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Final Report

REPRODUCTIVE HEALTH SURVEY
AZERBAIJAN, 2001

FINAL REPORT

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TABLE OF CONTENTS

Preface

During the 10 years since regaining its independence, Azerbaijan has faced considerable difficulties resolving some of the problems that linger from the previous system and grappling with the challenges of the transition period. The war—which caused the largest refugee and internally displaced population in the region— and ethnic, social, and economic problems have hindered reconstruction of governmental and administrative systems, including the health sector.
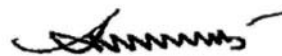
Reforms in public health care first require improvement of the health information system, particularly the statistics concerning maternal and child health. Population-based nationwide health surveys serve as a significant source of information in this field and assist in clarifying several health-related issues not covered by the official statistics.

This report reflects preliminary results of the first nationwide reproductive health survey conducted among Azeri women. The research was funded by the U.S. Agency for International Development, the United Nations Population Fund, and the United Nations High Commissioner for Refugees, through Mercy Corps, and was carried out by the Adventist Development and Relief Agency Azerbaijan with the technical assistance of the U.S. Centers for Disease Control and Prevention.

The research provides data on the reproductive health behavior of Azeri women as well as information on their fertility, planning status of pregnancies, abortions, use of women's health services, contraceptive knowledge and attitudes, and knowledge about STI and AIDS transmission and prevention. The survey results assist in revealing high-risk groups and provide a focus for future reproductive health programs.

I believe that the results of the survey will be useful for monitoring and evaluating the current reproductive health and family planning programs being implemented in the country as well as for planning effective new studies and projects in this field.

Academician Ali Insanov Minister
of Health Azerbaijan Republic

Acknowledgments

EXECUTIVE SUMMARY

With the dissolution of the Soviet Union at the beginning of the 1990s, Azerbaijan regained independence and moved toward a democratic society with a free market economy. While dealing with the difficulties of developing a new functional autonomous government, the nation also faced war with its neighbor and former Soviet Republic, Armenia, over the region of Nagorno-Karabakh. A large number of Azeris have been displaced by Armenia's ongoing occupation of 20% of the country. Azerbaijan has had to deal with the health impact of war, displacement, incoming refugees, and economic disruption at the same time that it has lost the resources of the large Soviet health system. The health of women has suffered under these recent circumstances. The 2001 Azerbaijan Reproductive Health Survey (AZRHS01), the first population-based national survey of its kind conducted in Azerbaijan, documented significantly poorer reproductive health indicators than those in other countries of Eastern Europe and the former Soviet Union.

The AZRHS01, conducted by the Adventist Development and Relief Agency (ADRA), Baku, with technical assistance from the Division of Reproductive Health, Centers for Disease Control and Prevention, Atlanta (DRH/CDC), employed a national probability sample of 7,668 women aged 15-44, including an oversample of conflict-affected areas with larger concentrations of internally displaced persons and refugees (IDP/Rs). The response rate was 93%. By collecting information from the general population as well as from those who are internally displaced, survey data can document specific needs associated with displacement, account for differences in reproductive health status between the two populations, and provide a useful tool for evaluating reproductive health programs and activities that specifically address displaced women and children.

The survey was designed to collect reproductive health information from a representative sample of reproductive-age women throughout Azerbaijan. The questionnaire covered a wide variety of topics related to reproductive health for all women regardless of marital status and included questions on family life education and sexual behavior for women aged 15-24 as well as questions on the nutritional status of women and their children.

Almost three out of five women (59%) who completed interviews were married or in a consensual union. About a quarter of the women had more than a secondary education, and just below 25% had not completed secondary school. Ninety percent of the survey population was Azeri; 4% were Talish; and the remainder were of other ethnic groups, including Lezgi, Tat, Avar and Russian. Azeri was the language spoken in 90% of households, followed by Russian (4%), Talish, (3%), and others (4%). Average household size was 4.9 persons. Ninety-one percent of households owned a television

set, but only 38% had a flush toilet, and a little more than one-third (35%) had electricity 24 hours a day.

Marriage and Fertility

Survey results show that Azeri women marry in their early 20s (the median age at first union was 22.3 years), report having first sexual intercourse at marriage, and have their first child soon after marriage (median age at first birth was 23.7 years). The age at first union is falling, a situation that has potential implications for future fertility patterns. As with women in other countries of the region, Azeri women initiate and complete childbearing at an early age and have a desired family size of two children. The highest fertility levels were among 20- to 24-year-old women and 25- to 29-year-old women, accounting for 36% and 32%, respectively of the total fertility rate. Compared with its Caucasus neighbors, Azerbaijan exhibits the lowest adolescent (age 15-19) fertility but the highest fertility rates for 20- to 24-year-old and 25- to 29-year-old women.

Pregnancy Intention Status

Fewer than half of the women who had been pregnant in the past 5 years (42%) reported that their most recent pregnancy was intended at the time of conception; 9% reported it as mistimed (i.e., wanted it at a later time); and 48% reported it as unwanted. Thus, 57% of women reported that their last pregnancy was unintended, and the majority of those (84%) reported it as unwanted rather than mistimed. The AZRHS01 found that the total induced abortion rate was 3.2 abortions per woman, 1.5 times the total fertility rate of 2.1 births per woman. Although abortions are legal in Azerbaijan and most abortions reported in the survey were performed in clinical settings, a substantial proportion are not reflected in the official statistics. The decreased ability of the reproductive health system to document the true magnitude of abortion levels is probably due to the underreporting of abortions performed in the private sector, inherent problems related to data registration in state-run medical facilities, and the persistence of abortion performed outside clinical settings. More than one in three women (35%) reported having had at least one abortion. Among those, 65% have had more than one abortion. Almost all abortions in the past 5 years were performed in a hospital or government clinic (70% and 26%, respectively); 3% took place outside of a medical facility, and only 1% were performed in a private clinic. Forty percent of abortions were performed in the first 6 weeks of gestation by vacuum aspiration (i.e., mini-abortions). One in five women reported early or late complications as a result of their abortions.

Among married women (legal or consensual marriages), 70% reported that they did not want to have

any more children, including 77% of those with two living children, 88% of those with three living children, and 93% of those with four or more living children.

Prenatal Care and Breast-Feeding

Just over two-thirds of Azeri women (70%) who gave birth in the past 5 years had received some prenatal care; of those, about two-thirds initiated their prenatal care in the first trimester. Pregnant women who received any prenatal care averaged 4.3 prenatal visits. According to the adequacy of Prenatal Care Index (Kotelchuck Index). Only 6% of births in the previous 5 years had received adequate care. The principal source of prenatal care was a women's consultation clinic (46%), followed by maternity hospital (36%) or a village hospital (13%). Two-thirds of women who attended prenatal clinics received some counseling about nutrition during pregnancy; about half of the women surveyed received information about breast-feeding (55%), delivery (54%), early signs of pregnancy complications (49%), and postnatal care (47%), but only two in five (38%) were counseled on the negative effects of smoking or alcohol. The majority of women with births in the past 5 years reported having their blood pressure measured as a part of routine prenatal care (82%); of those, one-fifth (19%) were identified as having high blood pressure. One-fourth of women reported pregnancy complications that required medical attention, including 1% who required hospitalization for these complications. Three-fourths (76%) of births took place in maternities or hospitals; however, one in four births in the past 5 years occurred outside of a medical facility. The prevalence of Cesarean deliveries reported between 1996 and 2001 was only 3%. Postpartum care was substantially less utilized than prenatal care (25% vs. 70%). Almost two fifths (38%) of births in the past 5 years resulted in at least one postpartum complication. The total stillbirth rate was 21 per 1,000 births. Twelve percent of all live births weighed less than 2,500 g at birth, and 5% of births took place before the 37th week of gestation. Almost all children born in the past 5 years were breast-fed (95%). The mean duration of breast-feeding was 11.6 months, but full breast-feeding averaged only 3.3 months, including exclusive breast-feeding, which lasted less than 1 month, on average.

Nutrition

Data from the 1996 National Health and Nutrition Survey of the Internally Displaced and Resident Population of Azerbaijan allow comparison of the change in prevalence of chronic and acute malnutrition in young Azeri children between 1996 and 2001. The nutritional status of the IDP/R population was similar to that of the non-IDP/R population on all the indicators of the survey. The prevalence of low height for age, or *stunting,* which is considered evidence of chronic malnutrition,

was 13% among children under 5 years old. In general, the problem of low weight-for-height, an indicator of acute malnutrition, was no greater among children under age 5 than expected, although the rate among children under age 2 was more than 3 times greater than the rate for children aged 2-5 (4% vs. 1%). Low weight-for-age, an indicator of general malnutrition, was found in 7% of children aged 3-59 months. This value reflects the greater prevalence of chronic malnutrition because the rate of acute malnutrition is much lower. Hemoglobin samples revealed a 32% rate of anemia among children aged 12-59 months. Among mothers of children aged 3-59 months, overweight was more common than underweight (38% and 6%, respectively). The prevalence of anemia was 40% among mothers of children aged 3-59 months, and the prevalence among pregnant mothers was similar (38%).

Infant Mortality

Infant mortality rates were directly calculated from responses to survey questions on the following topics for each live birth: the date of occurrence, sex of the child, survival status and, for children who had died, the age at death. Survey data were used to calculate mortality levels among respondents' children in the following categories: infant mortality (deaths before the first birthday), child mortality (deaths between 12 and 59 completed months of age), and child-under-5 mortality (i.e., deaths before the 5th birthday). Infant mortality was further divided into two periods: neonatal (0-27 days) and postneonatal (28-364 days). The total infant mortality rate was 81 deaths per 1,000 live births. Neonatal and postneonatal mortality were 38 and 43 deaths per 1,000 live births. Child mortality was calculated as 11 deaths per 1,000 live births. The mortality rate for children under age 5 was found to be 92 per 1,000 live births.

Contraceptive Awareness and Use

Azeri women demonstrated a relatively high level of awareness of the existence of some family planning methods. Eighty-seven percent of Azeri women had heard about at least one contraceptive method, generally the IUD, condoms, or the pill (83%, 58%, and 53%, respectively). On average, they recognized fewer than three modern methods. For the most widely known modern contraceptive methods, however, respondents had a serious gap between their awareness of a method and knowledge of how that method is used; the gap ranged from 17 percentage points for condoms to 32 percentage points for the IUD. A gap of similar magnitude was obvious between respondents' awareness of a contraception method and knowledge of where the contraceptive could be obtained, ranging from 14 percentage points for the condom to 24 percentage points for the IUD. Correct knowledge about the effectiveness of modern methods was also generally lacking. No modern

method was recognized as being very effective by a majority of women, partly because a substantial number of women lacked knowledge about how modern methods are used. Even when women who had never heard of a specific method were excluded, no method with high effectiveness (e.g., tubal ligation or IUD) was correctly recognized as highly effective by a majority. The first source of information about contraception was a friend or colleague (40%), followed by a relative other than a parent (19%), a physician (16%), a partner or boyfriend (11%), and the mass media (4% audiovisual media, 3% print media, and 3% books). These findings explain, in part, the poor quality of contraceptive information, which is often acquired through rumors, and argue for increasing the public health efforts to educate women about the benefits of contraception through official channels (school, mass media, and health providers).

Nearly three out of four women stated that they want more information about contraception (including 85% of women aged 20-24 years). Of those women, 67% said that a gynecologist would be the most reliable source of information and 10% said that mass media would be the most reliable source of information.

Contraceptive prevalence among Azeri women in union is among the lowest of that reported by any former Soviet republics having survey data. Only 55% of married women reported using any method of contraception in the month preceding the interview, and less than a quarter of those women used a modern method, mainly the IUD (6%). Just 1% of married women reported that they have been surgically sterilized. Although more than 90% of women with three or more children did not want any more children, only 7% had had a surgical sterilization. The public medical sector was generally the largest source of modern contraceptive methods in Azerbaijan (54%), followed by commercial outlets (35%). Private clinics and NGOs are an emerging source of oral contraceptives.

Most women using non-supplied methods (withdrawal and the rhythm method) stated that the major factors influencing their decision not to use a modern method were fear of side effects (90%), lack of or little knowledge (71%), cost (61%) or lack of access (53%), and partner preference for traditional methods (49%). More than two-thirds of women using traditional methods consider their method of contraception to be of equal or greater effectiveness than modern methods; only 25% recognized that the IUD or the pill are more effective methods in preventing pregnancy than the method they currently use. Conversely, the one-year failure rates for withdrawal and calendar method users were 26% and 30% respectively, compared with 21% for condom users, 15% for pill users, and just 1% for IUD users. In addition to higher than average method-specific failure rates (excluding users of IUD), the survey data showed considerably high discontinuation rates: 44% to 58% for traditional methods, 67% for condom, and 82% for pill users. A total of 53% of married women were estimated to have an unmet need for modern contraceptive methods, the highest proportion among Eastern European and former Soviet Union countries. Most of these women (84%) need methods

to help them effectively limit fertility while fewer need contraception to postpone childbearing. About two of every three women who have used a modern method in the past 5 years were advised by a health care provider to use the current or most recent method, but only 40% of them received general information about other methods and only one-third were told about the method's effectiveness. Like other countries in the region, only a minority of Azeri women received family planning counseling (32%) or were offered contraceptive supplies (2%) pre- or postabortion. Only 27% of women who gave birth in the past 5 years received information during prenatal care about family planning after birth, and just 34% received such information as part of postpartum care.

Young Adults

In stark contrast to other Eastern European countries, virtually all sexually experienced young adult women had their first sexual experience after marriage (95%); only 1% of all young adult women reported any premarital sex. Almost none reported using any contraception at first intercourse; 85% cited a desire to become pregnant as their main reason for not using contraception. Use of contraception at most recent intercourse was reported by about one-third (36%) of sexually experienced young adults (women aged 15-24 years). Of those not using contraception, three out of five (62%) were either already pregnant (37%) or wanted to become pregnant (25%). Almost all (98%) sexually experienced young women reported only one sex partner in their lifetime. Almost no sexually experienced young women had ever used condoms. Only one in five sexually experienced young women had ever discussed condom use with a partner. Nearly half of women (47%) stated that they would feel protected against pregnancy if a partner suggested using a condom, and more than one-third (37%) would feel protected against sexually transmitted infections (STIs), but about one in five (18%—22%) reported negative feelings about such a suggestion.

Women's Health

Only about one in two (57%) sexually experienced women had ever been examined by a gynecologist during a routine exam, including 22% who had been examined in the previous 12 months, and 21% who had their last exam more than 3 years ago. Just 2% of sexually experienced women had ever had a pap smear, and less than 1% had had their most recent test in the past 3 years. Fewer than one in three sexually experienced women (30%) had ever heard of breast self-examination, and only 10% had ever performed one. More than one-third of all women had been told by a physician that they had anemia, and more than half of this group (57%) had anemia occurring outside of pregnancy. A quarter of all women (27%) and 42% of currently married women reported that they had been diagnosed with pelvic inflammatory disease. Because extramarital sexual relations

are relatively uncommon among Azeri women, possible explanations for the high PID rates include: poor hygienic conditions and inadequate standards of care in abortion facilities that may increase the risk of postabortion infections, lack of routine gynecologic visits, and lack or inadequate treatment of STIs, possible acquired from an unfaithful partner. Additionally, one-third (32%) of sexually experienced women reported abnormal vaginal discharge and 2% reported genital sores or ulcers in the past 12 months. Attendance at infertility clinics was reported by 12% of women in union; 7% reported current fecundity impairment. Cigarette smoking was almost nonexistent among Azeri women.

Family Life Education

Three in four Azeri women of reproductive age supported family life education in school, and a majority believed that school-based courses on reproductive biology ("how pregnancies occur"), contraception, and STIs should start by age 16 (73%, 62%, and 60%, respectively). Less than 20% of women favored school-based education on those topics before age 14. A total of 56% of young adult women had talked about at least one sex education topic with a parent before age 18; however, only about one in five young women (22%) talked to a parent about abstinence, one in ten about how pregnancies occur, less than 6% discussed HIV/AIDS or other STIs, and just 4% talked about contraception. Only 40% of young women had had at least one school-based course or class on family life education before age 18, and few had had courses related to HIV/AIDS (7%), other STIs (3%), or contraceptive methods (2%). Survey results indicate that the quality of teaching of family life education should be improved: only 8% of young adults knew the time during the menstrual cycle when conception is most likely to occur, one in four (24%) were aware that decreases the risk of pregnancy, and 58% knew that a women could become pregnant at first intercourse. Most young adults either did not know or had misinformation about the effectiveness of most methods of contraception.

HIV/AIDS and Other STIs

Most (74%) Azeri women have heard of HIV/AIDS, but only one in five women (21%) knew that an HIV/AIDS infection could be asymptomatic; just 1% knew that HIV can be asymptomatic and cannot be spread by kissing or by medical or dental treatment (UNAIDS Knowledge Indicator 2). Two in five women identified both monogamy and condom use as prevention measures (UNAIDS Knowledge Indicator 1). Although awareness of HIV/AIDS was high, a lower proportion of women had heard of syphilis (41%), gonorrhea (35%), trichomonas (12%), chlamydia (8%), bacterial vaginosis (7%), genital warts (6%) or genital herpes (5%). Almost two-thirds (62%) of respondents

mentioned mass media as the most important source of information about STIs, but recent mass media messages were more often reported to be about HIV/AIDS, whereas messages on other STIs were considerably less common (54% vs. 13%). Friends and peers were the next most important source of information (14%). The National Working Group on STI Management and Guidelines, established in 1998 to increase STI knowledge among Azeri men and women of reproductive age, requires close collaboration between public health organizations, NGOs, and audiovisual media. In designing such educational campaigns, the working group needs to ensure that no misconceptions or needless threats are disseminated, because media imagery may be difficult to offset. Some groups of women, particularly those who are less educated or are younger than age 25, may require specialized interventions.

Physical and Sexual Abuse

Lifetime experience of spousal physical abuse was reported by 20% of Azeri women, comparable to reproductive health survey results in most other former Soviet bloc countries. One in four women (26%) reported witnessing abuse between parents as a child, and one in three reported experiencing abuse at the hands of a parent. Almost one in three (30%) women reported that they had been verbally abused by a partner or ex-partner, one in five reported some form of physical abuse, and one in ten reported spousal sexual abuse (i.e., being forced to have intercourse against their will). Only 1% of physically abused women reported the violence to police or discussed it with a health care provider, and even fewer sought legal counsel for recent domestic abuse. Most women failing to report domestic violence cited reasons related to social perception, such as bringing the family a bad reputation (48%), or personal embarrassment (13%). Six percent of women stated that they had been forced to have sexual intercourse; in 95% of those cases, the perpetrator was the woman's husband, consensual partner, or boyfriend.

Conclusion

The AZRHS01 showed that the women of Azerbaijan have inadequate knowledge of and access to diverse contraceptive methods. Doctors and nurses need preservice and inservice education and training in contraceptive technology as well as in contraceptive counseling skills. The public needs appropriate education through social marketing and family life education in schools.

Researchers in the United States have developed an "informed-choice" strategy for people to make contraceptive decisions on the basis of well-informed choices about family planning and protection against HIV/AIDS and other STIs. This strategy targets five areas: government policies,

communication programs, access to contraception, family planning program management and leadership, and counseling (Upadhyat U et al., 2001). Informed choice means that individuals and couples can make their own personal decisions on spacing and limiting children when given accurate information along with access to services and supplies to carry out their decisions. This principle has long been fundamental to family planning programs around the world; unfortunately, its implementation has been uneven.

Azeri culture supports monogamy and delay of sexual intercourse until a woman's marriage to an extent rarely found in other countries, even those of the former Soviet Union. These behaviors that have clear public health benefits and should be encouraged. However, given the difficulties in obtaining valid data from young people about their sexual behaviors, particularly when sexuality is a taboo topic (which seems to be the case in Azerbaijan), survey results on this subject should be interpreted with caution.

In Azerbaijan, fertility control has been predominately achieved through the practice of induced abortion. Abortion complications and their treatment burden an already struggling health system. Postabortion care activities, including emergency obstetric care, family planning counseling and services, and appropriate referral for other health care needs (such as those related to nutrition or violence), would seem a particularly useful way to prevent recurrent abortions and redirect funds toward preventive activities.

The national family planning program in Azerbaijan, a collaboration between the Azerbaijan Ministry of Health, the United Nations Population Fund, and several international and local NGOs, is in the early stages of development. It will take time to set official policies and budgets for programs throughout the country. Areas of emphasis—those requiring immediate attention—should be based on population-based data, such as that in this survey or other related surveys. To accurately judge continued needs and progress, public health officials will need more complete vital statistics, which require improvements in the system of immediate registration of births, deaths, abortions, immunizations, and other health events.

A national policy on family life curriculum could reach most young people in the country because almost everyone attends at least some secondary school. Family life education courses promoting delayed initiation of first intercourse and knowledge of human sexuality, contraception, and disease prevention have been shown to promote increased use of contraceptives, which protect against unintended pregnancy and STIs. Because Azeri schools currently lack such comprehensive education, a clear statement of government policy and dedication of resources will be required to bring it into existence.

Accurate information campaigns in the mass media and in the community can inform people of their right to make their own decisions, explain their options, and direct them to appropriate health care providers. Such campaigns should include information not only about HIV/AIDS but also about other STIs, such as syphilis, whose prevalence in Azerbaijan is much higher than that of HIV/AIDS and therefore poses a greater risk for Azeri men and women.

Improving access to reproductive health care should include improving the availability of a range of contraceptive methods and provision of a network of women's health clinics. The entire spectrum of women's health issues should be addressed because they ultimately affect reproductive health and the health of the nation's children.

Program management that improves the quality of care enhances clients' choices and improves contraceptive efficacy and continuation rates. Family planning programs must take into consideration that one or two methods of contraception will not be appropriate for every woman. Programs that offer a variety of methods, adequate information and treatment as needed empower women to use contraception correctly, consistently and to their best advantage.

Counseling can be crucial to helping couples think through their decisions. Couples who are unaware of the variety of family planning methods that are available may incorrectly assume that contraception is not for them. A knowledge of costs, effectiveness in preventing pregnancy and STIs, proper usage, and side effects are all necessary for couples to choose methods which meet their needs.

Evaluation is an important component of education and program efforts. Future population-based surveys and monitoring of vital statistics will allow public health planners to examine progress toward achieving reproductive health program objectives in terms of knowledge, attitudes, and practices of Azeri women. They will also help measure progress toward broad goals of reducing mortality and morbidity among children and reproductive-age women. Plans can then be adjusted on the basis of an understanding of which programs have been effective and which objectives require enhanced or alternative efforts. Once baseline data are available, continual implementation of needs assessment, policy setting, identification of targets, program planning, and objective evaluation can be used to achieve steady improvements in reproductive health.

CHAPTER 1

INTRODUCTION

With the dissolution of the Soviet Union in 1991, Azerbaijan again became an independent country. A nation of about 86,600 km^2 in the Caucasus region, it borders on Iran to the south, Armenia to the west, Georgia and Russia to the north, and the Caspian Sea to the east. The Great Caucasus Mountain range passes though the northeastern part of the country. Azerbaijan has only 0.2 hectares of arable land per capita. The industrialized Absheron Peninsula suffers from pollution of its air, soil, and water, including the Caspian Sea. The Azerbaijan State Committee on Ecology has classified the city of Sumgait, which is on the Peninsula, an ecological disaster area, a legacy of its years as a major industrial center of the Soviet Union. Approximately one-third of the population inhabits the Absheron area, including 1.8 million in Baku, the capital of Azerbaijan. Outside Baku (which consists of 11 administrative units or *rayons),* the country is divided into 65 administrative units (59 rayons and 6 cities) and the autonomous republic of Nakhchivan (consisting of 6 rayons and the capital, Nakhchivan city) (State Committee of Statistics of the Azerbaijan Republic [SCS], 1996; SCS, 2001)'. Approximately 51% of the 8.1 million people of Azerbaijan live in urban areas. About 30% of the total population is younger than age 15, and 6% are older than age 65. Women make up 51% of the population (SCS, 2001). The life expectancy at birth has been increasing recently; in 2000 it was 75.1 years for women but only 68.6 years for men (SCS, 2001).

Azeri, the predominant ethnic group, represented 83% of the total population at the 1989 Census (Goskomstat, 1989; Ministry of Health [MOH] and SCS, 2001). Before 1991, Russians (6%), Armenians (6%), and Lezgis (2%) were the largest ethnic minorities; most Armenians were clustered in the Nagorno-Karabakh region. After the disintegration of the Soviet Union and the war with Armenia, the ethnic composition was substantially affected by external migration and an influx of Azeri refugees from Armenia. Currently, Azeris represent more than 90% of the total population (SCS, 2001).

Eighty-nine percent of the population speak Azeri, a language of Turkic origin; 3% speak Russian,

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[1] For enumeration purposes, these administrative units were grouped into 10 regions according to their contiguous geographical location. See Table 1.1 at the end of the chapter includes the listing of *rayons* in each region, as defined by their enumeration statistical code.

2% speak Armenian, and 6% speak other languages (United Nations Population Fund [UNFPA], 1999b). In pre-Soviet times the Azeri language was written with the Arabic alphabet. The Soviet policy forced a change to Latin (in 1926) and later to Cyrillic lettering (in 1940) but the written language has recently returned to its Latin form (Gurbanov, 1967; Elliot, 1999). Literacy is estimated to be about 97% for the population over age 14, although rates are somewhat higher for men than for women (Central Intelligence Agency [CIA], 2001). More than 93% of the population identify themselves as Muslim, 2.5% as Russian Orthodox, and 2.3% as Armenian Orthodox (MOH and SCS, 2001). Most people report that they do not practice their religion, and both the culture and the government are secular, not theocratic.

Upon the collapse of the U.S.S.R. in 1991, Armenia and Azerbaijan, both former republics of the Soviet Union, engaged in a protracted war over Nagorno-Karabakh, the predominately Armenian-populated region within the Azerbaijan territory. In 1994,, the two countries reached a cease-fire agreement, but Armenia still occupies about 20% of Azerbaijan. The fighting has left Azerbaijan with some 790,000 internally displaced persons and refugees (IDP/Rs)—570,000 Azeri ethnics displaced from Nagorno-Karabakh and the surrounding occupied territories and 220,000 Azeri residents who fled Armenia and relocated in Azerbaijan when the war started—about 10% of its entire population (United Nations High Commissioner for Refugees [UNHCR], 1999). They constitute the largest proportion of IDP/Rs concentrated in one country of the Caucasus region. It is estimated that about two-thirds of IDP/Rs live in improvised housing conditions (e.g., public buildings, shelters, railroad wagons, mudhouses, dugouts, and tents) (United Nations Development Programme [UNDP], 1999).

The constitution of Azerbaijan, ratified in 1995, established the government as a democratic republic. Citizens age 18 and older are eligible to vote and presidential elections are held every 5 years. The president appoints the prime minister and the Council of Ministers, contingent upon approval by the National Assembly. The National Assembly is elected every 5 years, by a combination of direct and proportional representation. The country's president appoints both the president and the vice-president of the Constitutional Court, which has the right of judicial review over the legislation of the National Assembly and presidential decrees. More than 20 political parties are active in Azerbaijan (UNDP, 1999).

The shift from the command economy of the former Soviet Union to a new market economy has been a challenge for Azerbaijan. Three-quarters of Azerbaijan's exports are oil and gas; the rest consist mainly of machinery, cotton, and food products. Private sector employment increased to 56% in 1997, accounting for 46% of the gross domestic product (GDP). During the war with Armenia, inflation reached astronomical rates of growth—up to 1,664% annually in 1994—but it fell to an estimated 1.8% in 1999 (UNFPA. 1999a).

The transition to a market economy has had a negative impact on the welfare of the population. The unemployment rate is approximately 20%. The per capita GDP is just $537. In 1995, 68% of the population were classified as poor and 24% as very poor (MOH and SCS, 2001; World Bank, 1997). Food expenditures absorb an increasing percentage of the average family income (about 70% in 1997), yet consumption has fallen well below that needed to maintain health, especially consumption of meat, fish, and dairy products (UNDP, 1999). According to a recent United Nations Children's Fund (UNICEF) study, 17% of children younger than age 5 are underweight, about 20% are stunted, and 8% suffer from wasting (UNICEF, 2000).

During the Soviet Union years, the Central Ministry of Health in Moscow oversaw the Azerbaijan MOH. The Soviet Union handed down all plans and standards that the Republic should meet, even information sheets for patient education. The emphasis was on medical treatment and funds were allocated according to the number of hospital beds. The Soviet system provided various kinds of health care facilities. Hospitals existed at several levels: small rural hospitals; rayon, or district, hospitals for more severe cases; and republic-level hospitals for the most seriously ill and injured. Pediatric and adult polyclinics staffed with specialists served urban areas. Businesses with numerous employees sometimes had their own polyclinics. Rural areas also had polyclinics but without specialized physicians. Feldsher-ackucher points (FAPs) also served as the primary level of care for residents of the most rural regions. Educational institutions placed greater emphasis on producing physicians rather than nurses, physician assistants, or health practitioners from other disciplines (UNFPA, 1999b).

All the former Soviet-bloc countries have inherited the same centralized, government-supported health system (Semashko model), well known for its relative inefficiency in terms of structure, management, and resource allocation and for unresponsiveness to patients' needs. Recently, the system has been particularly affected by the acute lack of resources characterizing all social sectors in the newly independent states. Common features of this system are a massive reliance on hospital-based health care services, which generates too many hospitals and hospital-based specialized physicians, and an inadequate supply of primary health care services. In the transition to a market economy, the costly hospital-based curative system became impossible to maintain; most hospitals lacked minimum equipment, drugs, and supplies and could not afford the maintenance costs. In most former Soviet Union countries, health care deteriorated rapidly, particularly in the area of reproductive health services as reflected in the worsening of several outcome indicators (e.g., maternal and infant mortality, sexually transmitted infection [STI] prevalence, and utilization of preventive services). In many countries of the region, health reforms are currently in various stages of development but are hampered by limited resources, thus leaving many segments of the population uninsured or with minimum health benefits.

In Azerbaijan, the government health care reform efforts are ongoing, but challenged by the recent economic problems and territorial disputes. Although Moscow no longer has a role in health operations or planning, the organizational skeleton it created remains. During the Soviet era, health care was free. Today, even though physicians are still employed by the state, people generally end up paying for health care services out of already strained household budgets. Even though patients are required to pay for care that was previously free of charge, the physical infrastructure of the health care system has been allowed to deteriorate and equipment has gone without necessary repairs or has become obsolete. Physicians are unlikely to have the most up-to-date information and skills and pharmaceutical dispensaries lack necessary medicines. It has been 10 years since Azerbaijan gained independence, yet copies of old Soviet health education pamphlets are still distributed. In addition to MOH-operated clinics, a few private providers of health care exist, as do clinics operated by international organizations that reach out to displaced populations (UNFPA, 1999b).

After the collapse of the Soviet Union, GDP and wages in Azerbaijan declined. Government expenditures for health in 1999 represented 1.6% of the GDP, down almost 50% from the 1990 level of 2.9% (World Health Organization [WHO], European Public Health Information Network for Eastern Europe [EUPHIN/EAST], 2000). In reality, the decline has been even more dramatic, because as the total GDP declined, the population increased substantially in the aftermath of the Nagorno-Karabakh war with Armenia (Bladen et al., 1998). The real governmental expenditures on health are estimated to be less than one-quarter of the pre-independence level, amounting to only about US$7.00 per capita (1997 dollars). Most of the care is provided on a fee-for-service basis, with patients paying the largest share of costs; however, some categories, including pregnant and post-partum women, continue to receive free health coverage (Public Health Protection Law 360-IQ, 1997; Presidential Decree 62, 1997). According to World Bank estimates, the out-of-pocket costs for health accounted for more than 80% of spending in the health sector in 1995 (World Bank, 1997). Even when out-of-pocket costs are factored in, the health expenditures per capita (the sum of public and private expenditures on health divided by the country's population) amount to only US$36.00 per capita, lower than in Georgia and Kazakhstan (US$46.00 and US$86.00 per capita) but higher than in Armenia (US$27.00 per capita) (2001 dollars) (World Bank, 2001a).

During the 1990s, Azerbaijan experienced a steep increase in maternal mortality (UNFPA, 1999; SCS, 2001). However, after an initial surge in the maternal mortality rate (MMR) between 1991 and 1994, culminating in 43.8 deaths per 100,000 live births in 1994 (a rate almost 5 times higher than the 1990 level), MMR stabilized in the 1995-1999 period and started to decline in 2000. The official estimate of maternal mortality for 2000 was 37.6 deaths per 100,000 live births, almost 4 times higher than the 1991 level of 10.4 deaths per 100,000 live births (MOH and SCS, 2001). According to the official statistics, about 12% of the maternal deaths in the past 3 years were due to abortion, including 1% due to "artificial medical abortion" (WHO-EUPHIN/EAST, 2000; MOH, 2001a).

However, a recent UNFPA country assessment report suggests that the actual MMR is considerably higher (UNFPA, 1999b).

Several population-based studies conducted after 1990 documented that a substantial proportion of Azeri women deliver at home with the assistance of local midwives instead of government-employed physicians. The 1996 National Health and Nutrition Survey found that as many as one-third of all children younger than age 1 were born at home (Branca et al, 1996). Regional household cluster surveys of women with children under age 5 conducted in Northwest Azerbaijan in 1997 and 1999 documented that 25% of women had no prenatal care visits, and the proportion of newborns born at home increased from 37% in 1997 to 44% in 1999 (Buchholz, 1999). According to the Azerbaijan MOH, the proportion of women who delivered at home increased between 1990 and 2000 from 2.3% to 8.6% of the total labors "observed in establishments of the Ministry of Health" (MOH and SCS, 2001).

Abortion is the most common form of birth control; three-fourths of sexually active women reported at least one lifetime induced abortion in a small area sample survey of Relief International clinics (Posner et al., 2001). Almost two-thirds of women reported recent symptoms suggestive of STIs, and the prevalence of pelvic inflammatory disease due to (STIs) is estimated to be high (Claeys et al., 2001; Kerimova et al, 2000). The fertility rate started to drop prior to 1990, but the decline during the past decade has been at a faster pace. From a level of 3.3 births per woman in 1980, the total fertility rate (TFR) decreased slowly to about 2.7 in the period 1981-1993, then fell abruptly to slightly below a replacement level of 2 births per woman in 1998 (MOH, 2001a). The absolute number of births decreased by 36% between 1990 and 2000 (from 182,989 births to 116,994 births) (SCS, 2001). Women typically marry and begin families at a young age. Most do not have premarital sexual relationships and births out-of-wedlock are rare—less than 5% of all births, according to the MOH (MOH and SCS, 2001). Unmarried women generally do not live on their own, no matter what their age, education, or professional status.

Although the reported fertility rate has declined, the population is expected to continue to increase because of the great number of women of childbearing age who were born during the earlier periods of high fertility. The population is expected to stabilize at about 9.5 million in 2025. A net emigration from the country is taking place, mostly men from the larger cities going abroad to look for better economic opportunities. Infant mortality and under-5 mortality were officially reported as 12.8 deaths per 1,000 live births and 25.8 deaths per 1,000 live births, respectively, as of 2000 (MOH, 2001a; SCS, 2001). Both rates have declined considerably from those reported in the late 1950s and early 1960s. However, the official statistics may be plagued by problems such as the non-registration of births of infants who die shortly after birth and the misclassification of neonatal deaths and early deaths of premature infants as stillbirths. International agencies suggest that the actual

fertility rate is 2.2 births per woman (CIA, 2001) and that the mortality rates may be much higher. Mortality rates are reportedly higher for children in rural locations or with poor socioeconomic status (UNFPA, 1999b).

