in 1999, 2005, and 2010 regarding the best age to start family life courses in schools. In 2010, more women thought that education about “how pregnancy occurs” should start at later ages than was the case in the two previous surveys (top segments of bars in Figure 14.1.2). In all three years the majority of respondents regarded ages 14-15 as the best for introducing this topic, but in 2010 only slightly more than half of respondents gave that response while in 1999 and 2005 more than 80% respondents did so. Closely similar shifts are apparent in Figure 14.1.2 for courses on contraception and on STI. All these changes, as with several described earlier, are in a more conservative direction.

14.2 Discussions about Sex Education Topics with Parents

To elicit information about family-based exposure to sex education topics, all respondents aged 15-24 were asked whether, before they reached the age of 18, they had ever talked to a parent about such topics as the menstrual cycle, how pregnancy occurs, contraceptive methods, or HIV/AIDS and others STIs. The data for those aged 15-17 are truncated because they had not reached the age of 18, so the data for this age group should be considered as minimum estimates only.

Slightly more than three-fourths (77%) of young respondents had discussed at least one sex education topic with a parent (see Table 14.2 for “any topic”). The highest percentages emerged for respondents living in urban areas including Tbilisi, women with no child yet, those with university/postgraduate education, those in the highest SES (wealth quintile) group, women without sexual experience, and interestingly, those with monthly religious attendance. Remarkably, the youngest ages (15-17) reported higher percentages than did the two older age groups despite the truncation effect, perhaps signaling a social change toward more open discussions with teenagers.

When family life education topics were discussed with a parent, the discussions mostly related to the menstrual cycle (75%), and much less for discussions about how pregnancy occurs (15%), HIV/AIDS (7%), other sexually transmitted infections (4%), or family planning (2%). The age pattern just mentioned occurred for discussions about the menstrual cycle, not having sex before marriage, and HIV/AIDS, as the age 20-24 group reported less discussion with parents on these topics.

Discussions about HIV/AIDS with parents varied across the various subgroups. It was highest among the residents of Tbilisi (15%) and Mtskheta-Mtianeti (13%), women with high SES (12%), youth aged 15-17, and those with monthly religious attendance, when compared to their counterparts.

Trends appear in Figure 14.2.1, which shows the differences between the 1999, 2005, and 2010 surveys for discussions with parents. The largest improvement is for the topic of the menstrual cycle, with a 21 point rise from 1999 to 2005, declining only to 75% in 2010. For contraception a rise also occurred in 2005 but it nearly disappeared in 2010. The low levels for the other three topics held fairly steady.

14.3 Family Life Education at Schools

The school system provides an environment where young people can have conversations with well-informed adults about the issues that are important to their reproductive development. It is an institution to which most young people are connected, and it provides an important opportunity to disseminate consistent and accurate information about sexual health topics.

The next question explored in the 2010 survey was whether respondents aged 15-24 received formal or informal sexual education in school before age 18. The question asked about specific reproductive health-related topics, such as female and male reproductive biology, the menstrual cycle, how pregnancy occurs, contraceptive methods, and sexually transmitted infections, including HIV/AIDS.

As with the data on discussions of family life education topics with parents, the data on school-based education for those aged 15-17 are truncated, since these respondents had not yet reached the age of 18. Consequently, the results for this age group should be considered to be minimum estimates only.

Only 46% of young women had at least one school-based course that addressed sex education topics (Table 14.3). Respondents living in urban areas were more likely to have had such courses than those living in rural areas (50% vs. 41%) (Figure 14.3.1). The percentages also varied widely by region, ranging from 31% in Adjara to 55% in Mtskheta-Mtianeti. Prevalence of sex education at school was correlated with respondents' socioeconomic status (wealth quintile): only 35% of

Figure 14.2.1 Family Life Education Topics Discussed with a Parent Before Reaching Age 18, Among Young Women Aged 15-24

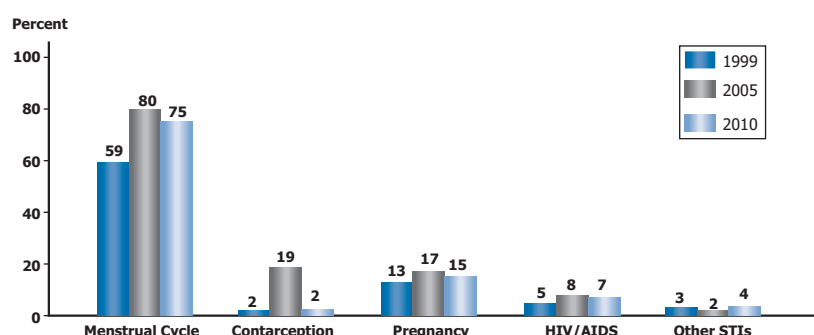


Figure 14.3.1 Selected Characteristics of Young Women Who Received Any Family Life Education in School Before Reaching Age 18 by Residence, Number of Children, and SES

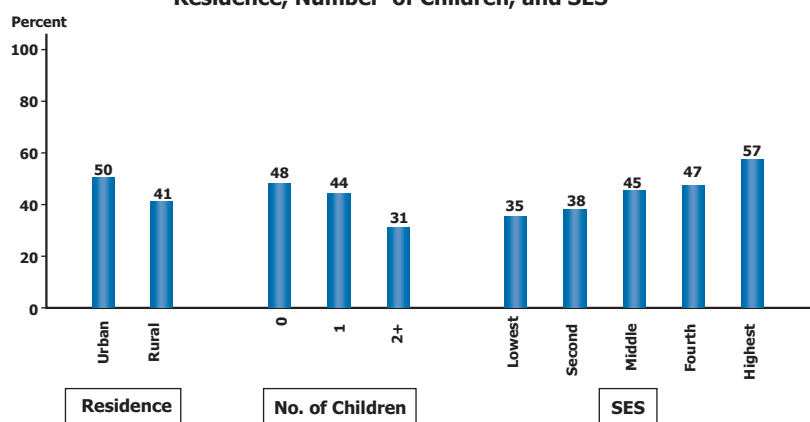
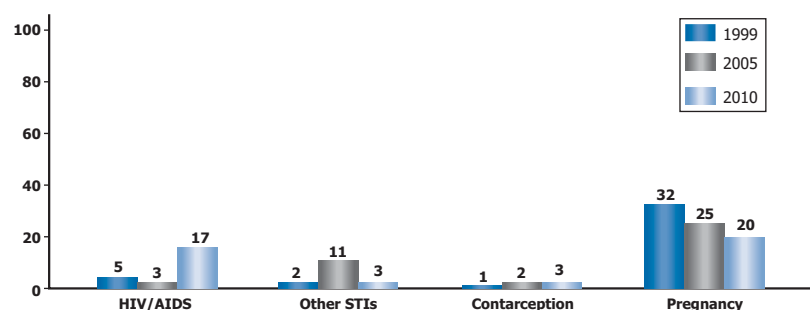


Figure 14.3.2 Percentage of Young Women Who had School-Based Education on Specific Family Life Education Topics Before Age 18 in 1999, 2005 and 2010



respondents with the lowest SES reported having had any sex education at school, compared to 45% of middle-SES and 57% of highest-SES respondents. Ethnicity was also a factor: while the respondents of Georgian and Armenian ethnicity showed 48%-49%, only 18% of Azeri respondents were exposed to any sex education topics at school.

Regarding topics, these young women were much more likely to have received lectures on female reproductive biology (41%), male reproductive biology (38%), the menstrual cycle (28%), how pregnancy occurs (20%), and HIV/AIDS (17%), than on other sexually transmitted infections (3%) or contraception (3%). For every topic, more urban than rural youth had had school courses.

Interestingly, for every sex education topic included in the survey, higher proportions of young women with no sexual experience reported exposure to courses in comparison to their sexually experienced counterparts, who are generally older. If courses in schools have become more common recently, women aged 15-17, who show the highest exposure on every topic, also dominate the group with no sexual experience. School exposure may help explain why the youngest women also report the most discussion with their parents, as documented above.

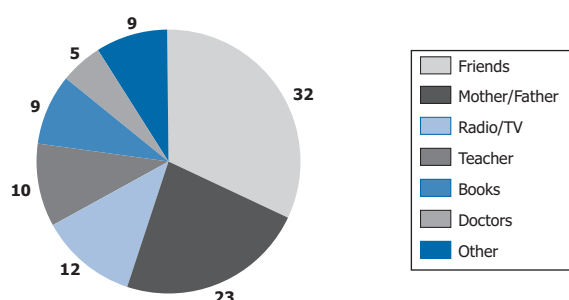
Trends in fact from 1999 to 2010 do show a significant increase at least for school-based exposure to information on HIV/AIDS (from 5% in 1999 and 3% in 2005 to 17% in 2010), and a slight increase in reported education on contraception (from 1% in 1999 and 2% in 2005 to 3% in 2010). However there has been a decline in school-based education on “how pregnancy occurs” (from 32% in 1999 and 25% in 2005 to 20% in 2010).

14.4 Sources of Information on Sexual Matters

To learn more about the main sources of information on sexual topics for young women aged 15-24, they were asked who/what had been their most important source of information on sexual matters. They most often named friends (32%) (Table 14.4 and Figure 14.4), and nearly one out of four mentioned that it was a parent (23%). Also, 12% cited radio or television as the most important source.

Teachers are of particular interest, related to the discussions above. They ranked overall as the third (10%) most important source of information (after friends and parents), but the percentage was especially high for the youngest women, aged 15-17 (15%). It was high also for the lowest wealth quintile (16%) and for Armenians (13%). It did not vary appreciably

Figure 14.4 | **Most Important Source of Information About Sexual Matters Among Women Aged 15-24 Years, 2010**



by residence. However certain regions showed high percentages: Samegrelo (13%), Imereti (13%), and Racha-Svaneti (17%). The reported information sources did not vary much by residence, except that radio and TV were mentioned more by rural respondents. Regions varied considerably in the reported reliance on friends, with the highest percentages in Kakheti (43%) and Samegrelo (39%), and also in Shida Kartli (35%) and Samtskhe-Javakheti (35%).

In considering all these results it must be remembered that they pertain strictly to the woman's single most important source of information. Most adolescents are exposed to multiple sources, but that would require a different analysis and a more complex one.

14.5 Impact on Knowledge about Fertility Issues from Exposure at School or with Parents

Correct knowledge of the most fertile time in a woman's cycle is vital to a couple's ability to assess the risk of pregnancy during unprotected intercourse. Survey information on this is important for programs devoted to the prevention of unintended pregnancies. Therefore the survey included a series of special questions, and the results were related to exposure to school-based or parental sex education.

Respondents aged 15-24 were asked 1) when conception is most likely to occur during the menstrual cycle; 2) whether breastfeeding increases, decreases, or has no effect on a woman's risk of getting pregnant; and 3) whether or not it is possible to get pregnant at the first sexual intercourse. The responses are organized in Table 14.5 according to whether or not the respondents discussed these topics with parents or were taught about them at school.

Regarding the first question, only a fifth of all young women correctly names the most fertile period (half-way between periods) during a woman's menstrual cycle. About half of all respondents (52%) said they "don't know;" and this was essentially the same regardless of instruction about the menstrual cycle in school-based courses (52%) or to discussions about

it with parents (54%). Considering both the "don't know" replies and the incorrect replies, an unfortunate 79% in both cases lacked correct information. In short, half of each group did not know the answer, and over half of the remainder gave a wrong answer. However the trend by age was somewhat encouraging, since the percentage replying correctly rose from 4% to 16% to 31% across the three age groups from 15-17 to 18-19 to 20-24, as shown in Table 14.5. There was a corresponding decline in the percentage saying they did not know.

Regarding the second question, only 38% of young respondents knew that breastfeeding can decrease the chance of pregnancy. This percentage was higher among women who had received information on how pregnancy occurs from a parent (44% vs. 37%), and those who were taught about it at school (45% vs. 37%). High percentages said they did not know, but they were lower in the groups with exposure. Consequently that left more respondents with exposure to fall into the "no effect" group than for respondents without exposure. In fact, more of those with exposure gave correct replies.

Once again, the age patterns are mildly encouraging: the percentage replying correctly rose from 16% to 30% to 54% across the three age groups in the table, and the percentage not knowing declined.

Finally, for the third question, the large majority of young women correctly confirmed the possibility of getting pregnant during a woman's first sexual intercourse. Having conversation about pregnancy with a parent raised the percent to 82% (yes) from 71% (no) for an 11 point improvement. However the difference was not significant for school exposure: 74% (yes) vs. 73% (no). Knowledge increased with age with 56% of those aged 15-17 to 73% of those aged 18-19 to 82% of those aged 20-24 giving the correct response.

Table 14.1.1 Percentage of Women Aged 15–44 Who Agree That Selected Sex Education Topics Should Be Taught in School
Reproductive Health Survey: Georgia, 2010

Characteristic	Family Life Education Topics				No. of Cases
	Any Family Life Education	How Pregnancy Occurs	Sexually Transmitted Infections (STIs)	Contraception	
Total	79.5	79.5	77.6	76.4	6,292
Residence					
Urban	83.1	83.1	81.6	80.9	2,975
Rural	75.5	75.5	73.1	71.3	3,317
Region					
Kakheti	72.9	72.9	69.8	66.3	498
Tbilisi	81.8	81.8	80.6	80.0	1,426
Shida Kartli	85.0	85.0	84.8	82.6	392
Kvemo Kartli	71.9	71.9	68.1	66.7	546
Samtskhe–Javakheti	82.5	82.3	78.7	77.6	481
Adjara	72.8	72.8	72.6	72.6	419
Guria	71.6	71.6	71.2	69.2	401
Samegrelo	86.4	86.4	82.9	81.2	477
Imereti	83.6	83.6	81.8	80.9	805
Mtskheta–Mtianeti	78.1	78.1	76.6	74.7	393
Racha–Svaneti	76.7	76.7	75.0	73.5	454
Age Group					
15–24	81.1	81.1	78.6	77.5	1,960
25–34	79.6	79.5	78.0	77.1	2,359
35–44	77.6	77.6	76.0	74.3	1,973
Number of Living Children					
0	82.0	82.0	79.5	78.3	2,276
1	82.4	82.4	80.3	79.2	1,286
2	77.7	77.7	76.6	75.4	2,069
3 or more	69.6	69.6	68.4	66.3	661
Education Level					
Secondary incomplete or less	70.8	70.8	68.1	66.8	1,330
Secondary complete	74.7	74.7	72.1	70.9	1,568
Technicum	84.9	84.9	83.4	80.9	903
University/postgraduate	85.8	85.8	84.6	83.9	2,491
Wealth Quintile					
Lowest	67.4	67.4	65.8	63.4	1,093
Second	77.5	77.5	74.0	72.9	1,385
Middle	79.7	79.7	77.8	76.4	1,413
Fourth	84.9	84.9	83.6	82.2	1,037
Highest	84.0	84.0	82.6	82.2	1,364
Ethnicity					
Georgian	81.8	81.8	80.2	78.9	5,488
Azeri	49.7	49.7	46.1	45.8	276
Armenian	74.0	74.0	68.8	66.9	364
Other	75.4	75.4	73.9	73.7	164
Employment					
Working	86.1	86.1	84.5	84.1	1,410
Not working	77.8	77.8	75.8	74.3	4,882

Table 14.1.2 Perceived Best Age to Start Family Life Education on "How Pregnancies Occur" and on Contraceptive Methods Among Women Aged 15–44 Who Agreed with Sex Education in School. Reproductive Health Survey: Georgia, 2010

Characteristic	Best Age to Start Courses on "How Pregnancies Occur"			Total	No. of Cases	Best Age to Start Courses on Contraception			Total	No. of Cases
	≤13	14–15	16+			≤13	14–15	16+		
Total	12.2	52.7	35.0	100.0	4,982	7.9	44.3	47.8	100.0	4,796
Residence										
Urban	13.1	52.8	34.1	100.0	2,466	7.7	44.7	47.5	100.0	2,405
Rural	11.2	52.7	36.1	100.0	2,516	8.0	43.8	48.2	100.0	2,391
Region										
Kakheti	16.9	53.8	29.3	100.0	360	11.5	43.2	45.3	100.0	330
Tbilisi	15.1	53.9	31.0	100.0	1,172	8.8	44.8	46.4	100.0	1,153
Shida Kartli	8.8	49.7	41.5	100.0	335	6.7	36.8	56.6	100.0	324
Kvemo Kartli	15.1	55.9	29.0	100.0	385	13.3	50.1	36.6	100.0	362
Samtskhe–Javakheti	6.4	50.8	42.8	100.0	403	4.4	37.2	58.4	100.0	382
Adjara	3.2	39.0	57.8	100.0	304	1.0	33.5	65.5	100.0	303
Guria	15.9	58.1	26.0	100.0	280	9.2	42.5	48.3	100.0	271
Samegrelo	12.6	57.2	30.2	100.0	417	6.6	50.5	42.9	100.0	393
Imereti	11.2	55.4	33.3	100.0	670	7.5	50.2	42.3	100.0	651
Mtskheta–Mtianeti	10.9	47.2	41.8	100.0	305	6.9	39.2	53.9	100.0	291
Racha–Svaneti	13.7	58.6	27.8	100.0	351	12.6	45.7	41.8	100.0	336
Age Group										
15–24	12.3	55.7	32.0	100.0	1,577	8.3	47.6	44.1	100.0	1,516
25–34	12.2	51.4	36.4	100.0	1,862	6.9	43.1	50.0	100.0	1,796
35–44	12.1	50.4	37.4	100.0	1,543	8.4	41.5	50.1	100.0	1,484
Number of Living Children										
0	12.0	55.9	32.1	100.0	1,858	8.0	47.0	45.0	100.0	1,783
1	14.3	51.3	34.3	100.0	1,043	8.7	43.5	47.8	100.0	1,001
2	11.4	50.6	38.1	100.0	1,613	7.0	42.5	50.5	100.0	1,563
3 or more	11.4	48.0	40.6	100.0	468	8.3	39.5	52.3	100.0	449
Education Level										
Secondary incomplete or less	11.7	53.5	34.8	100.0	924	9.1	45.5	45.4	100.0	873
Secondary complete	11.4	52.9	35.8	100.0	1,178	8.5	43.2	48.2	100.0	1,126
Technicum	11.6	46.6	41.8	100.0	757	6.1	41.1	52.7	100.0	726
University/postgraduate	13.2	54.4	32.5	100.0	2,123	7.5	45.4	47.1	100.0	2,071
Wealth Quintile										
Lowest	12.8	51.1	36.0	100.0	760	8.1	43.7	48.2	100.0	716
Second	10.2	49.7	40.1	100.0	1,071	8.1	40.7	51.2	100.0	1,018
Middle	12.6	54.5	32.9	100.0	1,132	8.2	46.5	45.2	100.0	1,092
Fourth	11.4	51.9	36.7	100.0	869	6.6	41.3	52.1	100.0	842
Highest	13.7	54.8	31.5	100.0	1,150	8.2	47.5	44.3	100.0	1,128
Ethnicity										
Georgian	11.8	53.5	34.7	100.0	4,449	7.1	45.3	47.6	100.0	4,297
Azeri	28.2	48.3	23.5	100.0	130	27.7	44.0	28.3	100.0	121
Armenian	6.6	49.4	44.0	100.0	277	5.2	34.5	60.2	100.0	256
Other	17.0	38.5	44.5	100.0	126	14.2	30.0	55.8	100.0	122

Table 14.1.3 Perceived Best Age to Start Family Life Education about Sexually Transmitted Infections Among Women Aged 15–44 Who Agreed with Sex Education in School. Reproductive Health Survey: Georgia 2010

Characteristic	Best Age to Start Courses on STIs			Total	No. of Cases
	≤13	14–15	16+		
Total	8.0	44.3	47.7	100.0	4,874
Residence					
Urban	8.3	44.3	47.4	100.0	2,424
Rural	7.6	44.4	48.0	100.0	2,450
Region					
Kakheti	11.8	46.3	42.0	100.0	347
Tbilisi	9.4	43.8	46.8	100.0	1,158
Shida Kartli	7.0	37.9	55.1	100.0	334
Kvemo Kartli	13.2	50.9	35.8	100.0	368
Samtskhe–Javakheti	4.3	35.5	60.2	100.0	388
Adjara	1.0	34.7	64.3	100.0	303
Guria	10.7	43.5	45.8	100.0	278
Samegrelo	5.5	49.3	45.2	100.0	400
Imereti	7.4	49.8	42.8	100.0	657
Mtskheta–Mtianeti	6.5	39.5	54.1	100.0	299
Racha–Svaneti	11.6	45.0	43.4	100.0	342
Age Group					
15–24	8.1	48.3	43.6	100.0	1,536
25–34	7.4	42.4	50.2	100.0	1,827
35–44	8.5	41.4	50.1	100.0	1,511
Children					
0	7.8	46.9	45.3	100.0	1,812
1	9.5	43.8	46.7	100.0	1,016
2	6.9	42.1	51.0	100.0	1,584
3 or more	8.8	40.7	50.5	100.0	462
Education Level					
or less	8.8	45.8	45.4	100.0	897
Secondary complete	8.1	43.3	48.6	100.0	1,139
Technicum	6.7	40.8	52.5	100.0	745
e	7.9	45.3	46.7	100.0	2,093
Wealth Quintile					
Lowest	7.6	43.7	48.7	100.0	744
Second	8.3	40.2	51.5	100.0	1,035
Middle	8.3	47.3	44.4	100.0	1,107
Fourth	6.3	41.4	52.3	100.0	856
Highest	8.9	47.2	43.9	100.0	1,132
Ethnicity					
Georgian	7.3	45.2	47.5	100.0	4,367
Azeri	28.0	43.8	28.2	100.0	122
Armenian	5.1	33.7	61.2	100.0	262
Other	14.1	32.8	53.1	100.0	123

Table 14.2 Percentage of Young Adult Women Aged 15–24 Who Discussed Selected Family Life Education Topics with a Parent Before They Reached Age 18
Reproductive Health Survey: Georgia, 2010

Characteristic	Family Life Education Topic							No. of Cases
	Any Topic	Menstrual Cycle	Not Having Sex Before Marriage	How Pregnancy Occurs	HIV/AIDS	Contraceptive Methods	Other STIs	
Total	76.8	74.9	16.6	14.9	7.2	2.0	3.7	1,960
Residence								
Urban	79.9	78.0	18.1	18.3	9.9	2.6	4.9	937
Rural	73.3	71.4	14.9	10.9	4.1	1.4	2.4	1,023
Region								
Kakheti	69.5	69.5	12.2	8.5	6.9	0.8	2.4	163
Tbilisi	80.2	78.9	19.0	19.8	14.6	3.9	7.2	451
Shida Kartli	78.2	73.9	20.7	17.6	1.6	0.0	0.5	133
Kvemo Kartli	71.7	70.2	11.3	11.3	6.4	0.8	3.4	181
Samtskhe–Javakheti	76.5	76.5	11.6	11.2	2.2	2.2	1.1	171
Adjara	79.2	74.3	25.2	23.3	4.0	2.5	4.0	131
Guria	89.5	89.5	9.2	8.5	7.8	2.6	2.6	104
Samegrelo	82.5	77.2	20.4	12.1	2.9	1.5	0.0	139
Imereti	72.0	71.4	13.3	10.8	2.5	0.6	2.0	251
Mtskheta–Mtianeti	77.6	76.0	11.5	9.8	13.1	4.4	8.7	121
Racha–Svaneti	71.3	67.4	14.0	6.2	2.8	2.2	0.0	115
Age Group								
15–17	80.3	78.5	15.8	12.1	11.1	2.0	4.9	481
18–19	78.6	77.8	19.2	17.4	7.8	1.8	3.6	380
20–24	74.2	71.8	16.0	15.3	4.9	2.1	3.1	1,099
Number of Living Children								
0	78.0	76.6	16.0	14.5	8.3	2.0	4.2	1,379
1	74.7	71.1	19.6	17.2	4.1	2.3	2.8	396
2 or more	68.6	65.6	15.8	13.7	3.2	1.1	1.1	185
Education Level								
Secondary incomplete or less	72.7	70.9	14.0	10.1	9.1	1.6	4.1	651
Secondary complete	77.5	75.7	17.4	17.3	5.5	1.6	2.5	604
Technicum	75.0	70.2	16.8	9.9	3.3	0.6	1.2	165
University/postgraduate	81.7	80.4	18.9	19.5	7.9	3.3	5.3	540
Wealth Quintile								
Lowest	68.8	65.9	10.8	10.6	2.7	0.7	0.6	327
Second	72.7	70.3	14.4	9.4	4.7	1.6	2.5	448
Middle	76.1	75.0	17.3	10.8	3.6	1.6	2.5	433
Fourth	78.7	77.6	18.3	21.6	11.1	3.0	5.9	336
Highest	83.6	81.4	19.6	19.8	11.8	2.7	5.6	416
Ethnicity								
Georgian	78.9	76.9	17.1	15.5	7.8	2.1	3.9	1,688
Azeri	57.1	56.3	9.3	6.1	2.1	0.0	0.0	92
Armenian	71.1	69.1	15.1	10.8	6.3	3.0	4.7	135
Other	61.4	59.9	19.5	23.1	0.0	1.8	3.4	45
Sexually Experienced								
No	78.7	77.4	16.0	13.4	8.5	1.8	4.0	1,188
Yes	72.9	69.7	18.0	17.8	4.6	2.5	3.1	772
Religious Attendance								
Monthly	80.3	78.2	17.9	16.1	9.9	2.9	5.0	882
Less than monthly	74.2	73.2	12.0	14.5	7.7	1.4	3.8	248
Holidays only	76.5	74.8	16.9	14.3	5.0	1.4	2.6	673
Never	61.5	58.5	14.9	10.3	0.5	0.6	1.1	157

Table 14.3 Percentage of Young Adult Women Aged 15–24 Who Were Taught Family Life Education Topics in School Before They Reached Age 18
Reproductive Health Survey: Georgia 2010

Characteristic	Family Life Education Topic								No. of Cases
	Any Topic	Female Reproductive Biology	Male Reproductive Biology	Menstrual Cycle	How Pregnancy Occurs	Other STDs	HIV/AIDS	Contra-ception	
Total	45.7	40.5	38.1	28.1	19.6	3.1	16.6	2.7	1,960
Residence									
Urban	49.9	42.6	39.5	32.2	21.0	4.4	20.6	3.5	937
Rural	40.8	38.1	36.6	23.4	18.0	1.6	12.0	1.7	1,023
Region									
Kakheti	47.6	45.5	45.5	26.8	18.7	2.4	12.6	1.2	163
Tbilisi	54.7	45.7	42.9	35.8	23.2	4.3	21.1	3.5	451
Shida Kartli	43.6	39.9	37.2	20.7	16.0	2.1	14.4	0.5	133
Kvemo Kartli	37.4	32.8	29.8	26.8	16.2	5.3	15.5	3.0	181
Samtskhe–Javakheti	44.0	37.3	35.4	24.3	11.6	1.5	10.8	1.1	171
Adjara	30.7	29.2	27.2	22.3	22.3	2.5	7.4	5.0	131
Guria	33.3	32.0	31.4	20.3	17.6	2.0	14.4	2.0	104
Samegrelo	42.7	37.4	32.5	18.9	18.4	1.9	16.0	1.5	139
Imereti	47.9	44.2	43.3	29.7	19.5	2.0	22.7	3.1	251
Mtskheta–Mtianeti	55.2	48.6	41.5	31.1	21.3	2.2	13.1	0.0	121
Racha–Svaneti	33.7	32.6	32.6	27.5	18.5	2.2	8.4	0.6	115
Age Group									
15–17	50.1	45.0	42.2	30.6	21.2	3.8	21.3	2.7	481
18–19	46.3	39.4	37.8	25.0	19.7	2.7	18.5	2.1	380
20–24	43.1	38.5	36.0	28.0	18.7	2.9	13.3	2.8	1,099
Number of Living Children									
0	47.5	41.9	39.6	29.3	20.0	3.3	18.3	2.8	1,379
1	43.7	38.7	36.7	26.4	20.4	2.6	12.5	2.5	396
2 or more	30.9	29.6	25.6	19.2	13.0	8.1	2.3	1.7	185
Education Level									
Secondary incomplete or less	41.1	37.0	34.8	24.2	18.5	3.0	15.5	2.3	651
Secondary complete	48.1	41.9	39.8	28.4	17.1	2.3	18.9	1.9	604
Technicum	50.3	49.7	46.2	28.0	25.2	3.8	9.8	5.0	165
University/postgraduate	47.6	40.7	38.2	32.7	22.2	3.8	17.5	3.3	540
Wealth Quintile									
Lowest	34.8	32.6	29.9	20.1	18.3	1.0	10.2	2.3	327
Second	38.1	35.0	34.3	22.4	14.6	1.0	11.6	1.1	448
Middle	45.3	42.2	39.9	22.6	19.2	2.5	13.3	2.0	433
Fourth	46.5	38.6	37.0	31.9	19.4	3.8	19.4	3.0	336
Highest	57.4	49.3	45.1	38.6	24.8	5.8	24.7	4.3	416
Ethnicity									
Georgian	47.9	42.3	39.9	29.2	20.5	3.5	18.4	2.9	1,688
Azeri	17.6	17.6	17.6	11.7	13.1	0.0	2.1	0.0	92
Armenian	48.7	42.9	40.8	30.7	14.9	0.6	9.7	3.0	135
Other	24.0	22.5	16.5	18.7	14.7	1.5	3.5	0.0	45
Sexually Experienced									
No	48.4	42.7	40.5	30.1	20.2	3.4	19.1	2.9	1,188
Yes	40.1	35.9	33.2	23.9	18.4	2.4	11.4	2.2	772
Religious Attendance									
Monthly	52.1	45.2	42.4	33.0	22.0	4.2	23.2	3.5	882
Less than monthly	52.7	45.1	43.5	28.2	18.5	1.6	17.1	1.8	248
Holidays only	38.2	35.3	32.8	23.5	16.8	2.5	10.9	2.2	673
Never	29.7	27.8	27.4	18.7	19.3	1.6	1.9	0.6	157

* Less than 25 cases.