These statistics should be interpreted with caution. The health information system during the Soviet times was often flawed by overreporting of "positive" results, which could bring rewards, and underreporting of undesired statistics, which could lead to disciplinary actions (Bladen et al., 1998). Even when the data collected were reliable, they usually satisfied the needs of "centralized" decision-making but were not always useful for describing the health status and the burden of disease on the population at subnational levels. Although the old system is no longer in place, some of its characteristics are likely to have been retained. In addition, with the emerging private health sector and the shifting of health costs from the state to the individual, official data are unlikely to be complete (Bladen et al., 1998).

The UNFPA Country Population Assessment of 1999 identified the need to assess the health situation related to reproduction, including but not limited to maternal morbidity and mortality, abortion, prenatal and postpartum care, reproductive tract infections, STIs and HIV/AIDS, and contraceptive awareness and use, and it called for a comprehensive nationwide survey to collect the necessary data (UNFPA, 1999a). In addition to those topics, other recommended areas of study were popular beliefs about fertility, ideal age of marriage, pregnancy and birth intervals, how fertility decisions are made, and how much money women are willing and able to pay for their reproductive health care.

In conclusion, Azerbaijan has undergone major socioeconomic and political changes: the war with Armenia, forced migration and population displacement, economic hardships, and deterioration of health and social services. These changes have affected practically all aspects of life for its people. The reported flaws associated with official statistics have prohibited any meaningful attempts at informed decision making, planning, and program evaluation in reproductive health. A nationwide survey was recommended to assess the reproductive health status of the population during this transition period, a period of profound changes in health needs and access to health care services. The national reproductive health survey conducted in Azerbaijan in 2001 (AZRHS01) is the first nationwide population-based survey aimed at providing a wide array of information about the current status of women's health in that country. The survey will aid in identifying unmet programmatic needs and will serve as a baseline for future studies and evaluations. The AZRHS01 was specifically designed to meet the following objectives:

- To assess fertility, abortion, contraception, and various other reproductive health issues in Azerbaijan.

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

- To study factors that affect fertility, contraceptive use, and maternal and infant health, such as geographic and sociodemographic factors, breast-feeding patterns, use of induced abortion, and availability of family planning services.

- To identify characteristics of women at risk for unintended pregnancy.

- To identify high-risk groups and focus additional reproductive health studies on them.

- To obtain data on the knowledge, attitudes, and behavior of young adults 15-24 years of age.

- To provide data on the level of reported STI symptoms and knowledge about transmission and prevention of AIDS.

- To provide data on women living in prolonged displacement.

Similar to the survey conducted in Georgia, completed in 2000, the AZRHS01 included an oversample of refugee women and women internally displaced by war and ethnic cleansing to document their specific health needs (Serbanescu et al, 2001). The disruption associated with living in improvised settings makes safe motherhood difficult, limits contraceptive access and use, increases the risks of HIV/AIDS and other STIs, neglects the special needs of adolescents, and may increase the risk of violence against women. Public health surveillance systems often exclude data collection and analysis essential to addressing the specific issues of IDP/Rs. To our knowledge, no country or organization has attempted parallel documentation of the reproductive health status of a nation and an internally displaced group within the country. By collecting information from the general population and from IDP/Rs, the AZRHS01 can document specific needs associated with displacement, account for differences in reproductive health status between the two populations, and provide a useful tool for evaluating existing reproductive health programs and activities that specifically address displaced women and children.

The Division of Reproductive Health, U.S. Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, coordinated survey activities and provided technical assistance to the local implementing agency, the Adventist Development and Relief Agency (ADRA), Baku, Azerbaijan.

TABLE 1.1

Census (SCS) Conditional Regional Division* and Corresponding AZRHS01 Identification of Each Region by Administrative Units in Each Regional Division

SCSS	0	1	2	3	4	5	6	7	8	9
AZRHS	Baku City	Nakhchivan Autonomous Republic[†]	Ganja City[‡]	North-East Region[¶]	North Region[¶]	West Region	South-West Region	Nogorno-Karabakh Region[‡]	South Region	Central Region
	Binagadi rayon	Babek rayon	Kapaz rayon	Absheron rayon	Aghsu rayon	Aghstafa rayon	Aghdam rayon	Khojaly rayon	Astara rayon	Aghdash rayon
	Garadag rayon	Julfa rayon	Nizami rayon	Devechi rayon	Shamakhy rayon	Dashkesan rayon	Agjabedi rayon	Khojavend rayon	Lerik rayon	Ujar rayon
	Yasamal rayon	Nakhchivan city		Guba rayon	Sheki rayon	Tovuz rayon	Fizuli rayon	Shusha rayon	Lenkeran rayon	Kurdamir rayon
	Narimanov rayon	Ordubad rayon		Gusar rayon	Balaken rayon	Shamkir rayon	Terter rayon	Khankendi city	Bilasuvar rayon	Yevlakh rayon
	Nasimi rayon	Sadarak rayon		Gobustan rayon	Gakh rayon	Gazakh rayon	Beilagan rayon		Yardymly rayon	Hajigabul rayon
	Nizami rayon	Shahbuz rayon		Khachmaz rayon	Gabala rayon	Gadabey rayon	Barda rayon		Jalilabad rayon	Ali-Bairamly city
	Azizbayov rayon	Sharur rayon		Sumgayit city	Goychay rayon	Goranboy rayon	Jebrail rayon[§]		Neftchala rayon	Imishli rayon
	Khatayi rayon			Siazan rayon	Ismailly rayon	Khanlar rayon	Kelbajar rayon[§]		Salyan rayon	Sabirabad rayon
	Surakhani rayon			Khyzy rayon	Oghus rayon	Samukh rayon	Gubadly rayon[§]		Masally rayon	Saatli rayon
	Sabunchu rayon				Zagatala rayon	Naftalan city	Lachin rayon[§]			Mingechevir city
	Sabail rayon						Zangilan rayon[§]			Zardab rayon

* State Committee of Statistics of the Azerbaijan Republic performed a pre-Census conditional regional division of the country for enumeration purposes (SCS, 1996).

† AZRHS01 was not conducted in this region.

‡ AZRHS01 included Ganja city in the West Region.

¶ For analytical purposes, this report combines the North-East and North Regions to obtain an adequate sample size.

§ Nagorno-Karabach region and five rayons in the South West part of the country constitute the occupied territories and were not included either in the 1999 Census conducted by the SCS or in the AZRHS01.

CHAPTER 2

METHODOLOGY

2.1 Sampling Design

The AZRHS01 is based on face-to-face interviews with 7,668 women at their homes. The survey was designed to collect information from a representative sample of women of reproductive age throughout Azerbaijan. The universe 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 Azerbaijan when the survey was carried out (excluding the autonomous region of Nakhchivan and the occupied territories of Nagorno-Karabakh and surrounding areas).

The questionnaire included information on each woman's education, employment, living arrangements, and other background characteristics as well as histories of marriage, divorce, cohabitation, sexual activity, pregnancy, and contraceptive use. Additional questions investigated health risk behaviors that may affect reproductive health (e.g., smoking and drinking habits), women's health screening practices, and intimate partner violence. The questionnaire was developed in English, translated into Azeri and Russian, and translated back to ensure accuracy and linguistic equivalency.

The household survey used a stratified multistage sampling design using the recent 1999 census as the sampling frame (State Committee of Statistics of the Azerbaijan Republic [SCS], 2000). For the AZRHS01, the geographic area of the Azerbaijan Republic was divided into four independent sampling strata. The strata were created by grouping regions with a similar concentration of IDPs and refugees (IDP/Rs), as recorded by the United Nations High Commissioner for Refugees (UNHCR, 2000). The sample was selected with probability proportional to the population size (PPS) within each stratum. Stratum 1 included six rayons that each consisted of more than 30% of their population constituted by IDP/Rs: Fizuli (53%), Xanlar (51%), Barda (44%), Naftalan (40%), Aghjabedi (32%), and Bilasuvar (31%). Stratum 2 included five rayons in which the IDP/Rs represented 20%-30% of the population: Imishli (25%), Saatli (23%), Belagan (22%), Mingechevir (21%), and Terter (20%). Stratum 3 included only the Baku district, which also had a relatively high concentration of IDP/Rs (14%). Stratum 4 included all other rayons, except those in Nakhchivan and the occupied territories of Nagorno-Karabakh and surrounding areas.

Figure 2.1
Number of Households in the 4 Strata of the AZRHS01 Sample and the 1999 Census
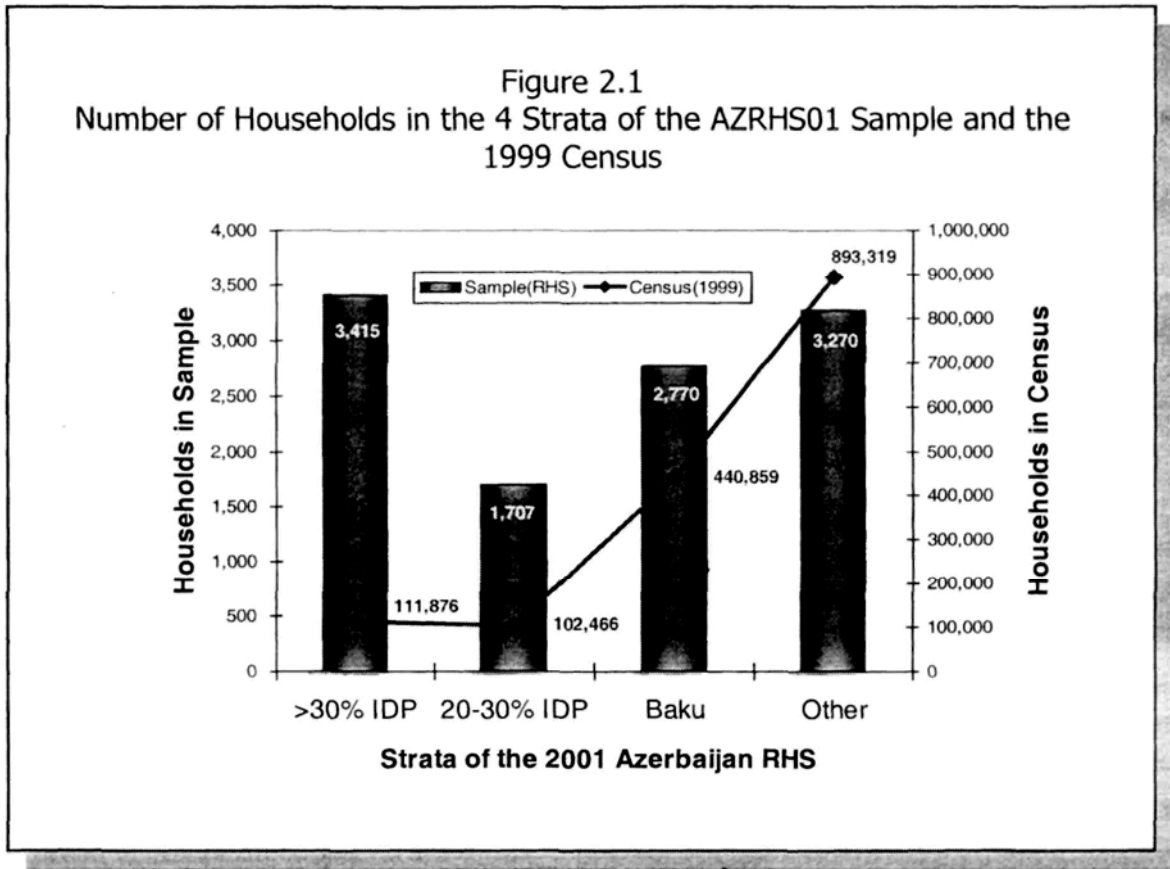
Regions with high concentrations of IDP/Rs (Strata 1 and 2) were oversampled for programmatic reasons. The oversampling in regions heavily populated by IDP/Rs was needed to include enough displaced women in the sample to allow independent estimates of their reproductive health status. This technique illustrates how surveys may be designed and integrated in the development, monitoring, and evaluation of targeted reproductive health programs. The oversampling of IDP/Rs was specifically designed to assess the reproductive health status of these women and measure the impact of the Azerbaijan Humanitarian Assistance Project (AHAP) funded by USAID and various projects targeting the IDP population supported by UNHCR and UNFPA. These projects aim to reduce the reliance on induced abortion by increasing access to and availability of effective contraceptive methods and by reducing the prevalence of STDs through the promotion of healthy behaviors among women (e.g., routine gynecologic exams) and child survival activities. These projects encompass various interventions, such as the establishment of modern health clinics for women; training of health professionals; development of information, education, and communication messages; social marketing; and provision of high-quality contraceptive supplies.

Figure 2.1 compares the distribution of households in the sample (shown with bars) and the distribution of households in the 1999 Census (line graph) by the four strata. Stratum 1, one of the

smallest of the strata according to the Census (areas with more than 30% IDP/Rs) actually contains the largest number of households in the sample (3,415 households). These 3,415 households represent 111,876 households in the Census, such that the sampling fraction for this stratum is 1 in 32.7 households. Similarly, Stratum 2, consisting of regions with 20%-30% IDP/Rs, contains 1,707 households corresponding to 102,466 households in the Census (sampling fraction is 1 in 60 households). In contrast, the sampling fraction for the stratum labeled "Other" is only 1 in 273.2 households.

The first stage of the three-stage sample design was a selection of Census sectors with probability proportional to the number of households in each sector, after the sectors were grouped into four strata. This stage was accomplished by using a systematic sample with a random start in each stratum. During the first stage, 300 census sectors were selected and became primary sampling units (PSUs), as follows: Baku (80 PSUs), regions with more than 30% of the population being IDP/Rs (100 PSUs), regions with 20%-30% of the population being IDP/Rs (50 PSUs), and all other regions (70 PSUs). In the second stage of sampling, clusters of households were randomly selected in each census sector chosen in the first stage. The cluster size was based on the number of households required to obtain an average of 20 completed interviews per cluster. The total number of households in each cluster took into account estimates of unoccupied households, average number of women aged 15-44 per household, the interview of only one respondent per household, and an estimated response rate of 90% in urban areas and 92% in rural areas. Finally, in each of the households selected, one woman between age 15 and 44 was selected at random for interview (ifthere was more than one woman was in the household).

Because only one woman was selected from each household containing women of reproductive age, all results have been weighted to compensate for the fact that some households included more than one eligible female respondent. Survey results were also weighted to adjust for oversampling of households in the regions with a high concentration of IDP/R population and the undersampling in regions in which less than 20% of the population consisted of IDP/Rs. Except for Table 2.3.1, all tables in this report present weighted results. The unweighted number of cases, used for variance estimation, is also shown in each table. Thus, the survey can be used to make national and subnational estimates because of the elaborate process used to weight the data—that is, to determine how many women in the population were represented by each woman in the sample.

2.2 Data Collection

The interviews were performed by 30 female interviewers, who were specially trained in interview techniques, survey procedures, and questionnaire content before the beginning of fieldwork.

Interviewer training was managed by the Adventist Development and Relief Agency Azerbaijan (ADRA), with the involvement of Shafag Rahimova, survey director; Conrad Vine, health coordinator; Farid Agamaliyev, project manager; Linda Fardy Hayes, survey consultant; and the U.S. Centers for Disease Control and Prevention (CDC) team (Florina Serbanescu and Natalia Melnikova for the reproductive health component and Geraldine Perry for the nutrition component). Interviewer training took place at the Ministry of Health International Training and Service Center just before data collection began; it consisted of 1 week of classroom training in fieldwork procedures and proper administration of the questionnaire and 1 week of practical training in the field with close monitoring by the trainers. At the end of the training period, six teams were selected, each consisting of four female interviewers, one nutritionist, and one supervisor. ADRA staff managed the fieldwork with technical assistance from the Division of Reproductive Health of the CDC.

Two fieldwork coordinators (Saida Ismaylova and Mahbuba Khalilova) supervised the fieldwork implementation. Fieldwork lasted from April through July 2001. Each team was assigned to visit a number of primary sampling units in all regions of the country and traveled by car throughout the country on planned itineraries. Interviews were conducted at the homes of respondents and lasted, on average, about 40 minutes (79 interviews are missing information about the duration of the interview). Although most interviews were conducted in Azeri, a Russian-language questionnaire was also available. All interviewers were bilingual. Completed questionnaires were first reviewed in the field by team supervisors and then were taken by the fieldwork coordinators to the national State Committee of Statistics (SCS) headquarters for data processing.

2.3 Response Rates

Of the 11,162 households selected in the household sample, 8,246 included at least one eligible woman (aged 15-44 years). Of those, 7,668 women were successfully interviewed, yielding a response rate of 93%. About 5% of women were absent and could not be interviewed during several revisits. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed (the individual refusal rate was only 1.2%). Response rates were lower in Baku and its environs (86%) than in other urban areas (94%) and rural areas (96%) (Table 2.3.1).

TABLE 2.3.1

Results of Household Visits and Interview Status of Eligible Women by Residence (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

			Residence		
Household Visits	**Total**		**Baku** [*]	**Other Urban**	**Rural**
Identified eligible women [†]	73.9		64.7	71.9	80.3
No eligible women	19.9		25.6	20.5	16.3
Unoccupied household	0.7		2.3	0.3	0.0
Resident(s) not at home	0.9		2.4	0.6	0.2
Household refusal	4.7		5.1	6.7	3.1
Total	100.0		100.0	100.0	100.0
No. of Households Visited	**11,162**		**2,770**	**3,401**	**4,991**
Eligible Women					
Completed interviews	93.0		85.5	94.0	95.7
Selected respondent absent	5.1		9.4	4.5	3.4
Selected respondent refused	1.2		4.3	0.7	0.2
Other [‡]	0.7		0.8	0.9	0.6
Total	100.0		100.0	100.0	100.0
No. of Eligible Women Identified	**8,246**		**1,792**	**2,447**	**4,007**
No. of Completed Interviews	**7,668**		**1,533**	**2,299**	**3,836**

[*] Includes several suburbs surrounding Baku.
[†] Includes women aged 15–44 years who had complete or incomplete interviews, who were absent or handicapped, or who refused to be interviewed.
[‡] Includes women with a handicap preventing them to be interviewed and women with incomplete interviews.

The distribution of women in the sample by 5-year age groups differs slightly from the official estimates for the year 1999: the survey sample slightly overrepresents adolescent women (15- to 19-year-olds) and underrepresents women aged 25-29 by 2 percentage points, after confidence intervals are taken into account (see top panel of Table 2.3.2). The sample retains the same over- and underrepresentation for women aged 15-19 and 25-29 for both urban and rural residents. At least two factors may have contributed to the differences observed: (1) official estimates reflect the age composition recorded in 1999, 2 years before the survey took place, and (2) lower response rates occurred among 25- to 29-year-old women, who are most likely to be employed and not at home. The distribution of women in the sample by marital status (by 5-year age groups), however, does not differ significantly from the Census estimates (see bottom panel of Table 2.3.2).

TABLE 2.3.2
Women with Complete Interviews
Compared with Official Estimates by Residence and Marital Status by Age Group
Reproductive Health Survey: Azerbaijan 2001
(Percent Distribution)

| Age Group | AZRHS01 (± 95% Confidence Interval) | | | | | | 1999 Official Estimates[*] | | |
	Total		Urban		Rural		Total	Urban	Rural
15–19	22.1	(1.2)	21.1	(1.2)	23.4	(1.2)	18.4	18.0	18.9
20–24	17.2	(1.1)	16.9	(1.1)	17.5	(1.1)	16.4	15.9	17.0
25–29	13.4	(1.0)	13.5	(1.0)	13.3	(1.0)	16.3	15.6	17.0
30–34	16.6	(1.0)	16.1	(1.0)	17.2	(1.0)	17.7	17.4	18.0
35–39	17.3	(1.1)	18.5	(1.1)	15.8	(1.1)	17.8	18.5	17.0
40–44	13.4	(1.0)	13.9	(1.0)	12.9	(1.0)	13.4	14.6	12.1
Total	100.0		100.0		100.0		100.0	100.0	100.0

Age Group	Currently Married		Previously Married		Never Married		Total	Currently Married	Previously Married	Never Married	Total
15–19	9.9	(2.1)	0.3	(0.4)	89.8	(2.1)	100.0	9.9	0.2	89.9	100.0
20–24	44.0	(3.5)	3.2	(1.2)	52.8	(3.5)	100.0	47.4	1.6	51.0	100.0
25–29	72.6	(3.2)	3.7	(1.4)	23.8	(3.1)	100.0	72.2	3.8	23.9	100.0
30–34	81.2	(2.4)	7.5	(1.6)	11.3	(2.0)	100.0	81.1	5.6	13.3	100.0
35–39	84.3	(2.3)	7.6	(1.7)	8.1	(1.7)	100.0	83.4	7.3	9.3	100.0
40–44	81.3	(3.7)	11.8	(2.5)	6.9	(1.9)	100.0	83.5	10.4	6.1	100.0

* SCS preliminary data based on the 1999 Census.

14

CHAPTER 3

CHARACTERISTICS OF THE SAMPLE

3.1 Household Characteristics

Similar to the definition used in other surveys and in the 1999 Azerbaijan Census, the AZRHS01 defined *household* as a person or group of persons who shared the dwelling and the related living expenses. Visitors were not counted in the household composition and were not included in the number of eligible respondents. After all eligible respondents in the household were listed, only one woman aged 15-14 was randomly selected for the individual interview.

The survey found that a typical Azeri household containing an eligible respondent consisted of almost five persons (Table 3.1.1). Households in Baku contained, on average, one person fewer than did rural households (4.4 persons per household vs. 5.3 persons per household). The larger household size in rural areas can be partially explained by higher fertility levels (see Chapter 4).

One-or two-person households (presumably childless women or couples) were very uncommon (1% and 5%, respectively); these types of households were more frequent in Baku and other urban areas (8% and 6%) than in rural areas (4%). Households consisting of eight or more members were also relatively uncommon; they were least prevalent in urban areas (4%) and most prevalent in rural areas (11%).

Socioeconomic well-being is an important determinant of reproductive health status. Information on household amenities (i.e., electricity, flush toilet, telephone line, and central heat) and ownership of various goods or properties (i.e., television; refrigerator; private car; video recorder; mobile phone; vacation home; and vegetable garden, orchard, or vineyard) collected in AZRHS01 is shown in Table 3.1.2. Response options to each of these items were "yes" and "no". In addition, information on the average hours of electricity available per day and on household crowding were obtained for each respondent. Crowding was determined by the total number of persons living in the household divided by the total number of rooms in the house (not including the kitchen or bathroom); if the result was being greater than one, respondents were classified as living in crowded conditions.

TABLE 3.1.1
Size of Households with at Least One Eligible Respondent by Residence (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Size of Household	Total	Residence		
No. of Persons per Household		Baku	Other Urban	Rural
1	0.7	0.9	1.1	0.3
2	5.1	7.0	5.2	4.0
3	11.7	16.6	12.4	8.3
4	28.5	35.6	31.0	22.3
5	25.3	23.8	25.7	25.7
6	14.5	9.1	13.2	18.8
7	7.1	3.3	7.2	9.3
8+	7.1	3.7	4.2	11.3
Total	100.0	.100.0	100.0	100.0
Average No. of Persons	4.9	4.4	4.7	5.3
Unweighted No. of Cases[*]	8,246	1,792	2,447	4,007

* Excludes one household whose number of inhabitants was unknown.

Only 38% of respondents lived in households with flush toilets, and about 40% had a telephone line at home. Only one-third of respondents had an uninterrupted power supply, and 1 in 5 had central heating. The proportion of households with such amenities varied significantly by residence. For example, Baku households were 12 times more likely than rural households to have flush toilets, 8 times as likely to have central heating and 24 hours of electricity daily, and 5 times as likely to have a telephone. The average Azeri household has 15 hours of electrical power per day (data not shown). The power supply is most limited in rural areas, where 50% of households have only 10 hours of electricity per day; compared to in other urban areas and Baku, 50% of households have 17 and 23 hours, respectively, of electricity daily). Generally, households of people who are not internally displaced persons and refugees (IDP/Rs) living in conflict-affected areas were the least likely to have a flush toilet, central heating, or uninterrupted power supply.

Televisions were available in almost every household surveyed, with women of reproductive age (91%); the proportion was highest in urban areas (95%-98%). Almost all households had refrigerators (78%), especially in urban areas, particularly in Baku(96%). As expected, almost all households in rural areas had a vegetable garden (89%), whereas only 1 in 2 and 1 in 5 urban and Baku households, respectively, had such gardens. Video recorders were not widespread: almost 2 . in 3 households in Baku but only 37% of respondents in other urban areas and 22% in rural areas owned a video recorder. Only 1 in 4 families owned a car in Azerbaijan, with little variation by

residence. Few families owned a vacation home or a secondary residence (14%). The use of mobile phones was low (19% of women reported that they had one) and was concentrated in Baku and other urban areas (41% and 17%). Crowding did not substantially differ between urban and rural households, although the average number of persons per household was lower in urban areas than in rural areas (data not shown). The IDP/R households were the most crowded.

TABLE 3.1.2
Households with Women Aged 15–44 Years That Had Basic Household Amenities and Goods by Residence and IDP/R Status
Reproductive Health Survey: Azerbaijan, 2001

	Total	Residence			IDP/R Status*		
		Baku	Other Urban	Rural	IDP/R	Non-IDP/CA	Non-IDP/NCA
Household Amenities							
Telephone line	41.8	74.3	56.3	15.6	27.9	29.6	46.5
Flush toilet	38.2	87.8	47.2	7.3	38.7	22.3	41.9
Electricity (24 hours)	35.0	85.3	34.2	10.8	43.7	18.5	37.9
Central heat	21.1	49.3	22.9	6.1	18.6	13.3	23.3
Household Goods							
Television	91.3	98.3	94.7	85.5	88.3	90.4	91.9
Refrigerator	78.1	95.6	84.6	64.8	68.9	76.4	79.7
Vegetable garden	61.3	20.7	50.9	88.6	32.7	80.7	60.3
Video recorder	35.5	60.9	37.0	22.0	31.2	29.8	37.5
Automobile	24.3	30.5	22.0	22.9	24.5	27.8	23.4
Cellular phone	19.1	41.1	17.3	9.5	16.6	15.2	20.3
Recreational home (villa)	14.0	17.0	11.8	14.1	2.3	15.9	15.0
Percentage of Households with Crowded Conditions†	85.0	86.0	82.9	85.9	94.7	82.2	84.4
Unweighted Number of Cases	7,668	1,533	2,299	3,836	1,272	3,047	3,349

* IDP/Rs include persons who fled Nagorno Karabakh, surrounding occupied territories (internally displaced persons) or Armenia (refugees) due to war; non-IDP/Rs were further divided into non-IDP/Rs living in conflict-affected areas (CA), where 20% or more of population is IDP/Rs, and non-IDP/Rs living in areas not/less affected by the war (NCA), that is areas with less than 20% of population being IDP/Rs.
† Total number of persons living in the household divided by total number of rooms in the house (not including kitchen and bathroom) was higher than one.

All of these household amenities and goods, including living in uncrowded conditions and having electricity 24 hours per day, were summed to create a score to classify the socioeconomic status (SES) of the household. Equal values were assigned for possession of each amenity or good. For each household, this inventory yielded a score whose reliability was assessed using the Cronbach coefficient alpha. Based on this initial evaluation only 10 items were selected for use in the SES score (alpha coefficient=.70) Possession of a vegetable garden, orchard, or vineyard and having electricity 24 hours per day were not included in the final score because the score is based exclusively on possession of items that are associated with high SES. Possession of a garden is inversely correlated with SES, and the electricity shortage among Azerbaijan households is common and relatively uninfluenced by household SES.

The score ranged from 0 to 10, where 0 represented the lower end (no amenities and goods included in the score) and 10 represented the higher end (all 10 items included in the score). The score was further divided into terciles to create three levels for the SES variable. Respondents with a score of 0-3 amenities were classified as living in households with low SES; those with scores between 4 and 6 were classified as having middle SES; and those with scores of 7 or higher were considered as having high SES. The same methodology to assess the socioeconomic distribution of the population has been used in other reproductive health surveys in Eastern Europe and former Soviet Union countries. According to this computation, almost half (49%) of reproductive age women in Azerbaijan live in households with a low SES, 39% have a middle SES, and only 12% are classified as high SES.

3.2 Characteristics of the Respondents

A total of 39% of the survey respondents in the sample were young adults (15-24 years of age) (Table 3.2.1). The age distribution was slightly younger in rural areas, where 41% of the women were young adults. Age distribution varied little by region; the only notable exceptions were in the South region, where the population was slightly younger than the country average (43% young adults) and the Central region, where the proportion of young adults was significantly lower (32%).

A slight majority of women were legally married (58%); additionally, less than 1 percent were in a consensual union (i.e., an unregistered marriage or living with a partner "as husband and wife" but not legally married). No significant urban-rural or regional differences in marital status were found. Divorce and separation appeared to be uncommon; only 3% of women reported that they had been previously married. Two percent of the women surveyed were widowed. More than 1 in 3 women (36%) had never been married or lived with a partner. Official statistics show that Azerbaijan has a fertility rate slightly above the replacement level of two children per woman (2.2 births per woman in 1999, according to the State Committee of Statistics of the Azerbaijan Republic (SCS). Fertility levels reported in AZRHS01 were similar to the official estimates. Although the percentage of

TABLE 3.2.1
Characteristics of Eligible Women with Complete Interviews by Residence and Region (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Total | Residence | | Region | | | | | |
		Urban	Rural	Baku	North North-East	West	South West	South	Central
Age Group									
15–19	22.1	21.1	23.4	20.3	23.3	21.4	21.4	26.6	19.2
20–24	17.2	16.9	17.5	17.9	18.6	19.9	16.1	16.3	12.7
25–29	13.4	13.5	13.3	13.7	14.6	10.0	15.0	12.4	14.3
30–34	16.6	16.1	17.2	16.4	16.3	17.3	16.8	16.3	16.8
35–39	17.3	18.5	15.8	18.4	14.4	18.7	17.3	16.4	19.7
40–44	13.4	13.9	12.9	13.2	12.7	12.7	13.3	12.0	17.2
Marital Status									
Legally married	57.8	58.3	57.1	59.4	58.2	59.5	55.7	54.3	58.1
Consensual union	0.7	0.8	0.6	1.1	0.4	1.0	0.4	0.6	0.4
Previously married	5.2	5.7	4.8	5.6	4.1	7.6	4.8	3.9	6.2
Never married	36.3	35.3	37.6	34.0	37.3	31.9	39.0	41.3	35.3
No. of Living Children									
0	43.2	41.3	45.5	40.2	44.0	40.0	46.2	48.1	42.3
1	9.5	10.3	8.5	13.3	9.2	9.2	8.2	6.7	8.2
2	23.4	26.5	19.6	28.2	22.6	26.3	20.5	17.9	22.3
3	16.3	16.4	16.3	14.3	15.5	19.0	17.1	16.0	18.0
4+	7.6	5.6	10.1	3.9	8.7	5.5	8.0	11.3	9.3
Education									
Primary or less	3.7	2.3	5.3	1.0	4.5	2.1	8.0	5.2	3.6
Secondary incomplete	20.8	16.5	26.0	13.7	23.8	22.4	17.7	27.8	19.7
Secondary complete	48.4	44.0	53.6	39.5	49.9	45.8	53.4	53.7	52.8
Technicum	15.2	18.9	10.9	20.1	13.5	16.4	13.5	9.8	16.9
University	11.9	18.2	4.3	25.7	8.4	13.5	7.4	3.5	7.0
Religion									
Muslim	98.3	97.1	99.8	94.4	98.8	100.0	99.9	100.0	99.0
Orthodox	0.9	1.7	0.0	3.6	0.2	0.0	0.0	0.0	0.5
Other	0.4	0.7	0.0	1.0	0.5	0.0	0.0	0.0	0.2
None	0.4	0.6	0.2	0.9	0.6	0.0	0.1	0.0	0.4
Ethnicity									
Azeri	89.8	94.8	83.9	91.7	82.4	99.7	97.3	76.9	99.2
Talish	3.9	0.5	7.9	0.9	0.1	0.0	0.0	22.8	0.1
Lezgi	1.5	1.6	1.4	2.7	3.5	0.0	0.0	0.0	0.0
Tat	1.3	0.8	1.8	0.0	5.1	0.0	0.0	0.0	0.0
Avar	1.1	0.0	2.3	0.1	4.3	0.0	0.0	0.0	0.0
Russian	0.8	1.5	0.0	3.1	0.2	0.0	0.0	0.0	0.6
Other	1.7	0.9	2.6	1.4	4.3	0.3	2.6	0.3	0.1
Language Spoken									
Azeri	90.1	92.4	87.2	84.9	85.6	100.0	97.6	83.3	98.8
Russian	3.7	6.8	0.1	14.3	1.4	0.0	0.2	0.1	1.2
Talish	2.7	0.0	5.8	0.0	0.0	0.0	0.0	16.6	0.0
Other	3.5	0.8	6.8	0.8	13.0	0.0	2.2	0.0	0.0
Employment									
Working	20.2	25.2	14.3	27.4	19.7	21.4	16.0	13.0	19.8
Not working	79.8	74.8	85.7	72.6	80.3	78.6	84.0	87.0	80.2
IDP/Refugee Status									
IDP/R	9.3	10.4	8.1	12.7	4.3	9.6	30.7	2.4	6.4
Non-IDP/R	90.7	89.6	91.9	87.3	95.7	90.4	69.3	97.6	93.6
Total	100.0	100	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	7,668	3,832	3,836	1,533	924	766	2,302	950	1,193

childless women was lower in urban than in rural areas (41% vs. 46%), more women in rural areas reported three or more children than did those in urban areas (26% vs. 22%); 27% of the women in the South and Central regions reported three or more children. Baku residents were the least likely to have three or more children (18%).

Most of the respondents (48%) had completed secondary education or attended some years of postsecondary school. The proportion who had received formal education beyond the secondary level was 1.5 times higher among urban than among rural residents (37% vs. 15%). Respondents residing in Baku were significantly more likely to have some postsecondary education (45%) than were respondents of other regions, particularly than those residing in the South region (13%).

Azeri was the predominant ethnic group (90%), followed by Talish (4%), Lezgi (1.5%), and Tat and Avar (1.3% and 1%). Most of the Talish population was concentrated in the South; Lezgis and Tats were more likely to reside in the North and Northeast regions. Russians represent less than 1% of the population; most Russian respondents reside in Baku (3%). Most respondents (90%) spoke Azeri at home; 4% spoke Russian, and 3% spoke Talish. Women in Baku were significantly more likely to speak Russian in the family than were women outside Baku, even if they had an Azeri background.

Most women (80%) reported that they did not work outside the house. Because of low job availability, rural women were even less likely to work outside the house (14% vs. 25% in urban areas). The proportion of women holding a job (including part-time work) was the lowest in the South region (13%) and the highest in Baku (27%).