Table 14.4 Most Important Source of Information About Sexual Matters
Among Young Adult Women Aged 15–24, by Selected Characteristics
Reproductive Health Survey: Georgia 2010

Characteristic	Most Important Source of Information										Total	No. of Cases
	Friends	Mother/ Father	Radio/ TV	Teacher	Books/ Prints	Doctor/ Nurse	Other Relatives	Partner/ Boyfriend	Does Not Remember	Other		
Total	31.9	23.1	11.6	9.8	8.7	5.2	2.3	1.2	2.9	3.3	100.0	1,960
Residence												
Urban	31.1	24.2	9.9	9.7	9.4	5.5	1.8	1.2	2.7	4.5	100.0	937
Rural	32.8	21.8	13.4	10.0	8.0	4.9	2.9	1.3	3.0	1.9	100.0	1,023
Region												
Kakheti	42.7	15.0	13.4	5.3	7.7	2.4	6.5	0.8	3.3	2.8	100.0	163
Tbilisi	33.0	22.7	10.1	10.7	8.1	5.1	1.9	0.7	2.2	5.6	100.0	451
Shida Kartli	35.1	18.1	13.3	11.7	10.6	6.4	2.1	1.1	0.0	1.6	100.0	133
Kvemo Kartli	24.5	23.4	13.2	9.1	6.8	6.4	5.3	4.2	5.7	1.5	100.0	181
Samtskhe–Javakheti	34.7	14.2	7.1	11.9	8.6	4.1	1.1	2.2	5.6	10.4	100.0	171
Adjara	25.2	41.6	11.4	4.0	3.0	9.9	0.0	0.5	1.5	3.0	100.0	131
Guria	24.8	34.0	17.6	1.3	11.1	6.5	1.3	0.7	0.7	2.0	100.0	104
Samegrelo	38.8	20.4	14.6	12.6	5.3	4.9	1.5	1.0	0.5	0.5	100.0	139
Imereti	28.0	22.1	10.2	13.3	16.7	3.1	0.8	0.6	4.2	0.8	100.0	251
Mtskheta–Mtianeti	31.7	21.3	12.0	8.7	6.0	8.2	3.8	1.6	4.9	1.6	100.0	121
Racha–Svaneti	29.2	24.2	14.6	17.4	9.0	0.0	4.5	0.0	0.6	0.6	100.0	115
Age Group												
15–17	30.8	25.8	11.9	14.7	7.0	3.2	1.4	0.2	2.0	2.9	100.0	481
18–19	30.8	27.1	9.7	9.7	7.8	4.8	1.6	0.9	3.1	4.4	100.0	380
20–24	32.9	19.9	12.1	7.3	10.0	6.5	3.1	1.9	3.2	3.0	100.0	1,099
Number of Living Children												
0	32.8	23.7	11.6	10.7	8.8	3.9	1.7	0.4	2.8	3.5	100.0	1,379
1	31.0	21.4	11.5	7.2	8.5	10.1	3.2	3.0	1.7	2.5	100.0	396
2 or more	23.8	19.5	11.7	6.6	7.7	8.1	7.8	5.8	6.5	2.4	100.0	185
Education Level												
Secondary incomplete or less	31.2	24.0	12.4	11.4	5.8	4.7	2.4	1.4	4.0	2.6	100.0	651
Secondary complete	36.3	23.4	9.2	9.4	8.1	4.0	3.6	1.6	1.9	2.4	100.0	604
Technicum	29.2	19.6	12.7	12.2	9.3	8.4	1.5	1.6	3.9	1.6	100.0	165
University/postgraduate	28.6	22.4	12.8	7.7	12.8	6.4	1.1	0.5	2.1	5.6	100.0	540
Wealth Quintile												
Lowest	30.9	19.9	11.5	16.4	5.0	5.6	4.7	1.0	3.8	1.3	100.0	327
Second	30.4	23.4	16.6	6.7	8.1	5.8	2.6	2.4	2.1	1.9	100.0	448
Middle	36.2	19.1	9.8	10.2	11.0	4.1	2.0	1.2	4.1	2.3	100.0	433
Fourth	32.3	28.4	10.3	7.1	8.9	3.8	1.6	0.7	3.5	3.3	100.0	336
Highest	29.8	23.7	9.9	10.6	9.1	6.6	1.8	0.8	1.5	6.2	100.0	416
Ethnicity												
Georgian	32.6	23.8	11.4	10.0	9.1	5.1	1.4	0.8	2.4	3.3	100.0	1,688
Azeri	29.6	18.9	17.2	6.7	0.0	3.0	11.1	2.4	9.0	2.2	100.0	92
Armenian	22.8	15.8	8.0	13.4	12.1	10.8	3.3	6.5	2.7	4.5	100.0	135
Other	34.3	24.7	13.0	1.8	4.1	0.0	13.9	1.8	5.0	1.5	100.0	45
Sexually Experienced												
No	32.8	24.1	11.6	11.1	8.9	3.2	1.6	0.0	3.0	3.7	100.0	1,188
Yes	30.0	20.9	11.5	7.1	8.3	9.5	3.8	3.8	2.6	2.4	100.0	772
Religious Attendance												
Monthly	35.8	21.1	10.6	10.2	10.8	2.9	1.5	0.6	2.2	4.2	100.0	882
Less than monthly	33.9	20.9	10.8	12.3	6.7	6.6	1.2	1.2	2.3	4.2	100.0	248
Holidays only	25.6	26.4	12.7	9.5	7.8	7.9	2.8	2.0	3.4	1.9	100.0	673
Never	33.2	23.1	13.6	5.2	3.6	5.8	7.1	1.4	5.0	2.0	100.0	157

**Table 14.5 Knowledge Among Young Adult Women Aged 15–24 Regarding
Selected Reproductive Health Issues by Whether or Not Specific Family Life Education
Topics Were Discussed with a Parent or Taught in School and by Age Group**
Reproductive Health Survey: Georgia, 2010

Reproductive Health Issue		Exposure to Family Life Education				Age Group		
Most Likely Time to Become Pregnant During Menstrual Cycle	Total	Discussed Menstrual Cycle With a Parent		Taught about Menstrual Cycle in School				
		Yes %	No %	Yes %	No %	15–17 %	18–19 %	20–24 %
Halfway	20.6	21.3	18.5	21.4	20.2	4.1	16.1	31.3
Before Period	17.8	18.2	16.7	16.6	18.3	7.7	18.3	23.1
Any time	9.6	9.1	11.1	10.8	9.2	10.5	9.8	9.1
Do not Know	52.0	51.4	53.7	51.1	52.3	77.7	55.8	36.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,960	1,470	490	525	1,435	481	380	1,099
Risk of Getting Pregnant While Breastfeeding	Total	Discussed "How Pregnancy Occurs" With a Parent		Taught about "How Pregnancy Occurs" in School		Age Group		
		Yes %	No %	Yes %	No %	15–17 %	18–19 %	20–24 %
Lower Risk	38.4	44.0	37.4	44.8	36.9	16.1	29.8	54.0
Has no effect	15.8	21.2	14.8	17.7	15.3	13.1	16.9	16.8
Higher Risk	0.6	0.5	0.6	0.4	0.6	0.0	1.3	0.6
Do not know	45.2	34.2	47.1	37.1	47.2	70.8	52.0	28.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,960	285	1,675	368	1,592	481	380	1,099
Possibility of Getting Pregnant at First Intercourse	Total	Discussed "How Pregnancy Occurs" With a Parent		Taught about "How Pregnancy Occurs" in School		Age Group		
		Yes %	No %	Yes %	No %	15–17 %	18–19 %	20–24 %
Possible	72.9	82.1	71.3	74.3	72.5	55.9	73.4	81.9
Not possible	5.4	5.0	5.5	5.0	5.5	4.8	4.6	6.1
Do not know	21.7	12.9	23.2	20.6	22.0	39.3	22.0	12.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,960	285	1,675	368	1,592	481	380	1,099

15

CHAPTER

YOUNG ADULTS SEXUAL AND CONTRACEPTIVE EXPERIENCE

The 2010 Georgia Reproductive Health Survey (RHS) included a module that was administered to adolescent and young adult women aged 15–24, to assess their sexual and reproductive behaviors, particularly regarding their risks of unintended pregnancy and sexually transmitted infections. This chapter explores several findings for this population in relation to sexual experience, contraceptive use, and sexual partners. All of these findings can be valuable for planning program strategies and sex education for young people.

15.1 Sexual Experience

In 2010, sexual experience was reported by nearly a third (32%) of young women aged 15–24, almost all of it after marriage (Table 15.1.1). Eleven percent of the adolescent sub-group (15–19 years old) reported sexual experience, compared to 52% of young adults (20–24 years old). The delay in sexual activity until marriage, into the later young adulthood years, was found also in the surveys conducted in 1999 and 2005 (Figure 15.1.1).

In Table 5.1.2 sexual experience was lower among young women in Tbilisi (30%) than in other urban areas (33%) or rural areas (35%). Sexual experience increased with education, except for young women with university or postgraduate education, of whom 66% were inexperienced, again related to the age at marriage. Sexual experience was reported more frequently by Azeri women (53%) than by women of other ethnic groups (30% of ethnic Georgians, 36% of Armenians, and 45% of all others). Premarital sex at first intercourse was highly uncommon, reported by less than 5% of women in any age, residential, education, wealth, or ethnic category, and by only 2% overall.

A life table methodology was used to show differences in age at first sexual intercourse across residence, education, socioeconomic status, wealth quintile, and ethnic groups (Table 15.1.3). Overall, there was a steady increase from less than 1% of young women initiating sex before age 15 up to 62% who had done so by age 24. One of the most significant differences occurs across educational levels (Figure 15.1.2). Well over half (60%) of those with secondary education or less had engaged in sexual activity prior to age 22, whereas only 39% with university or technicum education had done so. The majority of young women, regardless of educational level, had sexual experience by age 24 (66% of women with incomplete secondary education, 74% of women who had completed secondary education and 53% of women with technicum

Figure 15.1.1 Sexual Experience Among Women Aged 15-24 by Age Group; 1999, 2005 and 2010

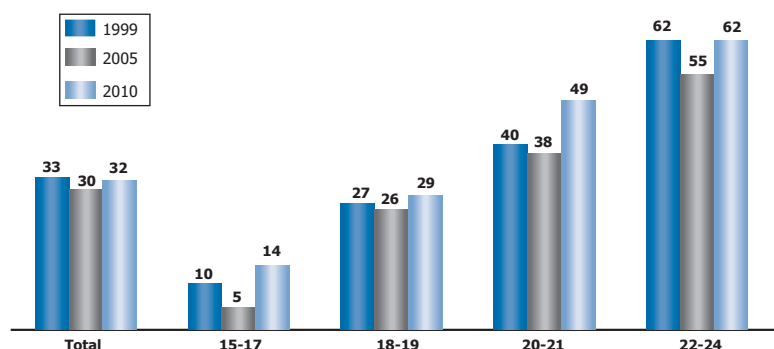
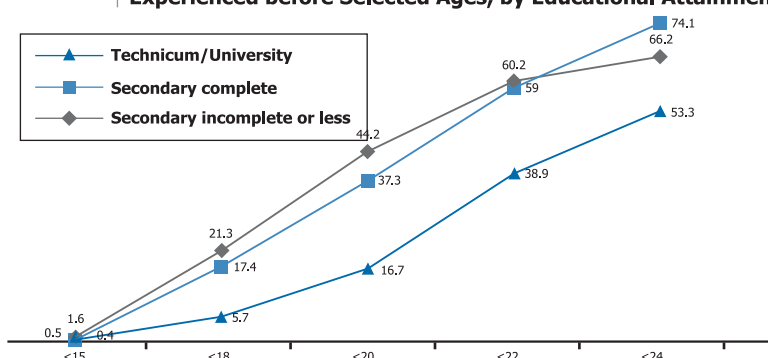


Figure 15.1.2 Percentage of Young Adult Women Who Became Sexually Experienced before Selected Ages, by Educational Attainment



or university education). Respondents in the lower two wealth quintiles tended to initiate sex at earlier ages, compared to wealthier young women.

Georgian and Armenian young women more frequently reported never having sex (70% and 64%, respectively); however, Azeri women who did have sexual experience tended to have their first intercourse at younger ages than women of other ethnicities. This may be explained by ethnic differences in average age of marriage.

Table 15.1.4 separates the two age groups under discussion and permits a focus just on ages 20-24. By that time many more young women are married, and the pattern still holds of very little sexual experience before marriage. Educational attainment is also more nearly complete by ages 20-24 (note in the last column of the table that there are 507 cases of 15-19 year olds with incomplete education but only 82 cases with university education).

The pattern of sexual experience according to education is strongly affected by the age at marriage, which is earlier among the low-education group. This produces an inverse relationship between level of education and sexual experience. Moving from the lowest to the highest education level, just for the 20-24 age group, the percentage with experience declines from 66% to 63% to 51% to only 40%.

15.2 Partner at First Intercourse

Table 15.2.1 depicts the age difference between respondents and their partners (most of them married) at first sexual intercourse. The majority of young women in Georgia (54%) had partners who were less than five years older. Young women in rural areas more often reported having had a partner who was five to ten years older (39%) compared to urban residents (34% and 36%). Regarding the small percentages with partners over 10 years older, this was slightly more common in Tbilisi and in rural areas (6.3% and 6.2%, respectively), compared to 4.3% in other urban areas. The disparity between the respondent's and her partner's age appeared to be widest among young women who were less than 18 years old at first intercourse: less than half (49%) had partners who were less than 5 years older unlike their counterparts (54% and 59%) (Figure 15.2.1).

Table 15.2.2 describes the respondents' relationship with her partner at first intercourse. As mentioned previously, the majority of young adults reported that their first sexual experience was marital; thus, partners at first sex were predominately husbands (95%), and more than 90% of all regional, educational, wealth, or ethnic groups reported their husband as the first sex partner. Among the 5% who were not married at the time of first intercourse, the majority were engaged

Figure 15.2.1 Age Difference Between Partners at First Sexual Intercourse, by Respondent's Age at First Intercourse and by Residence

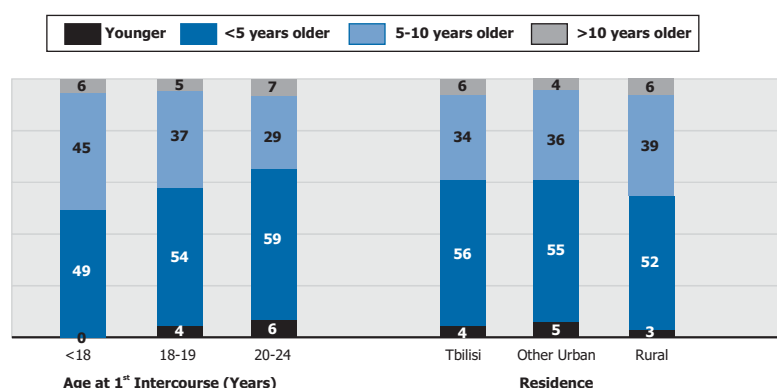
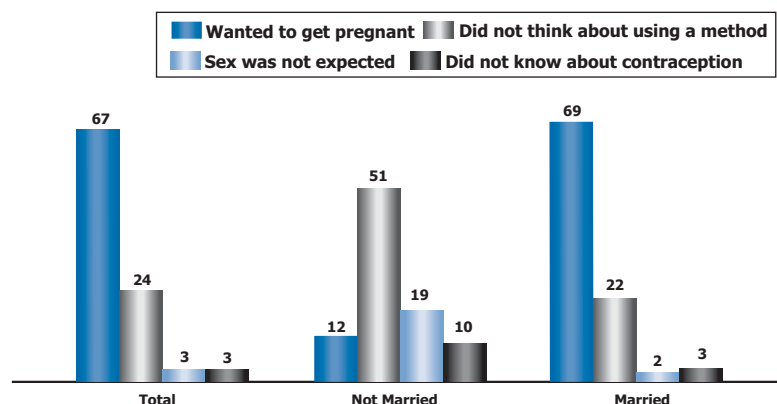


Figure 15.3.1 Most Commonly Cited Primary Reasons for Not Using Contraception at First Sexual Intercourse by Marital Status at First Sexual Intercourse



to be married to the partner (53%) (2.8%/5.3%). The husband as first partner was reported slightly less often by those living in Tbilisi (91%), by those with least education (93%), and by those of Azeri ethnicity (92%). Most young women had dated their partner for at least 6 months prior to the first sexual intercourse: only 24% dated for less than 6 months. The intervals were considerably spread out: another 14% dated for 6 to 11 months, 25% for 12 to 23 months, and 31% for 24 to 71 months (Table 15.2.3). There were only 40 cases of unmarried respondents; 60% of those reported premarital sex after dating their partner for up to 23 months.

15.3 Contraceptive Use at First Intercourse, Current Sexual Activity and Contraceptive Use

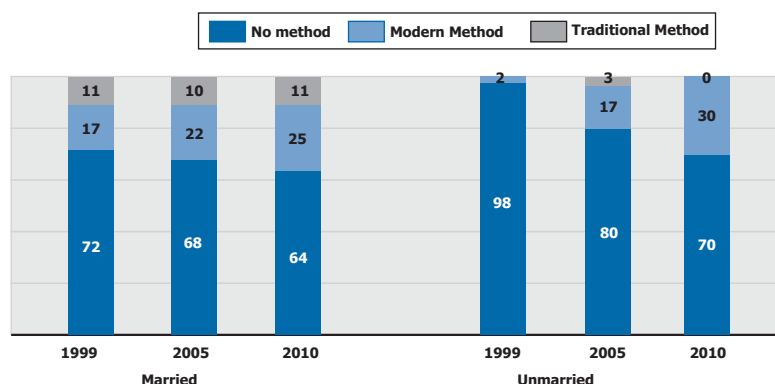
Contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status. The primary reason given by married respondents for not using a contraceptive method at first intercourse wanted to get pregnant (69%). Also important for them was not thinking about using a method (22%). A few said that sex was not expected then, or that they did not know about contraception (2% and 3% respectively) (Table 15.3.1).

The primary reasons were quite different for the 34 cases of unmarried respondents. Only 12% wanted to get pregnant, while 51% said that they did not think about contraception or that the sexual encounter was unexpected (19%) (Figure 15.3.1). Unfortunately, a full tenth of young women (10%) who were unmarried at the time of first intercourse did not know about contraception.

Current sexual activity is an important indicator for determining exposure to the risk of pregnancy, and it has implications for what method of contraception is most appropriate for an individual's reproductive behavior and intentions. The majority of married young women (61%) reported being sexually active within the last month. None of this group was pregnant or postpartum, suggesting a high probability of conception in the near future (Table 15.3.2). The cultural desire for a child soon after marriage is reflected in the high proportion (34%) who is currently pregnant or postpartum. Among the 35 cases of previously married young women, both sexual activity and pregnancy were relatively uncommon.

Table 15.3.3 shows that contraceptive use among young women is not common: among those married

Figure 15.3.2 Trends in Contraceptive Use at Last Sexual Intercourse, by Marital Status among Young Adult Women Aged 15–24 Years



only 20% at ages 15–19 and only 39% at ages 20–24 used a method. These low percentages partially reflect the desire to become pregnant, but also the lack of thought, and negligence, mentioned above. Among unmarried women only 30% of the 37 respondents in the table used a method at last sex. Of those unmarried women who did use contraception, almost all reported using condoms and none reported using a traditional method such as withdrawal or the calendar (rhythm) method. Among married young women, 25% used a modern method, with condoms (11%) and IUDs (9%) being the most common. Another 11% used a traditional method.

Regarding trends over the last decade, a favorable development is that the proportion of young women not using any contraceptive method during their most recent sexual encounter has declined quite steadily, especially among unmarried women (Figure 15.3.2). It is interesting that these trends are quite similar to the results of the 2009 Adolescent RH Survey, which found that 30% of sexually active unmarried female adolescents (aged 17–19) used contraception at first intercourse (in all cases condoms, as found above) and 70% used no contraception. (Kristesashvili et al., 2009)

Multiple lifetime partners were rarely reported by sexually experienced young women. In the top panel of Table 15.3.3, 98% of married young women reported having just one partner in the last twelve months. Among those previously married, 34% reported one and another 10% reported two or more, but over half (56%) said none. The bottom panel of the table pertains to lifetime experience; note that the percentage distribution is for only “one” or “two or more,” unlike the top panel. So among those with any lifetime experience at all, essentially 100% of married women reported only one partner, while 86% of the previously married reported one and 14% or one in seven reported two or more.

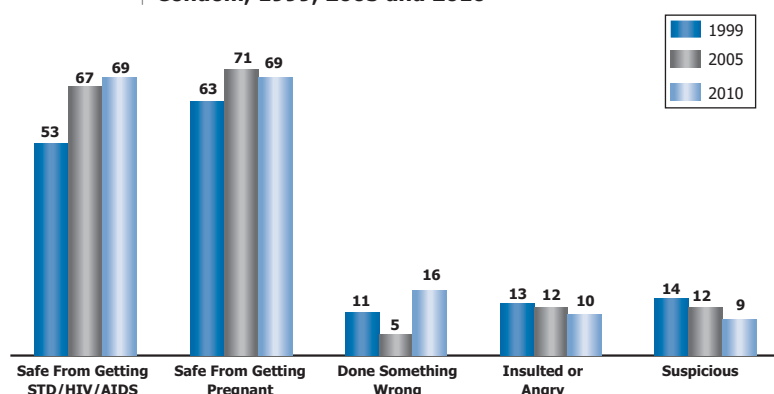
15.4 Opinions and Attitudes About Condoms and Condom Use

Sexually experienced young women were asked about the extent to which they agreed or disagreed with statements related to condom use (Table 15.4.1). Most respondents who had ever used condoms agreed that using condoms with a new partner is a smart idea (86%) and two-thirds (65%) agreed that women should ask their partners to use condoms. In contrast, only 57% of sexually experienced young women who had never used condoms agreed that using condoms with a new partner is a good idea, and only 19% agreed that women should ask their partners to use condoms. Far more never-users of condoms reported being uncertain about these statements (selecting “don’t know”) as opposed to agreeing or disagreeing. Interestingly, a slightly higher proportion of never-users (44%) than ever-users (43%) agreed that condoms are not necessary if you know your partner; unfortunately both betray ignorance about the true risks of unprotected intercourse.

Among all sexually experienced young women, 37% reported talking to a partner about condom use (Table 15.4.2); this was much higher (81%) among ever-users of the method than among never-users (19%). Overall discussion of condom use was considerably higher among residents of Tbilisi (62%), 20 to 24 year olds (40%), and young women with university or post-graduate education (47%) than in other subgroups. In addition (not shown), the percentage was nearly universal (95%) among those who relied on condom use at last sexual intercourse, suggesting that few men use the method without discussing it, and that discussion and use are mutually reinforcing.

Sexually experienced young women were asked if they agreed with specific statements about their partner or husband wanting to use a condom. Most (69%) stated that using a condom would make them feel safe from getting pregnant (Table 15.4.3). This varied

Figure 15.4.1 | How Respondent Would Feel if Partner Wanted to Use a Condom; 1999, 2005 and 2010



somewhat by various characteristics: 72% of urban women would feel safe from getting pregnant compared to 65% of rural women. Feeling safe generally increased with educational attainment; only 57% of young women with incomplete secondary or less education reporting feeling safe, compared to 70% with complete secondary education, 73% with technicum education, and 74% with university education. This reaction was very prevalent among those who were ever-users of condoms (74%) and women who had spoken to partners about condom use (75%).

Condoms, uniquely, are a method that offers dual protection against unintended pregnancy and sexually transmitted infection. When asked if condom use made them feel safe from getting STDs, including HIV/AIDS, 69% of young women agreed that it did. Again, there were disparities based on certain characteristics, with higher rates of agreement among urban women (73%), ever-users of condoms (83%), and those who had talked to a partner about using condoms (81%). Other reactions included 10% who said they would be insulted or angry, 9% who would feel suspicious that her partner might be sleeping with other women, and 16% who would feel like she had done something wrong. In summary, the high percentages for feeling safe from pregnancy and HIV/AIDS may suggest a slight decrease in stigma surrounding condom use (Figure 15.4.1).

Young people can be exposed to a wide range of attitudes and beliefs in relation to sex and sexuality. These sometimes appear contradictory and confusing. Sex education needs to include opportunities for young people to develop insights and attitudes, as it can be hard for them to act on the basis of having only information. Sex education aims to reduce the risks of potentially negative outcomes from sexual behavior, such as unwanted or unplanned pregnancies and infection with sexually transmitted diseases including HIV. It also aims to contribute to young people's positive understanding of their sexuality by enhancing the quality of their relationships and their ability to make informed decisions over their lifetime. In addition the skills young people develop as part of sex education are linked to more general life skills. Being able to communicate, listen, negotiate with others, ask for and identify sources of help and advice, are useful life skills that can be applied to sexual relationships. Sex education also helps equip young people with the skills to be able to differentiate between accurate and inaccurate information, and to discuss a range of moral and social issues and perspectives on sex and sexuality, including different cultural attitudes and sensitive issues like abortion and contraception.

Table 15.1.1 Reported Sexual Experience of Young Women Aged 15–24
by Marital Status at Time of First Sexual Experience by Residence
Reproductive Health Survey: Georgia 2010

Characteristic	Reported Sexual Experience			Total	No. of Cases
	No Sexual Experience	After Marriage	Before Marriage		
Total	67.7	30.6	1.7	100.0	1,960
15–19	88.5	10.6	0.8	100.0	861
20–24	47.8	49.6	2.6	100.0	1,099
Urban					
Total	69.8	28.3	1.9	100.0	937
15–19	91.5	7.8	0.7	100.0	391
20–24	50.6	46.5	2.9	100.0	546
Rural					
Total	65.1	33.2	1.6	100.0	1,023
15–19	85.3	13.6	1.0	100.0	470
20–24	44.4	53.4	2.2	100.0	553

Table 15.1.2 Reported Sexual Experience of Young Women Aged 15–24
by Marital Status at Time of First Sexual Experience by
Selected Characteristics.
Reproductive Health Survey: Georgia, 2010

Characteristic	Reported Sexual Experience			Total	No. of Cases
	No Sexual Experience	Marital	Premarital		
Total	67.7	30.6	1.7	100.0	1,960
Residence					
Tbilisi	72.6	25.0	2.5	100.0	451
Other Urban	66.8	32.0	1.2	100.0	486
Rural	65.1	33.2	1.6	100.0	1,023
Age Group					
15–17	95.9	3.9	0.2	100.0	481
18–19	78.8	19.5	1.7	100.0	380
20–21	58.9	39.7	1.3	100.0	388
22–24	40.8	55.8	3.4	100.0	711
Education					
Secondary incomplete or less	80.4	18.3	1.3	100.0	651
Secondary complete	58.0	40.4	1.6	100.0	604
Technicum	53.3	44.7	2.0	100.0	165
University /Postgraduate	66.3	31.3	2.4	100.0	540
Wealth Quintile					
Lowest	66.2	32.2	1.6	100.0	327
Second	61.2	36.6	2.2	100.0	448
Middle	69.1	29.5	1.3	100.0	433
Fourth	70.7	27.7	1.6	100.0	336
Highest	70.1	28.0	1.9	100.0	416
Ethnicity					
Georgian	69.6	28.9	1.5	100.0	1,688
Azeri	47.0	48.8	4.2	100.0	92
Armenian	64.0	34.0	2.0	100.0	135
Other	54.6	42.4	3.0	100.0	45

Table 15.1.3 Reported Sexual Experience Among Young Women Aged 15–24 Years
Before Given Ages (Life Table Estimates) by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Age at First Sexual Intercourse (Life Table Estimates)					Ever Had Intercourse	Never Had Intercourse	No. of Cases
	< 15	< 18	< 20	<22	< 24			
Total	0.8	13.6	28.7	49.2	62.3	32.3	67.7	1,960
Residence								
Urban	0.5	11.3	25.1	45.5	57.7	30.2	69.8	937
Rural	1.2	16.0	32.3	52.0	65.7	34.9	65.1	1,023
Education Level								
Secondary incomplete or less	1.6	21.3	44.2	60.2	66.2	19.6	80.4	651
Secondary complete	0.5	17.4	37.3	59.0	74.1	42.0	58.0	604
Technicum/university	0.4	5.7	16.7	38.9	53.3	36.5	63.5	705
Socioeconomic Status								
Low	0.3	15.3	30.9	51.7	54.9	32.3	67.7	189
Middle	0.9	14.4	30.5	49.2	64.4	34.3	65.7	855
High	0.9	12.4	26.2	47.4	60.2	30.8	69.2	916
Wealth Quintile								
Lowest	1.2	15.2	37.0	53.1	69.0	33.8	66.2	327
Second	1.7	18.6	34.3	60.2	69.8	38.8	61.2	448
Middle	0.7	12.0	26.2	45.0	61.0	30.9	69.1	433
Fourth	0.6	13.2	26.3	43.0	53.7	29.3	70.7	336
Highest	0.2	9.8	23.0	43.8	56.6	29.9	70.1	416
Ethnicity								
Georgian	0.5	11.3	26.2	46.9	58.9	30.4	69.6	1,688
Azeri	4.7	35.9	53.7	75.0	85.4	53.0	47.0	92
Armenian	1.3	16.6	31.1	41.6	67.3	36.0	64.0	135
Other	1.6	33.3	43.4	62.7	73.5	45.4	54.6	45

Table 15.1.4 Reported Sexual Experience of Young Women Aged 15–24 by Marital Status at Time of First Sexual Experience by Education and Current Age. Reproductive Health Survey: Georgia, 2010

Education and Age Group	Reported Sexual Experience (Percentage Distribution)			Total	No. of Cases
	No Sexual Experience	After Marriage	Before Marriage		
Total	67.7	30.6	1.7	100.0	1,960
15–19	88.5	10.6	0.8	100.0	861
20–24	47.8	49.6	2.6	100.0	1,099
Secondary incomplete or less					
Total	80.4	18.3	1.3	100.0	651
15–19	91.2	8.0	0.8	100.0	507
20–24	34.0	62.7	3.3	100.0	144
Secondary Complete					
Total	58.0	40.4	1.6	100.0	604
15–19	81.9	17.3	0.7	100.0	254
20–24	36.6	61.0	2.4	100.0	350
Technicum					
Total	53.3	44.7	2.0	100.0	165
15–19	*	*	*	*	18
20–24	48.8	48.9	2.3	100.0	147
University/Postgraduate					
Total	66.3	31.3	2.4	100.0	540
15–19	94.1	4.3	1.6	100.0	82
20–24	59.8	37.6	2.6	100.0	458

* Less than 25 cases

Table 15.2.1 Age Difference between Partners at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

	Age Difference				Total	No. of Cases [*]
	Partner Younger	Partner Less Than 5 Years Older	Partner 5–10 Years Older	Partner More Than 10 Years Older		
Total	3.6	53.6	37.0	5.8	100.0	769
Residence						
Tbilisi	4.2	55.8	33.7	6.3	100.0	148
Other Urban	5.1	55.1	35.5	4.3	100.0	191
Rural	2.6	51.8	39.4	6.2	100.0	430
Age at First Sex						
< 18	0.4	48.7	45.3	5.6	100.0	270
18–19	4.1	53.5	37.4	5.0	100.0	233
20–24	6.4	58.5	28.6	6.6	100.0	266
Marital Status at First Sex						
Not Married	2.4	48.4	47.1	2.1	100.0	39
Married	3.7	53.9	36.5	6.0	100.0	730

* Exclude 3 women who did not report the age of the first sexual partner.

Table 15.2.2 Relationship to Partner at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

Characteristic	Relationship to Partner at First Sexual Intercourse				Total	No. of Cases
	Husband	Fiancé	Boyfriend	Other		
Total	94.6	2.8	2.1	0.4	100.0	772
Residence						
Tbilisi	91.1	3.2	5.8	0.0	100.0	148
Other Urban	96.4	1.1	2.4	0.2	100.0	193
Rural	95.4	3.6	0.2	0.8	100.0	431
Age at First Sex						
< 18	93.0	3.8	2.1	1.1	100.0	272
18–19	95.8	1.8	2.2	0.2	100.0	233
20–24	95.2	2.8	2.0	0.0	100.0	267
Marital Status at First Sex						
Not Married	0.0	52.7	39.1	8.2	100.0	40
Married	100.0	0.0	0.0	0.0	100.0	732
Education Level						
Secondary incomplete or less	93.5	4.1	1.2	1.3	100.0	167
Secondary complete	96.2	2.0	1.9	0.0	100.0	304
Technicum	95.8	4.2	0.0	0.0	100.0	88
University/Postgraduate	92.9	2.6	3.9	0.6	100.0	213
Wealth Quintile						
Lowest	95.1	1.4	1.6	1.8	100.0	128
Second	94.3	5.1	0.0	0.5	100.0	210
Middle	95.7	2.9	1.2	0.2	100.0	170
Fourth	94.7	1.7	3.6	0.0	100.0	118
Highest	93.6	2.1	4.2	0.0	100.0	146
Ethnicity						
Georgian	95.0	2.4	2.5	0.2	100.0	628
Azeri	92.2	7.8	0.0	0.0	100.0	58
Armenian	94.4	0.0	1.8	3.8	100.0	64
Other	*	*	*	*	*	22

* Less than 25 cases in this category.

Table 15.2.3 Duration of Dating Before First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24 by Marital Status at First Intercourse
Reproductive Health Survey: Georgia, 2010

Duration of Dating Before First Sexual Intercourse	Total	Marital Status at First Sexual Intercourse	
		Not Married	Married
< 1 Month	4.0	2.1	4.1
1–5 Months	20.1	3.7	21.0
6–11 Months	14.2	21.6	13.8
1 Year	24.7	32.5	24.3
2–5 Years	31.2	30.4	31.2
6+ Years	5.0	2.3	5.1
Does not remember	0.9	7.3	0.6
Total	100.0	100.0	100.0
No. of Cases	772	40	732

Table 15.3.1 Most Commonly Cited Primary Reasons for Not Using Contraception at First Sexual Intercourse by Marital Status at First Sexual Intercourse Among Sexually Experienced Young Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

Reason	Total	Marital Status at First Sexual Intercourse	
		Not Married	Married
Wanted to get pregnant	66.6	12.1	69.3
Did not think about using a	23.7	50.8	22.4
Sex was not expected	2.9	19.4	2.1
Did not know about contraception	3.1	9.5	2.8
Partner was against it	1.3	0.0	1.3
Do not remember/Do not know	1.1	2.9	1.0
Respondent was against it	0.7	5.4	0.4
Other	0.7	0.0	0.7
Total	100.0	100.0	100.0
No. of Cases	759	34	725

Table 15.3.2 Current Sexual Activity Status Among Young Adult Women
Aged 15–24 by Current Marital Status and Age Group
Reproductive Health Survey: Georgia, 2010

Sexual Activity Status	Total	Current Marital Status			Age Group	
		Married	Previously Married	Never Married	15–19	20–24
Currently Sexually Active	19.3	62.6	18.8	0.1	5.8	32.3
Within the last month	18.5	61.0	4.2	0.1	5.6	30.9
1–3 months ago	0.8	1.6	14.6	0.0	0.2	1.4
Not Current Sexual Activity	2.1	2.1	74.2	0.0	0.7	3.5
Over 3 months ago but within last year	1.0	1.5	28.5	0.0	0.2	1.8
One year or longer	1.1	0.6	45.7	0.0	0.5	1.7
Currently Pregnant or Postpartum	10.4	34.0	7.0	0.0	4.9	15.6
Never Had Intercourse	67.7	0.0	0.0	99.7	88.5	47.8
No Response	0.5	1.3	0.0	0.1	0.2	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,960	734	35	1,191	861	1,099

Table 15.3.3 Use of Contraception at Most Recent Sexual Intercourse
by Current Marital Status and Age Group
Among Sexually Experienced Young Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

Contraceptive Method	All Young Women	Currently Married or in Union			Not Currently Married or in Union
		Total	Age Group		
			15–19	20–24	
Use of Contraception at the Most Recent Sexual Encounter	35.6	36.0	19.7	39.4	29.8
Modern Methods	25.5	25.2	15.5	27.2	29.8
Oral Contraceptives	3.9	4.2	3.7	4.3	0.0
IUD	8.0	8.5	3.9	9.5	1.0
Condoms	12.2	11.0	7.3	11.8	28.8
Spermicides	1.1	1.2	0.7	1.3	0.0
Tubal ligation	0.3	0.3	0.0	0.4	0.0
Traditional Methods	10.0	10.7	4.2	12.1	0.0
Calendar (rhythm) Method	3.1	3.3	1.5	3.7	0.0
Withdrawal	6.9	7.4	2.6	8.4	0.0
Unknown Methods	0.1	0.1	0.0	0.2	0.0
Did Not Use	64.4	64.0	80.3	60.6	70.2
Total	100.0	100.0	100.0	100.0	100.0
No. of Cases ^a	771	734	124	610	37

* Excludes 1 woman whose most recent sexual intercourse was forced.

Table 15.3.4

Number of Sexual Partners Reported in the Last Twelve Months and During Lifetime by Current Marital Status Reported by Sexually Experienced Young Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

Number of Sexual Partners	Total	Marital Status		
		Married	Previously Married	Never Married
In the Last Twelve Months				
None	5.2	1.5	56.1	*
One	93.2	97.7	33.7	*
Two or more	1.6	0.8	10.2	*
Total	100.0	100.0	100.0	*
Lifetime				
One	98.2	99.5	86.1	*
Two or more	1.8	0.5	13.9	*
Total	100.0	100.0	100.0	*
No. of Cases	772	734	35	3

* Less than 25 cases in this category.

Table 15.4.1

Beliefs About Condoms and Condom Use by Condom Experience
Among Sexually Experienced Women Aged 15–24
Reproductive Health Survey: Georgia, 2010

Belief	Ever Users (N=216)				Never Users (N=556)			
	Agree	Disagree	Don't Know	Refused	Agree	Disagree	Don't Know	Refused
Using condom with a new partner is a smart idea	86.1	5.3	6.7	1.9	56.6	11.3	28.7	3.4
Women should ask their partners to use condoms	65.1	26.2	6.8	1.9	19.1	44.3	32.4	4.1
It is easy to discuss using a condom with a prospective partner	46.5	37.8	13.3	2.3	13.4	42.8	39.2	4.5
Using condoms is not necessary if you know your partner	43.2	49.8	5.1	1.9	43.7	23.4	29.4	3.5
Condoms diminish sexual enjoyment	41.4	43.9	10.1	4.5	10.6	6.2	78.4	4.8
It is embarrassing to ask for condoms in FP clinics or pharmacies	13.2	80.1	4.9	1.9	15.0	56.6	24.4	4.0
People who use condoms sleep around a lot	1.5	89.4	7.2	1.9	5.1	69.3	21.5	4.1
Same condom can be used more than once	0.5	93.2	4.4	1.9	2.0	80.4	13.6	4.0

Table 15.4.2 Percentage of Women Who Have Ever Talked to a Partner About His Using Condoms by Condom Experience Among Sexually Experienced Women Aged 15–24 Reproductive Health Survey: Georgia, 2010

Characteristics	All Sexually Experienced Women		Women Who Have Ever Used Condoms		Women Who Have Never Used Condoms	
	%	N	%	N	%	N
Total	37.0	772	81.1	216	19.4	556
Residence						
Tbilisi	61.6	148	91.5	75	32.3	73
Other Urban	39.4	193	74.4	59	25.4	134
Rural	24.1	431	73.5	82	12.8	349
Age Group						
15–19	23.0	130	*	23	7.4	107
20–24	39.9	642	81.1	193	22.2	449
Education Level						
Secondary incomplete or less	24.1	167	77.1	33	11.7	134
Secondary complete	33.8	304	74.2	68	20.9	236
Technicum/university	46.9	301	86.6	115	22.7	186

* Less than 25 cases in this category.

Table 15.4.3 Percentage of Sexually Experienced Young Women Aged 15–24 Who Agreed with Specific Statements Regarding Their Feelings If a Partner/Husband Would Suggest Using Condoms Reproductive Health Survey: Georgia, 2010

Characteristic	Would Feel Safe From Getting STD/HIV/AIDS	Would Feel Safe From Getting Pregnant	Would Feel Like I had Done Something Wrong	Would Feel Insulted or Angry	Would Be Suspicious That He May Sleep Around	No. of Cases
Total	69.1	68.7	15.8	9.5	9.4	772
Residence						
Urban	73.2	72.1	19.8	11.8	10.8	341
Rural	65.1	65.2	11.9	7.2	8.0	431
Residence						
Tbilisi	78.9	75.3	23.7	10.5	5.3	148
Other Urban	67.9	69.3	16.3	12.9	15.8	193
Rural	65.1	65.2	11.9	7.2	8.0	431
Age Group						
15–19	68.7	68.6	8.9	10.0	11.1	130
20–24	69.2	68.7	17.3	9.4	9.0	642
Marital Status						
Currently married or in union	69.1	68.6	15.9	9.7	9.5	734
Not currently married or in union	69.4	69.1	14.2	6.3	7.9	38
Education Level						
Secondary incomplete or less	55.8	57.3	11.5	6.3	8.4	167
Secondary complete	69.6	70.1	16.1	12.5	10.4	304
Technicum	68.9	72.6	17.3	10.5	3.4	88
University/Postgraduate	78.2	73.5	18.1	7.4	10.9	213
Condom Use						
Ever users	83.2	73.9	17.1	4.5	4.2	216
Never users	63.5	66.6	15.3	11.5	11.5	556
Ever Talked to a Partner about Using Condoms						
Yes	80.7	74.5	18.6	5.0	4.5	282
No	62.3	65.2	14.2	12.2	12.2	490

16

CHAPTER

SEXUALLY TRANSMITTED INFECTIONS OTHER THAN HIV/AIDS

According to 2005 WHO estimates, 448 million new cases of curable sexually transmitted infections occur annually worldwide in adults aged 15-49. Women suffer more frequent and severe long-term consequences from STIs than men: chlamydial and gonococcal infections are important causes of pelvic inflammatory disease, ectopic pregnancy, and infertility, while human papilloma virus (HPV) is associated with cervical cancer. An STI during pregnancy can lead to premature rupture of membranes, premature labor, and postpartum endometritis. It is estimated that in pregnant women with untreated early syphilis, 25% of pregnancies result in stillbirth and 14% in neonatal death - an overall perinatal mortality of about 40% (WHO, 2010). Untreated gonococcal and chlamydial infections in women will result in pelvic inflammatory disease in up to 40% of cases. One in four of these will result in infertility (WHO, 2006). In addition, STIs increase the susceptibility to and the spread of HIV infection.

16.1 STIs in Georgia and Former Soviet Countries

In developing countries, STIs and their complications are one of the most important public health issues. Social and economic disruption is often followed by a substantial increase in adverse health conditions, especially infectious diseases including STIs. During the past 20 years, many former Soviet countries experienced major epidemics of STIs, particularly syphilis. The reported incidence of new cases of syphilis increased dramatically from 1990 to 1998 in Kazakhstan, Kyrgyzstan, Belarus, and the Russian Federation (Figure 16.1.1) (WHO, 2010). Georgia has the highest syphilis incidence rates among Caucasus countries (Figure 16.1.2). A rapid increase in the reported syphilis rate occurred in 1995-1998 and 2000-2002 in Georgia. The gonorrhea incidence rate reached a peak of around 30 new cases per 100,000 several times – in 1998, 2002 and 2006 (Figure 16.1.3) (WHO, 2010).

Rates of sexually transmitted infections are largely determined by four elements: the awareness, accessibility, acceptability, and effectiveness for early diagnosis and treatment of these diseases. The previous (1999 and 2005) and current (2010) Reproductive Health Surveys conducted in Georgia were designed to help determine the awareness, self-perceived risk, prevalence of testing, experience of symptoms, and treatment of STIs in a representative sample of sexually active women of reproductive age. That helps to identify the population subgroups with the greatest need of intervention, and to facilitate STI prevention and management policy recommendations.

Figure 16.1.1 Syphilis Incidence per 100,000 Population in Eastern Europe and Central Asia:1980-2008

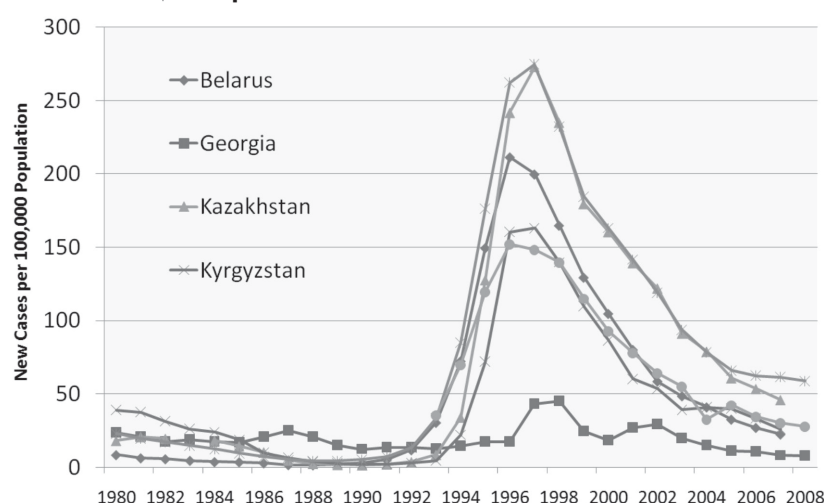
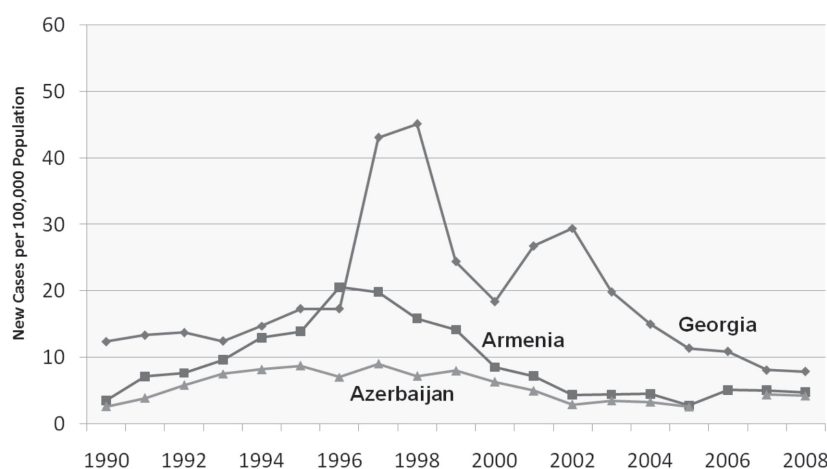


Figure 16.1.2 Syphilis Incidence per 100,000 Population in Caucasus Countries:1990 -2008



16.2 Awareness of STIs

Table 16.2 displays the percentage of respondents who reported that they had ever heard of the most common STIs in Georgia. Eighty-eight percent of all respondents had heard of at least one STI. Awareness of STIs varied substantially by respondent characteristics. Awareness of at least one STI was highest in the urban areas of the country (92%), among ages 25-44 (over 93%), in the top wealth quintiles (91%-94%), at high education levels (96%), and among women with sexual experience (94%). The majority of women in Tbilisi (93%), Shida Kartli (91%), and Mtskheta-Mtianeti (93%) had heard of at least one STI (Figure 16.2.1). The lowest levels of awareness were found among women living in Samtskhe Javakheti (77%) and Kvemo Kartli (78%), and among Azeri women (55%).

Knowledge of yeast infection ranked highest, at 88% aware, among the specific topics in Table 16.2, and syphilis ranked next, at 62%. However awareness of trichomoniasis, gonorrhea and chlamydia infections

was poor: only 37% to 44% of respondents had ever heard about those diseases. The condition of least awareness was genital herpes (28%). Generally, urban residence, older age, higher educational attainment, upper wealth quintiles, and sexual experience were associated with higher levels of awareness of the selected STIs.

From 2005 to 2010 awareness increased slightly for three STIs, namely yeast infection, chlamydia and genital herpes (Figure 16.2.2). Actual declines occurred for the awareness of syphilis, trichomoniasis and gonorrhea between the two surveys.

16.3 Awareness of Symptoms Associated with STIs

The 2010 survey also assessed the awareness of particular STI symptoms. Respondents who were aware of at least one STI were asked to cite spontaneously the symptoms that a woman with an STI might present. The degree of awareness was calculated according to a score that was based on the number of correct

Figure 16.1.3 Syphilis and Gonorrhea Infections Newly Diagnosed per 100,000 Population in Georgia:1995-2008

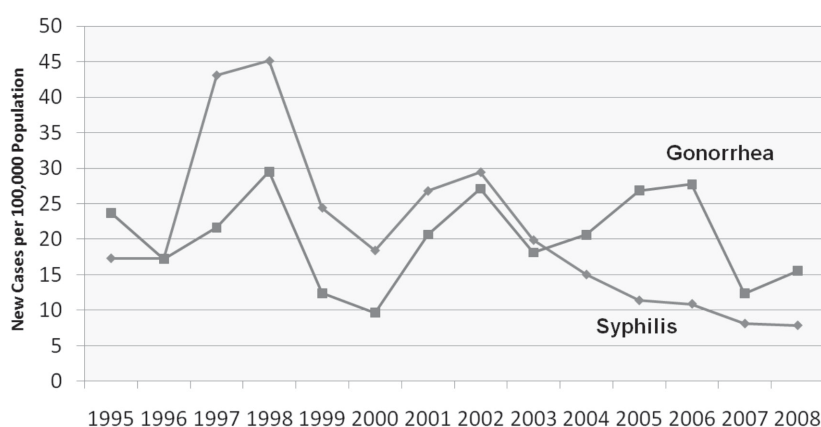
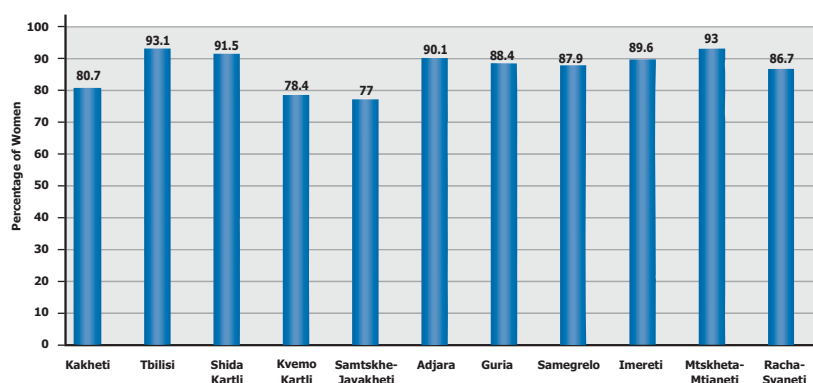


Figure 16.2.1 Awareness of at Least one STI Among Women Aged 15-44, by Region



STI symptoms listed by the respondent. Knowledge of a specific correct symptom was scored with +1, while the lack of it was scored with 0. Total scores ranged from 0 to 10 or higher.

About 20% of women were unable to list any symptom and were scored as completely unaware of STI symptoms. The majority of respondents mentioned one or two symptoms (25% and 26%, respectively). Only 11% of women cited four and more symptoms (Figure 16.3). More rural women than urban women failed to name any symptoms (24% vs. 16%) (Table 16.3.1). Awareness of STI symptoms increased in parallel with age, educational attainment and wealth quintile. Azeri and Armenian women were least able to list any STI symptoms. Sexually inexperienced women were less aware of STI symptoms than experienced women (32% vs. 13%).

Table 16.3.2 shows that the most commonly mentioned symptoms were vaginal discharge (55%), genital itching (34%), foul smelling discharge (32%), and abdominal pain (25%). On the other hand, the least mentioned symptoms included genital sores, ulcers or warts (5%), swelling in the genital area (4%), and weight loss (1%). In general, awareness of specific

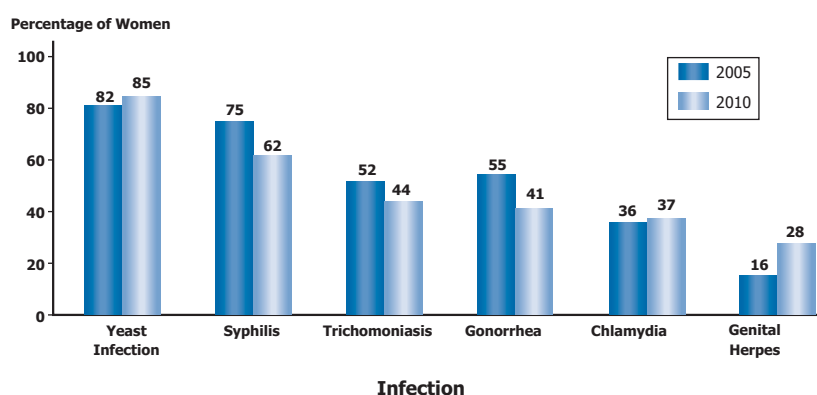
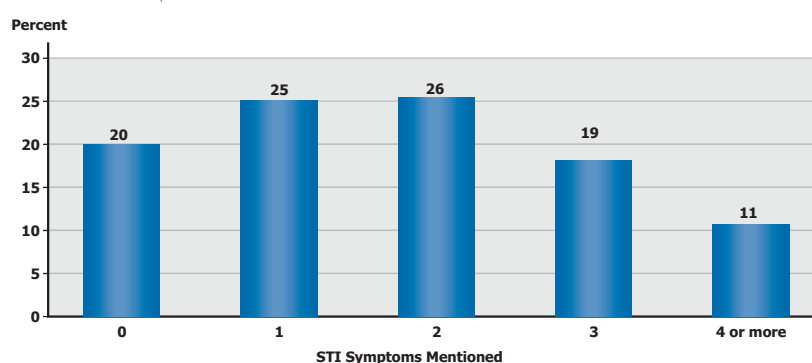
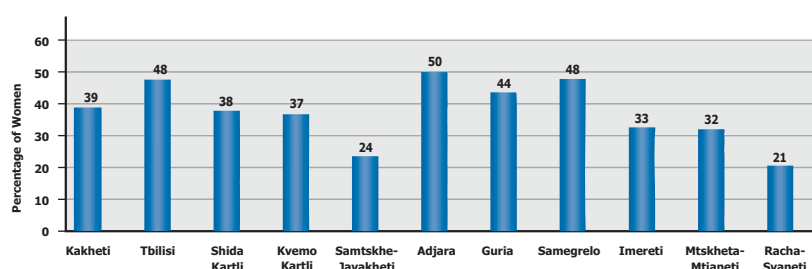
STI symptoms increased with age, educational attainment, and wealth quintile.

16.4 Self-Perceived Risk of Contracting an STI

Perception of risk of acquiring an STI is an important marker of a population's awareness about the basic risk factors and the ways to prevent these diseases. Respondents who were aware of at least one STI symptom were asked to rate their own risk of contracting an STI. The majority of Georgian women (55%) consider themselves at no risk at all; about 38% perceive that they are at low risk, and another 3% believe that their risk is moderate (Table 16.4). The perception of being at some risk of an STI acquisition was highest among women living in Tbilisi, Adjara, and Samegrelo regions (Figure 16.4). More urban women consider themselves at risk of a STI than rural women do. Generally, the self perception of a STI risk increases with higher educational attainment and upper wealth quintiles.

16.5 Self-Reported STI Testing

Women with sexual experience were asked if they were ever tested for each of several STIs. Overall, 29% of sexually experienced respondents reported being

Figure 16.2.2 Awareness of Selected STIs Among Women Aged 15-44; 2005 and 2010**Figure 16.3** Awareness of STI Symptoms Among Women Aged 15-44**Figure 16.4** Percent of Women Aged 15-44 Who Believe They Are at Some Risk of Contracting an STI, by Region

tested for at least one STI not including HIV/AIDS (Table 16.5.1). Testing for at least one STI was higher in urban than in rural areas (35% vs. 24%). The highest proportion of women tested for at least one STI was reported in Tbilisi (42%), followed by Adjara (30%) and Mtskheta-Tianeti (29%) regions (Figure 16.5.1). In general, women aged 30-44 years, with high educational attainment and in upper wealth quintiles, and those having two or more lifetime sexual partners were more likely to report STI testing.

The most frequently tested STI was yeast infection (27%) followed by trichomoniasis (7%), chlamydiasis (3%), and genital herpes (1%). Syphilis and gonorrhea were the most rarely tested STIs.

Figure 16.5.2 presents the comparison between the proportions of sexually experienced women of reproductive age who reported ever being tested for the selected STIs in the 2005 and 2010 surveys. From 2005 to 2010 self reported testing dramatically decreased for almost all selected STIs.

16.6 Self-Reported STI Symptoms

All sexually active respondents were asked whether they had experienced any of the symptoms associated with STIs during the 12 months prior to the interview (Table 16.6.1). One fifth of sexually experienced women reported that they had had a vaginal discharge with bad smell, 13% had itching or burning in genital area, 9% reported burning pain upon urination, 6% ex-

Figure 16.5.1 Percent of Sexually Experienced Women Who Have Ever Been Tested for an STI, by Region

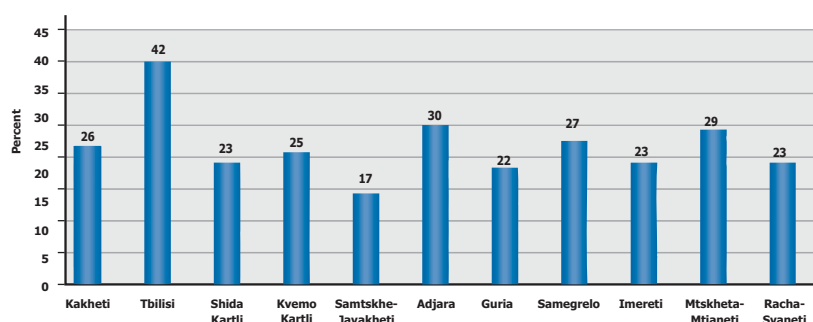


Figure 16.5.2 Percentage Ever Tested for STIs Among Sexually Experienced Women Aged 15-44; 2005-2010

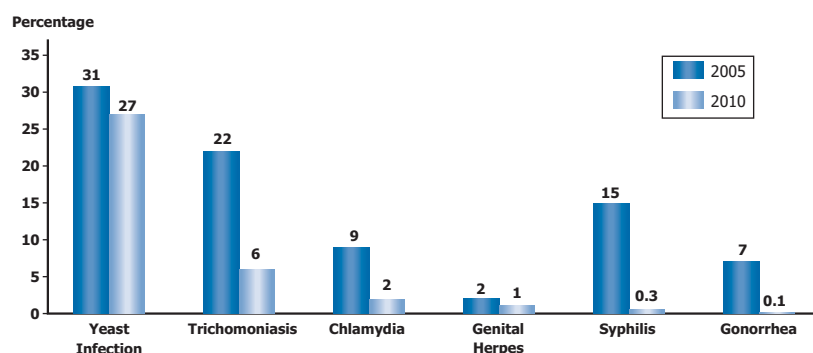
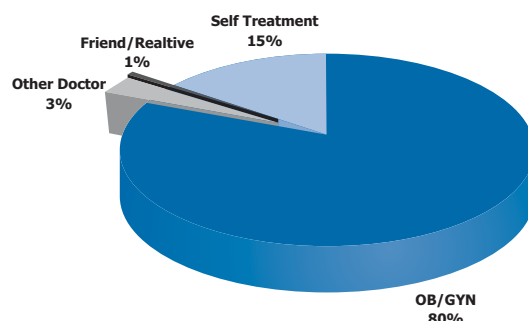


Figure 16.6 Person Who Provided STI Treatment for Sexually Experienced Women Aged 15-44 Who Sought Treatment for STI Symptoms



perienced pain during sexual intercourse, and 3% had sores, ulcers or warts in the genital area. All of these symptoms were more common in women from rural areas than from urban areas. Symptoms diminished regularly at higher wealth quintiles. Otherwise there were only irregular differences in symptoms according to age, region, education level, wealth index, or ethnicity.

More than half of women who experienced at least one of the STI symptoms in the past 12 months sought treatment. The percentage seeking treatment rose with educational attainment and wealth quintile (Table 16.6.2). The majority of respondents who sought treatment (80%) were treated by an obstetrician or gynecologist, while 15% relied on self treatment (Table 16.6.3 and Figure 16.6).

Respondents who did not seek treatment for STI symptoms during the past 12 months gave a variety of reasons for not doing so (Table 16.6.4). Two thirds reported that they did not seek treatment because they could not afford to pay for the service or treatment. This reason was especially predominant at ages 35-44, in rural areas, at the three lowest educational levels, and for the lowest wealth index. The other most common reasons for not seeking treatment were that about 12% of women declared that their symptoms disappeared over time; another 6% reported that they did not think they had an STI, and 4% feared knowing the diagnosis. However inability to pay was the predominant reason for not seeking treatment for STI symptoms among all categories of women.

Figure 16.7.1 Percentage Ever Tested for STIs Among Sexually Experienced Women Aged 15-44; 2005-2010

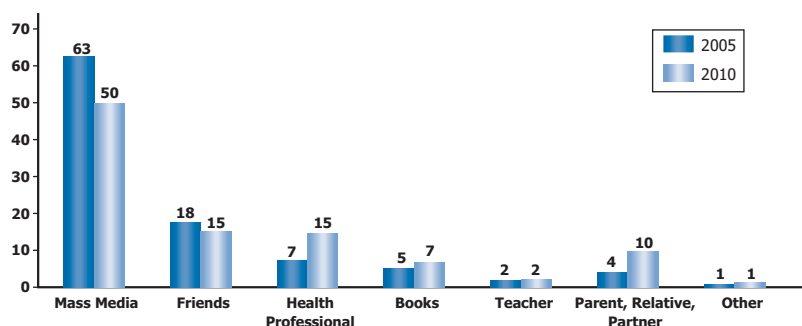
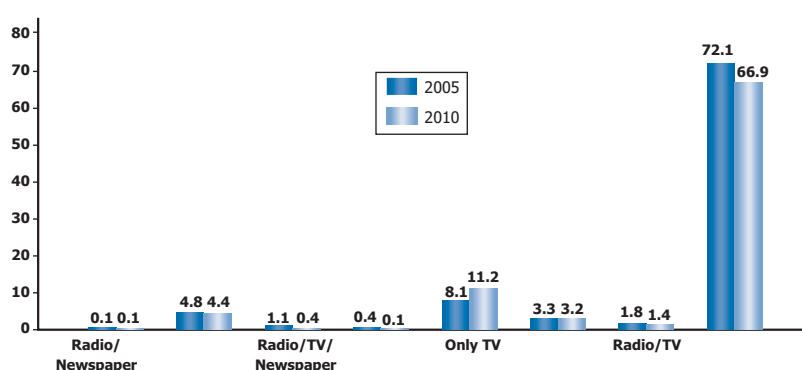


Figure 16.7.2 Recent Exposure to Radio or TV Messages on STIs All Women Aged 15-44: 2005 and 2010



16.7 Primary Sources of Information on STIs

Respondents who were aware of at least one STI were asked for their most important source of information about STIs, including HIV/AIDS. Television was by far the main source named (43%). It was followed by friends/colleagues (15%) and health care workers (14%), then next specialty books (7%) and print media (6%) (Table 16.7.1). Less than 1% of women mentioned a husband or a partner as the primary source of information. Also seldom mentioned as primary sources were parents (4%), other relatives (5%), teachers (2%), and the internet (2%). However those sum to an important 14%, or one in seven women. Also it must be remembered that these are primary sources. In reality many woman are affected by multiple sources of information.

A comparison of the 2005 and 2010 surveys shows increases for health care workers and parents/relatives/partners as important sources of information. Notably, mass media declined sharply as a principal source (Figure 16.7.1).

Respondents were also asked if in the past 6 months they had seen, heard, or read any public announcement or message about STIs on television, by radio, or in newspapers. As shown in Table 16.7.2 two thirds (67%) of women reported none at all; they had not

seen, heard, or read any message about STIs in these media sources. Among the rest of the women, a public announcement or a message was seen by 11% of respondents only on TV, was read by 3% only in newspapers, and was heard by less than 1% only on radio. The percentage of women reporting no exposure to either radio or TV during the past 6 months decreased by 5% between 2005 and 2010 (Figure 16.7.2).