Approximately 10% of all women in the sample were IDP/Rs because of the war in Nagorno-Karabakh and the surrounding territories, including 2% of women who fled Armenia when the war started. Most of the internally displaced families in Azerbaijan resided in the South-West region, where they constituted more than 30% of the population, and in Baku, where they accounted for 13% of the population. About 1 in 4 IDP/R families (26%) resided in temporary housing conditions in public buildings and other government facilities (e.g., hotels, schools, factories, sanatoria, health camps, farms, and other state-owned facilities); about 1 in 5 IDP/R families resided either in mudhouses (16%) or shelters built by nongovernmental organizations (4%); a few IDP/Rs were living in train wagons, dugouts, or tents (3%) (data not shown).

CHAPTER 4

FERTILITY AND PREGNANCY EXPERIENCE

One objective of the AZRHS01 was to assess the current levels of and trends in risk factors associated with reproductive behaviors and to identify factors that might change such behaviors. Policy makers and program managers may use the findings presented here to design programs that respond to the reproductive behavior of the population and tailor them to meet the needs of key subgroups. To obtain information about reproductive patterns, the questionnaire included a series of questions about marriage, divorce, sexual activity, contraceptive use, childbearing, the use of induced abortion, infertility, desired family size, planning status of all pregnancies in the past 5 years, and information about prenatal care for all births during the past 5 years. Information about pregnancies (i.e., births, abortions, and fetal losses) was collected through a complete lifetime pregnancy history for each woman up to the time of the interview. This information represents an important addition to vital statistics routinely compiled at the local and state level because it allows comparisons of fertility and abortion data by background characteristics and behaviors.

4.1 Fertility Levels and Trends

During the past decade, scientifically designed nationwide population-based surveys of reproductive health have been conducted in many countries of eastern Europe and the former Soviet Union with support from the U.S. Agency for International Development and the United Nations and technical assistance from the Centers for Disease Control and Prevention (Reproductive Health Surveys) or Macro Incorporated (Demographic Health Surveys). These surveys have used similar methodology and questionnaires, thus allowing for good comparability across countries. Such surveys have been implemented in several The countries of Eastern Europe and the former Soviet Union countries share a common history as well as recent social, political and economic changes following since the fall of communism; they have inherited the same state-subsidized health care system modeled after the Russian centralized system).

Demographically, most of these countries have much in common in the areas of fertility and fertility regulation practices. Nonetheless, at the last USSR Census, the total fertility rate among the Soviet republics differed sharply, an expression of their socioeconomic and cultural characteristics and

ethnic diversity. At the forefront were the Central Asian republics where, in all but one country (Kazakhstan), the total fertility rates (TFRs) ranged from 3.9 births per woman in the Kyrgyz Republic to 5.2 births per woman in Tajikistan (Brackett, 1993). The European Soviet republics (Ukraine, Russia, and Belarus) and the Baltic countries reported the lowest fertility levels— about 2 births per woman. Among the Caucasus countries, Azerbaijan had the highest fertility rate (2.8 births per woman), similar to the Kazakhstan rate of 2.9 births per woman. Although fertility levels started to decline throughout the Soviet republics before 1989, the decline continued in the 1990s, in some cases at a faster pace, resulting in fertility levels far below the replacement level of 2.1 births per woman in the European former Soviet countries and in a loss of about 1 birth per woman in the Central Asian republics.

TABLE 4.1.1
Three-Year Total Fertility Rates Among All Women
Survey and Official Estimates
RHS and DHS Surveys in Selected Eastern European and Former Soviet Union Countries

Region and Country		Total Fertility Rates (Live births per woman)		
		Time Period	Survey Estimates	Official Estimates
Eastern Europe				
Czech Republic	RHS	1990–1992	1.9	1.8
Moldova	RHS	1994–1996	1.8	1.7
Romania	RHS	1997–1999	1.3	1.3
Russia	RHS	1998–1999	1.3	NA
Ukraine	RHS	1997–1999	1.4	1.3
Caucasus Region				
Armenia	DHS	1998–2000	1.7	1.3
Azerbaijan	RHS	1998–2000	2.1	2.0
Georgia	RHS	1997–1999	1.7	1.3
Central Asian Republics				
Kazakhstan	DHS	1997–1999	2.1	1.9
Kyrgyz Republic	DHS	1995–1997	3.4	3.1
Turkmenistan	DHS	1998–2000	2.9	2.9
Uzbekistan	DHS	1994–1996	3.3	3.4

Current levels of fertility based on survey responses were estimated with the use of age-specific fertility rates calculated from information collected through the respondents' lifetime pregnancy histories (Table 4.1.1). The TFR was computed by accumulating the 5-year age group-specific fertility rates and multiplying the sum by 5. The TFR is thus defined as the average number of live

births a woman would have during her reproductive lifetime (15-44) if she experienced the currently observed age-specific fertility rates (ASFRs). Numerators for the ASFRs were calculated by selecting live births that occurred during the 36-month period preceding the survey and grouping them (in 5-year age groups) by the age of the mother at the time of pregnancy outcome (calculated from the mother's reported date of birth). The denominators for the rates represent the number of woman-years lived in each specified 5-year age group by those mothers during the 3-year period preceding the survey.

As shown in Table 4.1.1, the TFRs were the lowest in Eastern Europe, particularly in Romania, Russia, and Ukraine (1.3, 1.3, and 1.4 births per woman, respectively). The TFRs in the Caucasus region, with the exception of Azerbaijan (whose rate of 2.1 births per woman is at replacement level), were higher than in Eastern Europe but slightly lower than the replacement level of 2.1 births per woman. Only the Central Asian republics (except Kazakhstan) have fertility rates above replacement level. Under the assumption of replacement fertility levels held constant and zero net migration, the population of Azerbaijan will continue to grow to more than 10.5 million by the year 2025 and more than 12 million by 2050 (Kingkade, 1994).

Table 4.1.1 also shows that survey estimates in most countries were either identical or within survey sampling errors, compared with official estimates for the same time period. For example, the TFR for the 3 years preceding the survey in Azerbaijan was within the sampling error compared with the most recent official rate available (1997-1998), but it was probably higher than the current official reporting. (Ministry of Health [MOH], 2001). The only clear exceptions were Georgia and Armenia, countries where the survey estimates exceeded the official estimates by 30%. Although underreporting of births by civil registries may have played a role, particularly in Georgia, overestimates of the female population were more likely to explain lower official rates in both countries. Denominators used to calculate official fertility rates were derived from the 1989 Census projections without adjusting for the substantial outmigration experienced during the 1990s as a result of war (Armenia, Georgia) and territorial secession (Georgia), produced artificially lower ASFRs and TFRs than the survey estimates (Khachikyan et al., 2001., Serbanescu et al., 2001).

During the past 10 years, fertility rates declined in all countries presented in Table 4.1.2. Except for Uzbekistan and Kyrgyz Republic, most countries have relatively low fertility rates with high levels of childbearing among women in their 20s, followed by sharp declines at age 30 and older (Table 4.1.2). Like women in other countries of the region, Azeri women initiate and complete childbearing at an early age. The highest fertility levels are among 20- to24-year-old and 25- to 29-year-old women, accounting for 36% and 32%, respectively, of the TFR. Fertility among adolescent women (44 births per 1,000 women aged 15-19) is the fourth highest, contributing 11% of the TFR. Women aged 35-39 and 40-44 make minimal contributions to total fertility; their ASFRs account for only 5% and 2%, respectively, of total fertility.

Table 4.1.2

Three-Year Period[*] Age-Specific Fertility Rates and Total Fertility Rates Among Women Aged 15–44 Reproductive and Demographic Health Surveys (RHS and DHS) in Selected Eastern European and Former Soviet Union Countries

Country	Age-Specific Fertility Rate (per 1000)[†]						Total Fertility Rate[‡]
	15–19	20–24	25–29	30–34	35–39	40–44	
Eastern European Region							
Czech Republic, 1993	49	176	92	41	11	4	1.9
Romania, 1993	49	129	83	33	12	5	1.6
Romania, 1999	36	100	83	29	13	2	1.3
Russia (three oblasts[§]), 1996	44	115	58	30	7	2	1.3
Russia (three oblasts[§]), 1999	39	101	73	28	11	7	1.3
Moldova, 1997	57	158	88	40	17	6	1.8
Ukraine, 1999	49	114	66	36	14	4	1.4
Caucasus Region							
Georgia, 1999–2000	65	113	92	48	22	7	1.7
Armenia, 2000	50	149	88	35	16	3	1.7
Azerbaijan, 2001	44	151	133	58	19	9	2.1
Central Asian Region							
Kazakhstan, 1995	64	190	136	67	35	7	2.5
Kazakhstan, 1999	40	167	106	64	24	9	2.1
Uzbekistan, 1996	61	266	176	114	39	9	3.3
Kyrgyz Republic, 1997	75	246	179	113	47	13	3.4
Turkmenistan, 2000	30	184	195	105	48	14	2.9

* Three years prior to the interview.
† Age at pregnancy outcome.
‡ Number of births per woman.
§ Yekaterinburg, Perm, and Ivanovo, respectively (predominantly urban sample).
Source: Goldberg H et al., 1993; KIIS and CDC, 2001; MACRO International 1995–2001; Serbanescu F et al. 1995, 1998, 2001; VCIOM and CDC, 1998, 2000.

Compared with its Caucasus neighbors, Azerbaijan exhibits the lowest adolescent fertility but the highest fertility rates for 20-24 -year-old and 25-29-year-old women. As a result, its young-adult fertility rate of 195 births per 1,000 women aged 15-24 years is similar to the rate in Armenia (199 births per 1,000) and higher than that in Georgia (178 births per 1,000). Lower adolescent fertility rates in Azerbaijan were also observed in the 1989 USSR Census, which documented fertility of 29 births per 1,000 women aged 15-19, the second lowest rate in USSR at that time, after Turkmenistan (Brackett, 1993). Lower-than-average teenage fertility rates are probably the result of the higher mean age at first marriage in Azerbaijan (the highest mean among former Soviet republics at the most recent USSR Census) and low rates of nonmarital fertility for this age group.

Figure 4.1
Three-Year Period Age-Specific Fertility Rates for Several Time Periods
Among All Women Aged 15–39— AZRHS Survey, Azerbaijan, 2001
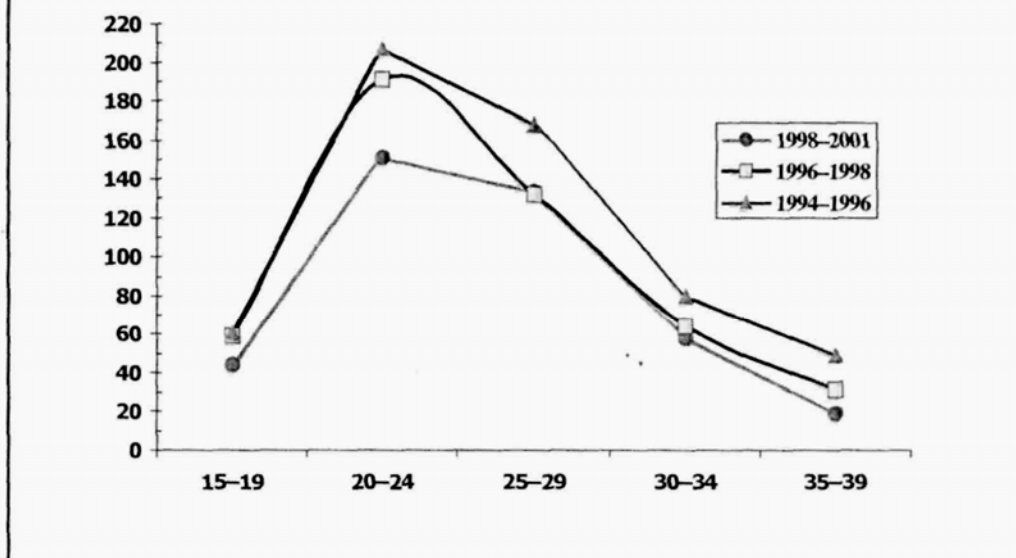
TABLE 4.1.3
Three-Year Period Age-Specific Fertility Rates for Several Time Periods
Among All Women Aged 15-

| Age Groups | Age-Specific Fertility Rate (per 1,000)* | | |
	1998–2001 AZRHS01[†]	1996–1998 AZRHS01[‡]	1994–1996 AZEHS01[¶]
15–19	44	59	61
20–24	151	191	207
25–29	133	132	168
30–34	58	64	80
35–39	19	31	49
40–44	(9)	(1)	§
Total Fertility Rate (per woman)	**2.1**	**2.4**	**2.8**

* Age at pregnancy outcome.
† Live births occurring between May 1998 and April 2001.
‡ Live births occurring between May 1996 and April 1998.
¶ Live births occurring between May 1994 and April 1996.
§ No data since a woman aged 40–44 in 1994–1996 would have been aged over 44 years at the time of the interview and thus not included in the sample. For this reason, the period TFR is only for women aged 15–39.
( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis.

Using the findings from AZRHS01, fertility trends can be estimated over several 3-year periods (Table 4.1.3 and Figure 4.1). These trends had to be restricted to women aged 15-39 years since the rates for older women (i.e., age at pregnancy outcome) either represent partial fertility rates (due to the inherent truncation of the time exposure) or cannot be assessed. For example, some women aged 40-14 in 1996-1998 would be more than 44 years old in 1999-2001, but only those aged 44 or younger would have been selected to participate in the survey. Similarly, all women aged 40-44 in 1994-1996 would have been more than 44 years old in 2001 and thus not included in the sample.

Compared with previous years (1994—1996), fertility declines in 1998-2001 are notable in all age groups. Given the peak in fertility at age interval 20-24 and 25-29, declines of these ASFRs would have a higher impact on the total fertility decline than would declines in all other ASFRs. For example, between 1994-1996 and the most recent 3-year period (1998-2001), the ASFRs for 20- to 29-year-old women (contributing to 68% of the TFR in both time periods) declined by 27% and 21%, respectively, and the TFR declined by 25%. Fertility decline among women aged 35-39 was even higher (a more than 60% decline), but because their contribution to the total TFR is quite low (5% in 1998-2001 and 9% in 1994-1996), the impact on the TFR decline was less substantial.

Similarly, the general fertility rate for 1998-2001, defined as the number of births per 1,000 women of reproductive age (15-44), was 71 births per 1,000 women aged 15-44 and 77 births per 1,000 women aged 15-39. General fertility rate for 1994-1996 was 107 births per women aged 15-39. Thus, between the two time periods general fertility rate declined by 28% (data not shown).

The cumulative past fertility of women interviewed in the AZRHS01 was calculated as the percent distribution of women by the number of live births and stratified by the current age of each woman at the time of the interview (Table 4.1.4). A total of 43% of all women aged 15-44 were childless at the time of the interview, but only 9% of women currently in union had not had their first child. Although few women reported a birth before age 20, by age 29, 70% of all women had given birth. Just 1 in 8 women (12%) remained childless by age 44.

Among currently married women, 40% of adolescents have already had their first child, 80% of 20- to 24-year-olds have given birth, and more than 90% of women at least 30 years old have had their first child. Only 4% of married women remained childless by age 40-44.. A minority of women had four or more children (12% of all women and 19% of currently married women).

TABLE 4.1.3
Number of Children Born Alive by Current Age of Respondents Among All Women and Among Women
Currently in Union Aged 15–44 (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Number of Children Born Alive	All Women						
		Age Group (Current Age)					
	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	42.7	95.9	62.6	30.0	17.7	12.4	11.8
1	8.7	3.0	15.4	15.6	8.1	7.1	5.7
2	20.6	1.1	16.7	32.7	35.3	27.0	19.4
3	16.0	0.0	4.5	16.3	25.6	29.2	27.6
4	7.5	0.0	0.6	5.1	9.1	14.8	19.4
5 or more	4.5	0.0	0.1	0.3	4.2	9.5	16.1
Total	100.0	100.0	.100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,668	1,207	1,207	1,156	1,533	1,531	1,034

Number of Children Born Alive	Women in Union						
		Age Group (Current Age)					
	Total	15–19	20–24	25–29	30–34	35–39	40–44
0	9.1	59.8	20.1	7.6	5.5	3.6	3.7
1	12.8	29.2	32.7	19.3	6.7	6.3	5.3
2	32.9	11.0	35.9	43.7	40.7	29.5	20.7
3	25.8	0.0	9.8	21.9	31.2	32.6	30.7
4	12.1	0.0	1.3	7.1	11.0	16.9	21.9
5 or more	7.3	0.0	0.2	0.4	5.0	11.1	17.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	5,166	157	658	910	1,301	1,270	870

4.2 Fertility Differentials

Table 4.2 shows the ASFRs and TFRs among different subgroups. Fertility among women living in urban areas, including Baku, was almost 20% lower than among rural women in the 3-year period preceding the interview. Most of the difference between rural and urban fertility rates was the result of higher ASFRs among rural residents aged 15-29; fertility at age 30 and older was similar in both rural and urban areas.

By region, women living in the Central areas and in Baku had the lowest levels of fertility (1.8 and 1.9 births per woman, respectively). Again, most differences in ASFRs by region were among young adults. The TFR was inversely related to the educational level; it decreased from a high of 2.3 births per woman among those with less than a complete secondary education to 1.8 births per woman among women

27

TABLE 4.2
Three-Year* Age-Specific Fertility Rates and Total Fertility Rates Among All Women Aged 15–44 Years by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

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	44	151	133	58	19	9	2.1
Residence							
Urban	32	132	128	57	19	9	1.9
Rural	57	171	139	59	19	9	2.3
Region							
Baku	37	123	111	·65	25	14	1.9
North & North-East	46	168	134	68	28	3	2.2
West	62	148	165	49	9	7	2.2
South-West	43	179	135	54	33	14	2.3
South	43	152	150	51	10	6	2.1
Central	33	148	119	51	8	9	1.8
Education							
Secondary incomplete or less	66	150	154	73	11	7	2.3
Secondary complete	39	175	123	54	24	9	2.1
Technicum	30	150	119	47	10	14	1.9
University/Postgraduate	9	83	162	80	24	3	1.8
Socioeconomic Status							
Low	53	171	140	65	19	7	2.3
Middle	39	140	130	50	19	11	1.9
High	25	117	112	53	16	8	1.6
Ethnicity							
Azeri	41	145	133	59	20	9	2.0
Other[‡]	66	198	131	53	8	6	2.3
IDP/Refugee Status							
IDP/R	51	135	126	65	31	19	2.1
Non-IDP/CA	37	148	119	50	16	10	1.9
Non-IDP/NCA	45	153	137	59	18	7	2.1

* Live births occurring between May 1998 and April 2001.

† Age at pregnancy outcome.

‡ Includes Talish, Lezgi, Tat, Russian, and other ethnic groups.

who attended university. Fertility differences according to education were more pronounced among younger women. Generally, women with the highest educational attainment had the peak of their fertility at ages 25-29, whereas women with the least education reached their highest fertility at age 20-24. Women with low socioeconomic status (SES) had, on average, 2.3 births per woman,

compared with 1.9 and 1.6 births per woman, respectively, among women with middle and high SES. Fertility rates were similar for IDP/R and non-IDP/R women.

4.3 Nuptiality

Because the main exposure to the risk of pregnancy occurs among women who are married or in a consensual union, reproductive health behaviors are greatly influenced by marital status. Survey results showed that the median age at first marriage among women aged 15-14 (15-49 in Central Asian republics and Armenia) is between 20 and 22 years of age in all countries mentioned in Table 4.1.1. Because 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 was typically within 2 years after first marriage), most countries of the region exhibit the highest fertility rates among currently married young adults (data not shown). 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 Azerbaijan (58%) was comparable to that of other countries of the region (ranging from 54% in Russia to 68% in Uzbekistan). In addition, a small proportion of women were living in consensual unions, particularly in Eastern Europe (10% of women in Russia, 6% in Romania, and 4% in Ukraine) but much less so in Central Asia (Table 4.3). At the time of the AZRHS01, less than 60% of women aged 15-44 were currently married (58%) or living in a consensual union (1%). Five percent of women were widowed, divorced, or separated (from a spouse or from a partner in a consensual union), subgroups that collectively constitute the category of "previously married." More than 1 in 3 women (36%) had never been married or lived with a partner.

The proportion of currently married (either legal or consensual marriage) women did not vary significantly by residence or region. Marital levels increased rapidly with age, from 10% among 15- to 19-year-olds, to 44% among women aged 20-24, and to 73% among 25- to 29-year-olds; the rate reached a maximum of about 84% for women aged 35-39 and started to decline thereafter. Consensual unions were uncommon across all age groups. Separation, divorce, and widowhood increased with age, reaching a maximum of 12% among women aged 40-44. The proportion of never-married women decreased abruptly with age, from 90% among 15- to 19-year-olds to 53% among women aged 20-24, 24% among women aged 25-29, and 11 % among women aged 30-34. Among women aged 35 or older, about 8% of women had never been married.

The proportion of women married or in union was significantly lower among women who did not complete high school (47%) than among women with a completed secondary or technicum education

TABLE 4.3
Current Marital Status for Women Aged 15–44 Years
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Marital Status | | | | Total | Unweighted No. of Cases |
	Married	Consensual Union	Previously Married	Never Married		
Total	**57.8**	**0.7**	**5.2**	**36.3**	**100.0**	**7,668**
Residence						
Urban	58.3	0.8	5.7	35.3	100.0	3,832
Rural	57.1	0.6	4.8	37.6	100.0	3,836
Region						
Baku	59.4	1.1	5.6	34.0	100.0	1,533
North & North-East	58.2	0.4	4.1	37.3	100.0	924
West	59.5	1.0	7.6	31.9	100.0	766
South-West	55.7	0.4	4.8	39.0	100.0	2,302
South	54.3	0.6	3.9	41.3	100.0	950
Central	58.1	0.4	6.2	35.3	100.0	1,193
Age Group						
15–19	9.5	0.4	0.3	89.8	100.0	1,207
20–24	43.2	0.8	3.2	52.8	100.0	1,207
25–29	71.8	0.7	3.7	23.8	100.0	1,156
30–34	80.1	1.1	7.5	11.3	100.0	1,533
35–39	83.8	0.6	7.6	8.1	100.0	1,531
40–44	80.7	0.6	11.8	6.9	100.0	1,034
Education						
Secondary Incomplete or Less	46.0	0.9	4.7	48.4	100.0	1,697
Secondary Complete	60.0	0.7	5.1	34.2	100.0	3,868
Technicum	69.1	0.4	6.4	24.1	100.0	1,215
University/Postgraduate	58.1	0.8	5.3	35.8	100.0	888
Socioeconomic Status						
Low	57.4	0.6	5.8	36.2	100.0	4,068
Middle	57.9	0.8	5.2	36.1	100.0	2,770
High	58.8	0.6	3.3	37.4	100.0	830
Ethnic Group						
Azeri	57.9	0.6	5.3	36.2	100.0	7,189
Other	56.7	0.9	4.9	37.5	100.0	479
IDP/Refugee Status						
IDP/R	60.5	0.5	6.1	33.0	100.0	1,272
Non-IDP/CA	55.8	0.5	4.9	38.9	100.0	3,047
Non-IDP/NCA	57.9	0.7	5.2	36.1	100.0	3,349

(61% and 70%, respectively) and those with university or postgraduate education (59%). In studying the impact of education on marital levels, it should be kept in mind that the youngest women are less likely to marry because they are still in school. Because at least some secondary education was compulsory in former Soviet-bloc countries, many young women could not marry before at least age 16 (the youngest age for official marital eligibility), resulting in lower marital rates among those with less than complete secondary education. Among women aged 20-24, however, the likelihood of being in a marital relationship, either consensual or formal, was inversely correlated with education. For example, 47%-52% of 20- to 24-year-old women with high school education or less were in union, compared with 23% of 20- to 24-year-olds with postsecondary education (data not shown).

4.4 Age at First Sexual Intercourse, Union, and Birth

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

Figure 4.4
Percent of Women Who Have Ever Been in Union and Ever Had a Live Birth
Before Given Ages and Median Age at First Event, Life Table Estimates
Reproductive Health Survey: Azerbaijan, 2001
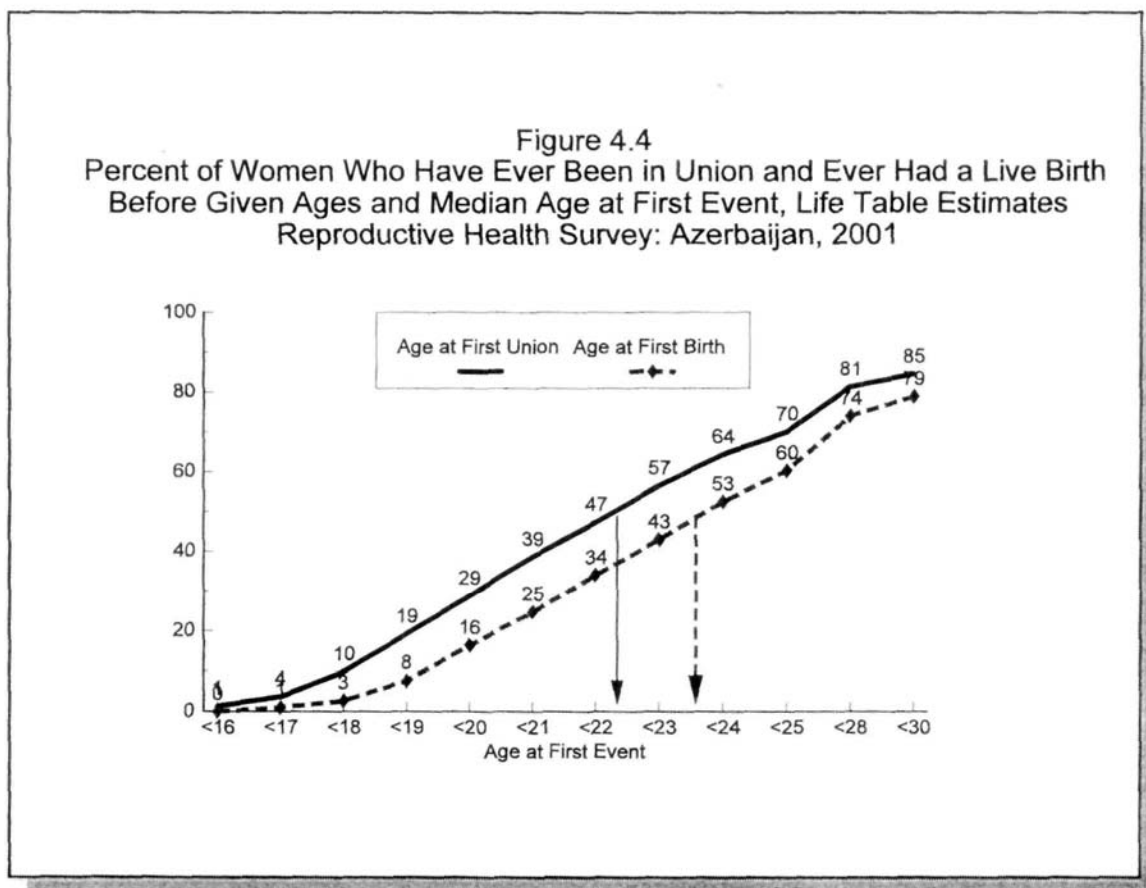
Table 4.4.1
Percent of Women Aged 15-44 Who Had Their First Sexual Relation, First Union, and First Birth
Before Selected Ages, By Current Age
Reproductive Health Survey: Azerbaijan, 2001

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	0.6	(7.8)	(10.2)	NA	NA	10.2	89.8	†	1,207
20-24	0.3	16.9	34.3	42.6	47.5	47.5	52.5	†	1,207
25-29	0.2	13.2	36.2	54.2	70.1	76.2	23.8	21.5	1,155
30-34	0.0	5.7	28.3	49.4	74.3	88.7	11.3	22.1	1,533
35-39	0.2	6.4	23.1	45.0	70.6	92.0	8.0	22.5	1,530
40-44	0.0	7.5	26.1	44.7	69.6	93.3	6.7	22.6	1,033
Total	**0.2**	**9.5**	**25.2**	**38.8**	**53.7**	**63.8**	**36.2**	**22.3**	**7,665**

Current Age	Age at First Union					Ever In Union	Never In Union	Median Age	Nº of Cases*
	≤15	≤18	≤20	≤22	≤25				
15-19	0.6	(7.7)	(10.2)	NA	NA	10.2	89.8	†	1,207
20-24	0.3	16.2	33.7	42.4	47.2	47.2	52.8	†	1,207
25-29	0.1	12.1	35.2	53.8	70.0	76.2	23.8	21.5	1,156
30-34	0.0	5.2	27.5	48.9	73.9	88.7	11.3	22.1	1,533
35-39	0.2	6.0	22.2	44.4	70.6	91.9	8.1	22.5	1,531
40-44	0.0	6.8	25.5	44.3	68.5	93.1	6.9	22.6	1,032
Total	**0.2**	**8.9**	**24.6**	**38.5**	**53.4**	**63.7**	**36.3**	**22.3**	**7,666**

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	0.1	(2.5)	(4.1)	NA	NA	4.1	95.9	†	1,207
20-24	0.0	6.9	22.1	31.5	37.4	37.4	62.6	†	1,207
25-29	0.0	2.1	21.7	40.4	62.0	70.0	30.0	23.3	1,156
30-34	0.0	0.6	14.7	35.6	63.5	82.4	17.6	23.4	1,532
35-39	0.2	1.0	11.2	30.5	59.4	87.6	12.4	24.0	1,530
40-44	0.0	1.5	12.2	28.9	57.8	88.0	12.0	24.0	1,033
Total	**0.1**	**2.5**	**13.6**	**26.8**	**44.2**	**57.3**	**42.7**	**23.7**	**7,665**

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

In Azerbaijan the median ages at first union and first birth were 22.3 and 23.7, respectively (Figure 4.4 and Table 4.4). Thus, most fertility for the youngest women is typically marital. Out-of-wedlock births are rare in Azerbaijan, and unmarried women contribute little to total fertility (less than 5% of births were out-of-wedlock, according to official records).

Information on age at first sexual intercourse, first union, and first live birth for all women are presented by age of the respondent at the time of interview in Table 4.4.1. The left side of the table shows the proportion of respondents within each age cohort (5-year age group) who have ever had sexual intercourse (top panel), ever been in formal or consensual marriage (middle panel), and ever had a live birth (bottom panel) before reaching specific ages. The overall median age (age by which 50% of women aged 15-44 have experienced the event) and the median age within each age group are also displayed for each event. By comparing the proportion of women within different cohorts who experienced various events before age 20, it is possible to detect whether the age of occurrence of each event has changed over time. For example, the proportion of women who had sexual intercourse before age 20 has increased from 26% among 40- to 44-year-olds to 34% among 20- to 24-year-olds; however, the proportion who reported premarital sexual experiences remained essentially unchanged in the two cohorts, because this increase coincides with an identical increase in the proportion of married women among younger cohorts.

In Azerbaijan 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. As shown in Table 4.4.1, median ages at first intercourse and first marriage for each cohort are virtual identical. Although young women aged 25-29 were initiating sexual activity about a year earlier than older women (e.g., women aged 40-44), they also marry a full year earlier. Thus, essentially no differences exist across subgroups in the time interval between the first intercourse and the first union, and premarital sexual intercourse is uncommon for all cohorts.

As mentioned previously, a higher proportion of women in the younger cohorts had their first marriage before age 20 (34% among 20- to 24-year-olds) than in the older cohorts (26% among 40- to 44-year-olds). Consequently, the median age at first union has decreased by a full year, from 22.6 to 21.5, between the two cohorts. This trend is particularly interesting and has potential implications for future fertility patterns and fertility control measures. Given that more Azeri women currently marry at younger ages than older cohorts (a return to some extent to traditional practices of the pre-Soviet era) and that they have a relatively early start (1-2 years after the first marriage) and end to childbearing, their fertility is likely to remain at the replacement level. However, compared with their counterparts in older cohorts, they will spend a greater number of their reproductive years at risk of unintended pregnancy and have a greater need for long-term, effective contraception; in the absence

of effective birth control methods, they will be more likely to rely on induced abortion to avoid unwanted births.

The most notable change between cohorts is manifested in the patterns involving age at first birth. The age at first birth has also decreased for younger cohorts, paralleling the decrease in the age at first union. A substantially larger proportion of women aged 20-24 had their first birth before age 20 than women aged 40-44 (22% vs. 12%). The time interval between the first union and the first birth within each cohort, however, has gradually increased. For example, the median age at first birth among 25- to 29-year-olds was 1.8 years later than their median age at first union, whereas median age at first birth among 40- to 44-year-olds was 1.4 years later than their median age at first union. These findings suggest that younger cohorts tend to marry younger than older cohorts but have a slightly later onset of childbearing than in the older cohorts. Among all reproductive age women, 85% had their first union by age 30 and 79% had their first live birth by that age (data not shown).

TABLE 4.4.2
Median Age at First Sexual Intercourse, First Union and First Birth Among Women Aged 15–44
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Median Age at First Intercourse	Median Age at First Union	Median Age at First Birth
Total	**22.3**	**22.3**	**23.7**
Residence			
Urban	22.3	22.4	23.8
Rural	22.1	22.1	23.6
Region			
Baku	22.3	22.3	23.8
North & North-East	22.0	22.0	23.5
West	22.0	22.0	23.5
South-West	22.6	22.6	24.3
South	22.2	22.2	23.5
Central	22.8	22.8	24.3
Education			
Secondary Incomplete or Less	21.2	21.3	23.0
Secondary Complete	21.5	21.5	23.0
Technicum	22.9	22.9	24.3
University/Postgraduate	24.3	24.3	26.1

Urban women initiate sexual activity, union, and childbearing at a slightly older age than rural women do, but the difference is not significant (Table 4.4.2). The intervals between these events are similar for urban and rural residents, a fact that may explain the lack of significant differences in

34

cohabitation and fertility rates by residential area. Differentials in median age of experiencing these events are significantly affected by education. The median age at first intercourse, first marriage, and first birth was 3.1 years older for women with university education than for those who had not completed secondary education.

4.5 Recent Sexual Activity

Current sexual activity is an essential indicator for estimating the proportion of women who are at risk of having an unintended pregnancy and are therefore in need of contraceptive services. It also has major implications for the selection of a contraceptive method that best suits the reproductive behavior and fertility preferences of each individual. As shown in Table 4.5 and Figure 4.5, 36% of all women aged 15-44 who were interviewed in the AZRHS01 reported that they had never had sexual intercourse. Additionally, 4% of all women were pregnant, and 4% reported postpartum abstinence at the time of the interview. For all women with sexual experience who were not currently pregnant or postpartum (56%), only 44% were currently sexually active (i.e., had intercourse within the month preceding the interview). Thus, if we exclude respondents who have never had intercourse, 79% of sexually experienced women were currently sexually active (44% of 56%).

Figure 4.5
Reported Sexual Activity Status, Women Aged 15–44
Reproductive Health Survey—Azerbaijan, 2001

35
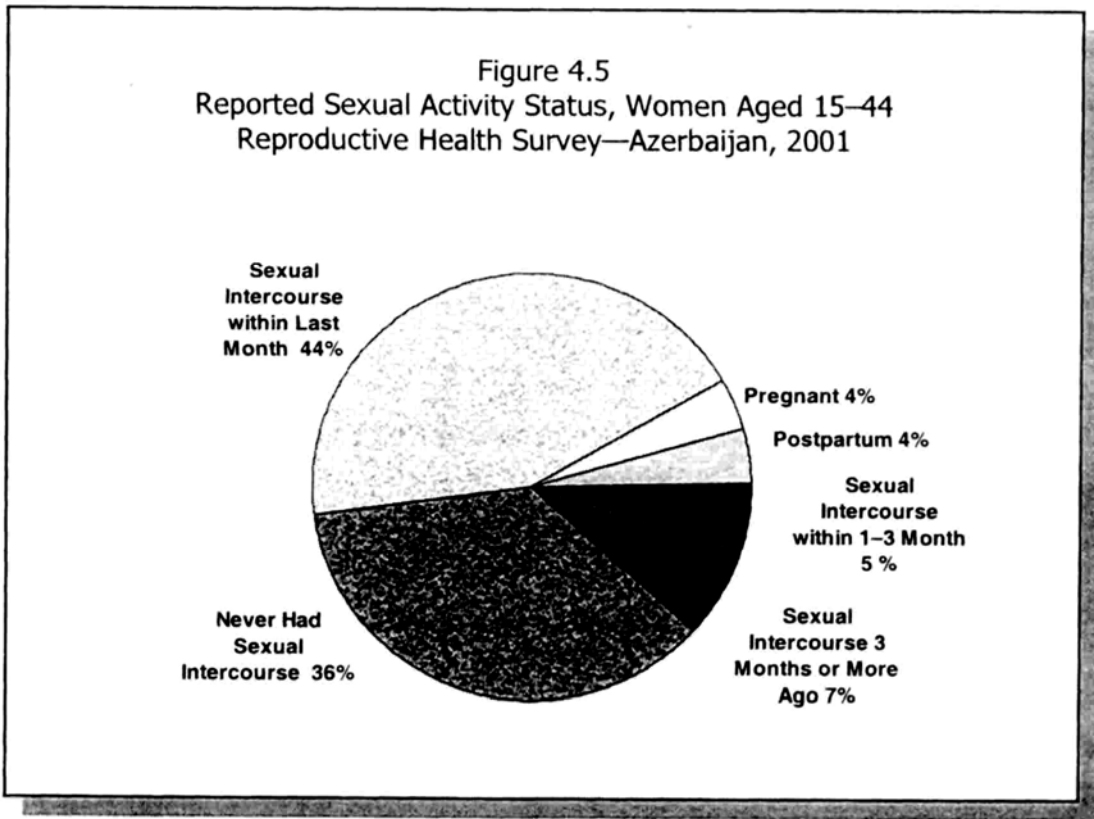
TABLE 4.5
Sexual Activity Status by Current Marital Status and by Current Age
Women Aged 15-44 Years
Reproductive Health Survey: Azerbaijan, 2001

Sexual Activity Status	Total	Married/ In Union	Previously Married	Never Married
		Marital Status		
Never Had Intercourse	36.2	0.0	0.0	99.7
Currently Pregnant	4.2	7.1	0.0	0.0
Postpartum	3.6	5.6	5.5	0.0
Ever Had Intercourse				
• Within the Last Month	44.1	75.3	1.2	0.1
• 1-3 Months Ago	4.7	7.6	4.2	0.1
• Over 3 Month Ago but Within Last Year	2.1	2.7	9.8	0.1
• One Year or Longer	5.0	1.6	76.1	0.0
• One Month or Longer-Unknown Interval	0.3	0.1	3.2	0.0
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,668	5,146	387	2,135

Sexual Activity Status	Total	15–24	25–34	35–44
		Age Group		
Never Had Intercourse	36.2	73.5	16.9	7.4
Currently Pregnant	4.2	5.4	5.8	0.9
Postpartum	3.6	3.7	5.1	1.9
Ever Had Intercourse				
• Within the Last Month	44.1	13.9	58.2	68.9
• 1-3 Months Ago	4.7	1.6	5.7	7.6
• Over 3 Month Ago but Within Last Year	2.1	1.0	2.8	2.8
• One Year or Longer	5.0	0.9	5.3	9.9
• One Month or Longer-Unknown Interval	0.3	0.0	0.1	0.7
Total	100.0	100.0	100.0	100.0
Unweighted No. of Cases	7,668	2,414	2,689	2,565

Among women who were married or living with a partner, 75% reported having had intercourse at least once within the past month and 7% had had intercourse 2 or 3 months previously (Table 4.5). Conversely, only 5% of previously married women had had intercourse within the past 3 months. Most previously married women (76%) reported that their last sexual intercourse occurred 1 or more years ago, presumably while they were still married. Less than 1 percent of never-married women reported having had any sexual experience.

Only 1 in 4 young adult women (i.e., those aged 15-24) reported sexual intercourse; of those, 53% reported their last sexual encounter within the past 30 days, and 34% were pregnant or in early postpartum. More than 80% of women aged 25 or older, over 80% reported sexual experience. Of those, more than two-thirds had had intercourse within the past month.

4.6 Planning Status of the Last Pregnancy

For each pregnancy ended since January 1996, all respondents were asked about the planning status of the pregnancy at the time of conception. Each pregnancy was classified as either planned (i.e., wanted at the time it occurred), mistimed (i.e., occurring earlier than intended), unwanted (i.e., the respondent wanted no more children), or unsure. Mistimed and unwanted pregnancies together constitute unintended pregnancies (Westoff, 1976). Considerable evidence indicates that women who are pregnant with an unintended pregnancy are more likely to seek an elective abortion, to enter prenatal care late or not at all, and to experience pregnancy or perinatal complications (Brown and Eisenberg, 1995). Data on pregnancy intendedness should be interpreted with caution, however, because they tend to underrepresent the level of unintended pregnancies. One common source of underreporting is induced abortions, which are not always reported; because most pregnancies ending in elective abortion are unintended, such pregnancies will be underreported to the extent that abortions are underreported. Abortion underreporting does not appear to be a major concern in AZRHS01 because abortion rates calculated from the survey exceeded recent officially reported levels. Another source of underreporting may stem from retrospective rationalization and ambivalence for unintended pregnancies ending in live births. Women are asked to report retrospectively their thoughts about the pregnancy intention at the time of conception, and retrospectively reported intentions after the child is born become more positive (Miller, 1994). Thus, data shown here represent conservative estimates of the true levels of intendedness for pregnancies ending either in abortions or in live births. Despite the potential underreporting of unintended conceptions, the data in Table 4.3 show some important differences in pregnancy intendedness by according to pregnancy outcome and background characteristics.

Not surprisingly, given the high rates and ratios of induced abortion, the proportion of pregnancies

that are unintended is quite high. Fewer than 1 in 2 women of childbearing age (42%) said that her most recent pregnancy was intended at the time of conception, 9% reported it as mistimed, and 48% reported it as unwanted. Thus, 57% of women reported their last pregnancy as unintended; most of those women (84%) reported it as unwanted rather than mistimed. However, most women whose last pregnancies resulted in live births said those births were intended (85%). Conversely, all but a small percentage of women whose last pregnancy ended in induced abortion reported that their conceptions were unintended (96%). It should be noted that a relatively high proportion (35%) of women whose last pregnancy ended in miscarriage or stillbirth reported these pregnancies as unwanted, 4 times the proportion of women with live births who reported an unwanted pregnancy. These data suggest that either unintendedness had a negative influence on pregnancy development and outcome or that some of these outcomes may have been induced abortions, reported as spontaneous abortions or stillbirths because respondent bias toward giving a more socially desirable response. The relatively high unintendedness of pregnancies reported as spontaneous abortions or stillbirths was similar to that observed in other Eastern European reproductive health surveys (Serbanescu, 1995, 1998, 2000).

Planning status of the last pregnancy did not vary significantly by residence, but unintended pregnancies increased with age and parity. Adolescents and women aged 20-24 were less

Figure 4.6
Planning Status of the Last Pregnancy by Pregnancy Outcome
Among Women Aged 15–44 with at Least One Pregnancy in the Past 5 Years
Reproductive Health Survey—Azerbaijan, 2001
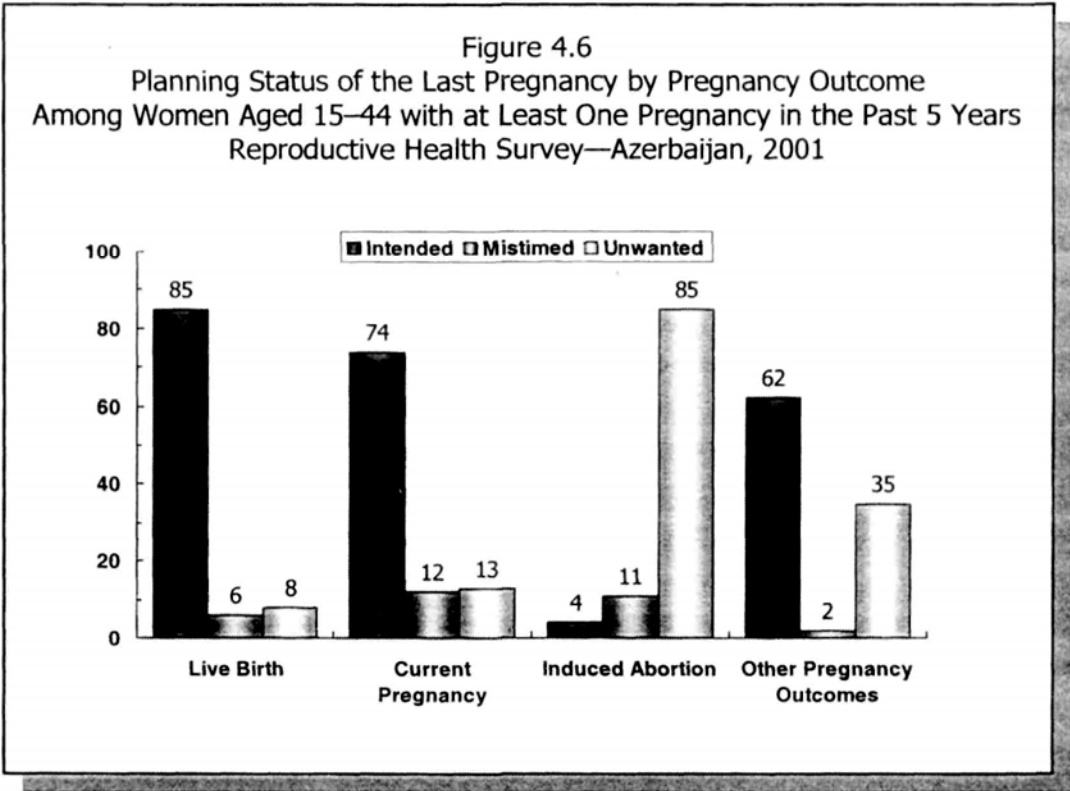
TABLE 4.6
Planning Status of the Last Pregnancy Among Women 15–44 Years of Age
With at Least One Pregnancy Since January 1996, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Planning Status of the Last Pregnancy | | | | | |
	Intended	Mistimed	Unwanted	Not Sure	Total	No. of Cases
Total	42.4	8.8	48.1	0.6	100.0	3,613
Pregnancy Outcome						
Current Pregnancy	74.3	12.0	13.2	0.5	100.0	374
Live Birth	85.1	6.0	8.3	0.5	100.0	1,202
Induced Abortion	3.5	10.8	85.0	0.7	100.0	1,862
Other Pregnancy Outcomes*	62.0	2.1	35.4	0.5	100.0	175
Residence						
Urban	39.4	9.8	50.0	0.8	100.0	1,777
Rural	46.1	7.7	45.9	0.4	100.0	1,836
Age Group†						
15–19	86.4	10.9	1.8	0.9	100.0	177
20–24	63.8	12.8	22.8	0.5	100.0	728
25–29	46.4	12.5	40.5	0.5	100.0	936
30–34	28.6	7.8	62.8	0.8	100.0	964
35–44	22.0	1.5	76.0	0.5	100.0	808
Marital Status‡						
Currently Married, in Union	40.4	9.0	50.0	0.6	100.0	3,449
Not Currently Married, in Union	83.1	5.1	10.8	1.0	100.0	164
No. of Living Children						
0	93.5	3.2	2.3	1.0	100.0	219
1	74.8	15.4	9.6	0.2	100.0	600
2	35.8	10.2	53.2	0.8	100.0	1,443
3	24.7	5.6	69.1	0.7	100.0	997
4+	19.3	3.0	77.7	0.1	100.0	354
Education						
Secondary incomplete or less	44.7	8.6	46.4	0.2	100.0	695
Secondary complete	42.2	9.2	47.6	1.0	100.0	1,872
Technicum	41.0	6.5	52.3	0.2	100.0	627
University/Postgraduate	41.7	10.9	46.9	0.4	100.0	419
Ethnic Group						
Azeri	41.1	9.0	49.3	0.6	100.0	3,386
Other¶	54.4	7.5	37.6	0.5	100.0	227
IDP/Refugee Status						
IDP/R	35.4	7.2	56.0	1.4	100.0	657
Non-IDP/CA	38.9	10.1	50.6	0.3	100.0	1,406
Non-IDP/NCA	44.3	8.8	46.3	0.6	100.0	1,550

* Includes pregnancies resulting in stillbirth, miscarriage or ectopic pregnancy.
† Age of the woman at the time of pregnancy outcome, except for 374 pregnant women for whom the age is that at the time of the interview.
‡ Marital status at the time of pregnancy outcome, except for 374 pregnant women for whom the marital status is that at the time of the interview.
¶ Includes Talish, Lezgi, Tat, Russian, and other ethnic groups.

likely to report unintended pregnancies (13% and 36%, respectively) than were women aged 25-29 (53%), 30-34 (70%), or 35 and older (78%). The ratio between unwanted and mistimed conceptions also varied with age; among 15- to 19-year-olds, most unintended pregnancies were mistimed rather than unwanted (the unwanted-to-mistimed ratio for these women was 1:16). Among women aged 20 or older, more pregnancies were unwanted than were mistimed. The unwanted-to-mistimed ratio for these women ranged from almost 2:1 among 20- to 24-year-olds to 3:1 among 25- to 29-year-olds, 8:1 among 30- to 34-year-olds, and 50:1 among those aged 35 or older. Thus, mistimed pregnancies are rapidly replaced by unwanted pregnancies as maternal age increases, primarily because spacing failure is replaced by the failure to end childbearing. As a result, virtually all unintended pregnancies among respondents were unwanted at older ages. A similar pattern can be seen when the planning status of the last pregnancy is examined in light of the number of living children. Women who had never had a live birth and women with one child were less likely to report that their last pregnancies were unwanted than were women with two or more live births. The level of unintended pregnancy did not vary significantly with education, socioeconomic status, ethnic background, or IDP/R status.

4.7 Future Fertility Preferences

Knowledge of reproductive intentions in a population is essential for helping couples choose the contraceptive method that will allow them to control when to have children. The preference among women for small families is reflected not only in declining fertility levels and high abortion rates but also in their stated desires not to have more children.

Among women in union, more two-thirds of respondents (69%) reported that they did not want to have more children (Table 4.7.1). Only 22% of women currently in union said they intended to have a child in the future, including 14% who wanted a child right away or within 2 years and 8% who wanted to wait at least 2 years before having another child. An additional 2% were unsure whether they wanted to have more children, and 7% said that they could not have any (more) children.

The intention to have any (more) children decreased rapidly with as the number of living children increased. By the time women had two children, most (77%-93%) were ready to terminate childbearing. Among those with no living children, almost 3 in 4 women (71%) wanted children; that proportion dropped to less than 16% among women with two or more children. Among women who wanted more children, the timing of the next birth was also influenced by parity: Most childless women wanted to have a child right away or within a year, whereas women with one or more children wanted to have another child after 2 or more years.

TABLE 4.7.1

**Fertility Preferences of Women Currently in Legal or Consensual Marriage Aged 15–44 Years
by Number of Living Children and by Age Group
Reproductive Health Survey: Azerbaijan, 2001
(Percent Distribution)**

Preference for Children	Total	No. of Living Children*					
		0	**1**	**2**	**3**	**4**	**5+**
Want more children	22.4	71.0	69.0	16.2	4.7	2.6	0.9
Want a child now	6.7	58.7	10.8	2.9	1.3	0.0	0.1
Want a child within a year	2.4	9.8	6.3	1.8	0.3	0.4	0.7
Want a child in 1-2 years	4.8	2.4	19.5	3.7	1.1	0.4	0.1
Want a child after 2 or more years	8.5	0.1	32.4	7.8	2.0	1.8	0.0
Want no (no more) children	69.4	1.9	21.5	77.2	88.4	92.7	92.6
Undecided if want (any)more children	1.7	0.0	3.6	2.3	0.4	1.5	0.0
Subfecund, infecund	6.6	27.0	6.0	4.3	6.6	3.2	6.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	5,146	276	728	2,001	1,535	467	139

Preference for Children	Total	Age Group					
		15–19	**20–24**	**25–29**	**30–34**	**35–39**	**40–44**
Want more children	22.4	79.0	49.5	34.4	18.2	8.8	4.5
Want a child now	6.7	27.6	10.2	8.1	5.9	4.1	3.2
Want a child within a year	2.4	6.9	4.5	3.0	2.7	1.3	0.4
Want a child in 1-2 years	4.8	13.7	12.0	8.3	3.7	1.6	0.4
Want a child after 2 or more years	8.5	30.8	22.8	15.0	5.9	1.8	0.5
Want no (no more) children	69.4	16.7	43.8	60.8	76.9	82.5	78.9
Undecided if want (any)more children	1.7	3.9	3.2	2.7	1.1	1.2	0.5
Subfecund, infecund	6.6	0.4	3.4	2.2	3.8	7.4	16.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	5,146	157	638	910	1,301	1,270	870

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

Women have had all the children they desire by a young age; consequently they have many years of exposure to the risk of unintended pregnancy. Younger women were much more likely than older women to want more children (see bottom panel of Table 4.7.1). The intention to have more children steadily decreased from 79% among the youngest age group to 50% for women aged 20-24, 34% among those aged 25-29,18% among women aged 30-34,9% among women aged 35-39, and only 4% for women aged 40 and older. Of those who desired additional children, most women wanted

to wait at least 1 year, except for the few women aged 35 or older who did not want to terminate childbearing and wanted to have a child right away. The desire to have a child within 1 year is lower among 15- to 19-year-olds (34%) and 25- to 29-year-olds (15%), presumably because they want to space the next pregnancy. These findings are important for the national family planning program, which should consider spacing methods for younger women and long-term or permanent methods for older women. Such low levels of desired childbearing, especially with limited availability of effective long-term contraception and the typically early start (and finish) of childbearing, increases the probability of unintended pregnancies and subsequent abortion.

TABLE 4.7.2
Percentage of Fecund Women in Union Reporting They Want No More Children
by Number of Living Children and Selected Characteristics
Fecund Women 15–44 Years of Age
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Total	Number of Living Children*				
		0	**1**	**2**	**3**	**4+**
Total	**74.3**	2.6	22.9	80.7	94.6	96.6
Unweighted No. of Cases	**4,836**	201	680	1,920	1,455	580
Residence						
Urban	73.9	5.5	22.3	82.3	93.6	95.9
Rural	74.8	0.0	23.7	78.1	95.7	97.1
Age Group						
15–24	38.8	3.5	10.1	71.3	85.8	†
25–34	72.4	1.4	22.2	77.3	91.5	92.2
35–44	91.1	2.1	60.2	90.7	97.7	97.9
Education Level						
Secondary or Less	72.8	0.0	23.0	79.8	94.3	97.1
Technicum	75.3	0.0	22.4	80.8	95.0	95.8
University/Postgraduate	73.7	9.4	23.5	80.9	94.2	98.7

* Women who were pregnant at the time of the interview are classified as having one more child than the actual number.
† Fewer than 25 cases in this category.

A total of 74% of Azeri women who can conceive reported that they do not want to have more children (Table 4.7.2). Only 23% of those with one living child wanted no more children, contrasting with 81% among two-child women and 95% among women with three or more children. The desire to terminate childbearing does not vary significantly by residence and education at any parity but is

directly correlated with age. Women younger than age 35 were less likely to report that they wanted to terminate childbearing at any parity.

Despite substantial differences in fertility between the Eastern European and Central Asian countries examined, rates of childbearing have fallen substantially in all places and reproductive intentions,

Figure 4.7
Percentage of Married Fecund Women of Reproductive Age
Who Want No More Children — RHS and DHS Surveys in EE and NIS
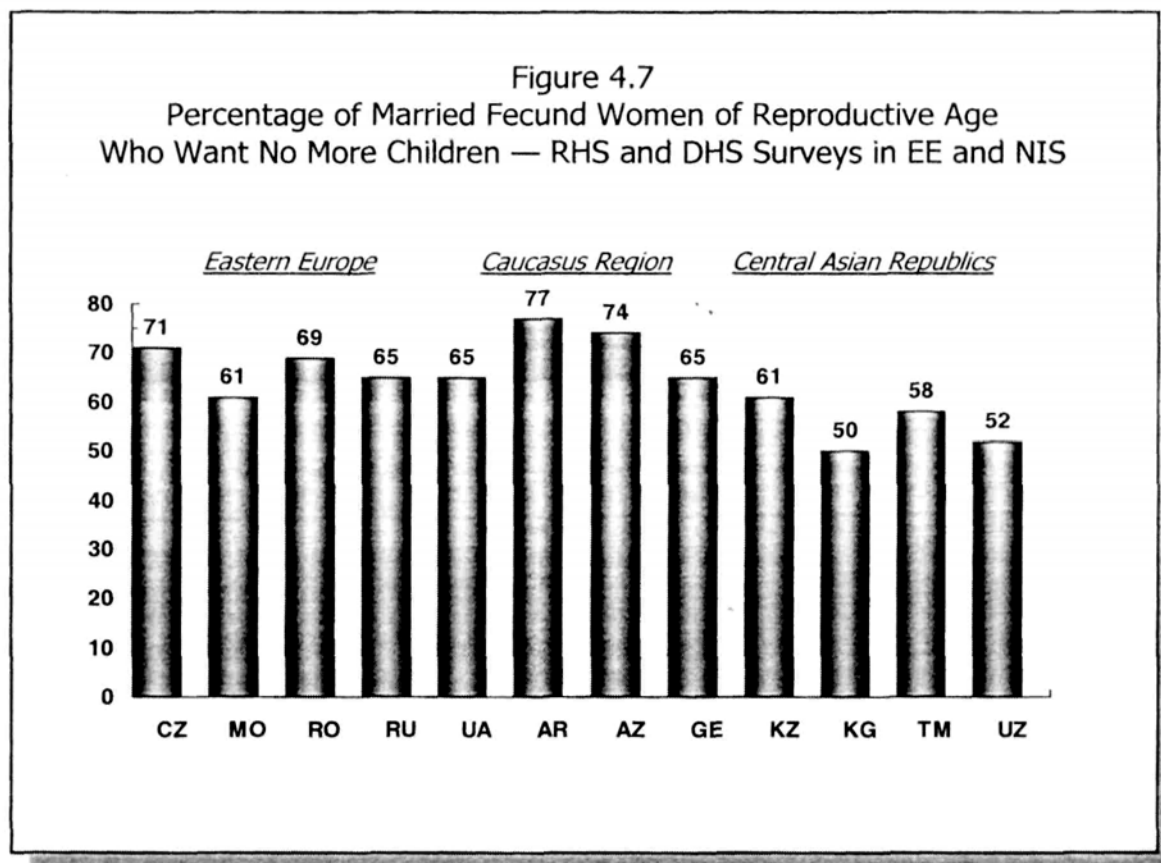
especially for couples with two or more children, are surprisingly similar (Figure 4.7). Although strongly influenced by different social norms, cultural values, and economic circumstances, reproductive intentions in these countries show a similar pattern. Among fecund women in union, between 50% and 77% want no more children. The desire to limit fertility is generally higher in Eastern European and Caucasus countries than in Central Asian countries.

Regardless of the region, the desire for additional children decreases rapidly with the number of living children. By the time women have two children (or three children, in Central Asia), they generally are ready to terminate childbearing. In Eastern Europe and the Caucasus Region, more than 80% of women with two or more children (90% in Romania and Russia) report that they want no

more children. In Central Asian Republics, most women with three, four, or more children report that they want to terminate fertility (data not shown).

As mentioned earlier, such low levels of desired childbearing, especially given the limited availability of effective long-term contraception and the typically early start (and finish) of childbearing, enhances the probability of unintended pregnancies and subsequent abortion. Public health officials and health care providers should always consider fertility preferences in their efforts to help couples satisfy their contraception needs.

CHAPTER 5

INDUCED ABORTION

As discussed below, induced abortion, not contraception, has been the main method of fertility control in the 15 independent countries that emerged from the collapse of the USSR. In most of those countries, the abortion-to-live-birth-ratios in 1989 were greater than one abortion for every live birth, although systematic underreporting of induced abortion was very likely (Popov, 1996). For the entire Soviet Union in 1989, the abortion-to-live-birth-ratio was 1.3:1, the abortion rate was 96 per 1,000 women aged 15-49, and the lifetime induced abortion rate was 3.3 abortions per woman. Economic, social, and cultural differences among the countries most likely have affected abortion reporting, making comparisons among countries difficult to interpret. Russia, Belarus, and Ukraine have consistently reported the highest rates of abortion, whereas the rates in Central Asia were substantially lower (Goskomstat USSR, 1990).

Several factors are widely believed to have contributed to the widespread use of abortion and underutilization of modern contraception. The relative isolation of the USSR from the contraceptive advancements in Western countries affected both the knowledge about and the availability of high-quality contraceptive methods. In addition, misconceptions among both family planning clients and providers about the health risks associated with certain modern methods, fatalistic attitudes toward health issues, and a medical system that promoted curative rather than preventive care, compounded by easy access to and low cost of obtaining induced abortions, have contributed further to the high reliance on induced abortion (Remennick, 1991, Popov, 1996). These patterns were further shaped by a climate of strong moralistic principles, which condemned premarital and extramarital pregnancies, disapproved of sex education in school, and discouraged open discussions about sex-related issues. The extent to which these factors continue to play a role in the use of induced abortion varies from one country to another, now that each country is in the process of developing new reproductive health policies and programs.

5.1 Abortion Levels and Trends

For several decades one of the most outstanding demographic features of most of the Eastern European countries has been the high reliance on induced abortion as a means of birth prevention. Induced abortion has been the single most important method of controlling fertility. In recent years,

abortion rates and ratios in many of these countries have been among the highest in the world. Factors frequently cited as contributing to widespread reliance on abortion include the limited availability of contraceptive methods; poor quality of the methods available; fears about possible side effects, particularly with hormonal methods; and easy access to and low cost of induced abortion.

Before the Soviet Union's breakup, Azerbaijan had the lowest abortion rate in the Caucasus region (23 abortions per 1,000 women aged 15-49, compared with 31 per 1,000 in Armenia and 51 per 1,000 in Georgia), and it was significantly lower than that in the Slavic republics (Goskomstat USSR, 1990). Since the breakup of the former Soviet Union, the reported vital statistics indicate a steep decline in the abortion rate (from 23 per 1,000 women aged 15—49 in 1989 to 12.7 per 1000 in 1998, and 7.7 per 1,000 in 2000), but this decline is not supported by the AZRHS01 data (MOH, 2001a). The ability of official abortion statistics to document the true magnitude of the abortion levels is hampered, however, by the underreporting of abortions performed in the private sector, inherent problems related to registration data in state-run medical facilities, and the persistence of abortion performed outside clinical settings. Similar barriers have led to discrepancies between official and survey-based abortion rates in other countries, particularly in the Caucasus region (Table 5.1.1).

TABLE 5.1.1

Three-Year General Abortion Rates per 1,000 Women of Reproductive Age, Survey and Official Estimates RHS and DHS Surveys in Selected Eastern European and Former Soviet Union Countries

Region and Country		Time Period	General Abortion Rates (No. of Induced Abortions per 1,000 women)	
			Survey Estimates	Official Estimates
Eastern Europe				
Moldova	RHS	1994–1996	43	43
Romania	RHS	1997–1999	74	62
Russia	RHS	1998–1999	80	NA
Ukraine	RHS	1997–1999	55	42
Caucasus Region				
Armenia*	DHS	1998–2000	81	17[†]
Azerbaijan	RHS	1998–2000	116	10
Georgia	RHS	1997–1999	125	18
Central Asian Republics*				
Kazakhstan	DHS	1997–1999	47	32
Kyrgyz Republic	DHS	1995–1997	45	31
Turkmenistan	DHS	1998–2000	26	NA
Uzbekistan	DHS	1994–1996	20	24

* General abortion rates (both official and survey-based) are for women aged 15–49and slightly lower than general abortion rates for women aged 15–44, since very few women aged 45 years or older reported any abortions.
† General abortion rate for women 15–49 in 1998.

Survey estimates in most countries were either within sampling error (e.g., Moldova, Uzbekistan) or slightly higher compared with official estimates for the same time period. In the Caucasus countries, however, the survey estimates exceeded the official estimates by a considerable margin (survey-based estimates were 6-11 times higher than official estimates). It is worth noting that all three countries in the Caucasus region experienced massive internal or external territorial disputes, population displacements, or outmigration that may have caused significant disruptions in the collection of health statistics in recent years.

Table 5.1.2 shows total and age specific abortion rates based on data from recent reproductive or demographic health surveys conducted in Eastern European countries and the Newly Independent states (Goldberg et al., 1993; KIIS and CDC, 2000; ORC/MACRO International 1995-2001; Serbanescu et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000). With the exception of Romania, where abortion was illegal until 1990, most of the Eastern European countries have had some of the highest abortion rates in the world for several decades (Table 5.1.2).

TABLE 5.1.2

Three-Year[*] Age-Specific Induced Abortion (IA) Rates and Total IA Rates Among Women Aged 15–44 Reproductive Health and Demographic Health Surveys in Selected Eastern European and Former Soviet Union Countries, 1993–2001

Country	Age Specific Induced Abortion Rate (per 1,000)[†]						Total IA Rate[‡]
	15–19	20–24	25–29	30–34	35–39	40–44	
Eastern European Region							
Romania, 1993	32	153	209	167	79	40	3.4
Romania, 1999	26	101	119	105	58	21	2.2
Russia (three oblasts[§]), 1996	44	144	145	94	55	31	2.6
Russia (three oblasts[§]), 1999	44	137	105	117	64	37	2.5
Moldova, 1997	12	74	81	46	31	16	1.3
Ukraine, 1999	13	91	91	69	33	18	1.6
Caucasus Region							
Georgia, 1999–2000	30	164	192	180	123	50	3.7
Armenia, 2000	6	99	175	131	82	30	2.6
Azerbaijan, 2001	6	86	177	176	132	63	3.2
Central Asian Region							
Kazakhstan, 1995	15	78	104	75	50	18	1.7
Kazakhstan, 1999	12	57	87	65	44	20	1.4
Uzbekistan, 1996	2	18	32	36	23	15	0.6
Kyrgyz Republic, 1997	6	57	77	81	58	22	1.5
Turkmenistan, 2000	1	18	48	49	35	18	0.9

* Three years prior to the interview.
† Age at pregnancy outcome
‡ Abortions per woman.
§ Yekaterinburg, Perm, and Ivanovo, respectively.
Source: KIIS and CDC, 2001; ORC/MACRO International 1995–2001; Serbanescu F et al. 1995, 1998, 2001; VCIOM and CDC, 1998, 2000.

The AZRHS01 found that abortion rates in Azerbaijan are higher than those reported in recent surveys in the Russian Federation (urban sample), Romania, and Armenia and much higher than in Moldova, Ukraine, and Central Asian republics, but lower than in Georgia. The age-specific abortion rates (ASIARs) shown in Tables 5.1.2, 5.1.3, and 5.1.4 represent the proportion of women in a specific age group who terminated pregnancy by induced abortion within the 3-year period preceding the survey. The rates were calculated by using the age of the woman at the time of the pregnancy's termination. The total induced abortion rate (TIAR) was calculated by summing the ASIARs for the same 3-year period used in the analysis of fertility levels. Similar to the total fertility rate (TFR), the TIAR describes the number of abortions a woman would have in her lifetime under the current ASIARs.

The AZRHS01 data indicate that the general abortion rate in the 3 years before the survey (May 1998-April 2001) was 116 abortions per 1,000 women aged 15-44, the total abortion rate was 3.2 abortions per woman, and the abortion-to-live-birth ratio was three abortions for each live birth (3:1). National sample surveys on reproductive health, which could have provided information about induced abortion levels based on women's self-reports, have never been carried out before in Azerbaijan, so comparisons with similar data on abortion are not possible.

TABLE 5.1.3
Three-Year* Age-specific Induced Abortion (IA)* Rates Among All Women
AZRHS01 and Ministry of Health (MOH) Estimates

Age-Specific Abortion Rates (per 1,000)†	AZRHS01	MOH‡
15–19	6	2
20–24	86	14
25–29	177	20
30–34	176	16
35–39	132	
40–44	(63)	6¶
Total Induced Abortion Rate (per woman aged 15–44)	3.2	0.3

* Induced abortions occurred between May 1998 and April 2001.
† Age at pregnancy outcome.
‡ Average of the most recent available official data (1998–2000).
¶ For women aged 35–49 years, official estimates of IA rates are not broken down into 5-year age groups. This rate represents ASIAR for 35-44, assuming that no abortions took place among women aged 44 years or older.
( ) Time exposed partially truncated because not all cases have exposure throughout the period of analysis.