In conclusion, the surveys show the lack of awareness and accurate knowledge about STIs among most groups of reproductive age women in Georgia. As a result most of them underestimate their risk of acquiring these infections. It is important to develop and disseminate culturally appropriate information, education, and communication programs for the young, the less educated, and those living in rural areas and in the lowest wealth quintiles. Appropriately integrated interventions can help prevent further spread of STI infections among these groups.

Table 16.2 Awareness of STIs Other than HIV/AIDS by Selected Characteristics
Among Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Selected STIs							No. of Cases
	At Least One STI %	Yeast Infection %	Syphilis %	Trichomoniasis %	Gonorrhea %	Chlamydia %	Genital Herpes %	
Total	88.0	84.8	61.8	44.1	41.4	37.4	27.7	6,292
Residence								
Urban	92.0	88.9	69.7	53.8	50.3	47.5	37.6	2,975
Rural	83.4	80.2	52.8	33.2	31.2	25.9	16.4	3,317
Region								
Kakheti	80.7	77.1	55.5	35.8	31.8	28.0	16.6	498
Tbilisi	93.1	89.4	73.7	60.2	55.0	53.9	42.7	1,426
Shida Kartli	91.5	89.9	52.5	36.7	35.9	28.2	16.0	392
Kvemo Kartli	78.4	74.4	49.4	34.6	34.1	28.6	21.3	546
Samtskhe–Javakheti	77.0	70.8	43.5	23.1	24.2	20.0	11.2	481
Adjara	90.1	86.3	56.5	46.2	37.8	36.6	32.7	419
Guria	88.4	83.8	68.4	37.8	42.4	36.4	23.2	401
Samegrelo	87.9	84.9	56.6	37.0	32.8	28.7	16.8	477
Imereti	89.6	88.6	67.8	41.7	43.2	35.3	26.7	805
Mtskheta–Mtianeti	93.0	90.9	67.3	46.8	43.2	40.5	27.8	393
Racha–Svaneti	86.7	86.1	49.7	26.6	28.2	20.1	12.8	454
Age Group								
15–19	68.6	63.7	21.5	10.8	11.1	8.1	7.5	861
20–24	84.9	81.3	50.2	31.5	30.4	28.5	22.0	1,099
25–29	93.1	90.4	67.0	47.1	42.6	40.7	30.3	1,191
30–34	95.1	92.1	77.3	56.0	50.0	47.1	33.1	1,168
35–39	94.7	92.5	80.4	59.7	57.3	50.2	36.6	1,051
40–44	94.7	92.5	82.8	68.3	64.8	56.4	41.3	922
Education Level								
Secondary incomplete or less	70.7	66.2	34.3	18.6	17.8	11.2	7.6	1,330
Secondary complete	87.1	83.5	53.4	34.2	29.9	28.6	18.3	1,568
Technicum	96.0	94.1	77.5	59.3	55.3	50.3	36.4	903
University/postgraduate	95.7	93.2	77.5	59.9	57.5	53.5	42.1	2,491
Wealth Quintile								
Lowest	79.9	75.1	47.4	25.0	23.7	19.5	11.8	1,093
Second	82.3	79.5	51.6	32.4	31.0	24.8	14.9	1,385
Middle	88.2	85.4	58.5	40.5	37.1	31.8	22.0	1,413
Fourth	91.1	88.1	67.1	49.1	47.0	42.6	32.7	1,037
Highest	94.4	91.3	76.3	63.2	58.7	57.7	47.3	1,364
Ethnicity								
Georgian	91.1	88.2	64.7	46.7	43.9	40.3	29.8	5,488
Azeri	54.6	50.8	25.7	13.7	13.1	7.7	3.8	276
Armenian	70.4	65.1	45.4	28.8	25.1	18.1	15.0	364
Other	84.6	79.6	67.1	48.1	46.7	34.6	27.3	164
Sexual Experience								
No	77.0	72.7	41.4	22.8	25.3	20.7	16.7	1,799
Yes	93.7	91.1	72.4	55.3	49.8	46.0	33.4	4,493

Table 16.3.1 Awareness of STI Symptoms Spontaneously Mentioned
by Selected Characteristics Among Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Number of Symptoms Spontaneously Mentioned					Total	No. of Cases
	None	1	2	3	4 or More		
Total	19.5	25.0	25.6	18.8	11.1	100.0	6,292
Residence							
Urban	15.9	23.3	26.4	21.2	13.2	100.0	2,975
Rural	23.7	26.8	24.6	16.2	8.7	100.0	3,317
Region							
Kakheti	18.8	31.3	27.7	13.9	8.2	100.0	498
Tbilisi	13.2	20.4	27.1	23.6	15.7	100.0	1,426
Shida Kartli	18.5	22.7	25.6	20.7	12.4	100.0	392
Kvemo Kartli	25.7	29.0	22.9	16.0	6.4	100.0	546
Samtskhe–Javakheti	51.4	23.0	15.4	7.8	2.5	100.0	481
Adjara	12.3	29.1	28.4	22.0	8.2	100.0	419
Guria	9.8	44.2	23.0	16.2	6.8	100.0	401
Samegrelo	11.3	19.2	29.7	25.4	14.5	100.0	477
Imereti	25.9	26.0	24.1	12.9	11.1	100.0	805
Mtskheta–Mtianeti	26.4	23.0	23.2	17.5	9.9	100.0	393
Racha–Svaneti	25.9	22.4	21.5	19.5	10.7	100.0	454
Age Group							
15–19	41.8	30.4	18.0	7.5	2.4	100.0	861
20–24	22.4	28.1	25.3	17.0	7.1	100.0	1,099
25–29	13.7	25.7	28.5	19.2	12.9	100.0	1,191
30–34	12.4	21.5	28.2	24.7	13.2	100.0	1,168
35–39	12.3	20.7	27.3	23.6	16.1	100.0	1,051
40–44	10.9	21.7	27.2	23.0	17.1	100.0	922
Education Level							
Secondary incomplete or less	35.7	28.6	22.1	10.1	3.5	100.0	1,330
Secondary complete	21.7	27.5	26.4	16.1	8.3	100.0	1,568
Technicum	11.6	19.5	29.8	23.2	15.9	100.0	903
University/postgraduate	11.6	23.1	25.7	24.1	15.5	100.0	2,491
Wealth Quintile							
Lowest	26.2	24.8	26.3	16.7	6.1	100.0	1,093
Second	26.1	26.9	24.6	16.0	6.4	100.0	1,385
Middle	19.8	27.9	24.5	16.5	11.2	100.0	1,413
Fourth	18.0	24.9	28.5	18.5	10.1	100.0	1,037
Highest	11.7	21.2	24.8	24.3	18.0	100.0	1,364
Ethnicity							
Georgian	16.6	24.9	26.3	20.0	12.2	100.0	5,488
Azeri	47.8	25.3	16.5	8.7	1.8	100.0	276
Armenian	42.2	21.2	22.1	11.7	2.9	100.0	364
Other	16.5	32.9	27.2	14.8	8.6	100.0	164
Sexual Experience							
No	31.7	29.1	22.3	11.4	5.4	100.0	1,799
Yes	13.2	22.8	27.3	22.7	14.0	100.0	4,493

Table 16.3.2 Awareness of Specific STI Symptoms Spontaneously Mentioned
By Selected Characteristics Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Symptoms										No. of Cases
	Vaginal Discharge %	Genital Itching %	Foul Smelling Discharge %	Abdominal Pain %	Burning Pain on Urination %	Redness in Genital Area %	Genital Sores, Ulcers or Warts %	Swelling in Genital Area %	Hard to Get Pregnant %	Weight Loss %	
Total	55.4	34.0	31.9	25.2	13.5	7.1	4.7	4.0	8.2	1.3	6,292
Residence											
Urban	60.6	36.0	37.1	26.1	15.5	8.8	5.2	4.8	7.1	1.5	2,975
Rural	49.5	31.6	26.1	24.1	11.3	5.1	4.2	2.9	9.3	1.0	3,317
Region											
Kakheti	43.0	27.7	25.0	26.7	9.5	5.7	5.4	2.8	20.3	0.3	498
Tbilisi	65.5	38.5	40.3	27.3	20.0	9.8	6.3	5.8	6.3	2.3	1,426
Shida Kartli	59.2	46.7	31.0	24.3	13.2	6.5	2.8	3.6	3.4	0.8	392
Kvemo Kartli	48.7	25.3	23.0	27.6	7.6	6.9	3.3	3.7	7.9	1.0	546
Samtskhe–Javakheti	35.6	19.6	12.6	13.4	2.0	0.5	0.6	0.2	3.9	0.0	481
Adjara	61.6	29.1	40.5	26.6	11.9	5.5	3.7	3.2	7.1	0.9	419
Guria	63.2	25.8	28.2	25.8	8.8	3.2	2.8	1.0	9.0	0.4	401
Samegrelo	59.2	41.2	32.3	36.5	18.7	10.8	5.7	4.7	9.6	2.2	477
Imereti	47.7	36.3	29.4	16.6	11.3	5.4	5.5	3.4	9.0	0.5	805
Mtskheta–Mtianeti	51.0	26.8	32.3	21.7	15.6	5.7	3.2	4.2	4.6	1.7	393
Racha–Svaneti	48.8	39.8	26.1	27.0	13.1	7.8	3.7	4.4	3.7	1.6	454
Age Group											
15–19	29.2	17.4	11.4	23.3	5.3	2.5	1.8	1.2	6.2	0.9	861
20–24	52.3	28.5	28.1	24.3	10.6	5.7	3.8	2.9	6.5	0.7	1,099
25–34	60.9	39.1	36.7	25.5	15.9	8.6	5.3	4.6	8.6	1.4	2,359
35–44	66.8	41.5	41.3	26.5	17.7	8.9	6.3	5.5	9.8	1.6	1,973
Education Level											
Secondary incomplete or less	37.8	20.8	17.8	23.0	7.0	2.6	1.6	1.5	6.9	0.8	1,330
Secondary complete	49.9	30.4	28.9	24.5	11.6	5.8	3.8	3.0	8.7	0.9	1,568
Technicum	64.5	42.2	40.8	29.7	16.2	8.4	6.3	4.3	8.1	0.9	903
University/postgraduate	65.8	41.0	39.0	25.3	17.6	10.0	6.5	5.8	8.5	1.8	2,491
Wealth Quintile											
Lowest	47.9	25.9	24.1	25.0	12.0	4.0	3.7	2.4	9.1	1.0	1,093
Second	46.6	30.4	24.7	22.5	9.7	4.6	3.0	2.0	8.2	0.8	1,385
Middle	52.9	37.0	31.1	23.8	10.3	6.9	3.8	3.7	8.5	0.7	1,413
Fourth	56.6	29.1	34.2	25.8	13.3	7.4	5.7	3.7	7.7	1.3	1,037
Highest	67.3	42.1	40.8	28.0	20.2	10.6	6.6	6.6	7.6	2.2	1,364
Ethnicity											
Georgian	57.7	36.3	34.2	25.4	14.6	7.8	5.1	4.3	8.3	1.4	5,488
Azeri	32.5	13.3	11.8	19.8	3.9	2.2	1.7	1.1	5.8	0.0	276
Armenian	36.9	17.0	19.6	24.8	5.2	1.4	2.1	0.9	7.8	0.3	364
Other	58.1	31.6	21.3	27.9	13.7	4.8	2.1	2.4	9.0	2.1	164
Sexual Experience											
No	39.7	23.5	19.8	24.9	8.2	4.7	3.0	2.0	6.7	1.2	1,799
Yes	63.5	39.4	38.2	25.3	16.3	8.3	5.6	4.9	8.9	1.3	4,493

Table 16.4

Self-Perceived Risk of Contracting an STI by Selected Characteristics
Among Women Aged 15–44 Who Are Aware of at Least One Type of STI
Reproductive Health Survey: Georgia, 2010

Characteristic	Self-Perceived Risk					Total	No. of Cases
	High Risk	Moderate Risk	Low Risk	No Risk at All	Doesn't Know		
Total	0.3	3.2	38.1	54.8	3.6	100.0	5,626
Residence							
Urban	0.4	3.6	42.5	50.5	3.0	100.0	2,777
Rural	0.3	2.6	32.6	60.2	4.3	100.0	2,849
Region							
Kakheti	0.4	3.1	35.7	50.6	10.2	100.0	413
Tbilisi	0.5	4.6	43.0	50.0	1.9	100.0	1,347
Shida Kartli	0.6	3.9	34.3	59.7	1.5	100.0	363
Kvemo Kartli	0.4	2.9	35.0	54.5	7.3	100.0	437
Samtskhe–Javakheti	0.2	2.0	21.6	66.5	9.7	100.0	386
Adjara	0.2	1.6	48.1	48.9	1.2	100.0	387
Guria	0.0	3.2	41.2	54.5	1.1	100.0	362
Samegrelo	0.2	1.7	45.9	50.7	1.5	100.0	429
Imereti	0.2	2.5	30.6	63.1	3.6	100.0	739
Mtskheta–Mtianeti	0.6	3.7	27.4	66.1	2.2	100.0	366
Racha–Svaneti	0.2	2.5	18.2	77.9	1.2	100.0	397
Age Group							
15–19	0.2	1.6	25.1	68.3	4.8	100.0	592
20–24	0.2	3.3	36.6	56.1	3.8	100.0	946
25–29	0.0	3.5	40.5	53.2	2.8	100.0	1,103
30–34	0.8	4.2	43.4	47.7	4.0	100.0	1,111
35–39	0.6	3.9	40.4	51.0	4.2	100.0	997
40–44	0.3	2.1	40.3	55.4	2.0	100.0	877
Education Level							
Secondary incomplete or less	0.5	2.2	27.3	62.5	7.4	100.0	978
Secondary complete	0.0	3.2	35.0	57.3	4.5	100.0	1,391
Technicum	0.1	3.0	39.6	53.6	3.7	100.0	870
University/postgraduate	0.5	3.6	43.9	50.6	1.4	100.0	2,387
Wealth Quintile							
Lowest	0.2	3.3	30.0	61.6	4.9	100.0	908
Second	0.2	2.4	34.4	57.7	5.2	100.0	1,185
Middle	0.3	2.4	35.2	58.5	3.6	100.0	1,266
Fourth	0.4	3.6	41.4	51.3	3.3	100.0	968
Highest	0.5	3.9	44.3	49.3	2.0	100.0	1,299
Ethnicity							
Georgian	0.4	3.2	39.5	54.0	2.9	100.0	5,055
Azeri	0.0	0.6	15.1	73.0	11.4	100.0	159
Armenian	0.0	2.0	27.2	60.7	10.2	100.0	271
Other	0.6	5.6	34.1	51.3	8.3	100.0	141

Table 16.5.1 Percentage of Sexually Experienced Women Aged 15–44 Ever Tested for Selected Sexually Transmitted Diseases (STIs), by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Had at Least One STI	STI-Testing for:						No. of Cases
		Yeast Infection	Trichomoniasis	Chlamydia	Genital Herpes	Syphilis	Gonorrhea	
Total	29.2	26.9	6.5	2.5	1.4	0.3	0.1	4,493
Residence								
Urban	34.6	32.0	8.4	3.2	1.6	0.3	0.1	2,048
Rural	23.7	21.6	4.5	1.7	1.1	0.2	0.2	2,445
Region								
Kakheti	26.2	24.2	4.8	2.5	1.6	0.2	0.2	380
Tbilisi	41.8	38.7	10.0	4.8	1.8	0.3	0.1	943
Shida Kartli	23.4	20.4	3.8	1.2	0.9	0.0	0.3	285
Kvemo Kartli	25.1	22.6	4.4	1.0	1.0	0.0	0.0	420
Samtskhe–Javakheti	17.4	15.3	1.7	1.7	1.4	0.5	0.0	350
Adjara	29.7	27.7	10.7	1.8	1.3	0.0	0.0	317
Guria	22.5	21.3	3.0	0.9	1.2	0.0	0.0	290
Samegrelo	26.7	25.3	4.6	1.9	1.4	0.3	0.3	326
Imereti	23.1	20.9	4.9	1.6	1.2	0.7	0.1	586
Mtskheta–Mtianeti	29.0	26.8	6.4	2.5	0.8	0.0	0.0	292
Racha–Svaneti	22.9	20.9	5.7	0.3	0.6	0.3	0.6	304
Age Group								
15–19	20.6	18.3	6.0	3.4	1.0	0.0	0.0	130
20–24	22.2	19.4	4.2	2.1	1.6	0.0	0.0	642
25–29	26.8	25.4	4.4	1.7	1.0	0.3	0.2	910
30–34	32.4	30.3	6.0	2.8	1.4	0.3	0.1	1,036
35–39	32.0	29.3	7.4	2.1	1.9	0.2	0.1	946
40–44	31.9	28.9	9.9	3.3	1.0	0.5	0.1	829
Education Level								
Secondary incomplete or less	19.5	17.5	3.4	0.5	0.6	0.1	0.1	802
Secondary complete	25.5	23.8	5.7	1.7	0.9	0.1	0.1	1,196
Technicum	32.8	29.6	6.9	3.2	1.4	0.6	0.0	740
University/postgraduate	34.7	32.0	8.2	3.5	2.0	0.3	0.2	1,755
Wealth Quintile								
Lowest	19.5	17.8	2.4	1.7	0.7	0.1	0.3	788
Second	24.5	23.0	3.8	1.4	0.4	0.0	0.1	1,032
Middle	24.4	22.4	6.9	1.2	1.1	0.4	0.1	1,018
Fourth	34.0	31.3	6.7	2.8	1.5	0.3	0.0	710
Highest	39.9	36.3	10.7	4.6	2.6	0.4	0.1	945
Ethnicity								
Georgian	30.7	28.2	7.1	2.7	1.5	0.3	0.1	3,859
Azeri	14.4	13.7	0.8	0.3	0.0	0.3	0.3	234
Armenian	22.2	19.5	2.6	0.8	1.6	0.2	0.0	270
Other	30.1	27.4	8.6	1.5	0.0	0.0	0.0	130
No. of Lifetime Sexual Partners								
1	28.8	26.6	6.1	2.3	1.3	0.3	0.1	4,324
2 or more	40.5	34.2	16.4	5.6	2.3	0.0	0.0	161
No response	*	*	*	*	*	*	*	8

* Less than 25 cases.

Table 16.6.1 Percentage of Sexually Experienced Women Aged 15–44 Who Experienced STI Symptoms in the Past 12 Months, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Symptoms					No. of Cases
	Vaginal Discharge with a Bad Smell %	Itching or Burning in the Genital Area %	Burning Pain on Urination %	Pain During Sexual Intercourse %	Sore, Ulcer or Warts in Genital Area %	
Total	20.4	13.2	9.3	6.2	2.6	4,493
Residence						
Urban	17.8	12.0	9.0	5.0	2.5	2,048
Rural	23.1	14.4	9.6	7.5	2.8	2,445
Region						
Kakheti	17.9	12.0	9.0	5.4	3.4	380
Tbilisi	18.0	12.0	9.6	4.7	3.0	943
Shida Kartli	28.1	16.9	9.5	7.1	1.8	285
Kvemo Kartli	21.0	12.4	9.2	5.8	2.2	420
Samtskhe–Javakheti	25.5	9.8	3.3	3.3	1.2	350
Adjara	19.3	12.4	7.4	8.1	2.0	317
Guria	15.6	7.5	10.2	7.2	0.3	290
Samegrelo	21.8	17.7	15.0	9.0	3.3	326
Imereti	19.2	14.5	8.8	6.3	2.5	586
Mtskheta–Mtianeti	29.8	14.9	10.5	8.8	5.2	292
Racha–Svaneti	22.3	13.2	10.0	8.6	4.3	304
Age Group						
15–19	28.1	15.2	13.0	7.6	7.3	130
20–24	19.3	10.8	8.2	6.7	2.0	642
25–29	17.7	10.7	6.5	5.2	1.7	910
30–34	21.5	15.5	9.8	7.2	2.4	1,036
35–39	21.2	14.0	10.5	5.8	2.8	946
40–44	20.6	13.6	10.2	5.9	3.3	829
Education Level						
Secondary incomplete or less	22.7	16.1	10.1	7.7	3.0	802
Secondary complete	21.9	12.6	9.4	7.1	2.5	1,196
Technicum	24.1	15.2	11.7	6.9	3.3	740
University/postgraduate	16.9	11.4	7.9	4.7	2.3	1,755
Wealth Quintile						
Lowest	24.6	16.2	10.6	7.3	1.8	788
Second	22.0	14.0	9.7	6.8	3.0	1,032
Middle	20.3	13.1	9.6	7.3	2.5	1,018
Fourth	20.2	12.6	8.9	6.3	3.1	710
Highest	16.8	11.1	8.1	4.0	2.6	945
Ethnicity						
Georgian	20.6	13.2	9.8	6.7	2.8	3,859
Azeri	21.0	12.8	5.3	2.3	2.6	234
Armenian	20.0	8.7	3.6	1.6	0.5	270
Other	14.5	19.9	13.3	8.6	1.5	130

Table 16.6.2 **Percentage of Sexually Experienced Women Aged 15–44**
Who Presented at Least One STI Symptom in the Past 12 Months and
Sought Treatment, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Sought Treatment	Did Not Seek Treatment	Not Sure	Total	No. of Cases
Total	56.5	43.2	0.3	100.0	1,220
Residence					
Urban	65.2	34.6	0.2	100.0	497
Rural	49.4	50.3	0.3	100.0	723
Age Group					
15–19	78.7	21.3	0.0	100.0	39
20–24	69.6	29.0	1.3	100.0	153
25–29	57.0	43.0	0.0	100.0	226
30–34	53.3	46.7	0.0	100.0	305
35–39	54.1	45.6	0.4	100.0	269
40–44	50.0	50.0	0.0	100.0	228
Education Level					
Secondary incomplete or less	47.1	52.4	0.4	100.0	222
Secondary complete	54.1	45.6	0.3	100.0	342
Technicum	57.7	42.3	0.0	100.0	234
University/postgraduate	63.2	36.5	0.2	100.0	422
Wealth Quintile					
Lowest	41.6	58.0	0.4	100.0	257
Second	53.7	45.8	0.4	100.0	293
Middle	52.4	47.6	0.0	100.0	258
Fourth	64.9	34.6	0.5	100.0	184
Highest	69.6	30.4	0.0	100.0	228

Table 16.6.3 Source of STI Treatment Among Sexually Experienced Women Aged 15–44
Who Sought Treatment for Recent STI Symptoms
By Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Source of STI Treatment					Total	No. of Cases
	OB/GYN	Other Doctor	Friend/Relative	Self Treatment	Other *		
Total	80.4	3.2	0.7	15.0	0.6	100.0	670
Residence							
Tbilisi	83.3	2.6	0.5	13.5	0.0	100.0	158
Other Urban	79.7	3.1	0.9	15.6	0.7	100.0	151
Rural	79.1	3.5	0.8	15.7	1.0	100.0	361
Age Group							
15–24	87.3	4.7	0.7	7.3	0.0	100.0	130
25–34	84.8	1.1	0.1	14.0	0.0	100.0	291
35–44	72.6	4.4	1.3	20.1	1.6	100.0	249
Education Level							
Secondary incomplete or less	69.2	5.3	0.9	22.9	1.7	100.0	106
Secondary complete	81.3	4.9	0.6	13.2	0.0	100.0	181
Technicum	79.8	3.0	0.0	16.1	1.1	100.0	129
University/postgraduate	84.9	1.1	1.1	12.5	0.4	100.0	254
Wealth Quintile							
Lowest	74.8	4.6	0.0	19.4	1.1	100.0	115
Second	83.5	3.6	1.0	11.8	0.0	100.0	149
Middle	75.3	3.7	1.0	18.6	1.4	100.0	134
Fourth	83.3	2.4	0.8	13.2	0.3	100.0	114
Highest	82.7	2.3	0.5	13.9	0.6	100.0	158

* Include Nurse/Midwife (1 case) and Pharmacist (2 cases).

Table 16.6.4 Primary Reason for Not Seeking Treatment Among Sexually Experienced Women Aged 15–44
Who Experienced STI Symptoms in the Past 12 Months and Did Not Seek Treatment, by Selected
Characteristics. Reproductive Health Survey: Georgia, 2010

Characteristic	Primary Reason for Not Seeking Treatment								Total	No. of Cases
	Cannot Afford Services or Treatment	Symptom(s) Disappeared	Didn't Think it Was an STI	Afraid of Knowing the Results	Doesn't Know Where to Go for Services	Services Far Away/Inaccessible	Other	Refused		
Total	67.4	11.9	5.8	4.2	2.0	1.5	5.9	1.4	100.0	550
Residence										
Tbilisi	65.6	17.2	0.0	4.3	6.5	2.2	3.2	1.1	100.0	83
Other Urban	57.9	16.4	4.9	9.3	1.5	1.0	8.9	0.0	100.0	105
Rural	70.6	9.0	7.7	2.6	0.9	1.4	5.8	1.9	100.0	362
Age Group										
15–24	64.2	14.7	6.0	3.5	0.0	3.7	4.2	3.6	100.0	62
25–34	62.4	11.9	7.6	4.3	2.8	1.4	8.8	0.9	100.0	240
35–44	72.4	11.1	4.3	4.2	1.8	1.0	3.9	1.3	100.0	248
Education Level										
Secondary incomplete or less	75.8	10.3	5.2	3.7	0.3	0.1	3.9	0.8	100.0	116
Secondary complete	74.7	8.2	5.6	3.5	0.7	1.4	3.8	2.1	100.0	161
Technicum	73.4	11.4	6.1	1.1	2.2	0.8	3.9	1.2	100.0	105
University/postgraduate	49.7	17.0	6.4	7.1	4.5	3.1	10.9	1.2	100.0	168
Wealth Quintile										
Lowest	74.1	11.7	6.1	2.4	0.0	1.6	3.3	0.8	100.0	142
Second	68.9	9.0	12.6	0.1	1.7	1.3	4.4	1.9	100.0	144
Middle	66.3	10.9	3.3	8.1	0.8	0.0	9.1	1.5	100.0	124
Fourth	58.8	13.2	5.3	4.5	3.4	4.7	8.7	1.4	100.0	70
Highest	63.3	16.5	0.0	6.7	6.2	0.9	5.1	1.3	100.0	70

Table 16.7.1 Primary Source of Information About STIs Among Women Aged 15–44
Who Were Aware of at Least One Type of STI, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Primary Source of Information												Total	No. of Cases
	TV	Friend/ Colleague	Health Profes- sional	Specialty Books	Print Media	Other Relative	Mother/ Father	Teacher	Internet	Husband/ Partner	Other	Doesn't Remember/ Refused		
Total	42.6	15.2	14.5	6.7	5.8	4.6	4.3	2.1	1.6	0.6	1.2	0.8	100.0	5,626
Residence														
Urban	40.3	15.6	15.5	7.2	6.8	3.5	4.2	2.5	2.6	0.5	1.0	0.4	100.0	2,777
Rural	45.5	14.7	13.4	6.0	4.6	6.0	4.3	1.6	0.4	0.7	1.4	1.2	100.0	2,849
Region														
Kakheti	39.4	21.6	13.5	7.6	4.3	4.7	3.7	1.6	0.6	0.4	1.2	1.4	100.0	413
Tbilisi	39.5	16.7	12.8	7.9	7.3	3.7	4.3	2.7	3.2	0.5	0.9	0.5	100.0	1,347
Shida Kartli	41.8	18.1	11.6	6.5	5.4	7.8	3.2	1.5	0.4	1.3	1.5	0.9	100.0	363
Kvemo Kartli	41.7	13.1	13.7	7.3	3.6	6.6	5.8	2.9	2.0	0.9	0.2	2.2	100.0	437
Samtskhe–Javakheti	76.8	3.0	3.6	3.4	4.4	2.0	0.6	1.8	0.6	0.0	2.4	1.2	100.0	386
Adjara	30.0	15.6	28.6	3.7	5.1	8.1	4.9	1.2	1.4	0.8	0.6	0.0	100.0	387
Guria	46.6	10.4	17.6	5.2	5.0	4.5	6.3	0.5	0.7	1.1	1.4	0.7	100.0	362
Samegrelo	34.6	16.1	14.7	8.0	4.4	5.9	9.2	1.0	1.0	1.9	2.5	0.8	100.0	429
Imereti	51.4	13.1	13.3	6.5	7.4	1.5	1.8	2.4	0.8	0.0	1.2	0.6	100.0	739
Mtskheta–Mtianeti	45.6	14.1	16.2	4.7	5.7	5.7	2.9	3.5	0.0	0.2	1.4	0.0	100.0	366
Racha–Svaneti	59.8	13.5	11.1	3.9	2.7	3.9	3.5	0.6	0.0	0.0	0.2	0.8	100.0	397
Age Group														
15–19	42.4	18.3	4.4	4.2	3.4	4.2	12.6	5.5	3.0	0.5	0.7	0.9	100.0	592
20–24	38.6	17.3	12.5	7.2	6.1	6.4	4.4	3.3	2.5	0.5	0.9	0.4	100.0	946
25–29	43.1	15.3	16.8	4.5	6.4	5.2	3.0	1.1	1.3	1.2	1.4	0.8	100.0	1,103
30–34	44.9	12.4	19.4	5.1	6.2	4.3	2.2	1.7	1.2	0.7	1.0	0.8	100.0	1,111
35–39	43.1	14.6	17.0	7.7	6.5	3.7	2.8	1.1	0.9	0.5	0.9	1.1	100.0	997
40–44	43.9	13.6	15.4	11.4	6.0	3.8	1.8	0.4	0.9	0.3	1.9	0.6	100.0	877
Education Level														
Secondary incomplete or less	47.8	16.2	8.7	2.2	2.7	6.9	8.2	2.2	1.2	0.9	0.9	2.1	100.0	978
Secondary complete	40.5	17.6	16.9	3.6	4.8	7.3	4.3	1.5	0.5	1.0	1.4	0.6	100.0	1,391
Technicum	45.6	13.4	16.5	8.0	5.9	4.0	1.5	3.1	0.3	0.2	1.3	0.2	100.0	870
University/postgraduate	40.6	14.0	15.0	9.9	7.8	2.3	3.4	2.0	2.8	0.5	1.1	0.4	100.0	2,387
Wealth Quintile														
Lowest	41.8	15.7	12.1	5.2	4.7	8.8	6.4	1.2	0.1	1.0	2.0	1.0	100.0	908
Second	47.5	15.2	13.7	4.8	3.9	5.3	4.4	1.2	0.3	1.2	1.1	1.4	100.0	1,185
Middle	46.6	12.9	14.4	7.2	6.5	3.9	3.1	1.9	0.7	0.5	1.2	1.1	100.0	1,266
Fourth	39.1	17.0	15.9	5.2	6.4	4.5	5.7	2.6	2.2	0.3	0.9	0.1	100.0	968
Highest	39.2	15.5	15.4	9.2	6.8	2.8	3.0	2.9	3.5	0.5	0.9	0.4	100.0	1,299
Ethnicity														
Georgian	42.1	15.5	14.6	7.2	5.9	4.2	4.2	2.2	1.7	0.6	1.2	0.5	100.0	5,055
Azeri	39.5	13.7	18.3	1.0	3.7	9.1	3.1	1.1	0.0	2.2	0.0	8.1	100.0	159
Armenian	55.0	11.6	11.0	1.9	6.3	4.3	4.8	0.7	1.5	0.9	1.0	1.1	100.0	271
Other	44.9	12.0	13.2	2.3	6.7	12.9	5.9	0.6	0.0	0.0	0.9	0.7	100.0	141
Sexual Experience														
No	40.4	19.6	4.9	7.5	5.2	4.3	8.5	4.9	2.9	0.0	1.0	0.7	100.0	1,422
Yes	43.6	13.3	18.7	6.3	6.1	4.8	2.4	0.9	1.0	0.9	1.2	0.8	100.0	4,204