Figure 5.1.1
Three-Year Period (1998–2001) Age-Specific Fertility and Abortion Rates Among All Women Aged 15–44 Years— AZRHS Survey, Azerbaijan, 2001
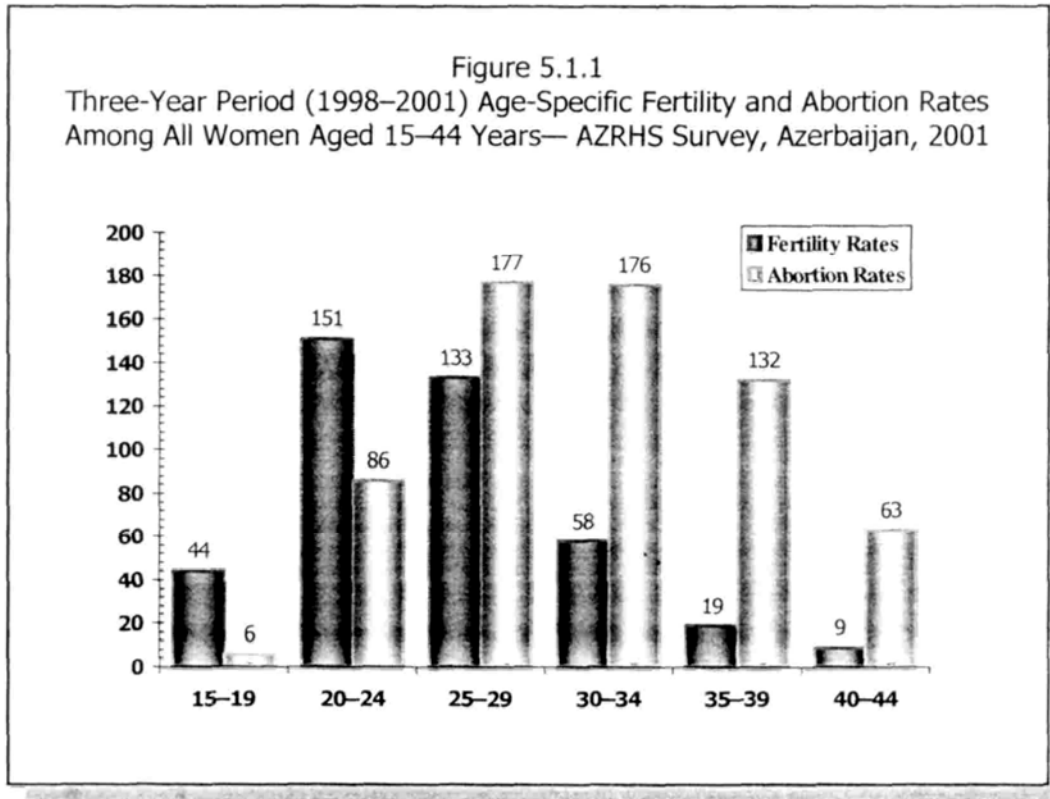
The TIAR was 1.5 times higher than the TFR during the 3 years prior to the survey (3.2 vs. 2.1). Unlike fertility, the age pattern of abortions in Azerbaijan is concentrated at age groups 25-29 (177 induced abortions per 1,000 women) and 30-34 (176 per 1,000), which together account for 50% of the TIAR. The third highest ASIAR occurred among women aged 20-24. Except for the youngest age groups, ASIARs are significantly higher than ASFRs (Figure 5.1.1). These findings suggest that Azeri women achieve their desired family size at young ages, after which most pregnancies are unintended and are intentionally terminated.

The official statistics do not routinely calculate lifetime total abortion rates. The USSR's statistics, however, show a pre-independence TIAR of 0.8 abortions per woman aged 15-49, the lowest lifetime abortion rate among former Soviet Union countries (Brackett, 1993). Based on the most recent ASIARs for abortions performed in governmental facilities reported by the Azerbaijan Ministry of Health (MOH), the estimated TIAR for the period 1998-2000 was 0.3 abortions per woman, two-thirds lower than the pre-independence level (Table 5.1.3). Compared with the survey estimates, the official ASIARs are generally low, but they are substantially lower for the two age groups that contribute to 50% of abortions: the ASIAR among women aged 25-29 (20 induced abortions per 1,000 women vs. 177 per 1,000), and the ASIAR among women aged 30-34 (16 induced abortions per 1,000 women vs. 176 per 1,000). It is likely that the underreporting of abortions among women aged 35-39 is of the same magnitude, but the official statistics do not allow for a separate ASIAR for this age group.

Figure 5.1.2
Three-Year Period Age-Specific Abortion Rates for Several Time Periods Among All Women Aged 15–39— AZRHS Survey, Azerbaijan, 2001

Legend:
- ● 1998–2001
- □ 1996–1998
- ▲ 1994–1996

TABLE 5.1.4
Three-Year Period Age-Specific Induced Abortion Rates for Several Time Periods Among All Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001

	Age-Specific Induced Abortion Rate (per 1,000)[*]		
	1998–2001	1996–1998	1994–1996
Age Groups	AZRHS01[†]	AZRHS01[‡]	AZEHS01[¶]
15–19	6	5	2
20–24	86	71	61
25–29	177	152	136
30–34	176	146	147
35–39	132	115	108
40–44	(63)	(69)	§
Total Induced Abortion Rate (per woman)	**3.2**	**2.8**	**2.3**

[*] Age at induced abortion.

[†] Abortions occurring between May 1998 and April 2001.

[‡] Abortions occurring between May 1996 and April 1998.

[¶] Abortions occurring between May 1994 and April 1996.

§ No data since a woman aged 40–44 in 1994–1996 would have been aged over 44 years at the time of the interview and thus not included in the sample. For this reason, the period TIAR is only for women aged 15–39.

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

50

AZRHS01 data permit estimation of abortion trends over several 3-year periods (Table 5.1.4 and Figure 5.1.2). These trends had to be restricted to women aged 15-39 because the rates for older women (age at outcome) represent partial abortion rates (due to the inherent truncation of the time exposure) or cannot be assessed. For example, some women aged 40-44 in 1996-1998 would be older than age 44 in 1999-2001, but only those aged 44 or younger would have been selected to participate in the survey. Similarly, all women aged 40-44 in 1994-1996 would have been older than 44 years old in 2001 and thus excluded from the sample.

Abortion rates were higher in 1998-2001 than in previous years (1994-1998) in all age groups. Given the peak in abortion at age intervals 25-29 and 30-34, changes in these ASIARs would have a greater impact on abortion trends than changes in other ASIARs. For example, between 1994-1996 and the most recent 3-year period (1998-2001), the ASIARs for 25- to 34-year-old women (contributing to more than 50% of the TIAR in both time periods) increased by 30% and 20%, respectively, while the TIAR for women aged 15-39 increased by 25% (from 2.3 to 2.9 abortions per woman aged 15-39). Increases in abortion rates among women aged 15-24 were even higher (200% and 40%, respectively), but because their contribution to the total abortion rate is quite low(16%in 1998-2001 and 14% in 1994-1996), their impact on the TIAR increase was negligible.

5.2 Induced Abortion Differentials

As shown in Table 5.2.1, the abortion rates among all women were equally high and varied little by background characteristics, except for internally displaced persons and refugees (IDP/Rs), who reported substantially higher rates. The TIAR in rural areas was about 20% higher than in urban areas (3.4 vs. 2.8 abortions per woman). Abortion rates in the South-West (where most of the IDP/R population resides) were substantially higher than in the rest of the country; the rates in the South region were the lowest. The TIAR was lowest for women with a university education; on average, women with lower levels of education reported 0.7 abortions more than women with postgraduate education did (3.2 vs. 2.5 abortions per woman). Most of the variation in abortion rates by education was the result of higher ASIARs among women aged 15-24 who had less than a university education. Women of Azeri ethnic background reported, on average, one abortion more than did those of other backgrounds. IDP/Rs reported the highest TIAR (4.7 abortions per woman) and higher ASIARs than non-IDP/R women.

One way to reduce unintended pregnancies that result in abortion is through the provision of family planning services. In countries around the world, increases in the use of modern contraceptives have, over time, been associated with decreases in the numbers of abortions (Cohen, 1998).

TABLE 5.2.1
Three-Year* Age-Specific Induced Abortion Rates and Total Induced Abortion Rates
Among All Women Aged 15–44, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Age-Specific Induced Abortion Rate[†]						Total Induced Abortion Rate
	15–19	20–24	25–29	30–34	35–39	40–44	
Total	6	86	177	176	132	63	3.2
Residence							
Urban	3	89	138	155	137	66	2.8
Rural	9	82	192	189	137	70	3.4
Region							
Baku	6	102	208	184	144	60	3.5
North & North-East	7	85	160	181	137	75	3.2
West	0	107	198	220	132	63	3.6
South-West	4	112	232	191	185	79	4.0
South	9	47	148	127	73	30	2.2
Central	6	60	138	55	137	66	2.8
Education							
Secondary incomplete or less	10	123	150	202	95	69	3.2
Secondary complete	5	99	190	180	129	61	3.3
Technicum	0	49	199	162	164	63	3.2
University/Postgraduate	0	23	130	152	147	57	2.5
Socioeconomic Status							
Low	8	79	163	156	129	64	3.0
Middle	5	86	190	199	132	61	3.4
High	3	107	186	201	144	64	3.5
Ethnicity							
Azeri	4	89	178	184	136	66	3.3
Other[‡]	19	60	166	123	92	24	2.4
IDP/Refugee Status							
IDP/R	15	118	248	241	203	107	4.7
Non-IDP/CA	6	78	175	170	157	59	3.2
Non-IDP/NCA	5	84	167	168	115	58	3.0

* Induced abortions occurred between May 1998 and April 2001.

† Age at pregnancy outcome.

‡ Includes Talish, Lezgi, Tat, Russian, and other ethnic groups.

As shown in Chapter 10, a large share of the potential demand for family planning services is among subgroups of women who have also reported higher rates of induced abortion (i.e., rural women, those who are less educated, women with two or more children, and IDP/R women), a finding indicating that access to services is not equal and that the family planning program needs to expand its reach.

TABLE 5.2.2
Women Aged 15–44 Who Had at Least One Abortion and Number of Lifetime Abortions among Women Who Ever Had an Abortion by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Ever Had an Abortion %	Ever Had an Abortion No. of Cases	Number of Lifetime Induced Abortions Among Women Who Have Ever Had An Abortion 1	2	3	4	5–6	7-9	10+	Total	No. of Cases
Total	35.4	7,668	35.3	23.6	15.6	10.0	8.4	4.7	2.4	100.0	3,139
Residence											
Urban	39.1	3,832	33.9	23.4	16.5	9.5	9.0	5.4	2.3	100.0	1,686
Rural	31.0	3,836	37.5	23.9	14.4	10.7	7.5	3.6	2.4	100.0	1,453
Region											
Baku	39.9	1,533	31.5	25.1	17.0	9.7	10.0	4.6	2.1	100.0	692
North&North-East	35.2	924	40.4	21.3	13.9	10.1	6.5	5.2	2.7	100.0	384
West	39.0	766	31.2	24.5	15.4	8.5	10.6	7.2	2.5	100.0	331
South-West	34.2	2,302	30.6	20.8	17.3	10.3	10.5	5.7	4.9	100.0	958
South	26.6	950	46.6	24.3	13.2	6.5	8.1	1.2	0.1	100.0	301
Central	35.8	1,193	31.5	24.9	17.4	14.4	5.6	3.8	2.4	100.0	473
Age Group											
15–19	0.0	1,207	*	*	*	*	*	*	*	*	5
20–24	12.0	1,207	56.4	23.3	11.5	6.0	2.3	0.5	0.0	100.0	181
25–29	37.6	1,156	48.2	26.3	14.9	5.2	4.2	0.6	0.6	100.0	485
30–34	55.1	1,533	34.1	26.3	14.6	10.8	8.2	4.3	1.7	100.0	890
35–39	64.0	1,531	33.1	21.0	16.8	10.0	8.6	7.3	3.1	100.0	941
40–44	59.7	1,034	25.8	22.6	16.7	13.1	12.8	5.3	3.8	100.0	637
No. of Living Children											
None	0.4	2,655	*	*	*	*	*	*	*	*	12
One	26.3	784	54.4	27.0	12.0	3.8	0.5	1.9	0.4	100.0	202
Two	64.0	2,094	36.8	24.9	15.6	9.3	8.1	3.8	1.5	100.0	1,336
Three	73.5	1,530	31.4	23.0	15.7	10.9	10.0	5.6	3.4	100.0	1,133
Four or More	76.0	605	30.9	20.5	16.6	12.6	9.4	6.7	3.2	100.0	456
Education Level											
Secondary Incomplete or Less	25.3	1,697	38.6	21.7	17.8	9.2	6.3	4.4	2.0	100.0	539
Secondary Complete	36.8	3,868	35.3	24.1	14.6	9.7	8.9	4.8	2.7	100.0	1,623
Technicum	46.2	1,215	29.6	23.5	18.0	12.6	7.9	5.6	2.9	100.0	610
University/Postgraduate	36.6	888	40.1	24.4	13.2	8.0	10.3	3.4	0.6	100.0	367
IDP/Refugee Status											
IDP/R	40.5	1,272	26.8	23.5	19.2	8.5	9.3	9.8	2.8	100.0	524
Non-IDP/CA	33.8	3,047	31.5	23.1	18.4	11.8	6.8	4.4	4.0	100.0	1,209
Non-IDP/NCA	35.1	3,349	37.5	23.7	14.5	9.8	8.7	4.0	1.9	100.0	1,406

* Fewer than 25 cases in this category.

Figure 5.2
Percent Distribution of Pregnancies by Pregnancy Outcome by Pregnancy Order
Pregnancies in the Past 5 Years —AZRHS01, Azerbaijan 2001

■ Live Birth ■ Induced Abortion □ Other Outcome

Category	Live Birth	Induced Abortion	Other Outcome
Total	41	53	6
Pregnancy Order			
First	86		13
Second	78	14	8
Third	44	50	6
Fourth	28	67	5
Fifth or Higher	15	81	4
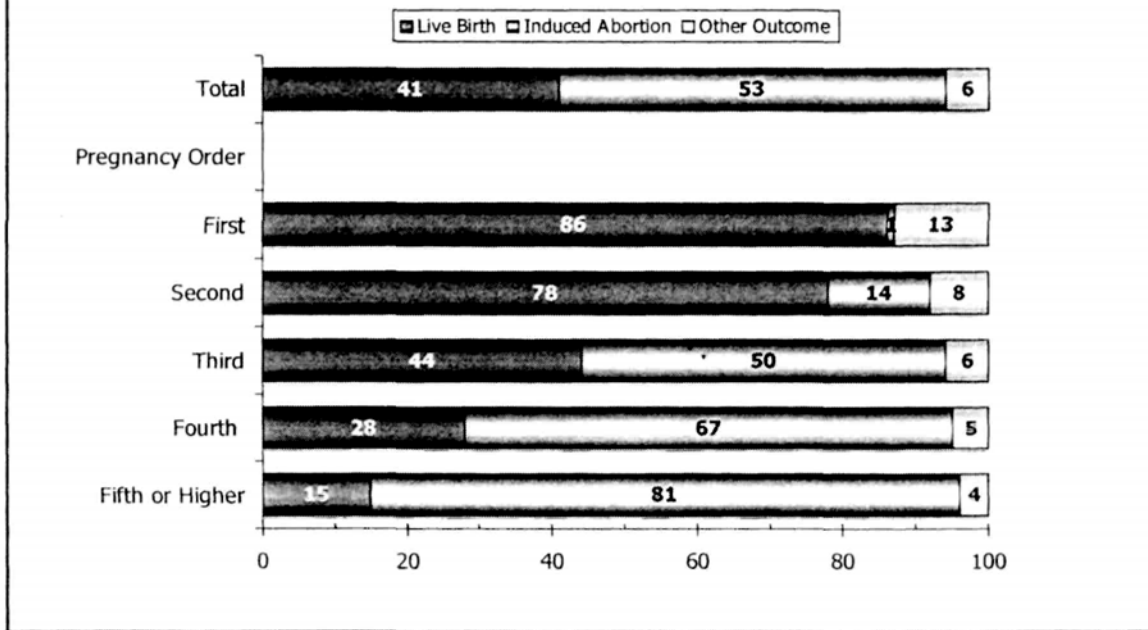
As shown in Table 5.2.2, 1 in 3 women of reproductive age (35%) reported having had at least one induced abortion. The likelihood of having an abortion is positively associated with age because exposure to pregnancy, particularly unintended pregnancy, increases with age. Although few adolescents reported any abortions (0.4%), by ages 20-24 the percentage rises to 12%; it increases to more than one-third among 25- to 34-year-olds and 60% among women aged 35 and older. The likelihood of having an abortion is also positively associated with the number of living children, which is also a strong predictor of unintendedness because women in Azerbaijan achieve their desired family size of one or two children fairly rapidly. The likelihood of having at least one abortion was somewhat greater among urban women, IDP/Rs, and women who have at least completed secondary education. In every region except the South, more than 1 in 3 women had had at least one abortion; just more than one-quarter of women in the South reported ever having an abortion.

As shown in Figure 5.2, the use of abortion was also heavily influenced by *pregnancy order,* which refers to all prior pregnancies, including live births, induced abortions, miscarriages, and other outcomes. Women with no prior pregnancies were the least likely to have pregnancies ending in abortion (1%) and the most likely to have a live birth (86%). The likelihood of abortion increases

rapidly among women who had any prior pregnancies. Although a woman with one prior pregnancy has a likelihood of abortion lower than that of having a live birth, once she has two or more prior pregnancies the likelihood of resorting to abortion is significantly higher than that of carrying the pregnancy to term. Thus, the induced-abortion-to-live-birth ratio is directly correlated with pregnancy order, increasing from 0.01:1 among women with no prior pregnancy, to 1.1:1 among women with two prior pregnancies, 5.4:1 among women with four or more prior pregnancies.

Because not all women were exposed to the risk of an unintended pregnancy and a subsequent abortion, in the right panel of Table 5.2.2 we restricted the denominator to include only women who have ever had an abortion. More than 1 in 3 women (35%) reported they had only one abortion, 24% had two abortions, 16% had three abortions, and 26% had four or more abortions, including 2% who had 10 or more lifetime abortions. Women who reported multiple abortions were more likely to be older, to have high parity, to be IDP/Rs, and to live outside the South or North-Northeast regions.

5.3 Abortion Services

As is the case with all the former Soviet republics, Azerbaijan was subject to the liberal abortion legislation and regulations issued by the former USSR. Abortion on request has been available within the first 12 weeks of gestation since the Soviet Supreme Council decree issued in November 1955. The decree, entitled "On the Elimination of Induced Abortion Prohibition," reinstated the first Soviet abortion law, which was issued in November 1920 and revoked in June 1936. With several additions and modifications, this 1955 law remained in force essentially unchanged. In 1987, early abortions by electric vacuum aspiration after obligatory pregnancy testing were authorized by the Order of the Ministry of Health of the USSR No. 757 (June 5, 1987). These procedures were called "mini-abortions" because they are performed in the earliest stages of gestation (in women whose menstrual period is no more than 20 days overdue, roughly corresponding to a maximum of 6 weeks of pregnancy), involve minimal cervical trauma (i.e., do not require cervical dilatation and anesthesia), and use electrical vacuum aspiration rather than sharp curettage. The same order permitted mini-abortions to be performed outside hospitals in ambulatory clinics. Starting in 1989, early pregnancy termination by vacuum aspiration was officially recognized as a legal abortion procedure, but it was reclassified as "menstrual regulation" and reported separately from the induced abortion statistics. Such reclassification, however, can be misleading because menstrual regulation does not require a pregnancy confirmation and is not regarded legally as an abortion (WHO, 1997). In all the former Soviet Union countries, menstrual regulation by vacuum aspiration is performed after pregnancy has been confirmed; its primary intent is to terminate an unwanted pregnancy, so it must be reported in the total abortion statistics.

Additional regulations were issued to permit induced abortion during the first 28 weeks of gestation on medical and social grounds (USSR MOH, Order No. 234 of March 1982 and Order No. 1342 of December 1987) and to briefly legalize "commercial" abortions in private clinics and "for-fee" sections of state hospitals (legalized in March 1988 by the USSR MOH and outlawed in December 1988 by a decree issued by the Council of Ministers) (USSR MOH; USSR Council of Ministers).

Under the current law, induced abortion can be performed only by ob/gyns by either vacuum aspiration or sharp curettage; abortion procedures are permitted only in medical facilities that have been state-certified for performing abortion. Outpatient medical facilities (e.g., women's consultation clinics [WCCs] and private clinics) can perform induced abortion only by vacuum aspiration.

The AZRHS01 collected information on respondents' last four abortions performed since January 1996 in a detailed abortion history that included questions about the reason for abortion; the place where the procedure was performed; abortion registration and payments; use of local or general anesthesia and antibiotic prescriptions; number of nights, if any, spent in the hospital after the procedure (abortion patients are released in the same day of the intervention if they do not have postabortion complications); and the presence or absence of early and late postabortion complications. Data were collected starting with the most recent procedure in an attempt to minimize recall biases. The data presented here are from detailed abortion histories of abortions that took place from July 1996 to June 2001.

Almost all abortions (90%) were reported to be completed in the first trimester of gestation. However, respondent reports on this issue are subject to several possible biases, including irregular menses, problems in recalling the event, and reluctance to admit abortions beyond the legal gestational limit. Almost 1 in 2 abortions (46%) were reported to be performed between 7 and 12 weeks of gestation, 43% were performed before 7 weeks, and 11% were reported as late abortions (13 weeks or more). The numbers are too small to draw any statistical conclusions, but late abortions were reported more often by rural women, women with less than complete secondary education, and women with low socioeconomic status (SES). Late abortions were more common among women with no prior induced abortions than among those with one or more prior abortions (data not shown).

Of all abortions reported by survey respondents in the past 5 years, approximately 40% were mini-abortions ([Table 5.3.1](#)). Mini-abortions were twice as prevalent among urban respondents as among rural residents (52% vs. 24%) and were most common among women living in Baku (62%). The proportion of abortions classified as mini-abortions decreased somewhat with woman's age and increased directly with education and SES. Mini-abortions were least prevalent among women in the South-West (14%), whereas in other regions they constituted one-quarter to three-fifths of the

TABLE 5.3.1
Induced Abortions Reported to Be Mini-abortions by Selected Characteristics
Pregnancies Ended in Abortion between July 1996–June 2001
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	% Mini-abortions	Unweighted No. of Cases
Total	**40.1**	**4,083**
Residence		
Urban	51.9	2,064
Rural	23.6	2,019
Region		
Baku	61.7	834
North&North-East	36.7	465
West	35.0	427
South-West	14.1	1,477
South	27.1	320
Central	44.2	560
Age Group(at Abortion)		
15–24	43.6	1,161
25–34	39.9	1,906
35–44	37.0	1,016
Education Level		
Secondary Incomplete	26.2	746
Secondary Complete	39.3	2,122
Technicum	46.5	808
University	55.8	407
Socio-Economic Status		
Low	25.0	2,196
Medium	51.4	1,450
High	60.2	437
IDP/Refugee Status		
IDP/R	35.6	828
Non-IDP/CA	38.9	1,637
Non-IDP/NCA	41.3	1,618
Year of Abortion		
1996–1997	39.0	604
1997–1999	37.8	1,556
1999–2001	42.4	1,923
Abortion Facility		
Hospital	33.8	2,979
Women's Consultation Center	59.6	944
Private Clinic	46.6	44
Outside a Medical Facility*	18.0	116

* About two-thirds of pregnancy terminations that took place outside a medical facility were performed by D&C (56%) or vacuum-aspiration (13%), presumably by a physician, "at woman's home" or "other residence."

abortion procedures reported (27%-62%). Mini-abortions were slightly less prevalent among IDP/Rs than non-IDP/R women. Although ambulatory clinics are not licensed to perform D&C (dilation and curettage) abortions, mini-abortions represented only 60% and 47%, respectively, of induced abortions performed in WCCs and private clinics. Thus, D&C abortions performed in ambulatory clinics, along with abortions performed outside medical facilities, are likely to substantially contribute to the underregistration of abortions reported by the Ministry of Health.

The proportion of induced abortions terminated by vacuum aspiration did not vary significantly by the year of pregnancy termination. The percentage of pregnancies terminations by vacuum aspiration was slightly lower among first abortions than among repeated abortions because first-order abortions were more often performed at gestational ages of 7 weeks or later (39% of first-time abortions were performed before 7 weeks of gestation compared with 45% of abortions of rank two or higher) (data not shown).

By law, all abortions must be performed in hospitals or ambulatory clinics or cabinets (offices) by ob/gyns. As shown in Table 5.3.2, most survey respondents' induced abortions occurring in 1996 or later were performed in gynecological wards (70%). About a quarter of them (26%) were performed in state-run ambulatory units, such as WCCs, and only 1% were performed in private clinics. Abortions performed in WCCs were more prevalent in urban areas (34%) than in rural areas (14%). In Baku, abortions performed in WCCs were still outnumbered by those performed in hospitals (40% vs. 58%). Abortions performed in private clinics and in WCCs increased with education and SES. Early abortions (i.e., mini-abortions) performed by vacuum aspiration were more likely to occur in hospital wards and WCCs (59% and 38%, respectively). Although most induced abortions at 7 weeks or later were performed in hospital wards (77%), 18% were reported to be performed in ambulatory units (17% in WCC and 1% in private clinics), and 4% were performed outside medical facilities. The distribution of location of abortions did not change between 1996 and 2001.

Only 3% of pregnancy terminations were reported to take place outside the health system; however, about two-thirds of those abortions (68%) were performed by either D&C or vacuum aspiration, suggesting that they were performed by qualified physicians at either their homes or the respondents' homes (data not shown). Because abortions performed outside medical facilities (either self-induced, performed by lay persons, or performed by doctors outside the health system) are illegal, it is likely that women were reluctant to admit these outcomes, in spite of the interviewer's assurance of anonymity and that this figure is probably an underestimate of the proportion of abortions performed outside the health facilities. Rural women were more likely to report such abortions than were urban women (4% vs. 2%); women residing in the South and Central regions (7%), those with less than

TABLE 5.3.2
Place of Pregnancy Termination for Abortions Performed between July 1996–June 2001
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

	Place of Pregnancy Termination					
Characteristic	Gynecologic Ward	Women's Consultation Clinic	Private Clinic	Outside a Medical Facility*	Total	Unweighted No. of Cases
Total	70.0	25.8	1.0	3.2	100.0	4,083
Residence						
Urban	62.6	34.1	1.0	2.4	100.0	2,064
Rural	80.5	14.3	0.9	4.3	100.0	2,019
Region						
Baku	57.5	39.7	1.6	1.2	100.0	834
North&North-East	66.5	31.7	0.0	1.7	100.0	465
West	75.0	21.1	0.8	3.0	100.0	427
South-West	81.1	14.3	1.8	2.9	100.0	1,477
South	86.1	4.7	2.1	7.0	100.0	320
Central	71.9	21.1	0.1	6.9	100.0	560
Education Level						
Secondary Incomplete or Less	76.9	17.4	0.1	5.6	100.0	746
Secondary Complete	71.6	24.5	1.1	2.8	100.0	2,122
Technicum	64.0	32.2	0.9	2.8	100.0	808
University	61.7	34.9	2.0	1.4	100.0	407
Socio-Economic Status						
Low	75.3	19.5	1.0	4.2	100.0	2,196
Medium	67.3	30.0	0.4	2.3	100.0	1,450
High	59.5	35.9	2.6	2.0	100.0	437
IDP/Refugee Status						
IDP/R	70.9	25.9	2.0	1.2	100.0	828
Non-IDP/CA	74.5	20.6	1.2	3.7	100.0	1,637
Non-IDP/NCA	68.6	27.3	0.7	3.4	100.0	1,618
Type of Abortion						
Induced Abortion	77.3	17.4	0.9	4.4	100.0	2,617
Mini-abortion	59.0	38.4	1.1	1.4	100.0	1,466
Year of Abortion						
1996–1997	69.4	26.5	0.4	3.7	100.0	604
1997–1999	72.0	25.2	0.8	2.0	100.0	1,556
1999–2001	68.6	26.2	1.3	3.9	100.0	1,923

* About two-thirds of pregnancy terminations that took place outside a medical facility were performed by D&C (56%) or vacuum-aspiration (13%), presumably by a physician, "at woman's home" or "other residence."

complete secondary education (6%), and those with low SES (4%) were slightly more likely to report abortions performed outside certified health facilities (data not shown).

Only 5% of abortions were preceded by testing for sexually tranmitted infections (STIs) (data not shown). STI screening was more slightly likely among women in Baku and the North-Northeast region and among those with a university education, high SES, and abortion taking place after the first trimester. No difference in screening was found between urban and rural areas. Tests for pregnancy confirmation were more likely to be performed when abortion procedures took place in ambulatory settings (either WCC or private clinics) than in hospital gynecologic wards.

Nearly 3 out of 5 abortions were reportedly due to method failure (Table 5.3.3). Almost all women claimed to be using traditional methods of contraception; just 4% of abortions were for pregnancies that occurred while a woman was using a modern method. Rural women, women living in the South region, and women with low SES were most likely to report contraceptive use (mostly traditional methods) before the aborted pregnancy.

In Azerbaijan, almost all abortions are performed for a fee (which varies from one facility to another). Reports of abortion payments were lower among rural women than urban women, outside of Baku, and increased directly with education and SES. At the time of the survey, mean charges for an abortion procedure were about 47 thousand manat (about US$10.00). The amount paid for an abortion ranged from no payment to, in one case, 900,000 manat (Table 5.3.4). Only 4% of abortions were performed at no charge; 11% of abortion payments were 20,000 or less, 38% were between 21,000 and 40,000 manat, 39% were between 41,000 and 100,000 thousand manat, and 3% were more than 100,000 manat. Less than 5% of women reported that abortion payments were only gifts of unknown amount or could not remember the amount paid.

Women in urban areas, including those living in Baku, those with university training, and those with high SES, were more likely to make, on average, larger abortion payments than other women. The cost of late abortions was 31% higher than abortions performed in the first 12 weeks of pregnancy. The average abortion payments were highest for WCCs and private clinics and lowest for procedures performed outside a medical facility.

Generally, abortion performed after 6 weeks of gestation is an inpatient procedure, but patients are released within the same day and do not have to spend the night in the hospital. Survey results confirmed that virtually all women who had abortions since 1996 (98%) had been released within the same day of the abortion procedure (data not shown). Only 2% of women with abortions had to be hospitalized for at least one night; the length of hospital stay varied with gestational age and the presence or absence of abortion complications.

TABLE 5.3.3
Use of Contraception at the time of Pregnancy for Abortions Performed between July 1996–June 2001
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Contraceptive Use | | | Unweighted No. of Cases |
	Any Method	Any Traditional Method	Any Modern Method	
Total	58.2	54.2	3.9	4,083
Residence				
Urban	51.4	46.4	4.9	2,064
Rural	67.7	65.1	2.6	2,019
Region				
Baku	47.3	41.1	5.9	834
North&North-East	60.3	56.1	4.2	465
West	57.1	53.7	3.4	427
South-West	62.1	58.7	3.4	1,477
South	74.2	71.3	2.9	320
Central	60.1	58.2	1.9	560
Education Level				
Secondary Incomplete	54.0	51.2	2.9	746
Secondary Complete	60.8	57.4	3.4	2,122
Technicum	57.0	51.2	5.8	808
University	54.5	49.0	5.2	407
Socio-Economic Status				
Low	64.8	61.8	2.9	2,196
Medium	52.2	47.2	4.9	1,450
High	52.6	47.8	4.6	437
IDP/Refugee Status				
IDP/R	49.3	46.6	2.6	828
Non-IDP/CA	61.1	58.9	2.2	1,637
Non-IDP/NCA	59.2	54.4	4.7	1,618
Type of Abortion				
Induced Abortion	61.0	58.2	2.7	2,617
Mini-abortion	54.0	48.2	5.8	1,466
Year of Abortion				
1996–1997	54.7	51.8	2.9	604
1997–1999	57.3	53.3	3.8	1,556
1999–2001	60.1	55.7	4.4	1,923
Gestational Age				
≤ 6 weeks	56.0	51.0	4.9	1,743
7–12 weeks	62.3	58.9	3.3	1,926
≥ 13 weeks	49.0	46.0	3.0	414

TABLE 5.3.4
Cost of Abortions Performed between July 1996–June 2001
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Cost of Abortion (in thousands manat)*								No. of Cases
	Mean Payment[†]	None	≤21	21–40	41–100	≥101	Do Not Remember[‡]	Total	
Total	46.5	4.3	11.3	38.4	39.0	2.7	4.2	100.0	4,083
Residence									
Urban	52.7	4.1	8.2	31.5	48.0	3.6	4.7	100.0	2,064
Rural	37.9	4.7	15.7	48.1	26.4	1.6	3.5	100.0	2,019
Region									
Baku	70.6	1.9	4.6	12.4	69.5	6.3	5.2	100.0	834
North&North-East	43.9	3.8	7.0	37.5	46.8	1.1	3.8	100.0	465
West	35.6	6.7	13.3	58.4	16.2	2.2	3.1	100.0	427
South-West	38.1	3.9	20.5	51.7	19.5	1.6	2.9	100.0	1,477
South	35.9	3.9	13.4	52.8	23.6	1.0	5.3	100.0	320
Central	35.6	7.6	19.1	42.9	23.9	2.1	4.4	100.0	560
Education Level									
Secondary Incomplete or Less	40.7	6.8	13.4	39.7	32.9	2.2	4.9	100.0	746
Secondary Complete	46.0	2.2	11.2	41.2	40.4	1.7	3.3	100.0	2,122
Technicum	47.8	4.9	11.1	36.9	37.7	3.6	5.8	100.0	808
University	56.6	9.6	8.3	25.4	45.1	7.4	4.2	100.0	407.0
Socio-Economic Status									
Low	37.6	4.0	16.0	47.9	27.1	1.2	3.8	100.0	2196.0
Medium	52.2	3.9	7.7	34.7	46.4	3.0	4.2	100.0	1,450
High	61.7	6.9	5.4	15.8	59.5	7.2	5.3	100.0	437
IDP/Refugee Status									
IDP/R	48.1	5.6	13.3	43.7	33.1	2.3	2.0	100.0	828
Non-IDP/CA	38.0	3.6	19.6	47.3	24.3	1.5	3.6	100.0	1,637
Non-IDP/NCA	48.5	4.3	8.7	35.0	44.2	3.2	4.8	100.0	1,618
Gestational Age									
≤ 6 weeks	47.7	4.1	12.0	34.5	44.2	2.0	3.2	100.0	1,743
7–12 weeks	42.2	4.8	12.2	42.8	32.6	2.2	5.4	100.0	1,926
≥13 weeks	59.9	3.7	4.7	35.3	45.7	7.9	2.8	100.0	414
Abortion Facility									
Gynecologic Ward	43.1	5.0	12.3	40.9	35.4	2.4	4.0	100.0	2,979
WCC	56.8	2.1	6.9	32.6	50.7	3.3	4.4	100.0	944
Private Clinic	57.3	0.0	10.3	38.1	40.5	8.3	2.8	100.0	44
Outside a Medical Facility	34.0	9.7	25.0	31.7	24.1	2.5	7.0	100.0	116

* At the time of the survey approximately 4,780 manat = $US 1.00.

† Mean payment per abortion does not include non-monetary payments or payments of unknown amount.

‡ Include38 women who reported non-monetary payments.

Nearly 3 in 5 abortions (59%) between 1996-2001 were performed without any anesthesia; one-third were performed with local (cervical) anesthesia and 5% involved intravenous anesthesia (Figure 5.3). The likelihood of receiving anesthesia was higher in urban areas than in rural areas, increased with the respondent's education and SES, and was directly influenced by gestational age (data not shown). Early abortions (i.e., under 7 weeks) were the most likely to be performed without anesthesia (62%), whereas about one-half (55%) of abortions performed at a gestational age of 13 weeks or higher received anesthesia. The likelihood of anesthesia for abortions performed by D&C was not significantly different from the likelihood for anesthesia with vacuum-aspiration abortions (43% vs. 39%). Women having hospital-performed abortions (which are more likely to be performed after 6 weeks and by D&C) were slightly more likely to receive anesthesia than were those who obtained abortions in a WCC (41% vs. 35%).