Table 16.7.2 Public Announcements on STIs Other Than HIV/AIDS Seen or Heard in the Past 6 Months by Selected Characteristics and by Media Source Among All Women Aged 15–44
Reproductive Health Survey: Georgia, 2010

Characteristic	Media Source									Total	No. of Cases
	None	Radio/ Newspaper	TV/ Newspaper	Radio/TV/ Newspaper	Only Radio	Only TV	Radio and TV	Only Newspaper	Doesn't Remember		
Total	66.9	0.1	4.4	0.4	0.1	11.2	1.4	3.2	12.4	100.0	6,292
Residence											
Urban	62.2	0.1	5.3	0.5	0.1	13.1	1.8	4.3	12.6	100.0	2,975
Rural	72.2	0.0	3.3	0.2	0.0	9.1	1.0	2.0	12.1	100.0	3,317
Region											
Kakheti	66.6	0.2	2.1	0.3	0.0	7.9	0.8	1.4	20.7	100.0	498
Tbilisi	63.0	0.1	6.3	0.9	0.2	14.0	2.3	4.4	8.8	100.0	1,426
Shida Kartli	73.8	0.0	2.8	0.0	0.0	19.5	0.8	1.8	1.4	100.0	392
Kvemo Kartli	69.7	0.0	3.7	0.1	0.0	7.4	2.0	2.6	14.4	100.0	546
Samtskhe–Javakheti	51.9	0.2	2.3	0.2	0.0	13.5	0.2	1.6	30.3	100.0	481
Adjara	78.5	0.0	7.5	0.0	0.0	3.4	0.7	2.8	7.1	100.0	419
Guria	72.0	0.0	4.2	0.0	0.0	13.4	1.8	1.8	6.8	100.0	401
Samegrelo	74.1	0.0	1.2	0.3	0.3	8.2	2.0	2.2	11.6	100.0	477
Imereti	61.9	0.1	3.7	0.4	0.1	12.5	0.5	4.7	16.0	100.0	805
Mtskheta–Mtianeti	62.7	0.0	5.9	0.2	0.0	13.5	1.7	2.9	13.1	100.0	393
Racha–Svaneti	72.6	0.0	2.1	0.0	0.2	11.9	1.2	1.1	10.8	100.0	454
Age Group											
15–19	74.6	0.0	2.3	0.1	0.0	8.2	1.7	0.8	12.2	100.0	861
20–24	68.4	0.0	3.7	0.5	0.0	9.7	1.5	3.5	12.7	100.0	1,099
25–29	65.4	0.1	3.9	0.8	0.2	12.8	1.3	2.8	12.8	100.0	1,191
30–34	64.3	0.1	4.1	0.1	0.1	12.6	1.7	3.9	13.1	100.0	1,168
35–39	65.2	0.1	5.6	0.4	0.0	11.4	1.1	4.1	12.1	100.0	1,051
40–44	61.8	0.1	7.2	0.4	0.3	13.5	1.1	4.4	11.1	100.0	922
Education Level											
Secondary incomplete or less	78.5	0.0	1.2	0.1	0.2	7.4	1.3	0.7	10.6	100.0	1,330
Secondary complete	69.5	0.1	3.4	0.1	0.1	9.8	1.3	1.8	13.9	100.0	1,568
Technicum	59.6	0.0	7.9	0.3	0.2	13.3	0.7	3.7	14.2	100.0	903
University/postgraduate	61.0	0.1	5.7	0.8	0.0	13.6	1.8	5.3	11.8	100.0	2,491
Wealth Quintile											
Lowest	79.3	0.0	1.5	0.0	0.0	7.5	0.6	1.6	9.5	100.0	1,093
Second	72.4	0.0	2.8	0.0	0.1	9.6	1.1	1.2	12.8	100.0	1,385
Middle	66.2	0.1	3.3	0.3	0.0	11.9	1.0	3.4	13.8	100.0	1,413
Fourth	65.3	0.1	4.9	0.6	0.2	11.4	2.5	2.9	12.1	100.0	1,037
Highest	57.5	0.1	7.6	0.8	0.2	13.9	1.6	5.6	12.6	100.0	1,364
Ethnicity											
Georgian	66.0	0.1	4.7	0.4	0.1	12.0	1.5	3.5	11.7	100.0	5,488
Azeri	85.3	0.0	1.2	0.0	0.0	4.2	0.6	0.6	8.1	100.0	276
Armenian	63.0	0.2	1.9	0.0	0.0	8.1	0.6	1.4	24.9	100.0	364
Other	67.4	0.0	4.7	0.0	0.0	6.8	1.0	3.0	17.1	100.0	164
Sexual Experience											
No	71.4	0.1	2.6	0.5	0.1	9.7	1.7	2.5	11.4	100.0	1,799
Yes	64.6	0.1	5.3	0.3	0.1	12.0	1.3	3.6	12.8	100.0	4,493

17

CHAPTER

HIV/AIDS

According to estimates from UNAIDS, 34 million people were living with HIV at the end of 2010. From the beginning of the HIV epidemic until now more than 16 million children have lost their parents due to AIDS. In 2010 alone, 2.7 million people were newly infected and around 390,000 children were born with HIV. Approximately 1.8 million AIDS related deaths occurred in the same year. Countries of Eastern Europe and Central Asia continue to have expanding HIV/AIDS epidemics. The HIV infection rate is growing faster in these countries than in any other region of the world. Injection drug use is the main route of HIV transmission in these countries but sexual transmission is increasing, especially between drug users and their partners.

17.1 HIV/AIDS in Georgia

Georgia is still considered a low HIV prevalence country, with an estimated prevalence of 0.087%, but HIV incidence has been increasing steadily over the last decade. There is a risk of a rapid spread of HIV infection in the future due to the high prevalence of injection drug use, sexually transmitted infections (STIs), Hepatitis B and C, and increased migration to neighboring countries, such as Russia and Ukraine, which are now experiencing growing HIV epidemics. The major route of HIV transmission in Georgia is injection drug use (55.5%), but in recent years sexual transmissions significantly increased and reached 37.5% of all transmissions [Figure 17.1]. Most HIV/AIDS cases belong to the 29-40 age group and the male population. Over a third of people living with HIV reside in the capital (Tbilisi) with another 31% in the Black Sea Coastal regions of Adjara and Samegrelo (data not shown).

Georgia is a low prevalence country, but HIV is increasing, so it is important to know the level of awareness and correct knowledge about HIV/AIDS in different population groups, especially among women of reproductive age, and identify factors that influence misconceptions related to HIV transmission. Therefore the 2010 survey collected detailed information about awareness, source of information, and correct knowledge related to HIV/AIDS.

17.2 Awareness and Correct Knowledge of HIV/AIDS

All respondents were asked if they had ever heard about HIV/AIDS. Even though the vast majority of women (96%) had heard about it, much lower percentages knew about the detailed items in Table 17.2. The high percentage having heard of the disease did not change significantly from the 2005 survey (95%)

Figure 17.1 HIV/AIDS Transmission Routes Among Cases Reported to the Georgian HIV Surveillance System

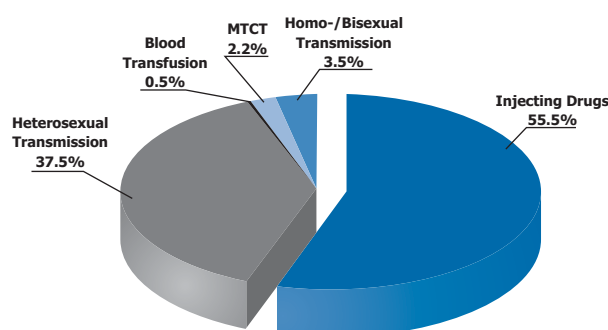
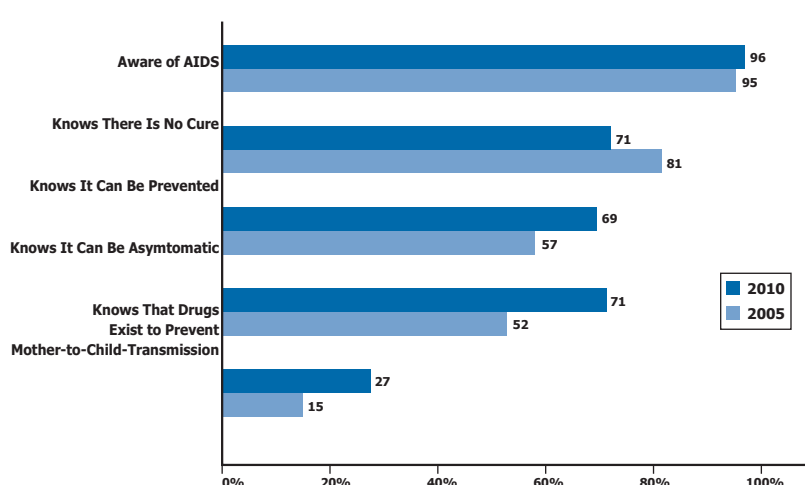


Figure 17.2.1 Awareness and Knowledge of HIV/AIDS Among Women Aged 15-44



(Figure 17.2.1). However the percentages having heard of HIV/AIDS were low in the subgroups of rural women (93%), women living in Kvemo Kartli Region (84%), women with incomplete secondary or less education (88%), women in the lowest wealth quintile (90%), and especially Azeri women (60%), followed by Armenian women (88%).

Simple awareness of HIV/AIDS does not necessarily reflect the level of actual knowledge about the disease. In order to better evaluate the correct level of knowledge those respondents who had ever heard about the disease were asked several additional questions (Table 17.2). Overall, 71% of women believed that no cure exists for HIV/AIDS an improvement from 2005 (10% less in Figure 17.2.1). Knowledge of this fact was higher in urban than in rural areas (76% vs. 65%). As in the 2005 survey, the level of knowledge about the absence of HIV/AIDS cure rose with respondent's age, educational level, wealth index and sexual experience. Only 33% of Azeri women and 55% of Armenian women knew that there is no cure for HIV/AIDS.

Only 71% of respondents overall knew that HIV infection can be asymptomatic. Those less likely to know about this item included women from rural areas

(60%), those living in Samtskhe Javakheti (51%) and Kvemo Kartli (55%), those in the 15-19 age group (64%), those with incomplete secondary or less education (50%), in the lowest wealth quintile (53%), and especially Azeri women (18%) (Table 17.2 and Figure 17.2.2). Poor knowledge is very important, since women who are unaware about this are at risk of HIV transmission if they have sex with an otherwise healthy HIV-positive partner. As shown in Figure 17.2.1 in 2010 the level of knowledge about asymptomatic HIV infection increased by 19% compared to 2005 but it still remains low, especially in certain subgroups. As a result, informational and educational interventions aimed to improve correct knowledge about HIV/AIDS should be conducted in the general population, together with special efforts in the subgroups where the level of HIV knowledge is especially low.

Respondents were also asked if they knew that the transmission of HIV can be prevented. Sixty-nine percent of women answered that they knew this. Knowledge improved about the prevention of HIV transmission from 2005 to 2010 (69% vs. 57%) (Figure 17.2.1). Regarding subgroup differences, knowledge was lower in rural than in urban areas (60% vs. 77%), among women living in Samtskhe-Javakheti (46%), among

Figure 17.2.2 Percentage of Women Who Know that HIV/AIDS Can be Asymptomatic, by Region

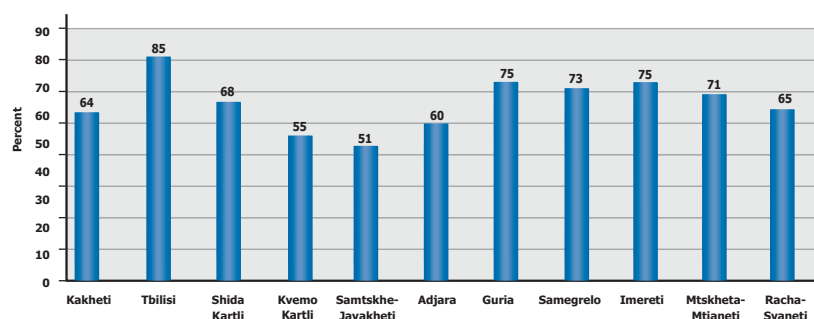
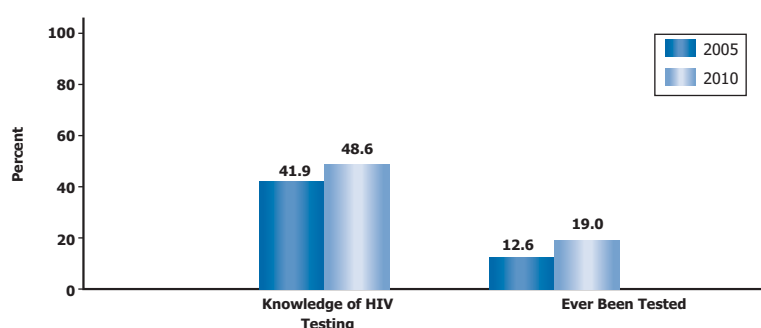


Figure 17.3.1 Knowledge and Experience of HIV-Testing Among Women Aged 15-44



women in the 15-19 age group (58%), those with the least education (50%), and those in the lowest wealth quintile (53%). Those with no sexual experience (65%), (young and unmarried) were less aware that there are ways to prevent HIV transmission. Azeri women showed the lowest level of this knowledge (24%), followed by Armenian women (44%) (Table 17.2).

The survey also assessed the knowledge of respondents about the existence of drugs to reduce mother to child HIV transmission (MTCT). The percentage of women who knew that such drugs exist increased from 15% in 2005 to 27% in 2010, both very low levels (Figure 17.2.1). The level of knowledge was higher in urban than in rural areas and was directly related to age, education level, and wealth index. Women living in Samtskhe-Javakheti and Azeri women were least aware about this, but all subgroups were deficient.

17.3 HIV Testing

Almost half of the respondents (49%) knew of at least one place where HIV tests are provided. As shown in Figure 17.3.1 that was an increase of 7% over the 2005 figure. Knowledge of a place was higher in urban than in rural areas (57% vs. 39%) (Table 17.3.1). The proportion of women knowing this information was highest in Tbilisi (62%) compared to other regions (Figure 17.3.2). Knowledge of a testing source increased with educational attainment and wealth index. Women in the 15-19 age group, those without sexual experi-

ence, and Azeri women were less likely to know about a place for HIV testing.

Actual testing for HIV is the next topic. The UNAIDS testing indicator for HIV is calculated as the proportion of all women who were tested for HIV and also received the test results, during the previous 12 months. This indicator is used for the assessment of the accessibility of HIV testing services in the general population, as well as the percentage of people who know their HIV status. The numerator for this indicator is the number of respondents reporting that they were tested for HIV and also received the test results during the last 12 months. The denominator is the total number of surveyed respondents. The result of the calculation showed that 5.0% of the reproductive age female population were tested for HIV infection and received test results in the last 12 months (Table 17.3.1).

Only 19% of respondents reported that they had ever been tested for HIV and received the test results. Most of these women (71%) were tested during antenatal care. The percentage ever tested for HIV was higher among urban women (23%), especially those who live in Tbilisi (26%) (Figure 17.3.3). Ever been tested increased with educational level and wealth index. Essentially no sexually inexperienced women have ever been tested. The lowest rate of HIV testing was found in Azeri women (8%), followed by Armenian women (10%).

Figure 17.3.2 Percentage of Women Who Know Where HIV Testing is Provided, by Region

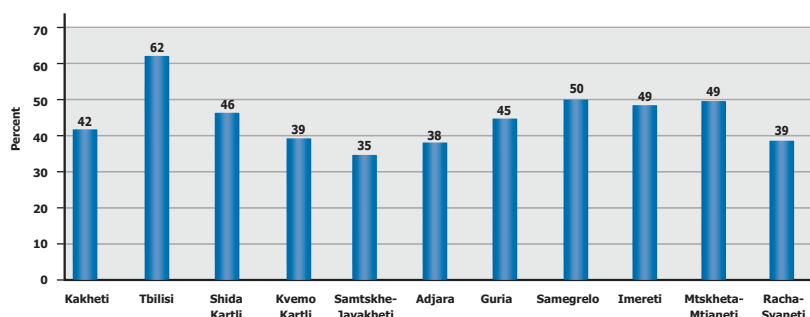


Figure 17.3.3 Percentage of Women Who Have Ever Been Tested for HIV, by Region

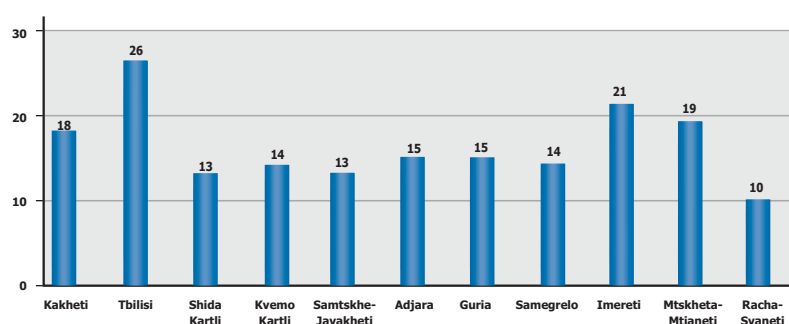
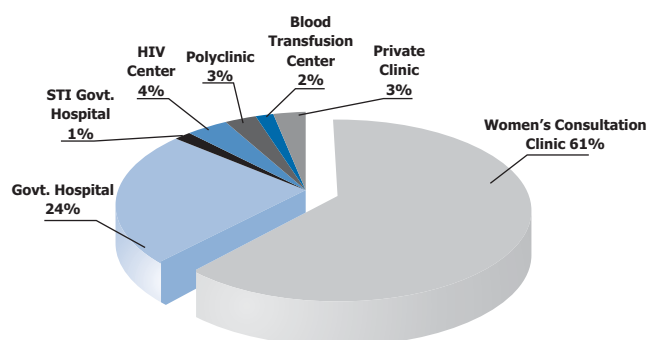


Figure 17.3.4 Location of Last HIV Test for Women Aged 15-44 Who Reported Ever Being Tested for HIV



Respondents who reported knowing where HIV testing can be provided were asked to state the most likely place where an individual can be tested. About one third of women (35%) mentioned an HIV center, followed by a women's consultation clinic (22%), a city hospital (17%) and a regional hospital (10%). Other facilities such as a polyclinic, blood transfusion center, primary health care center, and STI clinics were each mentioned by less than 5% of respondents (Table 17.3.2).

Among women who have ever been tested for HIV, 61% received the latest test at a women's consultation clinic, and 24% were tested at state hospitals (Figure 17.3.4 and Table 17.3.3). Only 4% were last tested at an HIV center and less than 2% were tested at an STI state hospital, suggesting that there still may be a

stigma associated with being tested in these types of medical facilities.

Women who received HIV testing during their lifetime were asked to report when the latest test was done. Nearly half (48%) were tested more than two years ago, 27% from 13 to 24 months ago, and another 26% in the past 12 months (Table 17.3.4). This was a considerable change regarding the last 12 months: its share of all tests rose from 15% in 2005 to 26% in 2010, suggesting a trend for tests to occur earlier. The distribution by time did not differ much by social and demographic characteristics, except that the share at 12 months was higher in rural areas, and it was especially high among women aged 15-24 years.

Figure 17.4 Recent Exposure to Radio or TV Messages on STIs, All Women Aged 15-44; 2005 and 2010

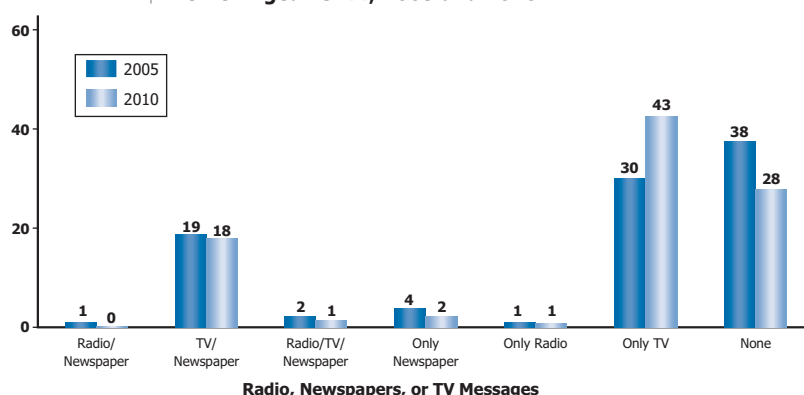
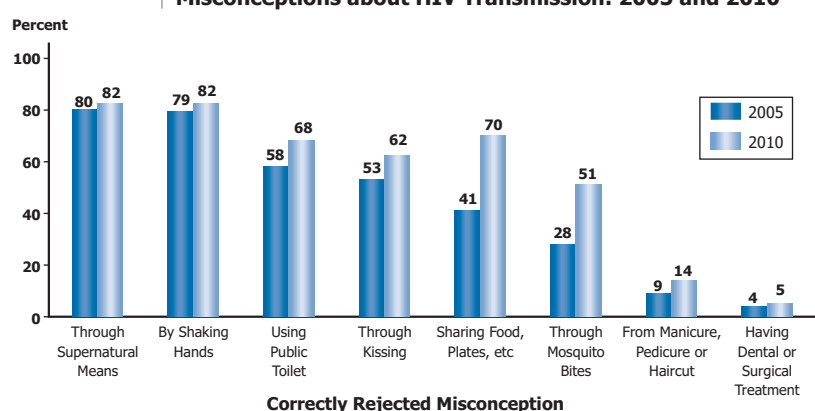


Figure 17.5.1 Percentage of Women Aged 15-44 Who Correctly Reject Misconceptions about HIV Transmission: 2005 and 2010



17.4 Sources of information on HIV/AIDS

All respondents were asked if, in the past six months, they have seen, heard, or read any public announcements or messages on television or radio or newspaper about HIV/AIDS (Table 17.4). Television is clearly the primary source of information: forty-three percent of women said that they had seen an announcement or message about HIV/AIDS only on TV. Newspapers alone were unimportant at only 2%, but the combination of TV and newspapers was reported by 18% of women. Radio was not important at all, either in combination or alone, and less than 1% had heard a message on radio only.

Almost a third of women (28%) had not seen, heard, or read any message on HIV/AIDS at all via these media during the previous 6 months. By subgroups the probability of not being exposed to any message was highest in rural areas (35%) and in Kvemo Kartli Region (41%), and was inversely related to education level and wealth index. Notably, 70% of Azeri women had no exposure to these media messages about HIV/AIDS. Compared to 2005, the proportion of women not being exposed to any message decreased from 38% to 28% in 2010. Meanwhile the percentage exposed to televised messages increased from 2005 to 2010: from 30% to 43% for television only in Figure 17.4.

17.5 Knowledge of HIV transmission

All respondents were presented with a list of common misconceptions about HIV transmission and asked to identify which ones were incorrect. The replies were classified as correctly rejecting a misconception if the answer was “no.” The percentages of women who correctly rejected the various are highlighted in Table 17.5.1. (None of the behaviors in this table have been identified scientifically as a mode of HIV transmission.) The majority of women (82%) correctly rejected the idea that HIV is transmitted through witchcraft or other supernatural forces, meaning that 18% of respondents either believed or were not sure whether witchcraft plays a role in HIV transmission. Shaking hands, and sharing food or utensils with an HIV carrier, were rejected by 82% and 70% of women, respectively. About two thirds of respondents rejected the idea that sharing a toilet can transmit HIV, and 62% rejected kissing an HIV infected individual as the source of HIV acquisition. Only about half of women (49%) knew that HIV cannot be transmitted through mosquito bite. Few respondents (14%) correctly rejected getting a manicure, pedicure or haircut as a transmission route for HIV, meaning that the majority of women believed it or was not sure about it. Having dental or surgical treatment was rejected only by 5% of respondents, perhaps related to distrust of sharp instruments (below).

Figure 17.5.2 Percentage of Women Aged 15-44 Who Have Correct Knowledge of MTCT, by Region

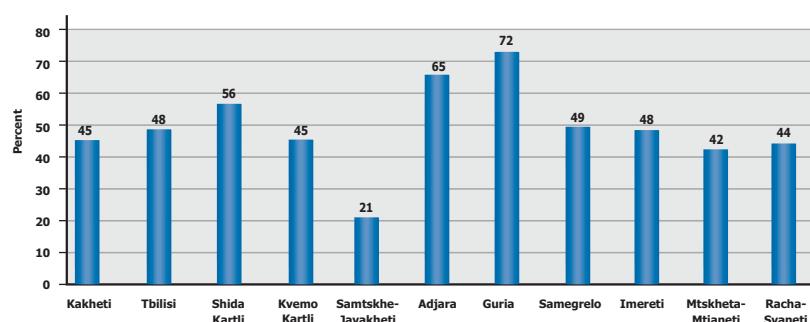
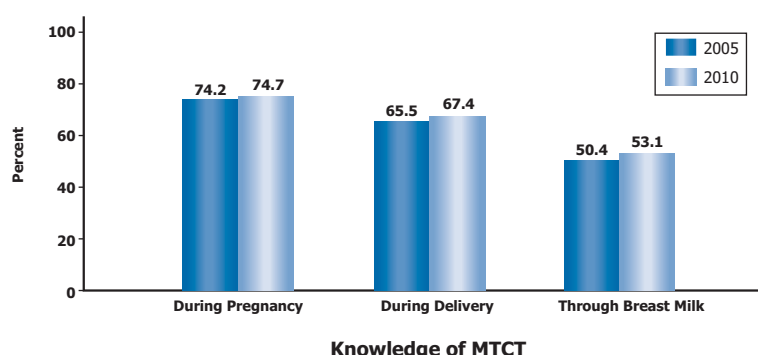


Figure 17.5.3 Percentage of Women Aged 15-44 Who Have Correct Knowledge of MTCT: 2005 and 2010



Knowledge of MTCT

These misconceptions of HIV transmission are more prevalent among certain subgroups of women: rural residents, those with incomplete secondary or less education and in the lowest wealth quintile, as well as those of Azeri ethnicity. Compared to 2005, the proportion of respondents who correctly rejected misconceptions improved for all items but especially for the following misconceptions: HIV can be transmitted through sharing food and utensils, using a common toilet, kissing, and mosquito bites. Unfortunately two misconceptions, acquiring HIV infection through getting a manicure, pedicure or haircut and from dental or surgical procedures, still remain prevalent in 2010 (Figure 17.5.1). This may be partly due to the influence of correct knowledge, namely that HIV can indeed be transmitted via contaminated sharp objects, and may be related to the widespread distrust of the general public about the sterilization procedures conducted at health care facilities and beauty salons.

Another area of interest in the survey was the level of knowledge about mother to-child HIV transmission (MTCT). Respondents were asked to name all possible means of HIV transmission from an HIV-infected mother to her child. As shown in Table 17.5.2 about half of the women (49%) knew about all three of the ways shown, including 51% of urban women and 46% of rural women. Knowledge of all MTCT mechanisms was highest in Guria (72%), followed by Adjara (66%), Shida Kartli (56%), Samegrelo (49%), Tbilisi (48%) and

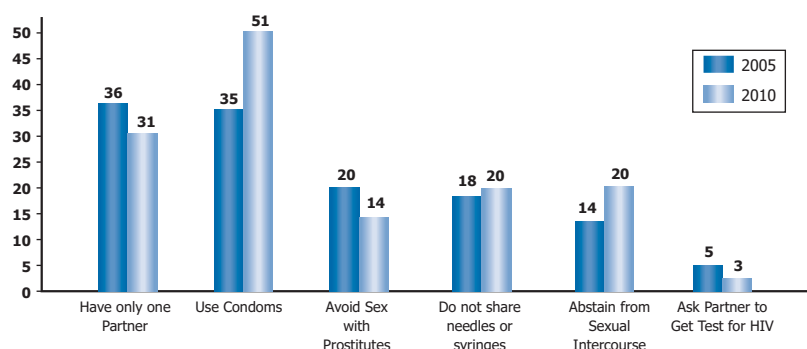
Imereti (48%) (Figure 17.5.2). Knowledge of all three modes increased generally with age, education level, and wealth index. Women with sexual experience also had more knowledge about MTCT. Armenian women were least likely to know about all three mechanisms. Focusing on the individual modes of MTCT, fewer respondents knew that HIV can be transmitted from mother to child through breastfeeding (53%), compared to during pregnancy (75%) and during delivery (67%). In 2010 the overall knowledge about MTCT was similar to 2005; however the knowledge of HIV transmission risk from breastfeeding rose slightly by 3% (Figure 17.5.3).

17.6 Knowledge of HIV prevention

Respondents were asked if they believe that measures exist to reduce the risk of contracting HIV infection. As Table 17.6.1 shows, over two thirds of all women (69%) believed that a person can do something to reduce the risk of acquiring HIV. Ten percent did not believe that such measures exist, and 21% did not know.

The percent believing in the existence of some measures was highest in urban areas, in older age groups, in higher education groups and at higher wealth levels. Lower percents occurred among rural respondents, women in the 15-19 age group, women with the least education and in the lowest wealth groups, also Azeri women.

Figure 17.6.1 Percentage of Women Aged 15-44 Who Spontaneously Named Selected Methods of Preventing HIV Transmission; 2005 and 2010



Note however that if the “don’t know” percentage is high, the other two percentages must be depressed. Thus 30.4% of rural women said “don’t know” and if they are removed the ratio between the sizes of the other two percentages change. Instead of 59.6% and 10.0% the adjusted percentages are 85.6% “yes” and 14.4% “no” instead of 59.6% and 10.0%. That means that among those with an opinion, by far believe that helpful measures to exist. This kind of adjustment is important for all subgroups with high “don’t know” percentages.

To inquire further about knowledge about HIV prevention, respondents were asked ways by which a person can reduce the risk of HIV infection. Thirty one percent of all women were unable to spontaneously mention any means of HIV prevention. Such respondents predominated in rural areas, in the Samtskhe-Javakheti region, in the 15-19 age group, lowest education and wealth groups, and among women with no sexual experience, and among Azeri women. About 16% of respondents spontaneously mentioned three ways of reducing the risk of HIV contraction, while 18% cited four and 34% listed five or more ways. Overall, the mean number of correct methods of HIV prevention was 3.3. Women living in urban areas and those with higher educational attainment and wealth index named had higher averages (Table 17.6.2).

About half of the women (51%) spontaneously mentioned “use condoms” as a means of HIV prevention (Table 17.6.3). Many more respondents named this strategy in 2010 than in 2005 (35%) (Figure 17.6.1). “Having only one partner” was mentioned as a preventive measure against HIV by 31% of women, down somewhat from 2005. “Abstinence form sexual intercourse” and “not sharing razors, blades, needles and syringes” were named by 20% of respondents, followed by “avoiding blood transfusion” (16%), “avoiding sex with prostitutes” (14%) and “avoiding injections” (13%).

In order to calculate an HIV prevention composite indicator, all respondents were asked prompted questions about three basic measures of HIV sexual transmission prevention: “always use condoms,” “being faithful to one uninfected partner who has no other partner,” and “abstaining from sexual intercourse.” Women were asked to agree or not with these three principal ways. With prompting, 71% of all women agreed with all three methods to prevent HIV sexual transmission (Table 17.6.4). The knowledge of all three methods was highest in urban areas, in ShidaKartli region, among women with high education and those in the highest wealth quintile. Azeri women were by far the least likely to agree with all three methods. Considering the individual components of the indicator, 82% of the respondents agreed with faithful to one partner,” 79% agreed with “always use condoms” and 78% agreed with “abstinence from sexual contact.”

17.7 Self-perceived risk of HIV/AIDS

Respondents who reported that they had ever heard of HIV/AIDS were asked to rate their own personal risk of contracting the infection. Their self-perception was assessed according to five alternatives: high risk, moderate risk, low risk, no risk, and don’t know. More than half (54%) considered themselves under no risk of getting HIV. Thirty eight percent believed that they were at low risk, and 3% thought they were at moderate risk. Feeling at high risk was reported by less than 1% of respondents (Table 17.7). In 2010 the self perceived risk of getting HIV infection remained very similar to that in the 2005 survey (Figure 17.7.1).

Table 17.7 shows the self-perceived risk of HIV infection for women by selected characteristics. The percentage who perceive themselves under no risk of contracting HIV was higher among rural women, and those living in the Samtskhe-Javakheti and Racha-Svaneti regions (Figure 17.7.2), also women aged 15-19 years, women at the two lowest education levels and three lowest wealth quintiles, and Azeri ethnicity.

Figure 17.7.1 Perceived Risk of Getting HIV/AIDS Among Women Aged 15-44; 2005 and 2010

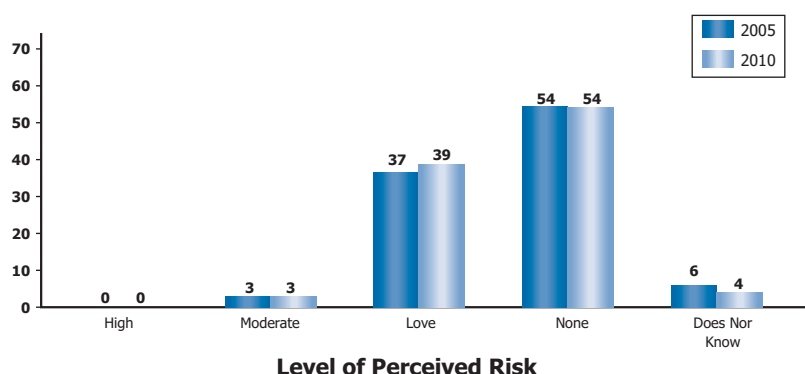
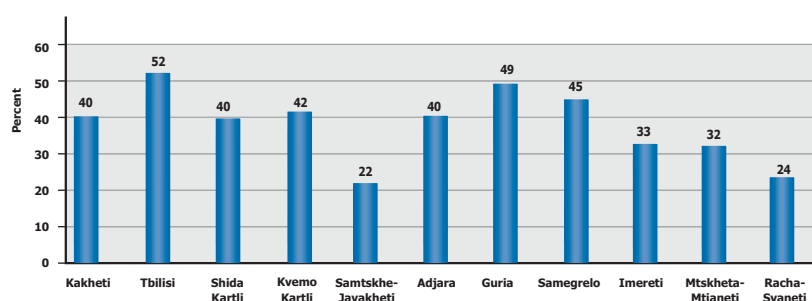


Figure 17.7.2 Percentage of Women Who Believe They Have Some Risk of Contracting HIV, by Region



Women perceiving themselves under “some” risk of HIV infection (low plus moderate risk in Table 17.7) were more numerous in urban areas including Tbilisi, in the Samegrelo and Imereti regions, at higher educational levels and in the highest wealth quintile.

In conclusion, the 2010 survey established that among women of childbearing age in Georgia, particular subgroups lack awareness of and correct knowledge about HIV/AIDS. These include young adults, rural residents, women with less education, and those in the lower wealth quintiles, as well as sexually inexperienced and Azeri women. The survey also showed that the rate of HIV testing still remains a challenge. Moreover, the level of awareness about places where HIV testing is provided is too low.

To improve knowledge about HIV/AIDS, intensive information and educational campaigns are urgently needed, in particular for the special groups named above. Common misconceptions about HIV transmission need to be addressed. Careful attention should be directed to educating women about their personal risks of acquiring HIV infection, to help them avoid risky behavior in the future. To raise the level of knowledge and influence public behavior, information and education campaigns must be organized in multiple ways: through mass-media, family doctors, and non-medical professionals trained as peer-educators.

Table 17.2 Percentage of All Women Aged 15–44 Who Have Heard of HIV/AIDS and Who Have Correct Knowledge of HIV/AIDS by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Have Heard of HIV/AIDS	Knowledge				No. of Cases
		That No Cure Exists for HIV/AIDS	That HIV Can Be Asymptomatic	That Transmission of HIV Can Be Prevented	That Drugs Exist to Reduce MTCT	
Total	95.8	71.2	70.6	69.0	27.4	6,292
Residence						
Urban	98.7	76.4	80.5	77.3	31.5	2,975
Rural	92.6	65.2	59.5	59.6	22.7	3,317
Region						
Kakheti	88.0	65.7	63.6	57.9	16.5	498
Tbilisi	99.6	77.9	84.6	78.1	31.2	1,426
Shida Kartli	99.0	80.1	67.7	76.1	29.2	392
Kvemo Kartli	83.7	59.4	54.7	53.6	20.1	546
Samtskhe–Javakheti	92.9	54.3	50.9	46.4	13.7	481
Adjara	97.7	67.5	59.5	78.3	37.7	419
Guria	99.6	80.4	75.0	62.4	20.2	401
Samegrelo	98.3	83.2	72.8	72.4	25.5	477
Imereti	97.7	67.4	74.6	67.5	30.8	805
Mtskheta–Mtianeti	98.9	68.3	70.5	70.9	29.1	393
Racha–Svaneti	98.4	67.9	64.8	67.5	27.2	454
Age Group						
15–19	93.6	63.3	63.9	57.4	17.4	861
20–24	95.0	69.2	71.5	69.2	28.0	1,099
25–29	96.5	74.1	71.8	71.9	31.1	1,191
30–34	96.7	75.2	72.5	71.2	29.4	1,168
35–39	96.5	73.0	72.6	73.8	32.0	1,051
40–44	97.1	73.7	72.2	72.3	27.3	922
Education Level						
Secondary incomplete or less	87.7	56.6	50.0	50.4	16.1	1,330
Secondary complete	96.2	68.3	64.1	63.6	22.0	1,568
Technicum	98.5	77.4	77.6	80.4	32.5	903
University/postgraduate	99.3	79.2	84.2	79.3	35.5	2,491
Wealth Quintile						
Lowest	90.2	62.1	52.9	53.2	16.5	1,093
Second	91.8	63.5	57.6	59.3	21.6	1,385
Middle	96.0	70.6	69.9	68.5	26.4	1,413
Fourth	98.9	74.6	77.2	72.8	31.7	1,037
Highest	99.6	80.1	86.3	83.0	35.5	1,364
Ethnicity						
Georgian	98.5	74.7	75.7	73.4	29.5	5,488
Azeri	59.9	32.6	18.0	24.2	6.0	276
Armenian	88.0	54.8	45.4	43.7	14.9	364
Other	94.0	63.9	56.0	62.1	24.0	164
Sexual Experience						
No	95.5	69.1	70.0	64.9	23.5	1,799
Yes	96.0	72.3	71.0	71.2	29.4	4,493

Table 17.3.1 Percent of Women Knowing an HIV Test Place and Percent Tested
Among All Women Aged 15–44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Knows at Least One Place to Get HIV Test	Ever Tested for HIV and Received Results	Tested and Received Results in the Past 12 Months	No. of Cases	Tested and Received Results During Antenatal Care	No. of Cases*
Total	48.6	19.0	5.0	6,292	71.3	1,099
Residence						
Urban	56.9	23.2	5.5	2,975	73.4	500
Rural	39.1	14.3	4.5	3,317	68.4	599
Region						
Kakheti	41.6	18.4	5.1	498	82.6	103
Tbilisi	62.0	26.0	5.8	1,426	73.7	241
Shida Kartli	46.2	13.2	4.1	392	57.4	64
Kvemo Kartli	39.1	14.3	3.7	546	76.0	93
Samtskhe–Javakheti	34.5	13.5	3.6	481	82.4	92
Adjara	38.0	15.5	5.0	419	55.6	82
Guria	44.6	15.4	3.4	401	71.4	55
Samegrelo	49.9	13.8	2.7	477	55.6	70
Imereti	48.5	21.1	6.7	805	74.1	153
Mtskheta–Mtianeti	49.4	19.0	6.7	393	77.6	81
Racha–Svaneti	38.5	9.8	2.3	454	68.6	65
Age Group						
15–19	24.3	3.0	1.6	861	75.8	74
20–24	47.7	20.0	7.7	1,099	72.2	363
25–29	58.8	30.3	8.3	1,191	69.5	344
30–34	56.8	29.1	5.7	1,168	68.0	199
35–39	53.8	19.2	4.6	1,051	79.0	96
40–44	53.1	12.8	1.5	922	69.7	23
Education Level						
Secondary incomplete or less	24.8	7.6	2.1	1,330	62.2	172
Secondary complete	43.2	17.8	5.2	1,568	68.5	330
Technicum	56.7	19.1	5.6	903	66.5	154
University/postgraduate	62.8	26.3	6.4	2,491	76.1	443
Wealth Quintile						
Lowest	32.5	10.9	3.2	1,093	58.8	177
Second	38.1	14.5	4.5	1,385	70.5	265
Middle	44.4	16.6	4.8	1,413	70.3	252
Fourth	53.2	20.4	5.5	1,037	71.8	177
Highest	65.6	28.0	6.2	1,364	76.3	228
Ethnicity						
Georgian	51.5	20.2	5.3	5,488	71.5	940
Azeri	18.1	7.7	1.1	276	81.1	55
Armenian	30.6	10.2	3.0	364	67.8	73
Other	47.3	18.5	5.8	164	59.2	31
Sexual Experience						
No	31.7	0.8	0.1	1,799	0.0	0
Yes	57.3	28.5	7.6	4,493	71.3	1,099

* Includes only women who gave birth in the last 2 years.

Table 17.3.2 Percentage of Women According to Most Likely Place for HIV Testing
Among Women Aged 15–44 Who Reported Knowing Where HIV-Testing Can Be Obtained
Reproductive Health Survey: Georgia, 2010

Characteristic	Most Likely Place										Total	No. of Cases
	HIV Center	Women's Consultation Clinic	City Hospital	Regional Hospital	Poly-clinic	Blood Trans-fusion Center	Primary Health Care Clinic/center	STI Clinic	Other *	Does Not Remember		
Total	35.1	22.3	16.7	10.4	4.5	4.4	2.5	2.1	1.3	0.7	100.0	3,150
Residence												
Urban	44.1	22.0	13.2	5.0	4.6	4.2	3.1	2.2	1.2	0.4	100.0	1,770
Rural	20.3	22.9	22.6	19.2	4.3	4.7	1.5	1.8	1.5	1.2	100.0	1,380
Region												
Kakheti	26.2	28.1	16.0	15.2	2.7	4.6	1.5	3.0	2.7	0.0	100.0	222
Tbilisi	56.8	18.3	7.6	1.1	4.5	4.8	2.5	2.9	1.2	0.3	100.0	928
Shida Kartli	17.9	28.6	20.1	22.6	6.0	1.7	1.3	0.9	0.4	0.4	100.0	189
Kvemo Kartli	35.4	20.1	19.3	6.9	7.7	2.6	3.3	2.6	0.7	1.5	100.0	217
Samtskhe–Javakheti	14.9	22.5	25.7	22.5	5.4	4.5	2.7	0.5	0.0	1.4	100.0	188
Adjara	19.2	13.1	37.4	19.6	2.3	0.9	6.5	0.5	0.5	0.0	100.0	172
Guria	12.1	18.8	24.7	12.1	13.5	9.4	2.2	5.4	1.8	0.0	100.0	187
Samegrelo	22.6	31.6	14.1	25.9	2.4	0.7	0.0	1.7	0.7	0.3	100.0	253
Imereti	22.1	27.5	22.1	9.0	2.3	9.2	2.3	1.0	2.3	2.3	100.0	418
Mtskheta–Mtianeti	32.3	23.5	16.9	7.7	10.4	1.9	2.7	1.2	3.1	0.4	100.0	199
Racha–Svaneti	30.4	14.3	19.8	21.2	6.0	1.4	0.5	0.5	1.8	4.1	100.0	177
Age Group												
15–19	37.4	9.8	16.0	11.4	10.1	4.8	3.4	5.1	0.7	1.2	100.0	219
20–24	31.5	24.6	21.4	10.7	4.7	1.7	1.8	1.3	1.4	0.9	100.0	550
25–29	29.1	30.3	18.6	10.5	3.2	2.9	2.2	0.6	1.7	1.0	100.0	694
30–34	35.9	25.9	15.2	9.9	2.4	4.9	1.8	2.2	1.0	0.7	100.0	648
35–39	37.7	21.3	13.7	8.8	5.5	4.7	3.7	2.8	1.5	0.4	100.0	571
40–44	42.1	13.5	14.4	11.6	4.0	8.2	2.6	2.0	1.2	0.3	100.0	468
Education Level												
Secondary incomplete	23.8	20.1	17.2	18.1	9.2	4.0	3.3	2.7	0.6	1.1	100.0	363
Secondary complete	23.8	26.5	22.9	12.2	4.7	3.0	1.9	2.6	0.9	1.6	100.0	690
Technicum	30.2	19.4	18.0	15.4	4.6	7.1	2.0	1.4	1.5	0.4	100.0	504
University/postgraduate	44.0	22.0	13.6	6.3	3.2	4.3	2.7	1.9	1.6	0.4	100.0	1,593
Wealth Quintile												
Lowest	18.7	23.2	24.8	18.2	5.6	3.4	2.3	1.8	1.3	0.7	100.0	389
Second	18.7	23.4	21.1	20.2	6.2	5.1	1.1	1.2	1.1	1.9	100.0	573
Middle	21.3	24.9	21.0	17.6	4.2	3.1	2.9	2.3	1.8	0.9	100.0	662
Fourth	35.7	24.0	15.3	6.3	5.0	6.4	2.7	2.4	1.2	0.9	100.0	588
Highest	54.3	19.2	11.0	2.2	3.2	3.9	2.8	2.1	1.2	0.0	100.0	938
Ethnicity												
Georgian	36.3	22.0	16.5	10.1	4.4	4.3	2.3	2.2	1.3	0.6	100.0	2,908
Azeri	14.8	17.0	32.7	21.6	3.9	1.6	0.0	0.0	1.7	6.7	100.0	54
Armenian	17.2	32.1	15.6	12.7	9.9	8.1	1.9	0.0	1.9	0.5	100.0	110
Other	30.7	25.9	13.6	7.6	2.2	5.7	10.7	2.6	1.1	0.0	100.0	78
Sexual Experience												
No	49.6	5.3	13.9	9.2	8.7	5.7	2.5	3.7	0.6	0.9	100.0	591
Yes	31.0	27.2	17.5	10.7	3.3	4.0	2.5	1.6	1.5	0.7	100.0	2,559

* Includes 27 women who mentioned Mobile Clinics and 9 women who mentioned Family Medicine Centers.

Table 17.3.3 Percentage of Women According to Site of Their Last HIV Test
Among Women Aged 15-44 Ever Tested for HIV, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Location of the Last HIV Test										Total	No. of Cases
	Women's Consultation Center	Govt. Hospital	HIV Center	Polyclinic	Blood Transfusion Center	STI Clinic	Private Clinic	Family Planning Clinic	Mobile Clinic	Other		
Total	61.2	24.3	4.1	3.1	1.7	1.5	3.1	0.4	0.2	0.4	100.0	1,582
Residence												
Tbilisi	63.5	16.2	7.5	3.5	2.0	1.3	5.5	0.4	0.2	0.2	100.0	476
Other Urban	68.4	16.8	3.2	4.1	1.8	2.2	1.9	0.8	0.0	0.7	100.0	417
Rural	54.1	37.0	1.7	2.0	1.3	1.2	1.9	0.1	0.5	0.4	100.0	689
Age Group												
15-24	62.2	27.8	2.2	1.5	1.1	2.1	3.1	0.0	0.0	0.0	100.0	361
25-34	62.6	24.8	4.2	2.4	1.0	1.1	2.6	0.7	0.2	0.5	100.0	847
35-44	57.2	20.0	5.8	6.2	3.7	1.7	4.3	0.0	0.6	0.5	100.0	374
Education Level												
Secondary incomplete or less	56.6	31.8	1.1	5.6	0.7	0.2	1.2	0.5	1.6	0.7	100.0	163
Secondary complete	59.6	30.0	3.4	2.6	0.6	1.2	1.6	0.0	0.1	0.8	100.0	369
Technicum	56.0	27.5	6.0	3.4	1.7	2.6	2.4	0.5	0.0	0.0	100.0	230
University/postgraduate	64.2	19.5	4.5	2.8	2.3	1.6	4.4	0.5	0.1	0.2	100.0	820
Wealth Quintile												
Lowest	54.1	38.8	2.1	2.9	0.0	1.6	0.3	0.0	0.2	0.0	100.0	196
Second	52.6	34.1	1.7	4.1	1.0	2.7	2.2	0.3	0.9	0.4	100.0	294
Middle	57.5	32.8	2.9	2.4	1.0	0.4	1.6	0.0	0.0	1.3	100.0	323
Fourth	66.9	18.1	5.1	1.9	4.0	1.1	2.3	0.4	0.0	0.3	100.0	295
Highest	66.1	14.3	6.0	3.7	1.6	1.7	5.6	0.7	0.2	0.0	100.0	474

Table 17.3.4 Percentage of Women According to Time Since Last HIV Test
Among Women Aged 15-44 Who Have Ever Been Tested for HIV
Reproductive Health Survey: Georgia, 2010

Characteristic	Time Since Last HIV Test			Total	No. of Cases
	12 Months	13-24 Months	More Than 2 Years		
Total	26.0	25.9	48.1	100.0	1,582
Residence					
Tbilisi	22.5	27.6	49.8	100.0	476
Other Urban	25.3	23.7	51.0	100.0	417
Rural	29.6	25.9	44.5	100.0	689
Age Group					
15-24	38.6	35.2	26.2	100.0	361
25-34	23.4	26.4	50.2	100.0	847
35-44	19.0	15.6	65.4	100.0	374
Education Level					
Secondary incomplete or less	23.5	27.8	48.6	100.0	163
Secondary complete	30.5	28.0	41.5	100.0	369
Technicum	26.7	27.9	45.4	100.0	230
University/postgraduate	24.2	24.0	51.7	100.0	820
Wealth Quintile					
Lowest	25.6	28.2	46.2	100.0	196
Second	29.8	28.8	41.4	100.0	294
Middle	28.8	22.7	48.5	100.0	323
Fourth	26.1	26.4	47.5	100.0	295
Highest	22.7	25.3	52.0	100.0	474

Table 17.4 Percentage of Women According to Primary Source of Information on HIV/AIDS
Among All Women Aged 15–44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Source of Information									Total	No. of Cases
	None	Radio/ Newspaper	TV/ Newspaper	Radio/TV/ Newspaper	Only Radio	Only TV	Radio and TV	Only Newspaper	Does Not Remember		
Total	28.1	0.3	18.1	1.4	0.6	43.0	1.5	2.1	5.0	100.0	6,292
Residence											
Urban	22.2	0.3	22.1	2.1	0.6	43.9	2.2	2.5	4.1	100.0	2,975
Rural	34.7	0.2	13.7	0.6	0.7	41.9	0.7	1.6	6.0	100.0	3,317
Region											
Kakheti	32.1	0.3	8.5	1.4	0.5	39.7	1.3	2.2	13.9	100.0	498
Tbilisi	21.8	0.2	23.8	2.6	0.7	44.0	3.0	2.3	1.6	100.0	1,426
Shida Kartli	35.3	0.2	11.2	0.6	0.4	49.7	1.2	0.8	0.6	100.0	392
Kvemo Kartli	41.0	0.3	14.6	1.9	0.4	31.4	0.4	2.1	7.9	100.0	546
Samtskhe–Javakheti	23.8	0.2	9.5	0.2	1.1	51.4	0.8	1.1	12.1	100.0	481
Adjara	32.3	0.7	32.3	0.0	0.0	31.3	0.0	3.0	0.4	100.0	419
Guria	23.4	0.0	16.0	0.2	0.0	56.2	0.8	0.6	2.8	100.0	401
Samegrelo	39.7	0.0	8.7	0.7	1.0	38.8	1.5	2.4	7.2	100.0	477
Imereti	18.2	0.2	18.6	1.3	1.2	51.7	1.1	1.6	6.1	100.0	805
Mtskheta–Mtianeti	25.3	0.4	18.8	1.0	0.2	46.2	0.8	4.6	2.9	100.0	393
Racha–Svaneti	31.3	0.0	9.4	0.2	0.2	52.0	0.4	1.8	4.8	100.0	454
Age Group											
15–19	29.6	0.0	11.1	1.5	0.4	47.7	1.4	2.2	5.9	100.0	861
20–24	28.7	0.1	18.1	2.1	1.5	40.5	1.5	2.2	5.4	100.0	1,099
25–29	26.7	0.3	17.1	1.9	0.9	44.8	1.4	2.3	4.6	100.0	1,191
30–34	28.0	0.2	18.9	1.1	0.6	41.1	1.5	2.5	6.1	100.0	1,168
35–39	27.2	0.6	22.3	0.4	0.3	42.6	1.2	1.6	4.0	100.0	1,051
40–44	28.0	0.4	22.7	1.2	0.1	40.6	1.8	1.7	3.6	100.0	922
Education Level											
Secondary incomplete or less	41.7	0.1	9.6	0.5	0.3	39.2	1.0	1.3	6.3	100.0	1,330
Secondary complete	32.4	0.2	13.0	0.8	0.8	43.9	0.7	2.1	6.0	100.0	1,568
Technicum	23.9	0.1	22.1	1.0	0.6	44.5	1.0	2.1	4.8	100.0	903
University/postgraduate	18.9	0.4	24.9	2.4	0.7	44.0	2.4	2.6	3.7	100.0	2,491
Wealth Quintile											
Lowest	44.9	0.0	8.1	0.1	0.4	39.1	0.8	2.2	4.5	100.0	1,093
Second	35.9	0.4	12.1	0.4	0.5	41.6	0.3	1.2	7.5	100.0	1,385
Middle	26.9	0.3	15.4	1.1	0.7	46.7	0.9	2.0	5.9	100.0	1,413
Fourth	21.1	0.3	23.0	2.2	1.2	43.8	2.0	2.8	3.7	100.0	1,037
Highest	18.6	0.2	27.2	2.6	0.5	42.5	2.7	2.3	3.5	100.0	1,364
Ethnic Group											
Georgian	25.1	0.3	19.7	1.6	0.7	44.6	1.6	2.1	4.2	100.0	5,488
Azeri	70.1	0.0	2.4	0.0	0.0	19.0	0.0	0.7	7.8	100.0	276
Armenian	33.7	0.2	8.4	0.3	0.5	41.7	0.3	2.2	12.7	100.0	364
Other	31.0	0.6	15.4	0.6	0.3	38.1	2.6	2.8	8.7	100.0	164
Sexual Experience											
No	25.9	0.2	16.6	2.1	0.7	44.4	2.0	2.7	5.3	100.0	1,799
Yes	29.2	0.3	18.9	1.0	0.6	42.2	1.2	1.7	4.8	100.0	4,493

Table 17.5.1 Percentage of Women Rejecting Misconceptions About HIV Transmission by Selected Characteristics Among All Women Aged 15-44
Reproductive Health Survey: Georgia, 2010

Characteristic	Misconceptions About How HIV Transmission Can Occur								No. of Cases
	Witchcraft	Shaking Hands	Sharing Food, Plates, Etc. With Someone Who Has HIV/AIDS	Sitting on a Toilet Seat After Someone Who is Infected	Through Kissing	Through Mosquito Bites	Getting a Manicure, Pedicure or Haircut	Having Dental or Surgical Treatment	
Total	81.6	81.6	70.2	67.6	61.8	51.0	13.8	4.9	6,292
Residence									
Urban	87.4	89.3	80.4	78.4	72.1	60.4	11.8	4.3	2,975
Rural	74.9	72.8	58.6	55.5	50.3	40.3	16.1	5.6	3,317
Region									
Kakheti	66.6	68.2	60.0	55.2	52.5	37.8	15.2	1.9	498
Tbilisi	88.8	93.6	84.3	80.3	76.7	61.6	11.4	3.1	1,426
Shida Kartli	89.7	85.4	70.4	66.3	65.9	51.9	16.6	6.1	392
Kvemo Kartli	63.9	60.0	52.0	52.0	47.1	37.3	9.0	3.6	546
Samtskhe–Javakheti	74.7	71.3	59.8	58.2	53.0	41.9	10.2	3.7	481
Adjara	84.5	80.1	65.2	68.9	46.9	60.7	25.9	12.6	419
Guria	80.2	88.4	65.4	65.8	62.6	49.4	12.0	4.6	401
Samegrelo	84.2	87.7	72.4	73.6	61.2	58.5	15.8	4.5	477
Imereti	84.0	81.2	70.3	64.3	62.7	42.3	11.4	5.1	805
Mtskheta–Mtianeti	86.9	81.9	70.2	63.9	61.4	48.1	16.2	6.8	393
Racha–Svaneti	83.5	82.4	65.0	60.2	58.6	48.3	17.1	7.8	454
Age Group									
15–19	78.0	78.2	62.2	58.7	54.4	42.6	15.1	5.5	861
20–24	80.9	82.5	70.4	68.9	62.4	51.8	13.7	4.9	1,099
25–29	84.4	82.0	69.3	68.4	60.1	52.6	14.2	4.5	1,191
30–34	81.1	81.1	70.8	68.4	64.0	50.6	11.2	3.6	1,168
35–39	82.4	82.0	74.4	70.7	65.5	53.0	12.8	4.6	1,051
40–44	83.1	84.2	75.5	72.2	65.8	56.7	16.0	6.1	922
Education Level									
Secondary incomplete or less	66.0	63.6	50.7	48.4	41.7	34.3	15.9	5.8	1,330
Secondary complete	80.3	77.5	62.7	60.6	52.1	45.2	16.9	6.3	1,568
Technicum	87.7	86.9	78.1	75.5	65.2	55.9	15.1	6.0	903
University/postgraduate	89.2	92.7	83.4	80.5	78.4	62.5	10.2	3.1	2,491
Wealth Quintile									
Lowest	68.6	67.5	53.8	49.8	44.6	36.6	16.6	4.5	1,093
Second	72.4	71.5	58.0	56.3	50.5	42.1	15.9	6.3	1,385
Middle	82.9	80.6	68.0	65.3	59.1	46.4	15.7	5.3	1,413
Fourth	85.9	88.5	78.2	78.1	70.3	60.6	11.9	4.9	1,037
Highest	91.5	93.0	84.6	80.8	76.4	62.7	10.5	3.6	1,364
Ethnicity									
Georgian	85.6	86.0	74.4	71.8	66.2	54.0	13.8	4.9	5,488
Azeri	37.8	30.2	21.3	21.7	16.7	14.3	8.7	2.4	276
Armenian	63.1	62.9	52.6	51.6	41.0	38.3	14.1	5.1	364
Other	70.4	73.4	61.6	54.8	49.4	48.5	22.0	7.2	164
Sexual Experience									
No	80.8	82.4	68.0	66.1	62.3	49.2	13.4	4.7	1,799
Yes	82.0	81.2	71.3	68.4	61.6	51.9	14.1	5.0	4,493

Table 17.5.2 Percentage of Women Knowing How Maternal-to-Child Transmission (MTCT) Can Occur Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	How MTCT Can Occur				No. of Cases
	During Pregnancy	During Delivery	During Breastfeeding	All Three	
Total	74.7	67.4	53.1	48.9	6,292
Residence					
Urban	78.4	72.3	55.7	51.3	2,975
Rural	70.5	61.7	50.2	46.2	3,317
Region					
Kakheti	64.7	59.5	46.4	44.6	498
Tbilisi	78.2	72.9	53.6	48.2	1,426
Shida Kartli	86.6	76.9	60.4	56.2	392
Kvemo Kartli	63.4	56.7	48.4	45.1	546
Samtskhe–Javakheti	43.3	42.1	30.3	21.0	481
Adjara	82.9	77.8	67.5	65.5	419
Guria	88.6	80.8	74.0	72.0	401
Samegrelo	75.8	68.9	51.3	48.7	477
Imereti	79.3	64.6	53.4	48.4	805
Mtskheta–Mtianeti	73.8	64.8	46.0	42.2	393
Racha–Svaneti	73.4	63.8	49.9	44.4	454
Age Group					
15–19	64.4	52.2	45.9	40.3	861
20–24	73.3	65.6	50.8	46.3	1,099
25–29	76.1	70.4	53.7	50.3	1,191
30–34	78.9	72.3	56.0	52.1	1,168
35–39	79.7	74.0	59.1	55.5	1,051
40–44	77.5	72.3	54.5	50.7	922
Education Level					
Secondary incomplete or less	61.3	51.6	42.4	39.2	1,330
Secondary complete	72.9	64.5	52.7	48.5	1,568
Technicum	81.7	73.1	55.1	52.2	903
University/postgraduate	81.2	76.2	58.8	53.7	2,491
Wealth Quintile					
Lowest	66.6	60.3	51.6	48.0	1,093
Second	69.3	61.4	50.4	46.9	1,385
Middle	75.1	65.1	50.1	45.7	1,413
Fourth	79.7	74.1	56.8	53.8	1,037
Highest	79.4	72.9	55.8	50.2	1,364
Ethnicity					
Georgian	78.8	71.2	55.7	51.6	5,488
Azeri	41.6	36.0	33.1	31.9	276
Armenian	42.9	39.3	32.5	23.8	364
Other	69.0	57.0	46.5	44.4	164
Sexual Experience					
No	69.7	59.6	49.2	44.0	1,799
Yes	77.3	71.4	55.2	51.5	4,493

Table 17.6.1 Percentage of Women Who Believe that Something Can Be Done to Reduce the Risk of Contracting HIV, Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Yes, Can Do Something	No, Cannot Do Something	Does Not Know	Total	No. of Cases
Total	69.0	9.8	21.2	100.0	6,292
Residence					
Urban	77.3	9.6	13.1	100.0	2,975
Rural	59.6	10.0	30.4	100.0	3,317
Region					
Kakheti	57.9	8.5	33.5	100.0	498
Tbilisi	78.1	10.7	11.1	100.0	1,426
Shida Kartli	76.1	10.3	13.6	100.0	392
Kvemo Kartli	53.6	10.6	35.9	100.0	546
Samtskhe-Javakheti	46.4	3.9	49.7	100.0	481
Adjara	78.3	8.7	13.0	100.0	419
Guria	62.4	23.8	13.8	100.0	401
Samegrelo	72.4	11.4	16.1	100.0	477
Imereti	67.5	7.6	24.9	100.0	805
Mtskheta-Mtianeti	70.9	7.8	21.3	100.0	393
Racha-Svaneti	67.5	12.1	20.4	100.0	454
Age Group					
15-19	57.4	12.5	30.0	100.0	861
20-24	69.2	10.0	20.8	100.0	1,099
25-29	71.9	9.3	18.9	100.0	1,191
30-34	71.2	9.4	19.5	100.0	1,168
35-39	73.8	8.4	17.8	100.0	1,051
40-44	72.3	8.5	19.2	100.0	922
Education Level					
Secondary incomplete or less	50.4	11.6	37.9	100.0	1,330
Secondary complete	63.6	11.1	25.3	100.0	1,568
Technicum	80.4	6.6	12.9	100.0	903
University/postgraduate	79.3	8.9	11.8	100.0	2,491
Wealth Quintile					
Lowest	53.2	11.9	34.8	100.0	1,093
Second	59.3	9.7	31.0	100.0	1,385
Middle	68.5	9.8	21.7	100.0	1,413
Fourth	72.8	10.8	16.4	100.0	1,037
Highest	83.0	7.8	9.2	100.0	1,364
Ethnicity					
Georgian	73.4	9.9	16.7	100.0	5,488
Azeri	24.2	5.7	70.1	100.0	276
Armenian	43.7	10.9	45.4	100.0	364
Other	62.1	10.1	27.8	100.0	164
Sexual Experience					
No	64.9	11.7	23.4	100.0	1,799
Yes	71.2	8.8	20.1	100.0	4,493