Figure 5.3
Type of Anesthesia Provided During Abortion Procedures
Induced Abortion Performed During the Past 5 Years
Reproductive Health Survey—Azerbaijan, 2001

No Anesthesia 59%

Do not Remember 2%

General Anesthesia 5%

Local Anesthesia 34%
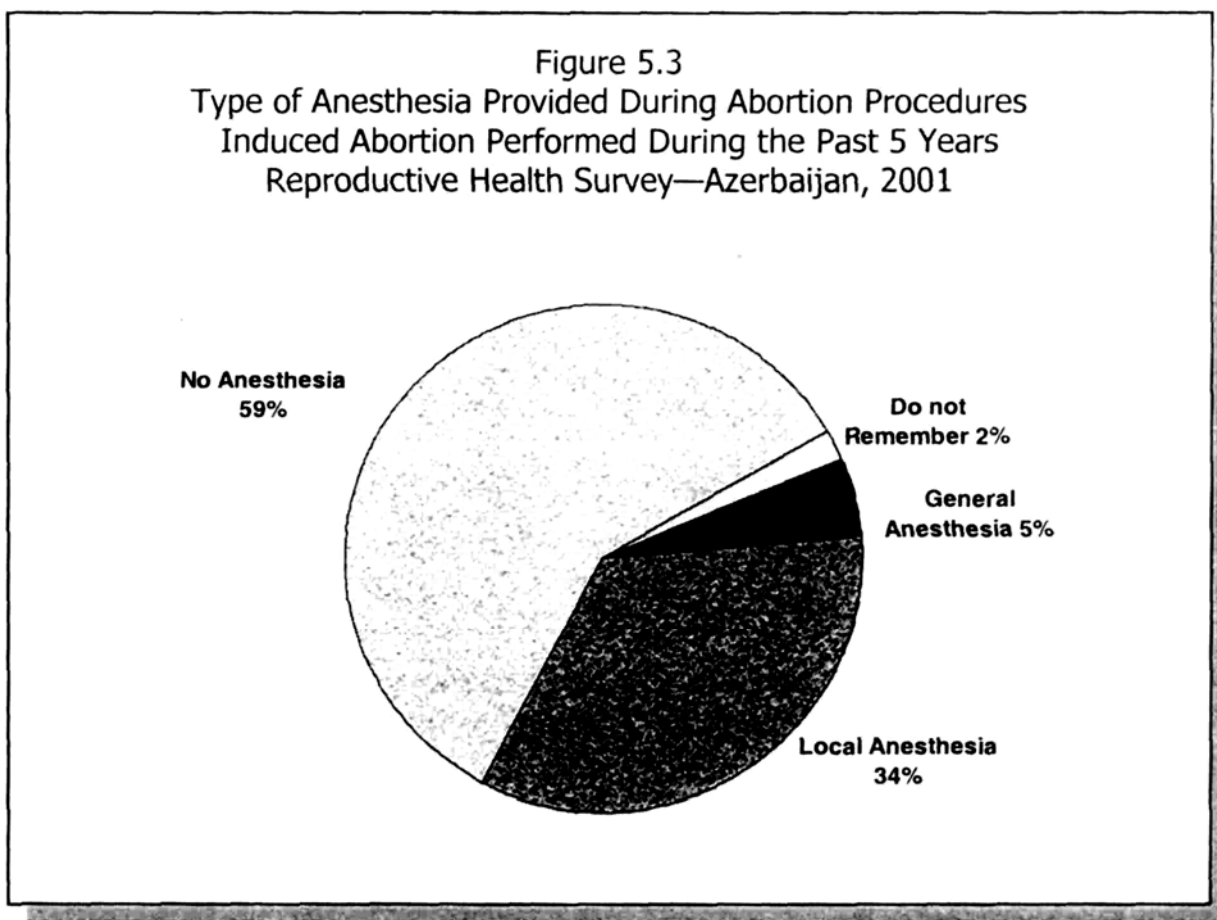
5.4 Abortion Complications

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 (Henshaw, 1990). 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. First-trimester abortion complication rates from studies performed in developed countries ranged from 0.9 per 100 abortion procedures in the United States (Hakim-Elahi et al., 1990), to 3 per 100 in France (Thonneau et al., 1998), and 6.1 per 100 in Denmark (Heisterberg and Kringlebach, 1989), but in the absence of an international standard definition of abortion morbidity, comparisons between countries are difficult to interpret.

Survey estimates of postabortion complications are usually based on symptoms or conditions reported by respondents and therefore may be less accurate than hospital based statistics. As shown in Table 5.4.1, 21% of all abortions performed since 1996 were followed by immediate complications (17%) or late sequelae (4%). This finding is consistent with the level of postabortion complications documented by other reproductive health surveys conducted in Eastern European countries with high abortion rates, as shown in Figure 5.4.

Figure 5.4
Prevalence of Early and Late Post-Abortion Complications
Among Women Aged 15-44 With at Least one Abortion in the Last 5 Years
RHS Surveys in EE and NIS

■ Early Complications □ Late Complications

	MO	RO	RU	UA	AZ	GE
Early Complications	11	8	14	14	16	8
Late Complications	5	2	6	5	4	2
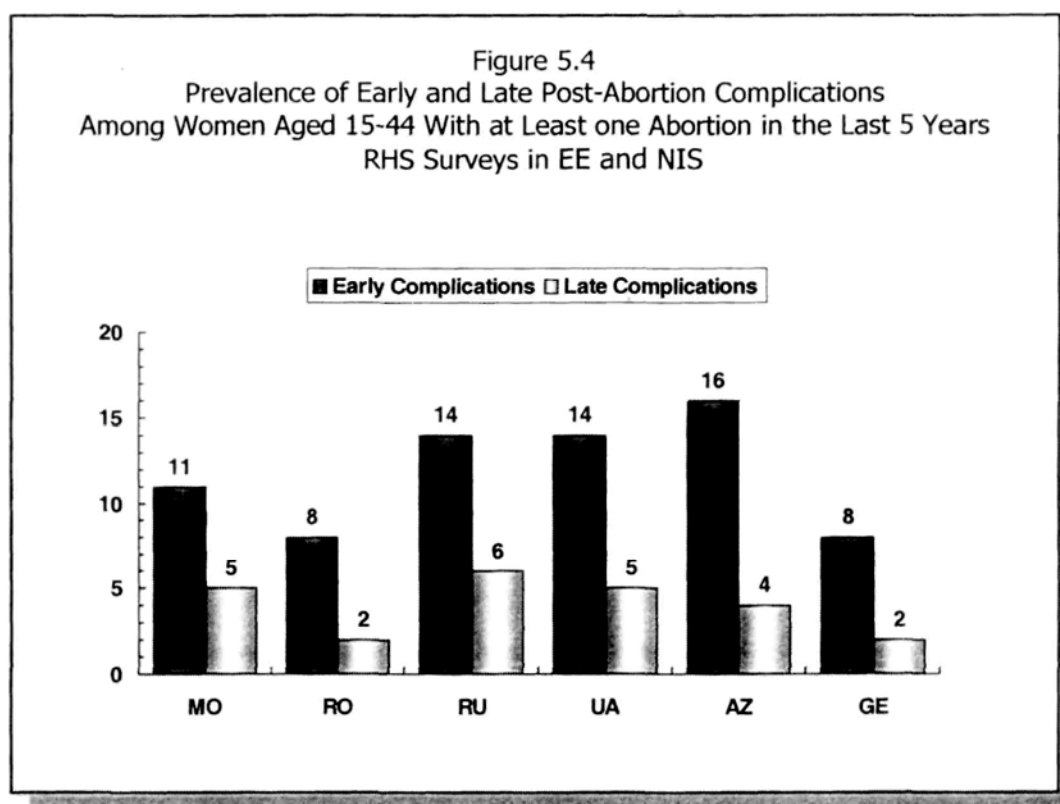
Table 5.4.1
Induced Abortions Performed between July 1996–June 2001 Treated with Antibiotics and
Induced Abortions with Early and Late Complications by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Antibiotic Treatment	Early Complications		Late Complications*	
	%	%	N	%	N
Total	20.6	16.5	4,083	4.1	3,731
Residence					
Urban	24.7	14.9	2,064	3.8	1,920
Rural	14.8	18.7	2,019	4.4	1,811
Region					
Baku	28.4	16.3	834	4.6	787
North&North-East	17.1	16.9	465	3.9	431
West	22.9	14.3	427	1.5	383
South-West	19.2	22.7	1,477	5.9	1,315
South	11.7	14.6	320	4.7	301
Central	17.9	14.7	560	4.2	514
Education Level					
Secondary Incomplete or less	9.7	17.8	746	3.1	672
Secondary Complete	17.6	15.9	2,122	4.8	1,928
Technicum	30.4	14.8	808	3.0	754
University	35.4	20.2	407	4.2	377
Socio-Economic Status					
Low	14.8	16.3	2,196	4.2	1,986
Medium	24.2	16.0	1,450	3.7	1,333
High	30.4	18.7	437	4.4	412
IDP/Refugee Status					
IDP/R	22.3	17.5	828	3.3	743
Non-IDP/CA	18.3	17.9	1,637	4.1	1,478
Non-IDP/NCA	20.9	15.9	1,618	4.2	1,510
Gestational Age					
≤ 6 weeks	20.6	14.1	1,743	2.7	1,585
7–12 weeks	19.0	17.3	1,926	4.7	1,764
≥13 weeks	27.8	22.9	414	6.9	382
Abortion Facility					
Gynecologic Ward	20.3	16.0	2,979	4.3	2,716
WCC	20.9	16.4	944	3.1	879
Private Clinic	35.4	25.2	44	10.3	37
Outside a Medical Facility	20.0	24.3	116	4.4	99
Early Complications					
Absent	17.0	0.0	3,297	2.3	3,037
Present	39.0	100.0	786	13.1	694

* Includes sequelae at six months after the abortion (352 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.

65

Early complications were most prevalent among women living in the South-West region (23%) and among women with late abortions (23%) or abortions performed outside of public medical facilities (24%-25%). As expected, abortions with early complications were more likely to be followed by late sequelae (at 6 months or more after the abortion was performed) than were abortions without any immediate health problems (13% vs. 2%).

Just 21% of abortions were followed with antibiotic treatment (Table 5.4.1). Women were more likely to receive antibiotic treatment if they lived in an urban area (especially Baku), attended postsecondary education, were of higher SES, had a late abortion, or had the procedure performed at a private clinic. Women who suffered early complications were nearly twice as likely to receive antibiotics (39%).

Most of the early complications involved prolonged pelvic pain (78%), severe or prolonged bleeding (42%), high fever (38%), and pelvic infection (27%); less than 1% of complicated abortions had perforations of the uterus (Table 5.4.2). With the exception of uterine perforation, it is difficult to assess how serious the other early complications might have been. An indirect approach to measure their severity is to consider early complications as serious when they required overnight hospitalization or were followed by late complications. As shown previously, few immediate complications required one or more nights of hospitalization, and 22% were associated with late complications. The prevalence of early complications increased by 50% after 13 weeks of gestation.

TABLE 5.4.2

**Induced Abortions Performed between July 1996–June 2001 with Early Complications
by Type of Complication and Gestational Age
Reproductive Health Survey: Azerbaijan, 2001**

Type of Early Complications	Total	Gestational Age (in weeks)		
		≤ 6	7–12	13+
Prolonged Pelvic Pain	77.7	83.7	73.7	75.9
Severe or Prolonged Bleeding	42.4	36.8	43.9	51.2
High Fever (over 38°C)	37.7	35.5	34.7	53.1
Infectious Vaginal Discharge	26.5	27.0	26.3	25.6
Uterine Perforation	0.4	0.2	0.1	2.1
No. of Abortions with Early Complications	786	289	382	115

5.5 Reasons for Abortion

Most induced abortions (64%) take place because of the woman's desire to not have a child ([Table 5.5](#) and [Figure 5.5](#)). Nearly 1 in 5 (18%) abortions were obtained because of economic or social reasons (e.g., low income, unemployment, fear of losing a job, or crowded living conditions), 14% because the woman wanted to space childbearing, and 1% for partner-related reasons (e.g., the partner objected to the pregnancy).Only 3% of abortions took place for maternal health reasons (i.e., pregnancy was threatening the woman's physical or mental health), and 1% took place because of fetal defects or potential risks for the baby.

The use of abortion for fertility control was mentioned slightly more often by rural women (who already have a higher mean number of living children than urban women); women who reside outside of Baku, especially in the North-Northeast (71%) and Central (70%) regions of the country; and women over age 34 (76%), 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 11% among women pregnant for the second time to 56% among women with two previous pregnancies and 71 % among those with four or more previous pregnancies. Socioeconomic reasons were reported more often in urban areas, especially in Baku (27%), where the cost of living is more expensive and adequate housing is an increasing problem.

Figure 5.5
Most Important Reason for Having an Induced Abortion
Women Aged 15–44 With at Least one Abortion in the Last 5 Years
RHS Surveys in EE and NIS

Legend: Limit Fertility ■ Socioeconomic Partner-Related Health-related

Region	Limit Fertility	Socioeconomic	Partner-Related	Health-related
MO	28	57	7	8
RO	53	30	11	7
UA	60	25	6	6
AZ	63	32	1	4
GE	66	29	2	4
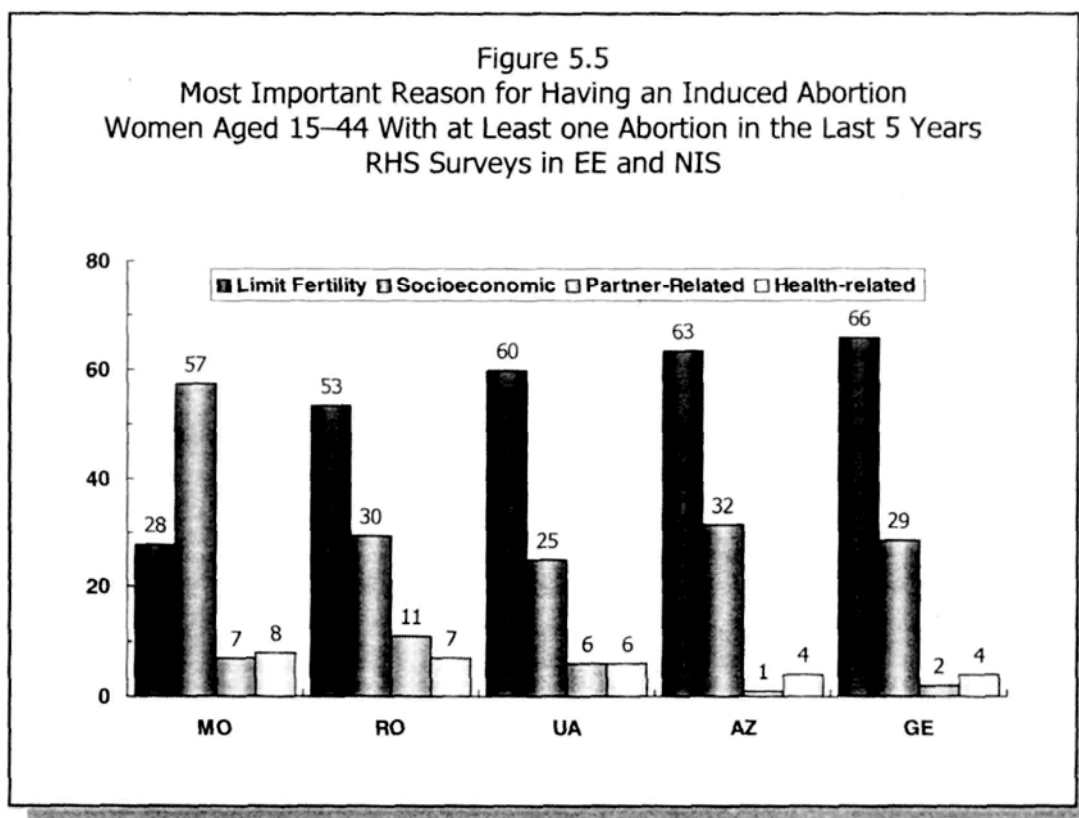
TABLE 5.5
Most Important Reason for Abortion for Abortions Performed Between 1995–2001
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Want No (more) Children	Socio-Economic Reason	Want to Postpone Childbearing	Risk to Maternal Health	Partner Objected to Pregnancy	Risk of Fetal Deformity	Other	Total	No. of Cases
Total	63.6	17.7	13.6	3.1	0.7	0.4	0.9	100.0	4,083
Residence									
Urban	61.9	19.3	13.0	3.7	0.8	0.5	0.8	100.0	2,064
Rural	65.9	15.4	14.5	2.2	0.7	0.2	1.0	100.0	2,019
Region									
Baku	52.7	26.9	11.0	5.4	1.5	0.6	1.8	100.0	834
North - NorthEast	71.3	10.1	15.6	1.7	0.2	0.4	0.8	100.0	465
West	63.8	15.7	17.5	1.9	0.7	0.0	0.3	100.0	427
SouthWest	60.8	19.2	13.6	4.8	0.2	0.6	0.8	100.0	1,477
South	65.4	21.9	10.7	1.4	0.1	0.6	0.0	100.0	320
Central	70.1	12.5	12.5	2.5	1.3	0.1	1.0	100.0	560
Age Group *									
15–24	54.2	19.0	20.0	3.7	1.4	0.2	1.5	100.0	1,161
25–34	61.8	16.3	16.9	3.1	0.7	0.4	0.8	100.0	1,906
35–44	75.6	18.8	1.7	2.5	0.2	0.5	0.6	100.0	1,016
Socio-economic Status									
Low	64.6	18.4	13.8	2.3	0.2	0.3	0.4	100.0	2,196
Middle	62.4	19.3	12.9	3.5	0.7	0.5	0.9	100.0	1,450
High	63.5	10.6	14.9	4.7	3.1	0.4	2.9	100.0	437
IDP/Refugee Status									
IDP/R	59.6	24.7	11.1	3.4	0.1	0.7	0.4	100.0	828
Non-IDP/CA	66.1	13.9	14.3	3.1	1.2	0.3	1.2	100.0	1,637
Non-IDP/NCA	63.7	17.3	13.9	3.0	0.8	0.3	0.9	100.0	1,618
Pregnancy Order									
First	†	†	†	†	†	†	†	100.0	10
Second	9.7	13.9	59.7	11.5	1.5	2.3	1.4	100.0	133
Third	55.5	17.0	21.6	4.0	0.5	0.4	1.0	100.0	541
Fourth	58.2	18.2	16.8	4.5	0.3	0.7	1.3	100.0	722
Fifth or Higher	70.8	18.0	7.8	1.7	0.9	0.2	0.7	100.0	2,677

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

Partner's objection to pregnancy was an uncommon reason for the respondent's decision to not carry a pregnancy to term, regardless of the respondent's background characteristics, presumably because most women were married at the time of having the abortion and the couple was in agreement on the abortion decision.

CHAPTER 6

MATERNAL AND CHILD HEALTH

Maternal and child mortality are measures of a nation's health and worldwide indicators of social well-being. The most recent World Health Organization (WHO) estimates for the newly independent states showed that the maternal mortality ratio (MMR) of 37 deaths per 100,000 live births in Azerbaijan in 1995 was higher than in Georgia and Armenia but substantially lower than in the Central Asian republics (Hill et al, 2001). According to the most recent official estimates, the MMR in 2000 was 37.6 deaths per 100,000 live births (State Committee of Statistics of the Azerbaijan Republic [SCS] , 2001). The same source places the infant mortality rate at 12.8 infant deaths per 1,000 live births. A recent nationwide UNICEF survey, however, estimated that both maternal and infant mortality are substantially higher (79 maternal deaths per 100,000 live births and 79 infant deaths per 1,000 live births, respectively) (UNICEF, 2000).

Adequate perinatal care is an essential step in preventing, identifying, and addressing risk factors that may affect the health of mothers and their babies. Under the USSR health guidelines, women's access to perinatal care was free of charge and consisted of three components: preconception care, prenatal care, and postnatal care. Prenatal care visits included a comprehensive health assessment at the beginning of pregnancy and continuous surveillance of health status throughout the pregnancy. Preconception and prenatal care counseling was generally offered by primary care providers and consisted of provision of a wide array of information, including health risks associated with pregnancy itself and those that can affect the development of the fetus, such as tobacco and alcohol use, maternal infection (e.g., rubella, toxoplasma, and sexually transmitted infections [STIs]), and genetic conditions. Though very detailed, preconception counseling was offered only to young couples prior to marriage without any follow-up before their planned childbearing. Standard prenatal care (for uncomplicated pregnancies) required routine visits according to gestational age: monthly visits before 12 weeks of pregnancy; bi-monthly visits from 12 to 30 weeks of gestation; and weekly or bi-monthly visits thereafter. Prenatal care included a general health risk assessment consisting of medical examination and a series of laboratory tests (i.e., blood, urine, vaginal bacteriological exams, and screening for STIs and isoimmunization Rh) that were repeated periodically. Postpartum care was performed in parallel with infant care visits several times during the first year postpartum (Notzon et al., 1999). After its independence from the Soviet Union in 1991, Azerbaijan was no longer able to sustain a comprehensive perinatal care system, and many maternal and child health indicators started to deteriorate.

This chapter examines selected aspects of maternal and child care in Azerbaijan (e.g., sources of health care, utilization of maternal care services, breast-feeding), to identify subgroups with specific needs for care and to investigate maternal and child health outcomes that may be related to the availability and quality of maternity care services. All estimates reported here are based on respondents' reports recorded in the lifetime pregnancy history and a detailed birth history for all births carried to term since January 1996.

6.1 Prenatal Care

Prenatal care is most effective when it is initiated in the early stages of pregnancy, is continued throughout gestation (according to recommended standards of periodicity), and is comprehensive (i.e., includes risk assessment, risk reduction or treatment of medical conditions, and counseling). This section describes the use of prenatal care among survey respondents for all pregnancies carried to term (either live births or still births) since January 1996. Women were asked in what week or month of gestation they had their first visit for prenatal care (not counting visits that were just for a pregnancy test or just for the delivery) and the number of prenatal care visits during pregnancy.

Of the 3,430 births reported since January 1996, just over two-thirds of women (70%) had received some prenatal care; of those, about two-thirds (45% of 70%, or 64%) received their first prenatal care visit in the first trimester (Table 6.1.1). Approximately 1 in 5 women had the first visit during the second trimester; 6% had their first prenatal care visit during the third trimester. The level of any prenatal care within different subgroups varied sometimes by a considerable margin (between 53% and 89%). Rural women, residents of the South region, those who did not complete secondary education or had a low SES, and women who had already had two or more births were more likely not to have any prenatal care. Similarly, the percentage of mothers who entered prenatal care in the first trimester varied widely, from a low of 32% to a high of 65%. Fewer than 1 in 2 women (45%) reported early prenatal care.

Women living in urban areas were more likely to start prenatal care earlier in pregnancy than women in rural areas were (55% vs. 35%). Early entry into prenatal care was highest among women living in Baku (61%) and lowest (34%) in the South. Early entry into prenatal care was highly correlated with the mother's education and SES; women who had not completed high school had a lower likelihood of initiating prenatal care early (32%) than did women with postsecondary education (60%). In addition, 47% of the women who had not completed high school reported receiving no prenatal care, whereas only 11% of women with a university education had no prenatal care. Similarly, women with low SES had a much lower likelihood of initiating prenatal care early in pregnancy than did women with high SES (35% vs. 65%). Internally displaced or refugee women (IDP/Rs) and women living in regions with a high concentration of IDP/Rs were slightly less likely

TABLE 6.1.1
Onset of Prenatal Care by Pregnancy Trimester and Number of Prenatal Visits for Births in 1996–2001
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Trimester of First Visit				Number of Prenatal Visits						Total	No. of Cases
	No Visits	1st	2nd	3rd	0	1–3	4–6	7–9	10+	Don't Know		
Total	30.3	44.8	19.3	5.6	30.3	38.9	17.4	7.7	5.3	0.4	100.0	3,430
Residence												
Urban	20.5	54.8	20.9	3.7	20.5	34.0	24.1	12.1	8.7	0.5	100.0	1,517
Rural	40.2	34.6	17.6	7.5	40.1	43.8	10.8	3.3	1.8	0.3	100.0	1,913
Region												
Baku	16.4	60.6	19.7	3.3	16.4	20.7	30.3	17.2	14.7	0.7	100.0	616
North & North-East	33.1	38.7	24.1	4.1	32.9	45.6	14.6	4.5	2.1	0.4	100.0	475
West	25.9	45.8	21.1	7.2	25.9	44.3	14.1	7.7	7.7	0.4	100.0	322
South-West	37.6	38.0	18.5	5.9	37.6	41.4	14.2	5.2	1.3	0.3	100.0	1,151
South	43.0	33.6	14.5	9.0	43.0	40.5	12.7	1.9	1.9	0.0	100.0	438
Central	30.5	50.7	12.3	6.6	30.5	43.9	14.9	8.5	1.8	0.4	100.0	428
Age Group(at Birth)												
15–24	32.2	41.3	19.7	6.7	32.2	39.5	16.7	6.3	5.0	0.3	100.0	1,625
25–34	28.7	48.3	18.0	4.9	28.7	37.8	18.8	9.0	5.1	0.5	100.0	1,582
35–44	25.7	48.3	24.5	1.6	25.7	41.5	13.8	9.9	8.3	0.8	100.0	223
Education Level												
Secondary incomplete or less	46.9	31.7	14.5	6.8	46.9	37.0	8.9	3.4	3.3	0.4	100.0	759
Secondary complete	30.1	42.6	21.2	6.1	30.0	42.5	17.3	5.4	4.5	0.2	100.0	1,782
Technicum	20.6	60.4	15.9	3.1	20.6	34.1	25.2	13.7	6.0	0.5	100.0	521
University	11.4	59.9	24.3	4.4	11.4	32.7	24.8	18.6	11.6	0.9	100.0	368
Socioeconomic Status												
Low	39.8	35.3	18.8	6.0	39.7	43.8	11.9	3.0	1.4	0.2	100.0	2,019
Medium	21.4	53.1	19.7	5.7	21.4	35.1	22.0	12.0	8.8	0.6	100.0	1,116
High	12.0	65.3	20.0	2.7	12.0	25.9	30.4	17.7	13.2	0.8	100.0	295
IDP/Refugee Status												
IDP/R	36.1	45.1	14.9	3.9	36.1	32.3	20.5	7.4	3.3	0.3	100.0	678
Non-IDP/CA	36.6	41.0	15.5	6.9	36.6	42.3	11.8	6.8	2.1	0.5	100.0	1,311
Non-IDP/NCA	28.1	45.6	20.7	5.6	28.0	39.1	18.3	8.0	6.3	0.4	100.0	1,441
Birth Order												
First	21.9	47.9	23.3	7.0	21.9	40.7	19.1	10.5	7.1	0.7	100.0	1,061
Second	32.3	43.7	18.5	5.6	32.1	36.2	19.2	7.2	4.8	0.4	100.0	1,111
Third	34.5	42.4	18.5	4.5	34.5	39.7	15.7	5.9	4.1	0.1	100.0	733
Fourth or higher	40.2	43.5	12.3	4.0	40.2	39.6	11.5	5.0	3.7	0.0	100.0	525
Baby Weight at Birth												
<2,500 grams	40.8	36.6	12.6	9.5	40.8	36.4	15.7	3.5	2.7	0.8	100.0	481
≥2,500 grams	28.9	45.9	20.2	5.0	28.9	39.2	17.7	8.3	5.7	0.3	100.0	2,949

to report any prenatal care, probably reflecting the fact that these women have a lower SES than women living in areas not directly affected by the Nagorno-Karabach war. Mothers of low birth weight (LBW) babies were more likely than mothers who gave birth to normal weight babies to have no prenatal care (41% vs. 29%).

Prenatal care should not only start early but also continue throughout pregnancy, according to recommended standards of periodicity. To assess the adequacy of prenatal care, it is necessary to monitor both the time of the first visit and the number of prenatal care visits once care has begun. Pregnancies ending in the 5 years prior to the survey averaged three prenatal visits; the range was 0 visits to 30 visits (data not shown). Among women with any prenatal care, the average number of prenatal care visits was 4.3. More than half of women with any prenatal care (39% of 70%, or 55%) had only 1-3 visits, and fewer than 1 in 10 women had 10 or more prenatal care visits (right panel of Table 6.1.1). A small proportion of women stated that they did not remember the number of prenatal care visits. Women who had 10 or more prenatal visits were generally the same women who started prenatal care early, because the number of visits was correlated with the month of initiation of care.

The adequacy of prenatal care is assessed by using the Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck index. This index combines the time of initiation of prenatal care (i.e., the month when prenatal care begins) with the number of visits received (according to American College of Obstetricians and Gynecologists recommendations). Inadequate care is defined as no or late prenatal care or less than 50% of recommended visits. The three remaining levels require early initiation of care (i.e., by the fourth month of gestation). Intermediate care requires 50%-79% of the recommended number of visits; adequate care, 80%-109%; and adequate care "plus," 110% or more of the recommended number of visits (Kotelchuck, 1994). By applying this index to data from the AZRHS01, only 6% of births within the past 5 years received adequate or adequate plus care, and 81 % received inadequate prenatal care (Figure 6.1.1). Standards of prenatal care for routine pregnancies in the era of the Soviet Union (still in effect in the Russian Federation but discontinued in many successor states) exceed U.S. standards, requiring early onset of prenatal care and an average of 14 prenatal care visits before delivery (Notzon et al., 1999).

In the AZRHS01, the principal source of prenatal care was a women's consultation clinic (WCC) (46%). The second source of most prenatal visits was a maternity (36%) or a village hospital (13%). Rural dispensaries and private clinics provided prenatal care for 2% and 1%, respectively, of pregnant women; only 3% of women received prenatal care at home (data not shown). Thus, 97% of women reported having most of their prenatal care in a medical facility. Women's clinics were the principal source for prenatal care for all pregnancies, irrespective of women's background characteristics, except in rural areas and the South and South-West regions, where most prenatal care

Figure 6.1.1
Adequacy of Prenatal Care Utilization Index*
Births in the 5 Years Prior to the Survey
Reproductive Health Survey: Azerbaijan, 2001

Intermediate 12%

Adequate 4%

Adequate Plus 2%

Unknown 1%
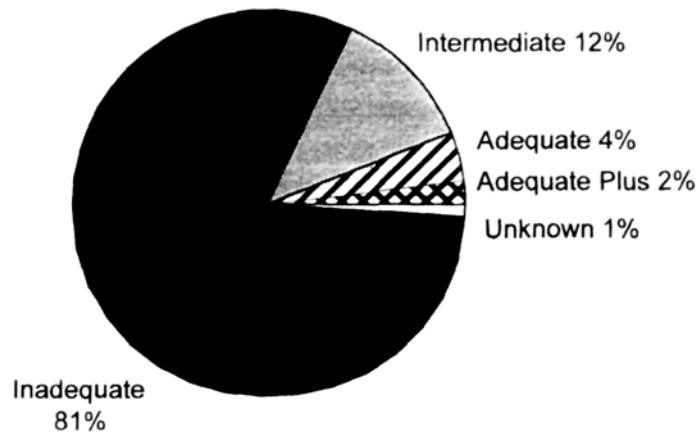
Inadequate
81%

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

was provided through hospitals. Generally, in WCCs and hospitals most care is provided by obstetricians (ob/gyns). Because WCCs and hospitals were the most used sources of prenatal care, most of the prenatal care visits (94%) were provided by ob/gyns; only 5% were provided by nurses or midwives (data not shown). Nurses provided as much as 38% of the prenatal care for the few women who received prenatal care at a rural dispensary or at home.

Prenatal care is frequently inadequate in the countries of Eastern Europe and the successor states of the USSR. In recent reproductive health (RHS) and demographic and health (DHS) surveys conducted in the region, the proportion of pregnant women with no prenatal care was less than 1% in the Czech Republic, 1% in Moldova, 4% in Russia, 8% in Armenia, 9% in Ukraine and Georgia, between 2% and 5% in Central Asian Republics, 11% in Romania, and 30% in Azerbaijan. Late prenatal care is also common. With the exception of the Czech Republic, where more than 90% of women began receiving care in the first trimester, in all other countries less than three-fourths of women entered prenatal care early (Figure 6.1.2). Late prenatal care was more prevalent in the Caucasus region than in other regions. In the United States it is recommended that at least 90% of

Figure 6.1.2
Percentage of Births with Prenatal Care Starting in the First Trimester
Births in the Past 5 Years* — RHS and DHS Surveys in EE and NIS

Eastern Europe _Caucasus Region_ _Central Asian Republics_

	CZ	MO	RO	RU	UA	AM	AZ	GE	KZ	KG	TM	UZ
Value	94	73	60	83	66	54	45	63	60	72	72	63

* Last birth in the past 5 years in CZ, RU, and UA
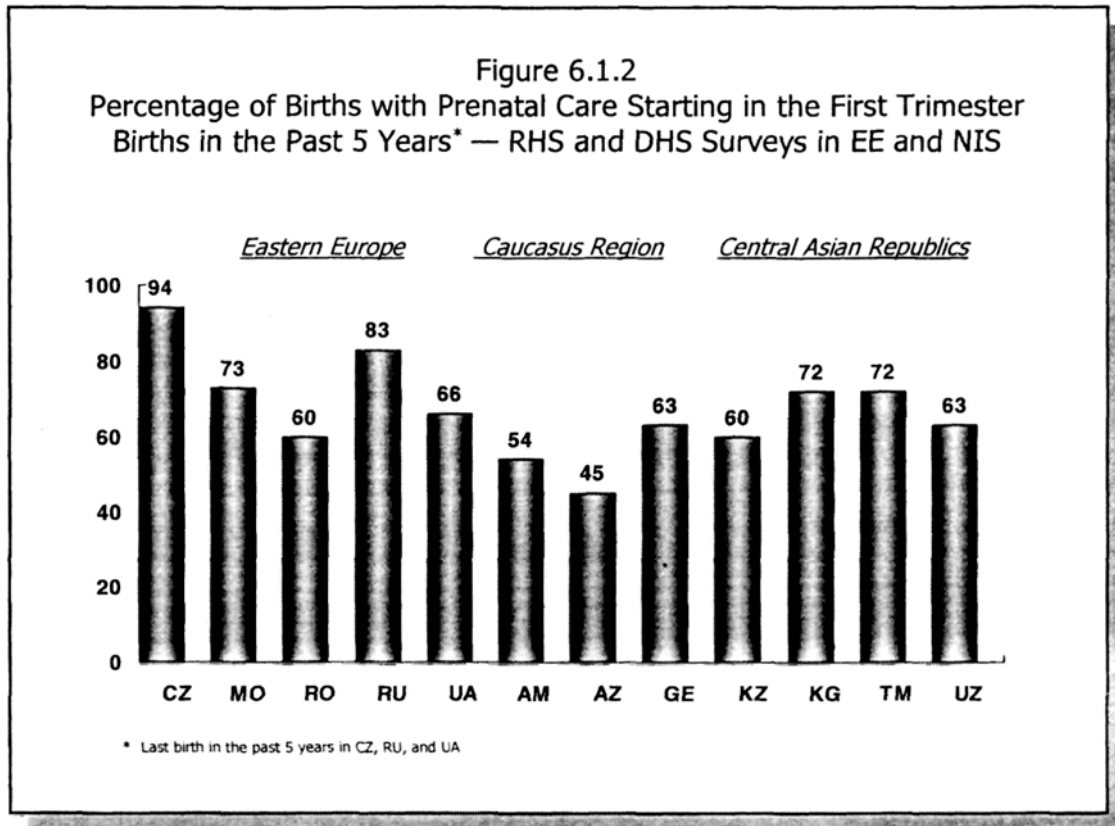
pregnant women enter prenatal care early; in 2000, 83% of mothers began prenatal care in the first trimester while only 4% had no prenatal care or late care (third trimester) (CDC, 2002).