Table 17.6.2 Percentage of Women Who Believe that Something Can Be Done to Reduce the Risk of Contracting HIV, Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Mean No. of Measures Named	Number of Measures Named					Total	No. of Cases
		0	1-2	3	4	5 or More		
Total	3.3	31.0	0.7	15.8	18.1	34.3	100.0	6,292
Residence								
Urban	3.8	22.7	0.5	16.1	18.8	41.9	100.0	2,975
Rural	2.7	40.4	1.0	15.5	17.4	25.8	100.0	3,317
Region								
Kakheti	2.6	42.1	1.6	15.5	16.8	24.1	100.0	498
Tbilisi	3.8	21.9	0.4	15.6	20.4	41.7	100.0	1,426
Shida Kartli	3.5	23.9	1.8	16.6	17.9	39.8	100.0	392
Kvemo Kartli	2.5	46.4	0.7	11.0	14.9	27.0	100.0	546
Samtskhe-Javakheti	2.0	53.6	0.2	10.9	19.4	16.0	100.0	481
Adjara	3.7	21.7	0.5	16.3	16.9	44.6	100.0	419
Guria	3.0	37.6	0.4	15.0	17.2	29.8	100.0	401
Samegrelo	3.6	27.6	0.3	12.9	18.5	40.7	100.0	477
Imereti	3.0	32.5	0.7	21.6	17.4	27.8	100.0	805
Mtskheta-Mtianeti	3.0	29.1	1.3	21.3	18.8	29.5	100.0	393
Racha-Svaneti	3.1	32.5	0.7	14.0	22.2	30.6	100.0	454
Age Group								
15-19	2.5	42.6	0.8	15.5	17.7	23.4	100.0	861
20-24	3.2	30.8	0.6	18.4	18.5	31.7	100.0	1,099
25-29	3.4	28.1	0.5	14.7	18.7	38.0	100.0	1,191
30-34	3.4	28.8	1.0	16.3	18.3	35.6	100.0	1,168
35-39	3.6	26.2	0.7	14.3	16.7	42.1	100.0	1,051
40-44	3.4	27.7	0.7	15.4	19.0	37.2	100.0	922
Education Level								
Secondary incomplete or less	2.2	49.6	0.3	16.0	15.5	18.7	100.0	1,330
Secondary complete	2.9	36.4	1.3	15.6	16.5	30.3	100.0	1,568
Technicum	3.8	19.6	0.3	17.5	22.0	40.6	100.0	903
University/postgraduate	3.9	20.7	0.7	15.3	19.4	43.8	100.0	2,491
Wealth Quintile								
Lowest	2.3	46.8	1.2	16.4	15.0	20.6	100.0	1,093
Second	2.6	40.7	0.4	17.4	18.4	23.1	100.0	1,385
Middle	3.2	31.5	1.2	14.6	17.4	35.2	100.0	1,413
Fourth	3.5	27.2	0.4	15.2	17.7	39.5	100.0	1,037
Highest	4.1	17.0	0.5	15.7	20.7	46.2	100.0	1,364
Ethnicity								
Georgian	3.5	26.6	0.8	16.7	19.1	36.8	100.0	5,488
Azeri	1.1	75.8	0.0	6.2	7.2	10.9	100.0	276
Armenian	1.9	56.3	0.2	10.1	15.1	18.4	100.0	364
Other	2.8	37.9	0.4	17.0	14.3	30.4	100.0	164
Sexual Experience								
No	3.0	35.1	0.8	15.5	18.5	30.1	100.0	1,799
Yes	3.4	28.8	0.7	16.0	18.0	36.5	100.0	4,493

Table 17.6.3 Percentage of Women Who Believe that Something Can Be Done to Reduce the Risk of Contracting HIV, Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Total	Residence			Age Group					
		Tbilisi	Other Urban	Rural	15-19	20-24	25-29	30-34	35-39	40-44
Methods to Prevent Sexual Transmission of HIV										
Use condoms	50.6	61.0	58.5	40.2	39.0	52.0	56.2	53.4	52.0	51.9
Have only one partner	30.5	35.6	34.0	25.5	22.8	28.5	32.1	31.8	36.6	32.5
Abstain from sexual Intercourse	20.3	25.1	23.1	15.9	18.8	19.4	19.1	20.9	22.8	21.1
Limit number of sexual partners	10.6	13.0	12.9	7.8	5.5	10.8	12.0	10.3	14.2	11.1
Avoid sex with persons who have	3.3	3.0	4.2	3.0	1.5	3.2	3.5	3.5	4.5	3.9
Ask partner to get test for HIV	2.6	4.2	2.2	1.9	1.4	1.6	2.8	3.5	3.1	3.3
Methods to Prevent Blood										
Do not share razors, blades, needles	20.0	26.4	22.1	15.1	13.3	20.1	22.1	20.0	25.0	20.2
Avoid blood transfusions	15.9	20.1	18.0	12.3	12.4	14.0	17.5	17.4	17.5	17.5
Avoid injections	13.5	17.0	16.2	9.9	11.4	12.3	12.4	13.3	17.3	15.0
Methods to Prevent the										
Avoid sex with prostitutes	14.3	14.4	16.8	12.9	8.2	13.3	16.3	15.2	17.5	16.3
Avoid sex with persons who inject	9.3	12.8	9.9	6.8	6.0	8.7	11.5	9.7	10.2	9.9
Avoid sex with bisexuals	1.6	1.8	2.7	1.0	1.0	1.4	1.2	1.5	2.3	2.7
No. of Cases	6,292	1,426	1,549	3,317	861	1,099	1,191	1,168	1,051	922

Table 17.6.4 Percentage of Women Who Believe that Something Can Be Done to Reduce the Risk of Contracting HIV, Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Principal Ways to Prevent Sexual Transmission of HIV				No. of Cases
	Be Faithful to One Partner	Always Use Condoms	Abstain From Sexual Intercourse	All Three	
Total	82.5	78.7	78.4	70.9	6,292
Residence					
Urban	88.5	85.2	84.5	77.5	2,975
Rural	75.7	71.3	71.4	63.4	3,317
Region					
Kakheti	66.1	63.0	61.6	54.1	498
Tbilisi	89.0	88.0	83.4	77.7	1,426
Shida Kartli	94.5	88.6	91.7	83.6	392
Kvemo Kartli	66.3	58.3	63.9	54.1	546
Samtskhe–Javakheti	76.6	71.0	75.0	68.6	481
Adjara	89.9	79.4	89.0	76.7	419
Guria	80.2	81.8	87.0	70.6	401
Samegrelo	85.7	82.2	80.2	76.5	477
Imereti	81.5	80.3	74.7	68.4	805
Mtskheta–Mtianeti	85.9	79.5	79.1	70.0	393
Racha–Svaneti	84.0	82.1	82.6	74.4	454
Age Group					
15–19	76.5	71.4	72.6	63.6	861
20–24	81.5	77.2	76.4	69.1	1,099
25–29	85.3	82.7	82.0	75.0	1,191
30–34	84.4	81.4	79.8	73.6	1,168
35–39	82.8	80.0	79.3	72.7	1,051
40–44	85.6	80.5	81.3	72.6	922
Education Level					
Secondary incomplete or less	68.4	62.6	64.8	56.0	1,330
Secondary complete	79.4	75.0	76.5	68.1	1,568
Technicum	90.0	85.9	83.3	77.0	903
University/postgraduate	90.0	87.8	85.7	79.1	2,491
Wealth Quintile					
Lowest	71.7	66.0	68.3	59.6	1,093
Second	74.2	71.4	69.5	63.3	1,385
Middle	82.9	78.5	80.3	71.8	1,413
Fourth	87.0	83.8	82.9	74.1	1,037
Highest	91.3	87.8	85.9	79.9	1,364
Ethnicity					
Georgian	86.1	82.6	82.0	74.4	5,488
Azeri	36.9	30.6	34.7	27.3	276
Armenian	70.6	63.6	65.0	59.2	364
Other	78.4	72.4	70.1	65.0	164
Sexual Experience					
No	79.8	75.6	76.1	67.3	1,799
Yes	83.9	80.3	79.6	72.8	4,493

Table 17.7 Percentage of Women Who Believe that Something Can Be Done to Reduce the Risk of Contracting HIV, Among All Women Aged 15-44 by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Perceived Risk of Contracting HIV					Total	No. of Cases
	High Risk	Moderate Risk	Low Risk	No Risk at All	Does Not Know		
Total	0.3	3.0	38.5	54.2	4.0	100.0	6,063
Residence							
Urban	0.3	3.8	44.4	48.1	3.3	100.0	2,942
Rural	0.2	2.1	31.4	61.5	4.8	100.0	3,121
Region							
Kakheti	0.2	3.2	36.3	49.1	11.2	100.0	439
Tbilisi	0.3	5.3	46.5	45.7	2.1	100.0	1,422
Shida Kartli	0.8	1.4	37.3	58.2	2.4	100.0	389
Kvemo Kartli	0.0	3.4	38.2	51.7	6.7	100.0	459
Samtskhe-Javakheti	0.3	1.0	20.7	66.6	11.4	100.0	453
Adjara	0.2	0.9	39.3	58.5	1.1	100.0	408
Guria	0.0	3.4	45.6	49.8	1.2	100.0	399
Samegrelo	0.0	0.5	44.4	53.2	1.9	100.0	472
Imereti	0.4	2.8	29.6	62.9	4.3	100.0	788
Mtskheta-Mtianeti	0.4	2.1	29.4	65.6	2.5	100.0	388
Racha-Svaneti	0.2	1.8	21.7	74.5	1.8	100.0	446
Age Group							
15-19	0.2	1.6	30.3	62.3	5.6	100.0	810
20-24	0.2	3.1	38.6	53.7	4.4	100.0	1,049
25-29	0.1	3.0	39.0	55.4	2.4	100.0	1,151
30-34	0.5	4.6	40.9	49.5	4.6	100.0	1,133
35-39	0.5	3.3	42.1	49.7	4.4	100.0	1,021
40-44	0.3	2.5	41.3	53.8	2.1	100.0	899
Education Level							
Secondary incomplete or less	0.4	1.3	29.4	61.7	7.2	100.0	1,182
Secondary complete	0.1	1.8	31.8	61.5	4.8	100.0	1,513
Technicum	0.0	2.6	40.6	52.3	4.5	100.0	893
University/postgraduate	0.4	4.8	46.6	46.5	1.6	100.0	2,475
Wealth Quintile							
Lowest	0.2	2.0	28.3	63.0	6.4	100.0	1,018
Second	0.1	1.2	33.1	60.8	4.7	100.0	1,292
Middle	0.2	2.7	33.0	60.2	3.9	100.0	1,367
Fourth	0.2	3.1	43.4	50.1	3.2	100.0	1,027
Highest	0.5	5.0	48.6	43.2	2.8	100.0	1,359
Ethnicity							
Georgian	0.3	3.3	40.0	53.2	3.3	100.0	5,414
Azeri	0.0	0.0	22.7	69.8	7.5	100.0	169
Armenian	0.2	1.3	26.4	61.9	10.2	100.0	326
Other	0.0	1.1	32.2	54.6	12.2	100.0	154

18

CHAPTER

DOMESTIC VIOLENCE

Violence against women includes a wide range of behaviors and acts that are perpetrated against women by their partners or other assailants. Domestic violence—also known as intimate partner violence (IPV), “battering,” or spousal abuse—is the most common form of violence against women. It occurs in all cultures and affects women of all ages and all socioeconomic and educational backgrounds. Although violence is not a primary focus of the reproductive health surveys, they provide a unique opportunity to study prevalence of violence and the characteristics of women who experience it. In addition to documenting IPV in the context of maternal and child health, survey findings can be used to raise awareness at the individual and community levels, to help educate law enforcement and social service agencies, to influence current public health policies, to develop laws to protect and benefit battered women and, ultimately, to predict future needs for support services and interventions for abused women.

The first two reproductive health surveys, in 1999 and 2005 (Serbanescu et al., 2001 and 2007), demonstrated the presence of domestic violence in Georgia. Then a large, specialized national survey in 2009 devoted specifically to domestic violence was carried out (Chitashvili et al., 2010, with UNFPA support), which utilized WHO methodology and yielded data comparable to those from other countries. It confirmed the level of violence and provided a wealth of detail concerning abuse of various types. The first Georgian law on domestic violence came into effect on June 9, 2006. In this law, the definition of domestic violence goes beyond physical violence to include psychological, economic, and sexual violence: “domestic violence refers to violation of constitutional rights and freedoms committed by one family member in relation to another family member, through physical, psychological or sexual violence, coercion or threat to undertake such actions.” (Government of Georgia, Law on Prevention of Domestic Violence, Protection and Support of Domestic Violence Victims, June 2006). The adoption of the law was followed by the development and approval of two periodic Action Plans on Elimination of Domestic Violence, Protection and Support to its Victims (2006–2008 and 2009–2010). Despite new legal regulations and increased efforts to raise awareness on domestic violence, formal reporting of acts of domestic abuse to the authorities remained relatively unchanged—the lifetime and current IPV reported by women of reproductive age in 2009 were comparable with the 2005 levels.

Since 2008, a coordination body (the State Interagency

Figure 18.1 Recent Physical and Verbal Abuse by Having Witnessed or Experienced Parental Physical Abuse as a Child Among Ever-Married Women Aged 15–44

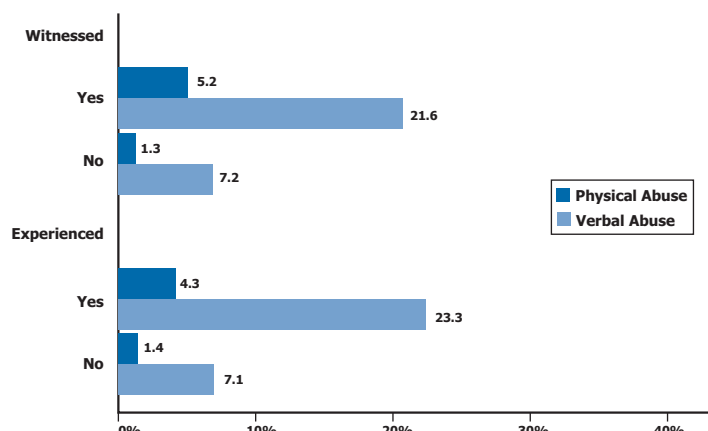
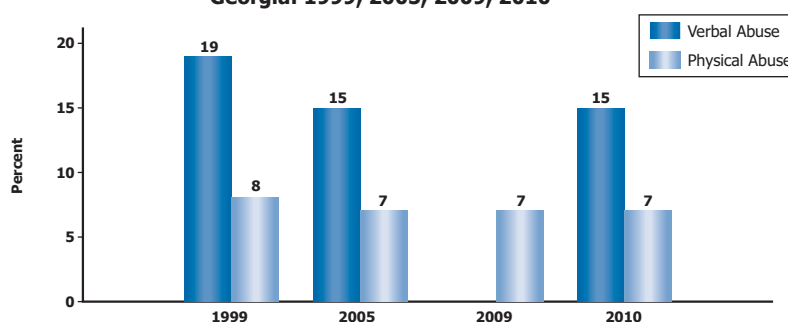


Figure 18.2.1 Reported Lifetime Abuse by Type of Abuse Among Ever-Married Women Aged 15–44, Georgia: 1999, 2005, 2009, 2010



Source: GERHS 1999, 2005, 2010 and the National Research on Domestic Violence against Women in Georgia, 2009

Coordination Council on Domestic Violence) was established by presidential decree to ensure the implementation of the domestic violence law. The Council, in partnership with the Young Lawyers Association of Georgia (GYLA) and with UNFPA support, developed the National Referral Mechanisms (NRM) for victims of domestic violence.

In 2010 UNIFEM (United Nations Development Fund for Women) with the support of the Swedish International Development Cooperation Agency (SIDA) and in collaboration with local NGOs and government agencies, implemented the project “Enhancing Prevention and Response to Domestic Violence,” which included building of two shelters for victims of domestic violence in Tbilisi and Gori. Currently, numerous non-governmental organizations, such as the Anti-Violence Network of Georgia, Georgian Young Lawyers’ Association, the Women’s Center, and Women for Democracy, in partnerships with donor organizations and governmental agencies, are very active in pursuing gender equality and violence prevention projects in Georgia.

The 2010 survey included a series of questions to assess the burden of domestic violence. The questions,

which focus principally on IPV, explore acts of violence perpetrated by current or former husbands and male partners with whom the respondent had lived as a couple. IPV, which can take a variety of forms including physical abuse, psychological abuse, and coercive sex, was documented using a modified version of the eight-item Conflict Tactic Scale (Straus, 1979). IPV in GRHS 2010 was defined as psychological, physical, and sexual abuse towards ever-married (whether legally or consensually) women. (a) Psychological abuse includes insults, curses, psychological threats, and gestures with intent of physical harm. (b) Physical violence includes pushing, shoving, and slapping, kicking, hitting with the fist or an object, being beaten up, and being threatened with a knife or other weapon. Women who experienced recent physical abuse were further asked about the severity of physical injuries and whether they sought help from law enforcement agencies, family, friends, or health care providers. (c) Sexual abuse is defined as any episode when the intimate partner “physically forced [the woman] to have sex against her will.” In addition, all respondents were asked about their history of witnessing physical abuse between parents or experience of abuse as a child or adolescent.

Figure 18.2.2 | Reported Lifetime and Recent Abuse (Past Year) by Type of Abuse Among Ever-Married Women Aged 15–44

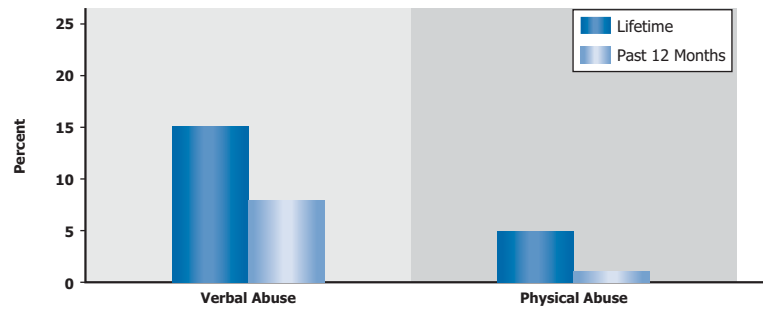


Figure 18.2.3 | Reported Lifetime Abuse by Type of Abuse and Educational Attainment Among Ever-Married Women Aged 15–44

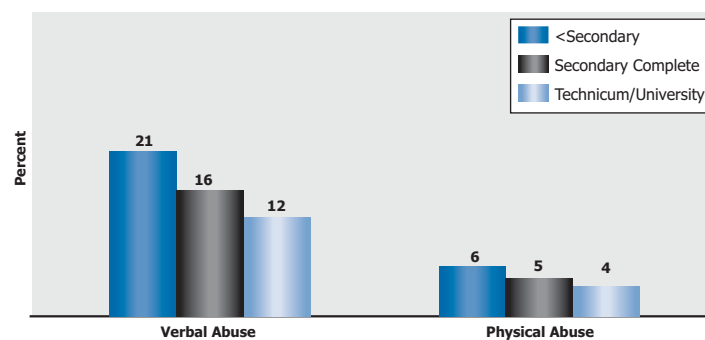
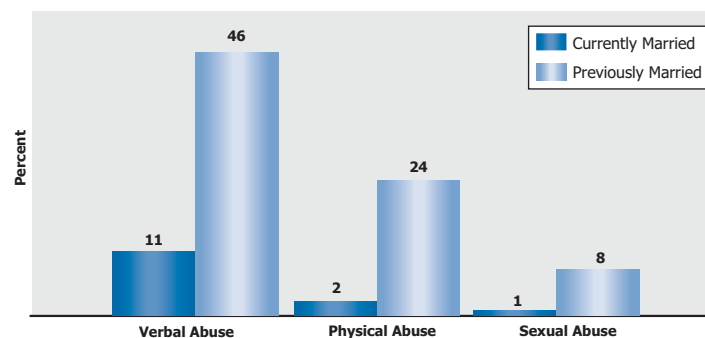


Figure 18.2.4 | Reported Lifetime Abuse by Current Marital Status Among Ever-Married Women Aged 15–44

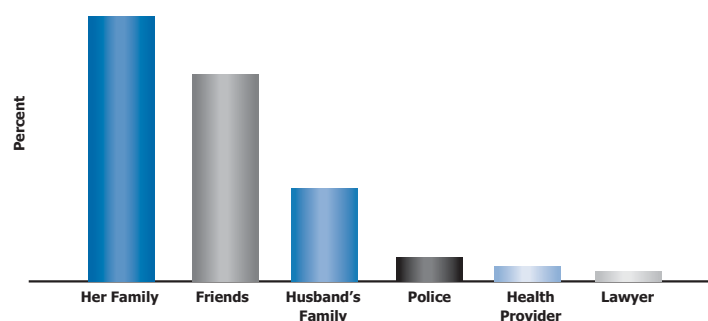


18.1 History of Witnessing or Experiencing Parental Physical Abuse

The 2010 survey included questions on abuse between parents when the respondent was growing up and abuse of the respondent as a child. Research into violence against women has revealed that experiencing and witnessing parental abuse during one's childhood are strong predictors of being in an abusive relationship as an adult (Hotaling and Sugarman, 1986). As shown in Table 18.1.1, 8% of all respondents reported having heard or seen abuse between their parents, and 8% recalled being physically abused by their parents during childhood. Compared to the 2005 survey the percentage of respondents who reported that they had experienced physical abuse as a child

decreased from 14% to 8% in 2010 (not shown). The highest prevalence of witnessing parental abuse was seen in women residing in Mtskheta-Mtianeti (12%), Adjara (11%) and Kvemo Kartli (11%) regions. Experiences of physical abuse in childhood were mostly reported by women from Racha-Svaneti (15%) and Samtskhe-Javakheti (14%) regions. Women belonging to Azeri and other minority ethnic groups had the highest percentages of witnessing and experiencing parental physical abuse. There were some noticeable, but not extreme differences in the percentages reporting these adverse childhood experiences among other socio-demographic groups. Women in rural areas, with the least education, and in the lowest wealth quintile, were most likely to have such experiences (Table 18.1.1).

Figure 18.3 Levels of Help-Seeking by Source of Help Among Ever-Married Women Aged 15–44, Who Reported Lifetime Physical Abuse



Women who reported having witnessed or experienced paternal abuse as a child were far more likely to experience lifetime or current (during the 12 months prior to the interview) physical or psychological abuse (Table 18.1.2 and Figure 18.1). The differences are quite remarkable.

18.2 Prevalence of Intimate Partner Violence

To measure the lifetime prevalence of intimate partner violence (IPV), women who ever had a marital partner (either formal or consensual) were asked if they had ever been verbally, physically or sexually abused by a partner or ex-partner. As in previous surveys, the 2010 survey shows that the prevalence of IPV reported remains low and relatively unchanged (Figure 18.2.1). Less than 20% of women reported lifetime psychological abuse in all reproductive health surveys. Lifetime exposure to physical and sexual abuse by current or previous intimate partner was reported by 7% to 8% of women. A similar percentage reported lifetime physical violence in the National Survey of Domestic Violence against Women of Georgia (Serbanescu et al., 2001 and 2007; Chitashvili et al., 2010).

As shown in Table 18.2 and Figure 18.2.2, about 15% of respondents recalled been exposed to lifetime verbal abuse and 8% reported current (during last 12 months) exposure to verbal abuse. The levels of physical and sexual abuse were low, with 5% reporting lifetime physical abuse, and 2% reporting lifetime sexual abuse. Less than 2% reported current physical or sexual abuse from an intimate partner.

Despite low national prevalence of IPV, differences exist according to women's characteristics in Table 18.2. Verbal abuse and physical violence were greater, in general, among women with less formal education (Figure 18.2.3) and lowest socioeconomic status, and among women of Azeri or "other" ethnic backgrounds. The age pattern is mixed: lifetime abuse of all three types definitely rises with age, as does recent verbal

abuse. However it is important to notice the higher prevalence (5%) of recent physical violence that is reported by young women aged 15 to 19. Surveys in other countries have also indicated that younger women are often at greater risk of current violence compared to older women.

Compared with currently married women, previously married women experienced far more verbal abuse, physical abuse, sexual abuse, suggesting that domestic abuse is a common factor associated with separation and divorce (Figure 18.2.4).

18.3 Seeking Help for Intimate Partner Violence

Seventy one percent of women who were subjected to physical abuse by an intimate partner sought help or disclosed their experience to others (Table 18.3.1). The majority of these women were most likely to talk about the abuse with a family member (54%) or a friend (42%), rather than to seek legal or medical help. Only 5% of women who were physically abused reported their experience to police, 3% sought medical help, and 2% turned to a legal adviser (Figure 18.3.1). Overall there were relatively small differences by individual characteristics, but greater help-seeking was found among women who were urban residents, younger, and not currently married/in union (including the previously married).

Legal or medical help was rarely sought, and was least likely to be sought by rural respondents, those not currently married or in union, those of low SES and in the lower wealth quintiles, also women with other than Georgian ethnicity (Table 18.3.1).

The most common reasons cited by physically abused women for not seeking formal help were the embarrassment associated with disclosing the abuse (28%) and the feeling that it was useless or would not do any good (23%). Other reasons mentioned were belief that the physical abuse was not very severe (10%), concerns that reporting violence would negatively af-

Figure 18.4.1 Prevalence of Lifetime Physical or Sexual Abuse by Gender Equity Status of the Household Among Ever-Married Women Aged 15–44

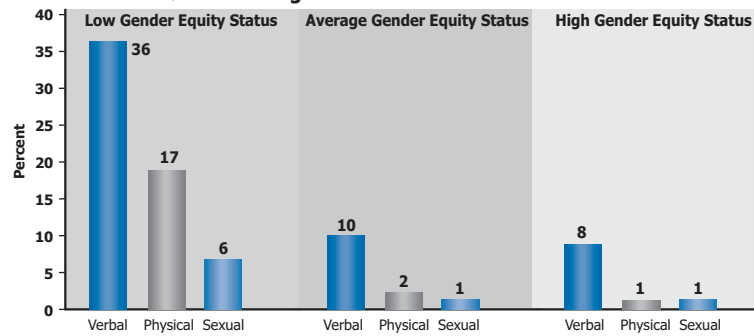
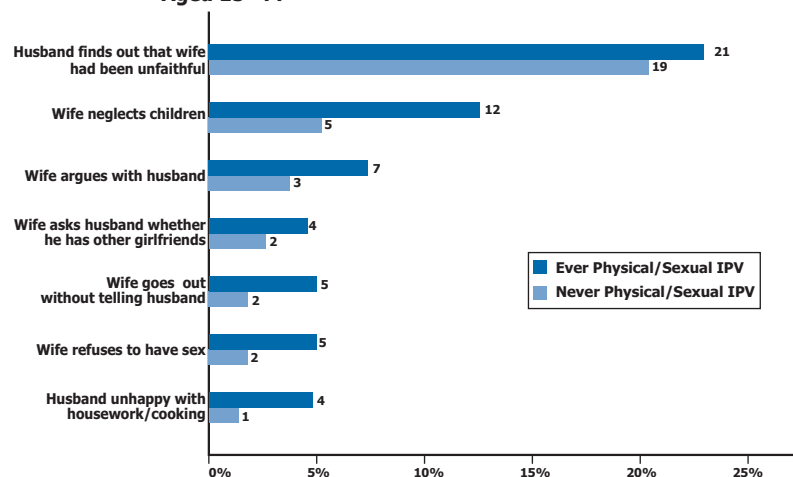


Figure 18.4.2 Agreement with Selected Justifications for Wife-beating by Experience of Physical Abuse Among Ever-Married Women Aged 15–44



fect the family's reputation (10%), fear of more beatings or being punished (8%) and fear of divorce or ending the relationship (6%) (Table 18.3.2). The reluctance to reveal domestic violence outside of the family was also found in the 2009 special study of violence ((Chitashvili et al., 2010).

18.4 Aspects of Intimate Partner Relationships and Gender Norms

Intimate partner violence is often triggered by a perceived transgression of gender norms in a family. Gender norms that are conducive to equity between marital partners help guarantee that men and women are in an equal position to use basic social services and make social, economic, and health-related decisions. The 2010 survey sought to measure the perceived roles and responsibilities of husbands and wives in Georgia and their correlates with IPV.

Ever-married respondents were asked about several aspects of their relationships with their husbands or partners, including expression of affection, tolerance of wife's contact with her family and friends, sharing of household chores, and whether the husband insists

on making all the decisions (i.e., demands the "final say"). Most respondents reported that their husbands usually shared household chores (72%). However, about half of women (50%) reported that their husbands frequently insist on having the final say; and 32% said their husbands need to know where they are all the time. Very few women stated that their husbands get angry if they speak with other men, limit their contacts with family and friends, or get very suspicious that the wife may be unfaithful (Table 18.4.1).

Behaviors of husbands that promote gender equity (e.g., sharing household chores, never insisting on having the final word in household decisions, never limiting wife's contacts with family and friends, not being suspicious or angry if she speaks with other men) were summed to create a score to classify the "gender norms status" of a family. Equal values were assigned for reports of each "positive" norm; possible scores ranged from 0 (no norm associated with gender equity in the household) to 5 (all 5 positive norms existed in the family). Respondents who reported 0 or 1 positive norm were classified as having relationships with low gender equity, those with 2 or 3 positive norms were classified as having average gender equity, and

those with 4 or 5 positive norms were considered as having high gender equity.

Most women were scored as having average gender equity (2745 of 4487 cases in Table 18.4.2). A marked pattern emerged, that women living in households with low gender equity were much more likely to be subjected to any type of violence than those who had high gender equity in their households (Figure 18.4.1).

Another set of questions explored women's acceptance of justification for wife-beating under certain circumstances (Table 18.4.3). Overall, almost 20 percent of ever-married women agreed with at least one circumstance under which they consider wife-beating justifiable. The large majority of these were women who thought that the husband would be justified in hitting his wife if he found out that she had been unfaithful (19%). Agreement that wife-beating is jus-

tifiable in the other circumstances included in the table was reported by 1%–5% of these ever-married women. The percent of women who were in agreement that wife-beating is justifiable in each of the circumstances was somewhat greater among those who reported lifetime physical or sexual abuse compared to those who had never been abused (Figure 18.4.2). The difference may perhaps be confounded with other factors since abuse is greater in rural areas and in low education, SES, and quintile groups. Additional details on domestic violence are found in the special 2009 study devoted to the subject (Chitashvili et al., 2010).

In summary, these various findings suggest that lack of empowerment, with poor gender equity, leaves women more vulnerable to verbal, physical or sexual partner abuse.

Table 18.1.1 Percentage of Women Aged 15–44 Years Who Have Witnessed or Experienced Parental Physical Abuse as a Child by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Witnessed Abuse	Experienced Abuse	No. of Cases*
Total	8.1	8.4	6,268
Residence			
Urban	7.6	7.5	2,967
Rural	8.7	9.3	3,301
Residence			
Tbilisi	6.6	6.4	1,422
Other Urban	8.7	8.7	1,545
Rural	8.7	9.3	3,301
Region			
Kakheti	9.3	6.7	493
Tbilisi	6.6	6.4	1,422
Shida Kartli	4.3	10.1	392
Kvemo Kartli	10.7	9.7	546
Samtskhe-Javakheti	8.3	13.6	479
Adjara	11.1	10.2	417
Guria	6.3	6.7	395
Samegrelo	6.7	5.0	477
Imereti	8.3	9.6	804
Mtskheta-Mtianeti	12.4	10.1	391
Racha-Svaneti	7.1	14.8	452
Education Level			
Secondary incomplete or less	9.4	10.0	1,321
Secondary complete	9.7	8.6	1,562
Technicum	8.2	9.1	898
University/postgraduate	6.3	7.0	2,487
Wealth Quintile			
Lowest	9.6	10.9	1,088
Second	9.4	9.3	1,378
Middle	7.8	7.9	1,406
Fourth	9.2	9.1	1,035
Highest	5.7	6.1	1,361
Ethnicity			
Georgian	7.5	7.8	5,467
Azeri	12.7	13.7	276
Armenian	10.6	8.3	363
Other	15.0	17.2	162

* Excludes 24 women who reported that they did not grow up with their parents.

Table 18.1.2 Percentage of Women Aged 15–44 Who Experienced Verbal, Physical, or Sexual Abuse in Lifetime or in Past 12 Months According to Whether They Witnessed Parental Violence or Experienced Physical Abuse Prior to Age 15. Reproductive Health Survey: Georgia 2010

Characteristic	Lifetime IPV		IPV During Last 12 Months	
	Verbal Abuse	Physical and/or Sexual Abuse	Verbal Abuse	Physical and/or Sexual Abuse
Total	14.8	5.0	8.4	1.6
Parental Violence				
Yes	37.3	13.5	21.6	5.2
No	12.6	4.2	7.2	1.3
Experienced Abuse				
Yes	39.0	12.0	23.3	4.3
No	12.6	4.4	7.1	1.4
No. of Cases	4,487	4,487	4,487	4,487

Table 18.2 Percentage of Ever Married Women Aged 15–44 Who Reported Intimate Partner Violence (IPV) in Their Lifetime and Percentage Who Reported IPV in the Last Year by Type of Abuse and by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Lifetime IPV			IPV During the Last 12 Months			No. of Cases
	Verbal Abuse	Physical Abuse	Sexual Abuse	Verbal Abuse	Physical Abuse	Sexual Abuse	
Total	14.8	4.5	1.7	8.4	1.4	0.5	4,487
Residence							
Urban	13.9	4.5	2.0	7.0	1.4	0.4	2,044
Rural	15.7	4.5	1.4	10.0	1.4	0.5	2,443
Residence							
Tbilisi	13.8	4.8	2.1	6.6	2.3	0.5	940
Other Urban	14.0	4.2	2.0	7.3	0.6	0.4	1,104
Rural	15.7	4.5	1.4	10.0	1.4	0.5	2,443
Age Group							
15–19	7.9	5.0	0.0	7.3	5.0	0.0	130
20–24	9.0	2.6	1.0	5.7	1.7	0.5	639
25–29	13.1	2.7	1.3	8.9	1.1	0.6	909
30–34	15.6	4.7	2.2	8.0	1.4	0.4	1,036
35–39	18.6	6.9	2.1	9.9	1.5	0.2	944
40–44	16.9	4.9	2.2	9.0	0.8	0.8	829
Marital Status							
Currently married/in union	11.4	2.4	1.0	8.4	1.0	0.4	4,098
Not currently married/in union	45.8	23.5	8.1	8.4	4.9	0.9	389
Number of Living Children							
0	12.9	6.1	2.8	5.8	1.9	0.5	472
1	13.6	5.2	1.9	6.4	1.6	0.3	1,285
2	15.8	3.7	1.2	10.7	1.1	0.5	2,069
3	13.5	3.2	2.0	6.7	1.2	0.6	539
4 or more	23.3	10.3	3.8	11.3	3.9	1.5	122
Education Level							
Secondary incomplete or less	20.7	6.4	2.0	12.8	2.2	0.2	801
Secondary complete	15.8	4.7	1.8	10.3	2.2	0.8	1,196
Technicum/university	12.4	3.8	1.6	6.2	0.8	0.4	2,490
Socioeconomic Status							
Low	23.9	8.2	2.6	14.4	2.5	0.6	462
Middle	15.0	4.7	1.7	8.2	1.3	0.5	2,011
High	12.7	3.5	1.6	7.4	1.2	0.4	2,014
Wealth Quintile							
Lowest	20.9	6.5	1.9	13.0	1.7	0.4	787
Second	14.9	4.2	1.6	10.0	1.4	0.6	1,032
Middle	13.0	3.9	1.3	7.1	0.8	0.3	1,017
Fourth	13.5	4.8	1.8	6.9	1.8	0.5	710
Highest	13.4	3.8	2.0	6.6	1.5	0.5	941
Ethnicity							
Georgian	13.4	3.9	1.7	7.7	1.2	0.5	3,854
Azeri	29.6	8.9	2.3	18.1	2.5	0.4	234
Armenian	13.2	6.0	1.9	5.7	1.1	0.0	269
Other	26.8	10.3	2.3	15.2	4.7	0.0	130

Table 18.3.1 Percentage of Ever-Married Women Aged 15–44 Who Were Physically Abused by an Intimate Partner and Sought Help by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Ever Sought Help	Source of Help						No. of Cases
		Respondent's Family	Friend	Husband's Family	Police	Health Provider	Legal Adviser	
Total	71.2	54.4	42.3	19.3	5.4	3.4	2.3	222
Residence								
Urban	76.3	55.3	48.3	19.7	5.1	3.5	2.8	100
Rural	65.7	53.5	35.9	18.8	5.7	3.3	1.7	122
Residence								
Tbilisi	73.3	55.0	48.3	21.7	5.0	5.0	3.3	46
Other Urban	79.4	55.6	48.2	17.5	5.3	1.8	2.2	54
Rural	65.7	53.5	35.9	18.8	5.7	3.3	1.7	122
Age Group								
15–24	82.4	54.6	52.5	22.4	0.0	0.0	0.0	18
25–34	63.7	48.4	36.8	21.8	5.0	3.2	1.4	84
35–44	73.4	58.4	43.5	16.8	7.0	4.4	3.4	120
Marital Status								
Currently married/in union	64.8	48.7	37.4	19.3	5.3	5.9	3.4	129
Not currently married/in union	77.9	60.3	47.5	19.2	5.5	0.8	1.1	93
Number of Living Children								
0–1	79.7	63.7	43.3	24.8	6.4	2.4	3.1	94
2	65.9	46.8	44.5	15.0	5.2	5.1	1.3	86
3+	59.1	45.0	34.9	13.0	3.0	2.4	2.0	42
Education Level								
Secondary complete or less	73.5	59.4	42.6	17.7	7.7	4.7	3.5	120
Technicum/university	68.7	49.0	42.1	21.0	2.9	2.0	0.9	102
Socioeconomic Status								
Low	71.6	58.9	40.1	29.4	10.3	3.2	1.9	45
Medium/High	71.2	53.5	42.8	17.2	4.4	3.4	2.3	177
Wealth Quintile								
Lowest	70.6	57.9	40.7	22.6	7.0	2.6	0.0	57
Second	60.7	51.7	26.6	14.9	7.1	3.7	2.6	45
Middle	74.7	58.3	37.3	23.0	0.0	2.1	0.0	47
Fourth	83.2	62.0	55.0	18.9	6.2	6.9	4.1	36
Highest	67.6	43.9	50.7	17.0	6.5	2.0	4.5	37
Ethnicity								
Georgian	71.4	52.8	45.0	18.6	5.7	4.5	3.0	168
Other	70.8	59.3	34.4	21.4	4.7	0.0	0.0	54

Table 18.3.2

Most Commonly Cited Reasons for Not Seeking
Formal Help Among Ever-Married Women Aged
15-44 Who Reported Lifetime Physical Abuse
Reproductive Health Survey: Georgia 2010

Main Reason You Have Never Sought Any Medical or Legal Help	No. of Cases	Total
Embarrassed	61	28.4
No use/would not do any good	47	23.0
Bring bad name to family	23	9.8
Injury not very severe	20	10.4
Afraid of more beatings/being punished	12	7.6
Afraid of divorce/end of relationship	9	6.3
Did not know where to seek help	7	3.1
Violence is normal/no need to complain	4	2.1
Afraid of losing the children	2	1.2
Thought would not be taken seriously/not believed/laughed at	1	0.5
Thought she would be blamed	1	0.5
Other	7	3.5
Don't know/Refused to answer	6	3.7
No. of Cases	200	100.0

Table 18.4.1 Percentage of Ever Married Women Aged 15–44 Who Reported Specific Gender Norms in the Household By Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Gender Norms						No. of Cases
	Husband Usually Shares Household Chores	Husband Wants to Have the Final Say	Husband Insists on Knowing Where Wife/Partner is at All Times	Husband Gets Angry If Wife/Partner Speaks With Another Man	Husband Tries to Limit Wife/Partner's Contact with Family and Friends	Husband Often Suspicious That Wife/Partner is Unfaithful	
Total	71.5	49.6	31.8	6.3	4.9	4.2	4,487
Residence							
Urban	72.7	46.1	29.7	7.4	5.2	5.1	2,044
Rural	70.4	53.2	34.1	5.1	4.6	3.2	2,443
Residence							
Tbilisi	70.4	40.6	31.6	9.4	6.0	6.2	940
Other Urban	74.9	51.5	27.9	5.5	4.4	3.9	1,104
Rural	70.4	53.2	34.1	5.1	4.6	3.2	2,443
Age Group							
15–24	74.4	50.1	36.6	7.6	5.3	5.2	769
25–34	72.2	48.8	32.6	6.2	4.9	3.4	1,945
35–44	69.7	50.2	29.1	5.7	4.8	4.5	1,773
Marital Status							
Currently married/in union	74.8	48.5	29.8	3.8	2.7	2.2	4,098
Not currently married/in union	41.4	59.7	50.6	29.0	24.7	22.3	389
Number of Living Children							
0–1	69.3	45.6	33.3	8.8	6.3	6.0	1,757
2	72.2	51.2	31.2	4.6	4.0	2.8	2,069
3 or more	75.4	55.1	30.0	4.5	4.1	3.4	661
Education Level							
Secondary complete or less	68.7	54.5	36.4	7.1	6.6	4.7	1,997
Technicum/university	73.8	45.7	28.3	5.6	3.6	3.7	2,490
Socioeconomic Status							
Low	63.4	54.0	35.7	8.7	5.9	6.7	462
Medium/High	72.5	49.1	31.4	6.0	4.8	3.9	4,025
Wealth Quintile							
Lowest	69.1	56.2	38.9	6.0	5.0	3.9	787
Second	68.8	54.2	35.0	5.8	5.7	3.5	1,032
Middle	72.1	51.6	28.5	4.0	3.3	2.8	1,017
Fourth	74.6	46.5	30.6	6.9	6.2	4.7	710
Highest	72.6	42.3	28.7	8.4	4.8	5.8	941
Ethnicity							
Georgian	73.5	47.8	30.0	5.3	4.0	3.5	3,854
Other	59.7	60.3	43.0	12.0	10.6	8.1	633

Table 18.4.2 Prevalence of Lifetime Physical or Sexual Abuse
by Gender Equity Status of the Household
Among Ever-Married Women Aged 15-44
Reproductive Health Survey: Georgia 2010

Gender Equity Status	Verbal Abuse %	Physical Abuse %	Sexual Abuse %	No. of Cases
Total	14.8	4.5	1.7	4,487
Low Gender Equity Status	35.9	16.5	5.9	907
Average Gender Equity Status	9.5	1.6	0.8	2,745
High Gender Equity Status	8.0	0.5	0.1	835

Table 18.4.3 Percentage of Ever Married Women Aged 15–44 by Whether
They Had Ever Experienced Physical or Sexual Intimate Partner
Violence in Their Lifetime and Their Agreement with Different
Reasons That May Justify Wife-Beating
Reproductive Health Survey: Georgia, 2010

Agreement with a Specific Reason	Total	Physical or Sexual Intimate Partner Violence in Lifetime	
		Never Abused	Ever Abused
The husband finds out that the wife has been unfaithful	18.7	18.6	21.0
The wife neglects the children	5.2	4.8	11.5
The wife argues with her husband	3.5	3.4	6.7
The wife asks her husband whether he has other girlfriends	2.5	2.4	4.2
The wife goes out without telling her husband	1.8	1.7	4.5
The wife refuses to have sex with her husband	1.6	1.5	4.6
cooking	1.3	1.2	4.4
Agreement with any reason	19.3	19.1	22.6
No. of Cases	4,487	4,265	222

ANNEX A: Institutional Participation

National Reproductive Health Council

Sandra Elisabeth Roelofs, Chairperson

Georgia Ministry of Labor, Health, and Social Affairs (MoLHSA)

Zurab Tchiaberashvili, Minister

Andrew Urushadze, Former Minister

Michael Dolidze, Deputy Minister

Rusudan Rukhadze, Head of the Healthcare Department

National Center for Disease Control and Public Health (NCDC)

Nata Avaliani, Director General

Maia Butsashvili, Deputy Director

George Kandelaki, Deputy Director

Paata Imnadze, Head of Science Board

Neli Chakvetadze, Academic Secretary

Khatuna Zakhashvili, Head of Communicable Diseases Division

Lela Sturua, Head of Noncommunicable Diseases Division

Marina Shakh-Nazarova, Chief Specialist

Nana Mebonia, Chief Specialist

Zhordania Institute of Human Reproduction

Giorgi Tsagareishvili, Head, Department of In-vitro Fertilization

Jenaro Kristesashvili, Head, Reproductive Function Formation Department

Georgian Association of Obstetricians and Gynecologists

Tengiz Asatiani, Vice President

Zaza Bokhua, Secretary General

Institute of Demography and Sociology

Giorgi Tsuladze, Head of Department

National Medical Center after Gudushauri

Zaza Sinauridze, Director General

John Snow Institute, Inc (JSI)

Nino Berdzuli, Senior Technical Advisor for Reproductive Health

Kartlos Kankadze, Country Director

Curatio International Foundation

Ketevan Chkhatarashvili, President

USAID/Georgia

Jonathan Conley, Mission Director

Jeri Dible, Director of Health and Social Development

Tamara Sirbiladze, Project Officer for GERHS10

Nana Chkonia, Administrative Officer

UNFPA/Georgia

Zahidul Huque, UNFPA Country Director for Armenia, Georgia and Azerbaijan and the Representative in Turkey

Tamar Khomasuridze, Assistant Representative

Lela Bakradze, Program Analyst

Marina Tsintsadze, Admin/Finance Assistant

UNICEF/Georgia

Roeland Monasch, UNICEF Representative in Georgia

Tinatin Baum, Social Policy Specialist

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

Florina Serbanescu, Survey Principal Investigator

Vasili Egnatashvili, Survey Consultant

Mary Goodwin, Epidemiologist

Paul Stupp, Sampling Statistician (Demographer)

Danielle Suchdev, Public Health Analyst (ORISE)

Alicia Ruiz, System Programmer (SAIC)

Fernando Carlosama, System Programmer (SAIC)

Jose Luis Carlosama, System Programmer (McKing Corp.)

Leo Morris, Survey Consultant (SAIC)

ANNEX B: Field and Data Entry Personnel

Field Coordinators:

Khatuna Zakhashvili

Marina Shakhnazarova

Team Supervisors:

Olga Tarkhan-Mouravi (Team I)

Nato Tsereteli (Team II)

Tea Niniashvili (Team III)

Dali Trapaidze (Team IV)

Khatuna Aladashvili (Team V)

Rusudan Etsadashvili (Team VI)

Sopo Datukishvili (Team VII)

Ia Kochiashvili (Team VIII)

Team Interviewers:

Team I

Leli Urushadze

Rusudan Chumburidze

Natalia Tskipurishvili

Lela Sabadze

Ana Nemsadze

Team V

Marika Khatashvili

Mariam Natsvlishvili

Keti Sanadze

Nana Gabriadze

Tina Gabrichidze

Eka Chubabria

Team II

Nino Shubladze

Tamila Lemonjava

Sopo Dolbadze

Nona Papukashvili

Eka Nodia

Team VI

Rusudan Chlikadze

Lia Sanodze

Maka Tevadze

Eliso Iobashvili

Ketevan Napireli

Team III

Eka Tsertsvadze

Lia Skhirtladze

Tea Gognadze

Tamar Dzodzuashvili

Irma Iremashvili

Team VII

Marina Chubinidze

Mariam Kuparadze

Eka Khmaladze

Lali Kudukhova

Shorena Komladze

Team Interviewers:

Team IV

Marina Baidauri

Marina Tsereteli

Nino Tsintsadze

Ketevan Galdavadze

Pikria Shavreshiani

Team VIII

Marina Lashkarashvili

Anna Kasradze

Khatuna Lomashvili

Khatuna Kutateladze

Sopo Guramishvili

Data Entry Supervisors:

Irina Kocharova

Konstantin Kazanjian

Data Entry Operators:

Natela Gognadze

Gulnazi Lomsadze

Liana Khuchua

Tamar Pilauri

Larisa Sedykh

Susanna Shakhbudagian

Irina Tkhinvaleli

Tsimi Chabukashvili-Chanadiri

References

- Alan Guttmacher Institute (1999). *Sharing Responsibility: Women, Society and Abortion Worldwide*. New York, NY: The Alan Guttmacher Institute.
- Aleshina N and Redmond G (2005). How high is infant mortality in Central and Eastern Europe and the Commonwealth of Independent States? *Population Studies*; 59:39–54.
- Ezzati M, Lopez AD, Rodgers A, Murray CJ, editors (2004). *Comparative Quantification of Health risks: Global and Regional Burden of Disease Due to Selected Major Risk Factors*. 959–1108. Geneva, Switzerland, WHO.
- Black RE (2010). Global, Regional, and National Causes of Child Mortality in 2008: a Systematic Analysis. *The Lancet* 5; 375(9730):1969–87.
- Bongaarts J (1991). The KAP-Gap and the Unmet Need for Contraception. *Population and Development Review*; 17:293–313.
- Brown SS, Eisenberg L, editors (1995). *The Best Intentions. Unintended Pregnancy and the Well-Being of Children and Families*. Washington, DC (USA): National Academy Press.
- Cates W, Jr. (1982). Legal abortion: The public health record. *Science*; 215(4540):1586-1590
- Centers for Disease Control and Prevention and ORC Macro (2003). *Reproductive, Maternal, and Child Health in Eastern Europe and Eurasia: A Comparative Report*. Atlanta, GA (USA): Department of Health and Human Services and Claverton, MD (USA): ORC Macro.
- Chanturidze T, Ugulava T, Durán A, Ensor T, Richardson E (2009). *Georgia: Health System Review*. *Health Systems in Transition*; 11(8):1–116.
- Chitashvili M, Javakhishvili N, Arutiunov L, Tsuladze L, Chachanidze S (2010). *National Research on Domestic Violence Against Women in Georgia. Final Report*. Tbilisi, Georgia. UNFPA.
- CoReform Project (2005). *Review and Analysis of Reproductive Health Legislation and Policy in Georgia*. Tbilisi, Georgia, USAID.
- DiFranza JR, Lew RA (1996). Morbidity and Mortality Associated with the Use of Tobacco Products by Other People. *Pediatrics*; 97:560–568.
- EngenderHealth (2002). *Contraceptive Sterilization: Global Issues and Trends*. Available at <http://www.engenderhealth.org/pubs/family-planning/contraceptive-sterilization-factbook.php>
- Finer LB and Zolna MR (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006. *Contraception*; doi: 10.1016/j.contraception.2011.07.013.
- Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM (2010). *GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10* [Internet]. Lyon, France: International Agency for Research on Cancer. Available from: <http://globocan.iarc.fr>.
See also Georgian European Policy and Legal Advice Centre (GEPLAC) (2008). *Georgian Economic Trends Quarterly Review*. October 2008. Available at: <http://www.geplac.org/eng/trends.php>
- Georgian Ministry of Health, Labor and Social Affairs, *Georgia National Reproductive Health Policy*, 2006, Tbilisi, Georgia: Government of Georgia, 2007.
- Goskomstat, USSR (1990). *Demographic Yearbook of the USSR, 1990*. Moscow: Goskomstat USSR.
- Government of Georgia (1997). *Law of Georgia of 10 December 1997 on Health Care*. Tbilisi, Georgia: Govern-

ment of Georgia.

Government of Georgia (2001). Law of Georgia on Medical Activities of 08 June 2001. Tbilisi, Georgia: Government of Georgia.

Government of Georgia (2002). Decree #31: Measures on the Improvement of the Registration System in the Demography Statistics. Tbilisi, Georgia: Government of Georgia.

Government of Georgia (2006). Law on Prevention of Domestic Violence, Protection and Support of Domestic Violence Victims, June 2006. Tbilisi, Georgia: Government of Georgia.

Gwatkin, D.R., S. Rutstein, K. Johnson, R.P. Pande, and A. Wagstaff. 2000. Socio-economic differences in health, nutrition and poverty. HNP/Poverty Thematic Group of the World Bank. Washington D.C.: The World Bank.

Hatcher RA, Trussel J, Stewart F, Nelson AL, Cates W, Stewart GK, Guest F, Kowal D (2004). The Essentials of Contraception: Efficacy, Safety, and Personal Considerations. In: Contraceptive Technology, 18th edition. New York, NY (USA): Ardent Media.

Henshaw SK (1998). Unintended Pregnancy in the United States. Family Planning Perspectives; 30(1):24–29 and 46.

Hotaling G and Sugarman DB (1986). An Analysis of Risk Makers in Husband to Wife Violence: The Current State of Knowledge Violence and Victims Vol 1, No. 2:101–124.

International Planned Parenthood Federation (IPPF)(2007). Abortion Legislation in Europe. Available at <http://www.ippfen.org/>

JSI Research and Training Institute, Inc (2009). Healthy Women in Georgia. Making a Difference. Tbilisi, Georgia, JSI.

Kesmodel U, Wisborg K, Olsen SF, Henriksen TB, Sechler NJ (2002). Moderate Alcohol Intake in Pregnancy and the Risk of Spontaneous Abortion. Alcohol & Alcoholism; 37(1):87–92.

Khomasuridze A, Kristesashvili J, and Tsuladze G (2005). Male Reproductive Health Survey, Tbilisi, Georgia: United Nations Population Fund (UNFPA).

Kristesashvili J, and Tsuladze G (2002). Adolescents' Reproductive Health Survey, Tbilisi, Georgia: United Nations Population Fund (UNFPA).

Kristesashvili J, Surmanidze L, et al. (2009). Adolescents' Reproductive Health Survey in Georgia, Tbilisi, Georgia: EU, UNFPA, EPF.

Kristesashvili, J, and Zardiashvili P (2009). "Comparative Analysis of Results of Adolescent Reproductive Health Surveys Conducted in Armenia, Azerbaijan and Georgia", EU/UNFPA co-funded project "Reproductive Health Initiative for Youth in the South Caucasus" (RHIYC), Tbilisi.

Lawn JE, Cousens S, Zupan J (2005). 4 Million Neonatal Deaths: When? Where? Why? The Lancet; 365 (9462):891–900.

Mattias Öberg, Maritta S Jaakkola, Alistair Woodward, Armando Peruga, Annette Prüss-Ustün (2011). World-wide Burden of Disease from Exposure to Second-Hand Smoke: A Retrospective Analysis of Data From 192 Countries. The Lancet; 377(9760):139–46.

MEASURE DHS, Demographic and Health Survey in Albania, Armenia, Azerbaijan Moldova, and Ukraine. 2005–2010, Calverton, MD, USA
Available at <http://www.measuredhs.com/pubs>

Miller WB (1994). Reproductive Decisions: How We Make Them and How They Make Us. In: Severy LJ, editor, *Advances in Population*, Vol 2. London: Jessica Kingsley Publishers: 1–27.

Moreau C., Cleland K., Trussel J. (2007). Contraceptive discontinuation attributed to method dissatisfaction in the United States. *Contraception*, 76(4), 267–72.

Morris L, 2000. History and Current Status of Reproductive Health Surveys at CDC. *American Journal of Preventive Medicine*; 19(1 Suppl):31–4.

Naimi TS, Brewer B, Mokdad A, Serdula M, Denny C, Marks J (2003). Binge Drinking among U.S. Adults. *JAMA*; 289:70–5.

Popov AA, David HP (1999). Russian Federation and USSR Successor States: Sex and Society. In: *From Abortion to Contraception: A Resource to Public Policies and Reproductive Behaviors in Central and Eastern Europe from 1917 to the Present* (David HP, ed.). Westport, CT: Greenwood Press.

Rahman A, Katzive L, Henshaw SL. 1998. A Global Review of Laws on Induced Abortion, 1985–1997. *International Family Planning Perspectives*; 24(2):56–64.

Rossier C (2003). Estimating Induced Abortion Rates: a Review. *Studies in Family Planning*; 34(2):87–102.

Sakvarelidze L., 2010. Health and Health Care Georgia 2009: Statistical Yearbook. Georgian National Center for Disease Control and Centers for Disease Control. Tbilisi, Georgia, NCDC.

Serbanescu F, Morris L, Nutsubidze N, Imnadze P, Shakhnazarova M (2001). Reproductive Health Survey, Georgia, 1999–2000. Final Report. Atlanta, GA (USA): Georgian National Center for Disease Control and Centers for Disease Control and Prevention. Atlanta, GA, USA.

Serbanescu F and Morris L (2003). Background, in: Morris L and Sullivan JM, eds., *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*, Atlanta, GA, USA: CDC and ORC Macro, 1–11.

Serbanescu F, Imnadze P, Bokhua Z, Nutsubidze N, Jackson DB, Morris L (2007). Reproductive Health Survey, Georgia, 2005. Final Report. Georgian National Center for Disease Control and Centers for Disease Control and Prevention. Atlanta, GA, USA.

Serbanescu F, Tefft M, Shakhnazarova M, Williams D, Berdzuli N, Berg C (2009). Reproductive Age Mortality Study, Georgia, 2008 — Part II: Maternal Mortality, Atlanta, GA, USA: Georgian National Center for Disease Control, JSI Research & Training Institute, Inc (JSI) and CDC. Atlanta, Georgia, USA.

State Department for Statistics (2003). Population of Georgia in 2002: Statistical Abstract. Tbilisi, Georgia: State Department for Statistics.

State Department for Statistics (2010). Key Population and Health Statistics. Available at: <http://statistics.ge>

Straus MA (1979). Measuring Intra-family Conflict and Violence: The Conflict Tactics Scales. *Journal of Marriage and the Family*, 41:75–88.

Tietze C and Henshaw S (1986). *Induced Abortion, a World Review*. New York: The Alan Guttmacher Institute, 1986, Chapter 8.

Tsertsvadze G, Bokhua Z, Tsuladze G (2010). Doctors' Attitudes Towards Family Planning Issues. Tbilisi, Georgia, UNFPA.

Ulizzi L, Zonta LA (2002). Sex Differential Patterns in Perinatal Deaths in Italy. *Human Biology*; 74: 879–88.

UNECE (United Nations Economic Commission for Europe (2002). *Dynamics of Fertility and Partnership in Eu-*

rope: Insights and Lessons from Comparative Research (Volume I). New York, USA and Geneva, Switzerland: United Nations.

UNICEF (2001). Progress since the World Summit for Children: A Statistical Review. New York, NY: UNICEF. Available at: <http://www.unicef.org/pubsgen/>

UNICEF (2005). The State of the World's Children 2006: Excluded and Invisible. New York, NY: UNICEF. Available at: <http://www.unicef.org/pubsgen/>

UNICEF (2009) State of the World's Children 2009: Maternal and Newborn Care. New York, NY: UNICEF. Available at: <http://www.unicef.org/pubsgen/>

UNICEF (2010) Multiple Indicators Cluster Surveys-Round 4 (MICS4). Available at: <http://www.childinfo.org/mics4.html>

UNICEF (2011) State of the World's Children 2011: Maternal and Newborn Care. New York, NY: UNICEF. Available at: <http://www.unicef.org/pubsgen/>

U.S. Agency for International Development (USAID) Georgia, 2009. Tuberculosis Profile. Tbilisi, Georgia, USAID.

U.S. Department of Health and Human Services (DHHS) (2006). The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Rockville, MD: DHHS and CDC.

U.S. Department of Health and Human Services (2010). How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: DHHS and CDC.

USSR Ministry of Health (1982). Order No. 234 of March 1982.

USSR Ministry of Health (1987). Order No. 757 of June 5, 1987 and Order No. 1342 of December 1987.

USSR Ministry of Health (1990). Order No. 484 of December 14, 1990.

Westoff CF (1976). The Decline of Unplanned Births in the United States. *Science*; 191:38–41.

WHO (1991). Indicators for Assessing Breast Feeding Practices (WHO/CDD/SER/91.14). Geneva, Switzerland: World Health Organization.

WHO (2002). WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model (WHO/RHR/01.30). Geneva, Switzerland: World Health Organization.

WHO Framework Convention on Tobacco Control (2003). WHO Press. Geneva, Switzerland. Available at <http://whqlibdoc.who.int/publications/2003/9241591013.pdf>

WHO and Center for Medical Statistics and Information [CMSI], (2003). Comparison of Completeness of Data Collected by Two Systems; Evaluating Cause of Death Certification by Physician and ICD-10 Coding of Underlying Causes of Death by SDS Coding Staff. Tbilisi, Georgia: WHO and CMSI.

WHO (2006). Global strategy for the prevention and control of sexually transmitted infections: 2006-2015.

WHO (2008). Global Burden of Disease Report, 2004 update. Available at: http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf

WHO (2010). Sexually Transmitted Infections. Fact sheet N°110.

WHO (2010a). Trends in Maternal Mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and

the World Bank. Geneva, Switzerland: World Health Organization.

WHO (2010b). Global Tuberculosis Control. Geneva, Switzerland: World Health Organization.

WHO Regional Office for Europe (2011a). European Health for All Database (HFA-DB)(online version). Copenhagen, Denmark: WHO. Available at <http://www.euro.who.int/hfadb>.

WHO (2011b). World Health Statistics 2011. Available at: www.who.int/entity/whosis/whostat/EN_WHS2011_Full.pdf

Wilsnack SC, Klassen AD, Wilsnack RW (1984). Drinking and Reproductive Dysfunction among Women in a 1981 National Survey. *Alcohol, Clinical and Experimental Research*; 8(5):451–458.

You D, Wardlaw T, Salama P, Jones G (2010). Levels and Trends in Under-5 Mortality, 1990–2008. *The Lancet*; 375: 100–03.