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

Because the initiation and frequency of prenatal care visits evaluate only the quantitative dimension of the prenatal care (i.e., adequacy of utilization of services), the AZRHS01 included additional questions aimed at assessing information received and measurements performed during the prenatal visits, that is, the adequacy of the content of prenatal care (Table 6.1.2).

TABLE 6.1.2
Pregnancy Counseling on Specific Topics During Prenatal Care Visits
by Selected Characteristics
Births in the 5 Years Prior to the Survey among Women with Any Prenatal Care
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Nutrition	Breast-Feeding	Delivery	Post-natal Care	Pregnancy Complications	Effects of Smoking	Effects of Alcohol	Family Planning	No. of Cases
Total	65.7	54.7	54.2	46.9	49.1	37.9	37.7	26.8	2,303
Residence									
Urban	72.7	59.5	58.3	50.3	52.6	41.0	40.8	27.4	1,197
Rural	56.4	48.2	48.7	42.3	44.5	33.8	33.5	26.0	1,106
Region									
Baku	81.4	67.9	65.7	55.6	58.5	47.4	47.0	29.6	510
North & North-East	61.8	54.6	53.2	48.5	51.0	39.0	38.4	28.1	323
West	66.8	46.5	51.2	41.6	44.0	29.7	29.7	23.6	236
South-West	47.4	43.5	42.3	34.6	38.2	26.5	26.8	20.3	712
South	57.3	49.2	47.3	44.3	46.0	35.6	35.6	27.6	230
Central	64.1	52.1	52.8	44.4	43.9	37.6	37.4	26.3	292
Education Level									
Secondary Incomplete or less	57.6	50.8	48.7	40.4	41.0	28.3	28.6	18.0	403
Secondary Complete	61.8	51.8	51.6	45.5	48.0	36.0	35.5	26.8	1,173
Technicum	74.2	59.1	57.9	50.0	54.4	46.0	46.2	29.4	400
University	79.1	63.9	65.0	55.5	56.5	46.4	46.1	33.9	327
IDP/Refugee Status									
IDP/R	65.1	60.1	54.6	50.2	53.9	42.9	43.6	35.3	415
Non-IDP/CA	55.3	46.6	47.1	38.5	39.7	31.3	31.5	23.1	824
Non-IDP/NCA	67.8	55.5	55.5	48.1	50.4	38.5	38.1	26.4	1,064
Birth Order									
First Birth	72.4	59.2	58.8	51.6	55.5	43.2	42.8	30.2	809
Second Birth	65.5	54.3	53.3	44.7	46.5	35.7	35.4	23.8	740
Third Birth	61.1	54.1	54.7	48.6	49.7	37.4	37.6	29.6	450
Fourth or Higher	51.9	41.8	40.8	34.8	34.9	27.8	27.8	19.5	304
Prenatal Care Visits*									
4–6	60.9	51.6	51.7	44.5	46.8	34.6	34.2	24.8	1,882
7–9	84.4	65.8	61.0	57.4	58.7	53.7	54.9	34.3	259
10+	89.9	72.1	69.0	57.2	59.4	50.6	50.0	36.6	147
Place of Prenatal Care									
Rural Clinic	50.8	47.5	47.5	43.0	44.1	25.1	24.5	20.6	372
Polyclinic	72.9	60.4	59.3	50.8	53.9	44.5	44.3	33.9	961
Hospital	64.1	51.7	51.8	44.2	46.3	35.9	35.8	21.4	889
Home	45.7	38.0	35.9	37.3	33.7	21.6	21.6	11.3	81

* Exclude 15 women who did not remember how many prenatal care visits they had.

TABLE 6.1.3
Selected Measurements Performed During Prenatal Care Visits
by Selected Characteristics
Births in the 5 Years Prior to the Survey among Women with Any Prenatal Care
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Blood Pressure Measured	Blood Sample Taken	Urine Sample Taken	Weight Measured	Height Measured	No.of Cases
Total	82.1	72.0	66.3	47.6	46.1	2,303
Residence						
Urban	87.9	84.6	80.0	62.2	60.0	1,197
Rural	74.3	55.2	47.8	28.0	27.5	1,106
Region						
Baku	91.8	93.2	91.3	84.1	80.7	510
North & North-East	81.3	75.2	67.7	50.4	50.7	323
West	87.4	66.7	59.4	35.4	33.9	236
South-West	72.2	44.5	38.0	16.9	15.8	712
South	71.3	57.5	48.9	22.7	21.0	230
Central	76.6	65.3	60.6	32.2	30.5	292
Age Group (at Birth)						
15–24	78.4	67.6	60.3	42.1	40.8	1,072
25–34	86.1	76.8	72.2	51.9	50.2	1,079
35–44	82.0	72.1	69.3	58.7	56.5	152
Education Level						
Secondary Incomplete or less	72.9	57.6	51.5	36.7	35.9	403
Secondary Complete	80.6	67.7	60.3	40.6	39.2	1,173
Technicum	87.8	83.5	79.7	60.0	58.6	400
University	91.6	90.6	88.6	70.4	67.6	327
Socioeconomic Status						
Low	72.9	60.1	53.3	33.0	32.3	1,190
Middle	88.5	80.0	74.1	55.9	53.6	858
High	95.0	89.8	88.4	74.3	72.4	255
IDP/Refugee Status						
IDP/R	78.3	63.8	58.2	48.6	46.5	415
Non-IDP/CA	76.9	55.9	48.0	24.0	23.6	824
Non-IDP/NCA	83.6	76.3	70.9	52.1	50.5	1,064
Number of Prenatal Visits						
4–6	79.3	66.4	59.9	40.3	39.2	1,882
7–9	93.6	94.1	91.6	73.7	70.4	259
10+	95.4	98.9	96.2	86.8	83.3	147
Place of Prenatal Care						
Village Hospital of Dispensary	70.6	45.7	32.6	25.1	23.3	372
WCC or Private Clinic	87.9	85.1	81.2	69.3	68.2	961
Maternity	80.7	70.2	64.8	31.5	29.4	889
Home	64.5	17.6	12.0	7.8	8.4	81

* Exclude 15 women who did not remember how many prenatal care visits they had.

Two-thirds of women who attended prenatal care clinics received some counseling about nutrition during pregnancy (66%); about 1 in 2 women received information about breast-feeding (55%), delivery (54%), potential complications during pregnancy and their early signs (49%), and postnatal care (47%); about 1 in 3 women received information about the negative effects of smoking and alcohol (38%); and only 27% of women received information about family planning after birth. Maternal characteristics that appear to be associated with lower levels of counseling for most of the topics include rural residence, residence in the South and South-West regions, less than complete secondary education, having three or more previous births, and receiving most of the prenatal visits in rural dispensaries or at home. The proportion receiving information during prenatal care visits was directly correlated with the number of prenatal visits.

In addition to counseling, the first prenatal care visit should include a detailed medical history of the woman and her family, including information about risk, factors and genetic disorders; a detailed obstetrical history; a comprehensive physical examination; measurements of blood pressure; urinalysis; basic blood tests; ultrasound; and tests for various types of infection. Monitoring of mother's weight, blood pressure, and basic blood tests is extended during the follow-up visits, but ultrasound exams are carried out only two more times, at 16-28 weeks and at 36 weeks (Notzon et al., 1999). Despite these guidelines, prenatal care in the past 5 years did not always include required measurements (Table 6.1.3). About 1 in 6 women who had any prenatal care since January 1996 did not have her blood pressure measured at least once during prenatal care; 1 in 4 women did not have a blood exam, 1 in 3 women did not have an urine exam, and about 1 in 2 women never had her height or weight measured.

Only about 1 in 3 pregnancies (37%) had had at least one ultrasound exam (Table 6.1.4). Maternal characteristics associated with higher levels of ultrasound exams include urban residence (51%), residence in Baku (73%), postgraduate education (62%), high socioeconomic status (SES) (66%), having seven or more prenatal care visits, and having most of prenatal visits in polyclinic. Lower prevalence of ultrasound exams was associated with rural residence (17%), livingin the South region (11%), and having most prenatal care at home (16%).

Survey data do not allow us to differentiate between use of ultrasound for selected specific indications (e.g., confirmation of gestational age, assessment of fetal viability, fetal malformations, fetal growth, fetal presentation, multiple pregnancy, examination of the placenta, and assessment of amniotic fluid) and use for routine screening, either during early pregnancy (16-20 weeks) or in late pregnancy (after 20 weeks). Most women, however, had their first ultrasound exam before 20 weeks of pregnancy, suggesting the use of ultrasound for specific indications rather than for screening. Women in urban areas, including Baku; those with high educational attainment; those with seven or more prenatal care visits; and those whose primary source of prenatal care was a polyclinic or

TABLE 6.1.4
Use of Ultrasound Exams During Pregnancy by Time of the First Exam, by Selected Characteristics
Births in the Five Years Prior to the Survey among Women with Any Prenatal Care
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Had Ultrasound Exam | | Time of First Exam | | | |
	%	No. of Cases	4–20 weeks	21 or more weeks	Total	No. of Cases
Total	36.7	2,303	60.0	40.0	100.0	805
Residence						
Urban	51.2	1,197	61.4	38.6	100.0	594
Rural	17.3	1,106	54.5	45.5	100.0	211
Region						
Baku	72.6	510	64.6	35.4	100.0	360
North & North-East	29.2	323	46.7	53.3	100.0	97
West	30.0	236	71.6	28.4	100.0	79
South-West	20.3	712	60.6	39.4	100.0	145
South	11.0	230	45.1	54.9	100.0	37
Central	27.5	292	57.4	42.6	100.0	87
Age Group (at Birth)						
15–24	30.3	1,072	55.2	44.8	100.0	314
25–34	41.5	1,079	64.5	35.5	100.0	420
35–44	50.6	152	56.8	43.2	100.0	71
Education Level						
Secondary Incomplete or less	28.0	403	52.1	47.9	100.0	101
Secondary Complete	30.1	1,173	55.7	44.3	100.0	337
Technicum	43.0	400	66.7	33.3	100.0	169
University	62.2	327	65.8	34.2	100.0	198
Socioeconomic Status						
Low	20.5	1,190	51.8	48.2	100.0	242
Middle	46.1	858	57.0	43.0	100.0	393
High	65.7	255	75.9	24.1	100.0	170
IDP/Refugee Status						
IDP/R	47.0	415	67.4	32.6	100.0	132
Non-IDP/CA	25.2	824	64.2	35.8	100.0	206
Non-IDP/NCA	37.6	1,064	58.2	41.8	100.0	467
Prenatal Care Visits						
4–6	29.6	1,882	57.5	42.5	100.0	536
7–9	60.0	259	66.9	33.1	100.0	153
10+	78.1	147	61.3	38.7	100.0	112
Don't Know	*	15	*	*	100.0	4
Place of Prenatal Care						
Village Hospital of Dispensary	12.3	372	36.6	63.4	100.0	43
WCC or Private Clinic	51.3	961	58.6	41.4	100.0	496
Maternity	29.2	889	67.8	32.2	100.0	258
Home	16.2	81	*	*	100.0	8

* Fewer than 25 cases in this category.

maternity hospital were slightly more likely than other women to have their first ultrasound exam during the first 20 weeks of pregnancy.

6.2 Intrapartum Care

All births should occur in medical facilities where adequately trained personnel can monitor the progress of labor and delivery. According to AZRHS01, most deliveries in the past 5 years took place in maternity wards (56%) or village hospitals with inpatient obstetrical care (17%) (Table 6.2.1 and Figure 6.2.1); however, 1 in 4 births were delivered outside medical facilities and less than 1% were delivered in a private clinic. Home deliveries were relatively high among rural residents (36%), those living in the Central, South, and South-West regions (35%, 36%, and 39%), those with low levels of education or low SES (39% and 36%, respectively), IDP/R women and non-IDP/Rs living in conflict-affected areas (41 % and 35%), those with four or more other births (42%), and those with no prenatal care (48%).

Figure 6.2.1
Place of Delivery for Births in the 5 Years Prior to the Survey
Reproductive Health Survey—Azerbaijan, 2001

Maternity 56%
Village Hospital 17%
Private Clinic 1%
At Home 26%
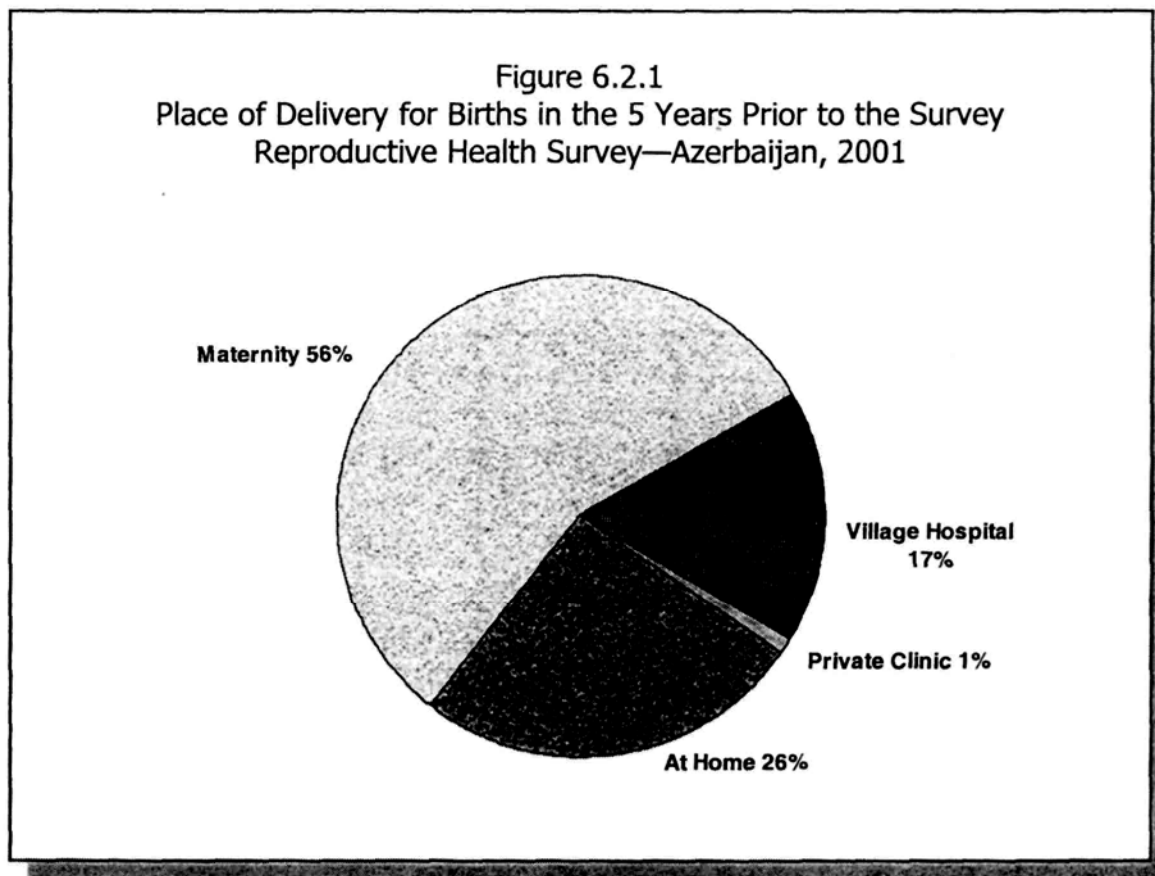
TABLE 6.2.1
Place of Delivery for Births in 1996–2001 by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Place of Delivery | | | | | | |
	Maternity	Village Hospital	Private Clinic	Dispensary	Home*	Total	No. of Cases
Total	56.1	16.8	0.5	0.3	26.3	100.0	3,430
Residence							
Urban	78.5	3.7	0.5	0.1	17.3	100.0	1,517
Rural	33.5	30.0	0.4	0.5	35.5	100.0	1,913
Region							
Baku	82.0	3.5	0.4	0.0	14.1	100.0	616
North & North-East	57.9	18.3	0.2	0.0	23.6	100.0	475
West	56.3	20.7	1.1	0.4	21.5	100.0	322
South-West	35.2	23.5	0.1	2.1	39.1	100.0	1,151
South	33.1	30.4	0.0	0.1	36.4	100.0	438
Central	54.9	8.4	1.2	0.5	34.9	100.0	428
Age Group (at Birth)							
15–24	52.6	18.8	0.6	0.5	27.5	100.0	1,625
25–34	58.8	15.0	0.4	0.2	25.7	100.0	1,582
35–44	65.0	13.1	0.0	0.2	21.7	100.0	223
Education Level							
Secondary incomplete or less	41.1	19.7	0.2	0.1	38.9	100.0	759
Secondary complete	52.9	20.0	0.3	0.5	26.4	100.0	1,782
Technicum	72.3	8.9	0.3	0.0	18.4	100.0	521
University	78.6	7.2	1.8	0.4	12.0	100.0	368
Socioeconomic Status							
Low	42.1	21.0	0.3	0.5	36.2	100.0	2,019
Medium	67.4	14.8	0.6	0.2	17.0	100.0	1,116
High	89.8	1.6	0.9	0.1	7.6	100.0	295
IDP/Refugee Status							
IDP/R	47.3	10.6	0.0	1.5	40.7	100.0	678
Non-IDP/CA	44.8	18.6	1.0	0.5	35.0	100.0	1,311
Non-IDP/NCA	59.9	17.3	0.4	0.1	22.3	100.0	1,441
Birth Order							
First	66.1	15.7	0.7	0.4	17.1	100.0	1,061
Second	55.3	16.8	0.5	0.4	27.0	100.0	1,111
Third	49.7	19.6	0.0	0.3	30.4	100.0	733
Fourth or higher	42.8	15.1	0.4	0.0	41.6	100.0	525
Trimester of First Visit							
No prenatal care	33.3	18.5	0.2	0.2	47.9	100.0	1,128
First	69.1	13.7	0.7	0.6	15.9	100.0	1,497
Second	64.2	19.1	0.6	0.1	16.0	100.0	626
Third	47.8	23.6	0.0	0.2	28.3	100.0	179

* Includes one delivery on the way to the hospital.

TABLE 6.2.2
Average Time Between Admission and Delivery and Nights Spent in a Medical Facility
by Selected Characteristics
Births in the Five Years Prior to the Survey
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Average Time (Hours) between Admission and Delivery	Nights Spent in a Medical Facility Between Delivery and Discharge				Total	No. of Cases
		≤4	5	6-7	≥8		
Total	7.3	54.4	9.9	24.1	11.6	100.0	2,391
Residence							
Urban	7.8	41.7	12.0	30.1	16.2	100.0	1,240
Rural	6.6	70.9	7.1	16.3	5.6	100.0	1,151
Age Group (at Birth)							
15–24	7.4	57.2	11.0	22.3	9.6	100.0	1,137
25–34	6.6	52.2	8.3	27.7	11.8	100.0	1,087
35–44	9.9	49.0	12.2	14.2	24.7	100.0	167
Education Level							
Secondary Incomplete or less	7.0	56.0	8.5	22.9	12.6	100.0	436
Secondary Complete	7.2	60.5	8.7	20.6	10.2	100.0	1,229
Technicum	6.9	43.9	12.7	31.4	12.0	100.0	403
University	8.1	42.7	12.6	29.7	14.9	100.0	323
Socioeconomic Status							
Low	7.0	65.4	8.4	19.3	6.9	100.0	1,233
Middle	7.4	48.9	10.1	26.2	14.7	100.0	886
High	7.7	32.0	14.6	34.8	18.6	100.0	272
IDP/Refugee Status							
IDP/R	5.4	52.0	7.6	24.7	15.7	100.0	378
Non-IDP/CA	6.6	80.8	4.6	10.2	4.4	100.0	865
Non-IDP/NCA	7.6	49.8	11.1	26.6	12.5	100.0	1,148
Birth Order							
First Birth	9.7	51.7	7.8	24.4	16.1	100.0	845
Second Birth	5.7	54.2	10.3	26.4	9.1	100.0	768
Third Birth	5.4	56.2	13.2	23.3	7.3	100.0	479
Fourth or Higher	6.8	61.7	9.9	17.4	10.9	100.0	299
Baby Weight at Birth							
< 2,500 grams	6.3	61.2	6.1	21.2	11.5	100.0	283
≥ 2,500 grams	7.4	53.7	10.3	24.4	11.6	100.0	2,108
Type of Delivery							
Vaginal	6.8	55.7	10.1	24.0	10.2	100.0	2,329
Caesarian Section	22.7	6.2	2.7	28.5	62.6	100.0	62
Pregnancy Complications							
Any Complications	8.8	49.8	10.6	23.7	15.9	100.0	659
No Complications	6.7	56.1	9.6	24.2	10.0	100.0	1,732

Seventy percent of births in the past 5 years were delivered by physicians, 19% by midwives or nurses, and the remaining 11 % by untrained birth attendants (data not shown). Virtually all deliveries that took place in maternities or private clinics were delivered by a physician (92%-94%), compared with two-thirds of deliveries in village hospitals and 22% of home deliveries. Deliveries not assisted by a health professional (i.e., a physician, midwife, or nurse) were more likely to occur in rural areas than in urban areas (17% vs. 6%), in the South and Central regions (19% and 16%), among women with less than complete secondary education (18%) and low SES (17%), and among IDP/R women (18%).

The average time spent in a medical facility prior to delivery was about 7 hours; the range was from less than 1 hour to 4 days (Table 6.2.2). According to data published in the literature, the average duration of labor ranges from 6 hours (for multiparous women) to 10 hours (for nulliparous women) (Duig, 1975). Thus, many women, particularly those giving birth for the first time were admitted for delivery at or right after the onset of labor. The average time spent in the hospital prior to delivery did not vary greatly by mother's background characteristics. It was slightly shorter for less educated women, IDP/R women, and multiparous women. Women with any pregnancy complications and those who delivered by caesarean section (C-section) were more likely to report a long predelivery hospital stay, probably because they required closer monitoring of pregnancy, medical temporization of delivery, and use of C-section to end long labors.

About half of women who gave birth in a medical facility were discharged in the first 4 days after delivery (54%), and 10% were discharged after 5 days (Table 6.2.2, right panel). One in four women (24%) was discharged after 6-7 days, and 12% of women spent 8 or more days in the hospital after delivery. Rural women, women with lower levels of education and low SES, non-IDP/R women living in conflict-affected areas, and women with three or more prior births were more likely to be discharged after a short postpartum hospital stay. As expected, women who delivered by C-section were more likely than women with vaginal deliveries to have hospital stays of 8 or more days (63% vs. 10%).

The C-section rate varies considerably among countries, from about 5% to more than 20% of all deliveries. The optimal rate is not known, but little improvement in birth outcomes has been demonstrated if the rate is higher than 7%. In Azerbaijan, most births are delivered vaginally, and the prevalence of C-section among all deliveries between 1996 and 2001 was only 2.6% (Table 6.2.3). Before the dissolution of the USSR, the C-section rate for all Azerbaijan, though not routinely published, was estimated to range from 0.7% to 7% (Petrikovsky and Hoegsberg, 1990).

TABLE 6.2.3
Percentage of Caesarean Deliveries by Selected Characteristics
Births in 1996–2001 Delivered in Medical Facilities
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Caesarean Deliveries (%)	Unweighted No. of Cases
Total	2.6	2,391
Residence		
Urban	4.0	1,240
Rural	0.7	1,151
Region		
Baku	6.4	530
North & North East	1.5	366
West	2.4	253
South-West	1.9	692
South	0.0	278
Central	0.8	272
Age Group (at Birth)		
15–24	1.2	1,137
25–34	2.9	1,087
35–44	10.1	167
Education		
Secondary incomplete or less	1.4	436
Secondary complete	2.3	1,229
Technicum	2.0	403
University	5.8	323
Socioeconomic Status		
Low	1.7	1,233
Medium	3.2	886
High	3.8	272
IDP/Refugee Status		
IDP/R	2.8	378
Non-IDP/CA	1.3	865
Non-IDP/NCA	2.8	1,148
Birth Order		
First	2.9	845
Second	2.4	769
Third	2.3	477
Fourth or higher	2.5	300
Pregnancy Complications		
Yes	4.4	283
No	2.4	2,108
Baby Weight at Birth		
<2,500 grams	3.6	659
≥2,500 grams	2.2	1,732
Prolonged Labor		
Yes	6.5	83
No	1.4	2,280
No labor	100.0	28

Women residing in urban areas were about 5 times as likely to have a cesarean delivery as women residing in rural areas. Women aged 35 or older reported C-section rates higher than those of women aged 34 or younger (see Table 6.2.3). The C-section rate increased directly with education and SES but was not significantly different among IDP/R and non-IDP/R women. Women who experienced prolonged labor were more likely to deliver by C-section than were women with labor of normal duration. Births with labor duration of more than 20 hours (more than 14 hours for multiparous women) were almost 5 times more likely to be delivered by C-section than were births with a shorter duration of labor. Almost half of C-sections, however, were performed before the onset of labor.

Respondents were asked to identify the most important reason for they had delivered by cesarean section (Figure 6.2.2). The most frequent reasons given by the respondents included: fetal malpresentation (16%), previous C-section (15%), prolonged labor (12%), C-section performed on request (11%), obstetric hemorrhage (8%), fetopelvic disproportion (7%), and fetal distress (7%); 1 in 5 women (21%) reported that the C-section indication was due to "other" factors. Women who lived in rural areas were twice as likely to report having a C-section due to prolonged labor (10% vs.

Figure 6.2.2
Most Important Reason for C-Section Delivery
Births between 1996–2001
Reproductive Health Survey—Azerbaijan, 2001
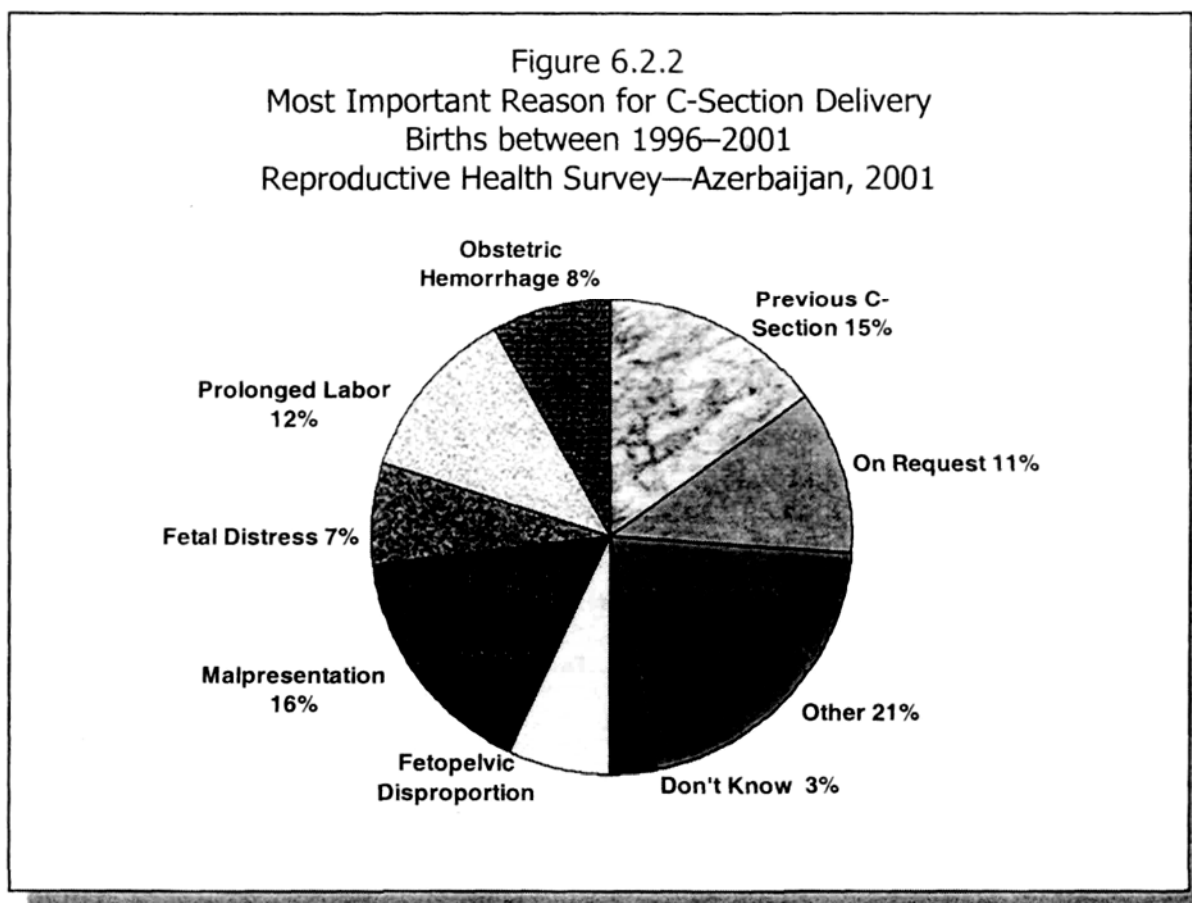
24%) and to obstetric hemorrhaging (7% vs. 14%). Women from the urban areas had a significantly higher number of C-sections due to having previous C-sections than rural women did (17% vs. 3%) (data not shown).

6.3 Postnatal Care

After delivery, it is important to assess the health of both the mother and the infant and to provide counseling regarding breast-feeding, proper child care, nutrition, and family planning. The postnatal period is a critical time that allows the health care provider to evaluate the physical and psychological health of a new mother and her infant, to detect and treat postpartum complications, and to provide the counseling and support needed to address any specific problems related to child care and family planning. Under the USSR health system, pregnant women were required to report to rural dispensaries, village hospitals, and WCCs for their monthly checkups; moreover, they were required to give birth in maternity wards or rural hospitals, where mothers with uncomplicated deliveries remained for about 5-7 days following delivery. Within a few days after hospital discharge, a health professional would make a house visit to examine the baby and counsel the mother. If the child were healthy, a nurse would return to the mother's home weekly during the first month postpartum. After that, both mother and child would continue to be seen regularly (at 1, 3, 6, 9, and 12 months) by a physician or a nurse at the polyclinic for physical examination, routine measurements, immunization, and postpartum counseling (Notzon et al., 1999).

Perinatal care in Azerbaijan has changed since the dissolution of the Soviet-controlled system. Although the standards of care inherited from the Soviet system are still in effect, their application is less rigorously enforced. The AZRHS01 identified that 26% of births took place at home. The medical assistance at birth and location of delivery can greatly affect the health of mothers and the babies' chance of survival, particularly for LBW babies. Even in uncomplicated deliveries, giving birth at home reduces the likelihood of postnatal care for both the mother and her baby.

The AZRHS01 provides information about the use of postnatal care and the content of postnatal counseling (Table 6.3.1). Postnatal care was substantially less utilized than prenatal care (25% vs.70%) (see also Table 6.1.1). Its use was very low among both urban and rural women (27% and 23% respectively), increased slightly with maternal education, and was the highest among women living in households with high SES. Postnatal care was highest among first-time mothers and lowest among women with two or more births. Lower utilization of maternal care services among high-parity women has long been recognized and explained through greater responsibilities within the household related to child rearing compounded with greater confidence and experience among this group of women. The use of C-section for delivery was associated with much higher rates of

TABLE 6.3.1
Use of Postnatal Care and Information Received During Postnatal Visit(s)
by Selected Characteristics
Births in the Five Years Prior to the Survey—Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Postnatal Care		Information Received During Postnatal Care						
	%	No. of Cases*	Nutrition	Immunization	Breast Care	Breast Feeding	Child Care	Family Planning	No. of Cases
Total	25.1	3,355	66.0	71.4	63.3	16.2	66.1	34.2	864
Residence									
Urban	27.3	1,482	66.4	70.8	62.3	14.0	64.6	36.5	397
Rural	22.8	1,873	65.6	72.2	64.4	19.0	67.9	31.5	467
Region									
Baku	34.8	603	76.9	75.6	70.5	17.1	72.6	41.5	207
North & North-East	19.3	469	66.7	65.7	62.7	12.7	64.7	33.3	93
West	26.8	310	62.6	78.9	55.4	11.1	63.7	32.2	83
South-West	25.1	1,126	60.8	72.5	57.1	23.2	64.8	24.5	280
South	18.8	430	59.1	67.4	63.8	16.1	65.1	37.3	85
Central	27.9	417	55.7	66.2	61.7	20.2	58.9	27.7	116
Age Group (at Birth)									
15–24	24.9	1,596	63.6	69.4	61.3	21.3	64.1	33.6	412
25–34	25.1	1,549	70.2	76.2	65.9	12.0	70.2	35.8	403
35–44	26.9	210	56.9	55.6	60.7	6.2	53.8	28.2	49
Education Level									
Secondary Incomplete or less	22.9	745	62.5	65.5	64.6	19.1	62.0	26.1	169
Secondary Complete	23.4	1,741	64.3	73.5	60.7	16.1	65.7	35.2	428
Technicum	28.1	511	68.2	70.6	69.3	16.9	70.1	37.7	153
University	32.8	358	73.7	74.0	62.7	12.1	68.6	38.5	114
Socioeconomic Status									
Low	23.4	1,980	63.8	71.5	62.7	18.4	65.2	29.7	471
Middle	23.1	1,086	66.9	72.0	61.6	13.5	68.0	37.7	275
High	41.0	289	70.9	70.0	68.4	15.2	64.9	40.9	118
IDP/Refugee Status									
IDP/R	26.1	665	77.5	83.5	73.2	21.8	75.2	39.3	178
Non-IDP/CA	28.4	1,281	56.7	68.6	55.9	21.0	59.2	27.2	314
Non-IDP/NCA	24.2	1,409	66.6	70.3	63.6	14.1	66.4	35.3	372
Birth Order									
First Birth	29.6	1,035	69.3	72.9	64.0	27.7	69.0	38.4	302
Second Birth	22.4	1,085	71.9	77.1	68.7	11.7	71.8	32.8	265
Third Birth	23.7	725	61.1	65.3	63.6	5.3	63.2	35.6	175
Fourth or Higher	22.7	510	48.4	62.3	47.1	7.8	47.1	22.2	122
Postpartum Complications									
Any Complications	27.1	1,313	65.1	72.4	62.9	14.8	62.6	34.4	347
No Complications	23.9	2,042	66.6	70.8	63.5	17.2	68.4	34.1	517

* Excludes 75 pregnancies resulting in stillbirths.

TABLE 6.3.2
Time between Delivery and First Postpartum Visit
Mothers who Had any Postpartum Care after Delivering a Live Birth in the Past 5 Years
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Time between Delivery and First Postpartum Visit (in weeks)				
	≤1	1–2	≥2	Do Not Remember	No. of Cases
Total	**72.4**	**8.3**	**17.8**	**1.5**	**864**
Residence					
Urban	65.2	8.6	23.4	2.8	397
Rural	81.0	7.9	11.1	0.0	467
Region					
Baku	66.7	7.3	23.1	3.0	207
North & North-East	80.4	3.9	13.7	2.0	93
West	59.4	13.9	25.2	1.4	83
South-West	77.8	8.9	13.1	0.2	280
South	73.8	9.0	16.9	0.2	85
Central	80.1	10.0	9.8	0.0	116
Age Group (at Birth)					
15–24	75.1	5.9	17.7	1.3	412
25–34	70.1	8.5	19.7	1.6	403
35–44	66.4	24.3	7.1	2.2	49
Education Level					
Secondary Incomplete or less	83.8	7.6	7.9	0.7	169
Secondary Complete	73.5	8.1	17.2	1.3	428
Technicum	68.7	4.5	24.3	2.5	153
University	57.2	13.9	26.5	2.4	114
Socioeconomic Status					
Low	79.0	5.9	14.4	0.8	471
Middle	68.4	9.7	20.6	1.3	275
High	60.1	12.6	22.8	4.4	118
IDP/Refugee Status					
IDP/R	74.8	6.3	18.7	0.2	178
Non-IDP/CA	81.3	10.8	7.9	0.1	314
Non-IDP/NCA	69.6	7.9	20.3	2.1	372
Place of Delivery					
Maternity/Private Clinic	61.2	11.3	24.7	2.7	441
Village Hospital/Dispensary	80.1	7.3	12.6	0.0	156
Home	91.2	2.3	6.5	0.0	267
Birth Order					
First Birth	67.8	10.5	20.1	1.6	302
Second Birth	71.7	7.1	19.0	2.2	265
Third Birth	75.5	7.4	15.8	1.3	175
Fourth or Higher	83.9	5.5	10.7	0.0	122

87

postnatal care use (45%), probably because of the overlap with postsurgical care (data not shown).

Most women who received postnatal care were counseled about child immunizations (71%), child care (66%), nutrition (66%), and breast care (63%). However, counseling about planning for future pregnancies and contraception (34%) and about breast-feeding (16%) were significantly lower. The type of health advice given during postnatal care did not vary significantly with maternal characteristics, except for women who had had their fourth child, which lowered the percentage of information presented during the postnatal care visit. A direct relationship was found between education level and the percentage of women reporting receipt of information during the postnatal period for each characteristic except breast care and breast-feeding.

As mentioned previously, the timing of the first postpartum visit is supposed to be during the first week after the hospital discharge. Most women surveyed (72%) reported having a postnatal care visit within the first week after delivery (Table 6.3.2). This table also shows that 8% reported having a postnatal care visit 1 to 2 weeks after delivery and 18% having a postnatal care visit 2 or more weeks after delivery. Some women reported not remembering when they had their postnatal visit (1.5%).

The questionnaire asked each mother if and when a health professional checked the baby's health after delivery (Table 6.3.3); 62% of the babies were seen by a health professional soon after hospital discharge. Urban women (75%), particularly those living in Baku (80%), were much more likely than rural women to receive those services (49%). Women from the South, South-West and West areas were less likely to have a high well-baby clinic's attendance. Women who had a university degree (75%) and women who reported a high SES (79%) were most likely to take their baby to a health professional to be examined. Women who delivered by a C-section were more likely to report taking their child for a examination than were women who delivered vaginally (84% vs. 62% respectively) (data not shown). Of the women who took their newborn to a health professional to be examined, 53% took their child within the first week of delivery, 25% took their child within 1 or 2 weeks after delivery, 21% went to visit the health care professional after 2 weeks, and a small percentage (1.5%) did not remember when they took the newborn to a well-baby clinic (Table 6.3.4).

The proportion of women who registered their newborns was 86% (Table 6.3.4). Eighteen percent (urban) and 17% (rural) of women registered their child within the first week after delivery. Most women registered their child 1 or more weeks after delivery. Forty-six percent of women registered their child 1 to 4 weeks after delivery, and 37% registered their child more than 4 weeks after delivery.

TABLE 6.3.3
Time Between Delivery and First Well-Baby Clinic Visit by Selected Characteristics
Live Births Delivered in Hospital in the 5 Years Prior to the Survey
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Well Baby Visit	Number of Cases	≤1 week	1–2 weeks	>2 weeks	Do Not Remember	Number of Cases
Total	62.2	3,355	52.9	25.2	20.6	1.4	1,957
Residence							
Urban	75.4	1,482	47.1	29.2	22.0	1.8	1,056
Rural	49.0	1,873	61.8	19.1	18.5	0.6	901
Region							
Baku	80.4	603	42.4	34.3	22.6	0.7	482
North & North-East	67.3	469	50.3	28.7	19.9	1.1	314
West	51.2	310	55.7	14.3	28.5	1.5	174
South-West	49.1	1,126	69.7	13.6	14.9	1.8	547
South	50.4	430	54.4	23.8	18.7	3.0	219
Central	58.8	417	66.9	16.0	16.1	1.0	221
Age Group (at Birth)							
15–24	59.6	1,596	53.1	23.9	21.6	1.4	896
25–34	64.2	1,549	52.3	26.3	19.8	1.5	930
35–44	69.6	210	54.2	26.7	18.7	0.4	131
Education Level							
Secondary Incomplete or less	60.0	745	56.8	18.7	22.7	1.8	403
Secondary Complete	58.8	1,741	52.8	26.5	19.0	1.7	957
Technicum	67.3	511	49.6	31.0	19.3	0.1	331
University	75.3	358	50.5	24.3	24.4	0.8	266
Socioeconomic Status							
Low	55.3	1,980	60.6	20.0	17.7	1.7	1,015
Middle	67.9	1,086	47.2	28.0	23.7	1.1	718
High	78.9	289	41.5	36.1	21.5	0.9	224
IDP/Refugee Status							
IDP/R	60.5	665	55.5	24.6	19.7	0.2	365
Non-IDP/CA	52.8	1,281	67.8	15.2	14.9	2.1	649
Non-IDP/NCA	64.6	1,409	49.8	27.1	21.8	1.4	943
Place of Delivery							
Maternity/Private Clinic	69.1	1,720	41.3	34.2	23.1	1.5	1,088
Village Hospital/Dispensary	48.9	614	60.0	16.6	22.9	0.4	300
Home	56.5	1,021	78.8	6.9	12.9	1.4	569
Birth Order							
First Birth	64.7	1,035	47.0	27.5	24.0	1.5	614
Second Birth	62.3	1,085	53.0	27.3	18.4	1.4	638
Third Birth	60.3	725	57.3	22.0	19.1	1.5	430
Fourth or Higher	58.7	510	61.5	18.2	19.5	0.7	275

TABLE 6.3.4

Percentage of Babies With Birth Certificates Issued and Time between Delivery and Certification Visit
Live Births in the 5 Years Prior to the Survey
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Baby Certified		Time of Birth Certification (in weeks)			
	%	No of Cases	≤ 1	1–4	>4	No. of Cases
Total	85.9	3,355	17.5	45.7	36.8	2,887
Residence						
Urban	87.6	1,482	18.3	43.5	38.2	1,301
Rural	84.1	1,873	16.7	48.0	35.3	1,586
Region						
Baku	86.3	603	13.3	46.9	39.8	521
North & North-East	88.8	469	19.1	44.5	36.4	418
West	88.6	310	25.4	40.5	34.1	273
South-West	84.7	1,126	18.5	43.1	38.4	971
South	83.1	430	13.1	55.4	31.5	365
Central	79.7	417	16.4	42.7	40.9	339
Age Group (at Birth)						
15–24	84.8	1,596	18.4	43.1	38.5	1,350
25–34	86.5	1,549	17.1	47.6	35.3	1,349
35–44	90.3	210	13.9	52.3	33.8	188
Education Level						
Secondary Incomplete or less	79.3	745	22.3	35.2	42.4	611
Secondary Complete	86.5	1,741	14.3	49.0	36.7	1,486
Technicum	89.8	511	22.3	48.8	28.9	462
University	91.2	358	16.8	46.1	37.1	328
Socioeconomic Status						
Low	83.5	1,980	17.5	45.6	36.9	1,676
Middle	89.0	1,086	17.8	44.2	37.9	956
High	87.3	289	16.6	51.5	31.9	255
IDP/Refugee Status						
IDP/R	89.5	665	21.7	50.1	28.1	590
Non-IDP/CA	80.6	1,281	17.5	40.2	42.3	1,078
Non-IDP/NCA	86.5	1,409	16.9	46.2	36.9	1,219
Place of Delivery						
Maternity/Private Clinic	87.4	1,720	17.7	46.8	35.5	1,492
Village Hospital/Dispensary	84.1	614	17.7	44.9	37.4	532
Home	83.8	1,021	17.1	43.7	39.1	863
Birth Order						
First Birth	83.3	1,035	16.6	40.9	42.5	863
Second Birth	87.6	1,085	16.8	48.1	35.1	952
Third Birth	87.2	725	18.1	46.4	35.5	637
Fourth or Higher	86.0	510	21.0	50.0	29.0	435

90

6.4 Smoking and Drinking During Pregnancy

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

Only 0.5% of births during the 5 years prior to the survey occurred to mothers who were smokers at the time they discovered they were pregnant. Only 0.4% continued to smoke during their pregnancy (data not shown). The proportion of women who smoked prior to getting pregnant or during pregnancy was slightly higher in the areas of Baku and the North-Northeast areas of Azerbaijan (1% and 0.9%). The highest smoking prevalence prior to pregnancy was reported by women aged 40-44 (4.8%); 1.3% of the women who reported having an LBW baby reported smoking prior to knowledge of the pregnancy and during the pregnancy (data not shown).

Similar to the low prevalence of women smoking during pregnancy was the percentage of women drinking during pregnancy. Only 0.8% of women reported drinking during their pregnancy. Urban women were more likely to report drinking during pregnancy than rural women were (1.4% vs. 0.2%). Women with a university degree had higher prevalence of drinking during pregnancy than women in the other education categories (2.6%); women with high SES (3.3%) reported drinking more often during pregnancy than did the women of low and medium SES (0% and 1.2%, respectively) (data not shown).

6.5 Pregnancy and Postpartum Complications

Routine measurement of blood pressure is an essential component of health risk assessment during prenatal visits. However, as is the case with other health measurements and diagnostics, self-reports of medical conditions may reflect a combination of risk factors and differences in reporting. In particular, the data suggest a higher likelihood of complete reporting of health problems from individuals with better access to medical care. As shown in Table 6.5.1, most women with births in the past 5 years (82%) reported measurement of their blood pressure during pregnancy, and one-fifth (19%) were identified as having high blood pressure (HBP). Only 1 % were hospitalized due to HBP.

Measurement of blood pressure was less common among women who lived in a rural area or in the South or South-West regions, had not completed secondary education, had a low SES, and had received prenatal care in a village hospital. The prevalence of reported HBP during pregnancy was highest among women who lived in the Southwest region (23%), who were age 35 or older (28%), had less than a university education, and had a medium SES (23%). Women who received prenatal care in a rural clinic or village hospital were more likely to report HBP than were women who received prenatal care at other sites.

Twenty-five percent of women with recent births reported pregnancy complications requiring medical attention (Table 6.5.2).The conditions mentioned most often were anemia (8%), edema/water retention (8%), bleeding (96%), and HBP (5%). Pregnancy complications that required medical attention were slightly more prevalent among women residing in urban areas than in rural areas (27% vs. 22%) and were more prevalent among first-order births than among third or higher order births (29% vs. 21%). Women who lived in the southern region of the country (16%), were aged 20-24 (21 %), who had completed less than a university degree, or who were of low SES (23%) reported fewer pregnancy complications. In contrast to other former Soviet Union countries, hospitalization rates for pregnancy complications were low. Only 3% of Azeri women with pregnancy complications reported that they had been hospitalized for those conditions, whereas 30% of such women in Moldova, 32% in Ukraine, and 50% in Russia reported hospitalization (data not shown).

A total of 38% of women reported at least one postpartum complication (Table 6.5.3). Reported postpartum complications ranged from 28% of women experiencing severe uterine pain to 1% of women experiencing breast infections. Reports of postpartum complications were less than 38% only among residents in the North-Northeast regions of Azerbaijan (29%). The highest reports of postpartum complications came from women with a maternal age of 15-24 (41%) and from women who had had any pregnancy complication (50%) or prolonged labor (48%).

TABLE 6.5.1
Routine Measurement of Blood Pressure (BP) During Pregnancy, Reported High Blood Pressure (HBP)
During Pregnancy, and Hospitalization Rate for HBP
Births in the 5 Years Prior to the Survey among Women with Any Prenatal Care
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Routine Measurement of BP During Pregnancy	HBP During Pregnancy	% Pregnancies Hospitalized for HBP	No. of Cases
Total	82.1	18.6	1.0	2,303
Residence				
Urban	87.9	18.2	1.3	1,197
Rural	74.3	19.1	0.6	1,106
Region				
Baku	91.8	16.7	1.0	510
North & North-East	81.3	19.2	1.1	323
West	87.4	17.9	1.1	236
South-West	72.2	22.6	0.8	712
South	71.3	16.5	1.3	230
Central	76.6	20.6	0.1	292
Age Group (at Birth)				
15–24	78.4	16.6	0.8	1,072
25–34	86.1	19.2	0.8	1,079
35–44	82.0	28.4	3.2	152
Education Level				
Secondary Incomplete or less	72.9	20.5	2.1	403
Secondary Complete	80.6	18.0	0.3	1,173
Technicum	87.8	21.7	1.3	400
University	91.6	14.8	1.6	327
Socio-economic Status				
Low	72.9	16.6	0.5	1,190
Middle	88.5	22.5	1.5	858
High	95.0	13.0	0.9	255
IDP/Refugee Status				
IDP/R	78.3	17.4	0.9	415
Non-IDP/CA	76.9	23.0	0.7	824
Non-IDP/NCA	83.6	17.8	1.0	1,064
Birth Order				
First Birth	82.8	19.7	1.6	809
Second Birth	83.2	16.5	0.6	740
Third Birth	80.7	19.2	0.8	450
Fourth or Higher	78.9	19.7	0.1	304
Place of Prenatal Care				
Village Hospital or Dispensary	70.6	23.6	1.3	372
WCC or Private Clinic	87.9	17.6	0.5	961
Maternity	80.7	18.5	1.5	889
Home	64.5	11.4	0.0	81

TABLE 6.5.2

Pregnancy Complications That Required Medical Attention by Selected Characteristics
Births in the 5 Years Prior to the Survey among Women with Any Prenatal Care
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Any Complication	Anemia	Edema/ Water Retention	Bleeding	High Blood Pressure	Risk of Preterm Labor	Diabetes	Urinaay Tract Infection	Risk of Miscarriage
Total	24.5	7.8	7.6	5.5	4.7	3.5	3.1	2.8	1.1
Residence									
Urban	27.1	8.8	8.7	6.8	5.0	4.9	3.8	3.2	1.5
Rural	21.9	6.8	6.5	4.2	4.5	2.0	2.4	2.4	0.6
Region									
Baku	26.2	7.7	9.2	8.9	2.8	6.1	4.7	3.6	1.9
North-Northeast	24.5	10.7	8.8	5.6	4.5	2.1	2.8	2.4	0.6
West	28.7	7.7	6.7	4.8	8.8	4.6	1.7	3.0	0.0
Southwest	27.9	7.0	8.9	3.0	8.2	4.2	3.2	3.8	1.0
South	16.8	2.5	4.6	3.4	2.1	1.7	2.5	2.6	1.1
Central	23.4	9.1	6.0	5.1	4.3	2.4	3.3	1.4	1.9
Age (at Birth)									
15–19	26.7	9.4	11.4	4.4	4.2	2.1	5.0	2.9	0.2
20–24	21.1	7.6	5.8	5.4	3.8	4.2	2.1	3.2	1.2
25–34	25.2	7.6	7.3	5.4	4.8	3.0	2.6	2.1	1.0
35–44	33.5	6.9	11.2	9.2	10.8	4.9	7.9	5.0	2.4
Education Level									
Secondary Incomplete or less	23.8	8.6	7.9	4.0	5.6	2.2	2.7	2.5	0.8
Secondary Complete	22.8	6.8	7.4	5.2	3.3	3.0	3.2	2.7	0.9
Technicum	25.3	7.8	7.1	6.3	5.6	4.1	3.4	1.5	1.1
University	31.9	11.1	8.7	8.9	8.1	7.0	3.0	5.5	2.1
Socioeconomic Status									
Low	23.1	7.2	6.6	3.9	4.6	2.8	2.5	2.0	1.0
Middle	26.0	8.3	8.2	7.0	5.3	3.8	3.9	3.6	0.8
High	26.3	9.2	10.8	8.5	3.2	5.7	3.4	4.4	2.2
IDP/Refugee Status									
IDP/R	23.7	8.8	8.3	4.0	4.4	3.3	2.9	3.3	0.9
Non-IDP/CA	24.3	6.9	7.3	5.4	5.6	3.9	4.2	2.1	1.9
Non-IDP/NCA	24.6	7.9	7.6	5.7	4.6	3.4	2.9	2.9	0.9
Birth Order									
First Birth	28.5	8.3	9.9	6.8	6.5	4.4	4.5	4.7	1.4
Second Birth	23.6	8.2	6.7	6.2	3.6	3.5	2.3	2.8	1.0
Third Birth	21.4	7.0	6.2	3.5	4.1	2.5	2.5	0.9	0.7

TABLE 6.5.3
Postpartum Complications by Selected Characteristics
Births in the Five Years Prior to the Survey
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Any Complication	Severe Uterine Pain	Infectious Vaginal Discharge	Dysuria	Severe Vaginal Bleeding	High Fever (>39 C°)	Infection of the Surgical Wound	Breast Infection	Loss of Consci- ousness
Total	37.6	27.9	8.3	9.4	6.7	8.4	1.0	7.4	3.2
Residence									
Urban	39.5	27.3	8.7	9.5	6.4	10.5	0.9	9.0	3.3
Rural	35.6	28.4	8.0	9.3	6.9	6.2	1.1	5.9	3.0
Region									
Baku	41.3	29.8	8.9	8.2	'8.4	14.4	1.5	10.9	3.8
North & North-East	29.0	23.0	4.7	7.7	4.9	6.4	0.2	4.7	2.6
West	37.6	28.8	9.7	8.7	5.2	6.4	1.1	9.7	2.0
South-West	40.0	31.6	9.0	8.9	6.8	7.4	1.1	6.7	2.0
South	43.0	30.4	13.7	11.7	6.5	6.2	1.4	4.7	2.5
Central	41.3	27.9	7.0	13.6	9.7	8.7	1.4	9.2	6.3
Age (at Birth)									
15–24	40.9	30.5	10.2	10.2	7.8	8.0	0.9	7.4	3.0
25–34	34.1	25.4	7.0	9.0	5.5	8.7	1.0	7.6	3.6
35–44	35.3	24.0	3.8	5.4	5.9	9.4	2.0	6.2	1.4
Education Level									
Secondary Incomplete	34.8	25.9	5.9	10.2	6.9	6.2	0.9	6.6	2.2
Secondary Complete	37.9	29.9	8.4	9.3	6.1	9.1	0.8	7.7	4.0
Technicum	41.1	25.3	11.6	8.8	6.4	8.0	0.9	8.1	2.8
University	37.1	26.1	8.7	8.7	9.3	10.1	2.2	7.0	1.7
Socio-economic Status									
Low	35.7	26.9	7.6	9.5	7.1	7.5	1.1	6.9	3.0
Middle	39.6	29.4	9.2	9.1	6.1	9.1	1.1	8.2	3.8
High	40.3	27.6	9.1	9.9	6.8	10.3	0.3	7.3	2.0
IDP/Refugee Status									
IDP/R	42.1	33.4	9.8	12.5	4.7	12.7	0.6	10.0	2.8
Non-IDP/CA	38.1	28.7	8.7	8.5	6.9	7.7	0.8	7.2	3.1
Non-IDP/NCA	36.8	26.9	8.1	9.1	6.9	7.9	1.1	7.1	3.2
Birth Order									
First Birth	38.2	25.1	9.5	11.3	7.9	8.8	1.5	8.8	2.9
Second Birth	38.5	30.8	9.4	8.2	6.8	6.9	0.5	6.1	2.8
Third Birth	36.0	27.7	6.1	8.6	5.4	9.5	1.0	7.4	3.8
Pregnancy Complications									
No	33.5	24.3	7.3	7.3	5.2	6.4	0.8	6.4	2.8
Yes	50.2	38.7	11.7	16.0	11.1	14.5	1.7	10.5	4.4
Prolonged Labor									
No	37.2	27.6	8.4	9.3	6.6	8.1	1.0	7.4	3.0
Yes	48.0	36.6	5.6	12.5	10.1	16.6	2.5	7.4	8.8

6.6 Poor Birth Outcomes

Of all births during the 1996-2001 period, 21.2 per 1,000 were stillbirths (Table 6.6). The stillbirth rate was highest among women living in urban areas, residents of the West and Central regions, women aged 35-44, women with postsecondary education, and women with three or more previous births. The stillbirth rate did not vary significantly by the IDP/R status. Complicated pregnancies that required hospitalization were significantly more likely to end in a stillbirth than were uncomplicated pregnancies (42 per 1,000 vs. 15 per 1,000). Compared with normal labor, prolonged labor (i.e., more than 20 hours for nulliparous women and more than 14 hours for multiparous women) was associated with a more than 2 times higher prevalence of stillborns (52 per 1,000 vs. 20 per 1,000).

The total LBW rate (defined as the percentage of live births with birth weight less than 2,500 g) for infants born alive during the 1996-2001 period was 12%. However, higher rates were found among rural women; women in the South-West, South, and Central regions (18%, 15%, and 14%, respectively); women with low education (16%) or low SES (16%); IDP/R and non-IDP/R women living in conflict affected areas (16%); women with at least three prior births; women with no prenatal care (17%); and those who delivered at home (18%). Women who had prolonged labor (18%) or who delivered by C-section prior to the labor induction (24%) were more likely to report LBW, but their numbers are small. Interestingly, most LBW babies were delivered at term (data not shown). The reported prematurity rate (defined as the percentage of live births delivered before 37 weeks of gestation) for the same time period was 4.7%. Higher reported prematurity rate was associated with "no labor" (21%), pregnancy complications (8%), older age (10%), and high SES (9%).

TABLE 6.6
Poor Birth Outcomes by Selected Characteristics
Births in 1996–2001
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Stillbirth Rate (per 1,000 Births)	No. of Births	Low Birth Weight Rate (% Live Births <2,500 grams)	Preterm Birth Rate (% Live Births<37 wks)	No. of Live Births
Total	21.2	3,430	11.9	4.7	3,355
Residence					
Urban	25.6	1,517	9.7	5.2	1,482
Rural	16.8	1,913	14.2	4.1	1,873
Region					
Baku	21.8	616	8.0	7.4	603
North & North-East	11.2	475	10.4	2.6	469
West	38.3	322	12.8	6.7	310
South-West	20.9	1,151	17.3	4.2	1,126
South	15.1	438	14.7	4.5	430
Central	30.8	428	12.9	2.8	417
Age Group at Birth					
15–24	18.7	1,625	11.5	5.0	1,596
25–34	19.2	1,582	12.2	3.5	1,549
35–44	53.1	223	13.4	9.5	210
Education					
Secondary incomplete or less	15.6	759	15.9	4.2	745
Secondary complete	20.4	1,782	12.2	5.1	1,741
Technicum	26.8	521	9.2	4.0	511
University	28.2	368	6.4	4.4	358
Socioeconomic Status					
Low	18.9	2,019	15.3	3.8	1,980
Middle	25.0	1,116	8.3	4.9	1,086
High	19.9	295	7.0	8.6	289
IDP/Refugee Status					
IDP/R	20.5	678	15.8	3.0	665
Non-IDP/CA	19.1	1,311	15.1	4.3	1,281
Non-IDP/NCA	21.8	1,441	10.7	5.0	1,409
Birth Order					
First	25.7	1,061	11.7	5.9	1,035
Second	19.9	1,111	9.4	4.0	1,085
Third	7.3	733	14.1	3.0	725
Fourth or higher	33.5	525	15.7	5.5	510
Prenatal Care					
No prenatal care	18.6	1,127	16.6	4.5	1,103
Any prenatal care	22.3	2,303	9.9	4.7	2,252
Pregnancy Complications					
Yes	41.8	858	11.8	7.7	823
No	14.5	2,572	12.0	3.7	2,532
Prolonged Labor					
Yes	52.4	112	17.3	7.4	102
No	20.3	3,290	11.7	4.4	3,225
No labor	0.0	28	23.8	20.9	28

6.7 Breast-Feeding

The AZRHS01 included questions about breast-feeding patterns and duration for all children under 5 years of age. As shown in Table 6.7.1, most babies (95%) born during 1996-2001 were breast-fed for at least a short period of time. The percentage of babies ever breast-fed varied little by selected characteristics. Rates of breast-feeding were slightly lower among women living in urban areas, including Baku; women living in the Central region; and women living in households with a high SES. Infants who were delivered by C-section had a lower rate of breast-feeding than did those delivered vaginally (82% vs. 95%). LBW babies were slightly less likely to be breast-fed than were those with a birth weight of 2,500 g or more (92% vs. 95%), but the difference is not statistically significant.

According to WHO recommendations, early suckling (i.e., within the first hour postdelivery) should be promoted after all spontaneous deliveries. Table 6.7.1 (right panel) includes the time elapsed between delivery and initiation of breast-feeding. Of infants who were breast-fed, only 13% began breast-feeding during the first hour after birth; Most children began breast-feeding between 2 hours after birth and the completion of the first day (38%) or during the second day of life (26%). About 1 in 5 babies (23%) began breast-feeding only after 48 hours of life. Breast-feeding initiation within the first hour was higher among rural than among urban women (17% vs. 9%), was inversely related to the SES of the mother, and increased with birth order. Caesarean delivery substantially reduced the likelihood of early breast-feeding. For infants delivered by C-section, breast-feeding was more likely to be initiated after 2 days, if ever.

An infant is "exclusively" breast-fed if he or she receives only breast milk and is "almost exclusively" or predominantly breast-fed if he or she receives breast milk accompanied by water or other liquids (except other types of milk). Children with exclusive or almost exclusive breast-feeding are considered to be "fully" breast-fed (Labbok and Krasovec, 1990). These indicators are recommended by WHO to assess the adequacy of breast-feeding practices in a population and allow for comparisons with findings from other countries. The WHO recommendations state that "all infants should be fed exclusively on breast milk from birth to 4-6 months of age" and that some breast-feeding should be maintained until the child is at least 1 year old (WHO, 1991).

The proportion of children under 5 years old still being breast-fed at the time of the survey was calculated by single month of age (0-59 months); the denominator included all live births in those 5 years, regardless of survival (Table 6.7.2). Those proportions were summed together to calculate the mean duration of breast-feeding. This method is known as the "current status mean" method (WHO, 1991). Durations of exclusive and full breast-feeding were calculated in the same way.

TABLE 6.7.1
Percentage of Children Ever Breast-fed and Their Initiation of Breast-feeding
by Selected Characteristics
Live Births in 1996–2001
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Children Ever Breast-fed | | Initiation of Breast-feeding | | | | | | |
	%	No. of Cases*	1 Hour or Less	2-23 Hours	24-47 Hours	48 Hours or More	Unknown	Total	No. of Cases†
Total	94.7	3,247	12.9	38.1	26.0	22.6	0.4	100.0	3,070
Residence									
Urban	93.5	1,434	8.8	32.9	29.3	28.7	0.3	100.0	1,331
Rural	95.8	1,813	16.9	43.2	22.7	16.8	0.4	100.0	1,739
Region									
Baku	92.3	584	9.4	26.2	31.5	32.2	0.7	100.0	538
North & North-East	95.5	456	16.9	40.9	18.7	23.4	0.0	100.0	438
West	93.5	301	9.8	41.0	29.0	20.2	0.0	100.0	287
South-West	96.6	1,085	14.1	41.0	23.9	20.7	0.3	100.0	1,033
South	98.5	419	10.8	44.7	26.8	17.6	0.1	100.0	412
Central	91.6	402	14.9	36.4	31.1	16.1	1.5	100.0	362
Age Group at Birth									
15–24	95.8	1,547	12.7	38.3	27.4	21.5	0.2	100.0	1,475
25–34	93.4	1,496	13.5	38.5	24.4	23.2	0.3	100.0	1,404
35–44	94.4	204	10.8	33.8	25.4	28.2	1.8	100.0	191
Education									
Secondary incomplete or less	95.8	723	12.6	44.0	21.8	21.4	0.2	100.0	691
Secondary complete	94.8	1,683	14.9	38.0	25.6	20.9	0.6	100.0	1,587
Technicum	92.9	493	6.7	35.6	30.7	26.7	0.2	100.0	462
University	94.2	348	12.8	29.5	29.9	27.7	0.0	100.0	330
Socioeconomic Status									
Low	95.6	1,913	14.8	41.9	23.4	19.5	0.4	100.0	1,815
Middle	94.0	1,054	11.0	35.2	27.4	26.2	0.2	100.0	997
High	92.2	280	9.5	27.3	35.2	27.2	0.8	100.0	258
IDP/Refugee Status									
IDP/R	96.6	643	15.3	34.0	25.2	25.5	0.0	100.0	615
Non-IDP/CA	95.2	1,240	12.3	39.5	27.9	19.3	1.0	100.0	1,173
Non-IDP/NCA	94.3	1,364	12.7	38.4	25.7	23.0	0.3	100.0	1,282
Birth Order									
First	93.2	1,000	10.3	33.2	28.7	27.5	0.3	100.0	939
Second	95.8	1,057	13.6	40.4	24.9	21.0	0.1	100.0	1,015
Third	95.6	704	14.2	39.4	24.9	21.1	0.3	100.0	666
Fourth or higher	93.9	486	15.8	42.0	23.8	17.3	1.0	100.0	450
Type of Delivery									
Vaginal	94.9	3,191	13.1	38.6	26.1	21.8	0.4	100.0	3,024
Caesarian section	81.9	56	1.3	6.7	17.7	74.3	0.0	100.0	46
Weight at Birth									
<2,500 grams	91.5	429	14.8	30.0	24.8	29.3	1.2	100.0	389
≥2,500 grams	95.1	2,818	12.7	39.1	26.1	21.8	0.3	100.0	2,681

* Excludes 108 babies who died soon after birth.
† Excludes 108 babies who died soon after birth and 130 children who were never breast-fed.

99

TABLE 6.7.2
Mean Duration of Breast-feeding in Months, by Type of Breast-feeding, by Characteristics
Live Births in 1996–2001
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Exclusive Breast-feeding	Full Breast-feeding*	Any Breast-feeding
Total	0.4	3.3	11.6
Residence			
Urban	0.3	3.1	10.8
Rural	0.6	3.5	12.5
Region			
Baku	0.3	2.8	10.3
North & North-East	0.5	3.8	11.7
West	0.0	2.6	9.1
South-West	0.1	4.4	12.3
South	1.1	3.8	15.5
Central	1.9	3.7	11.0
Age Group at Birth			
15–24	0.6	3.6	11.1
25–34	0.3	2.9	11.8
35–44	0.0	3.5	14.9
Education Level			
Secondary incomplete or less	0.3	3.6	11.6
Secondary complete	0.6	3.4	11.9
Technicum	0.3	2.3	11.8
University	0.3	2.8	8.3
Socioeconomic Status			
Low	0.4	3.8	13.0
Middle	0.5	2.7	10.7
High	0.5	3.2	7.8
IDP/Refugee Status			
IDP/R	0.1	4.6	11.6
Non-IDP/CA	0.4	3.5	12.5
Non-IDP/NCA	0.5	3.1	11.6
Birth Order			
First	0.7	3.5	10.5
Second	0.2	3.5	11.6
Third	0.1	3.1	13.7
Fourth or higher	0.9	2.9	12.4
Type of Delivery			
Vaginal	0.4	3.3	11.5
Caesarian Section	0.0	1.5	9.7
Initiation of Breastfeeding†			
<24 hours	0.5	3.0	11.3
24–47 hours	0.6	4.2	12.2
≥48 hours	0.0	3.1	11.6
Weight at Birth			
<2,500 grams	0.1	1.8	10.3
≥2,500 grams	0.5	3.4	11.6

* Children with exclusive (only breast milk) or almost exclusive (breast milk and other liquids excepting formula or other milk) breast-feeding.
† Excludes 11 live births whose time of initiation of breast-feeding was unknown.

The mean duration of any breast-feeding was 11.6 months. For most of this time, however, breast-feeding was only partial. The mean duration of exclusive breast-feeding was 0.4 month and, with the exception of women residing in the Central region, did not vary greatly by maternal characteristics. Women in the South-West and West regions, those who gave birth after age 34, and IDP/Rs had lower mean durations. In addition, babies delivered by C-section, those with LBW babies, and babies who initiated suckling 48 hours or more after birth had lower mean durations of exclusive breast-feeding. Thus, few children in Azerbaijan were exclusively breast-fed for the minimum 4-month period recommended by WHO.

6.8 Infant and Child Mortality

Although higher than in most of the former Soviet-bloc countries of the Central and Eastern Europe, the infant mortality rate (IMR) in Azerbaijan is comparable to the rates reported by Central Asian Republics (Table 6.8.1). Mortality rates from government sources, however, tend to underestimate

TABLE 6.8.1
Infant Mortality Rates for 5-Year Periods Based on Survey and Official Estimates
RHS and DHS Surveys in Selected Eastern European and Former Soviet Union Countries

| Region and Country | | Infant Mortality Rates (Infant Deaths per 1,000 Live Births) | | | | Ratio (SurveyRate/ Official Rate) |
		Time Period	Survey Estimates[*]	±95% Confidence Intervals	Official Estimates[†]	
Eastern Europe						
Romania	RHS	1995–1999	31.5	(19.5–43.5)	20.9	1.5
Ukraine	RHS	1995–1999	15.2	(9.3–21.1)	13.9	1.1
Caucasus Region						
Armenia	DHS	1996–2000	36.1	(25.3–47.0)	16.3	2.2
Azerbaijan	RHS	1996–2000	74.4	(61.6–87.2)	17.2	4.3
Georgia	RHS	1995–1999	41.6	(30.4–52.8)	24.3	1.7
Central Asian Republics						
Kazakhstan	DHS	1995–1999	61.9	(45.3–78.5)	24.3	2.5
Kyrgyz Republic	DHS	1993–1997	61.3	(47.0–75.7)	29.3	2.1
Turkmenistan	DHS	1996–2000	73.9	(63.2–84.7)	31.9	2.3
Uzbekistan	DHS	1992–1996	49.1	(35.9–62.4)	30.1	1.6

* Source: KIIS and CDC, 2001; ORC/MACRO International 1995–2001; Serbanescu F et al. 1995, 1998, 2001.
† Source: WHO European Public Health Information Network (EUPHIN) for Eastern Europe (www.euphin.dk/phfa.asp); Azerbaijan Ministry of Health; Georgian Ministry of Health.

the real IMR, sometimes by a considerable margin. Recent RHS and DHS surveys conducted in the region estimate much higher rates than the official reports, particularly in the Caucasus region and Central Asian Republics. Survey-based infant mortality estimates exceeded the official rates by 10% in Ukraine; by 50%-70% in Romania, Uzbekistan, and Georgia; by more than 100% in Armenia, Kazakhstan, Kyrgyzstan and Turkmenistan; and by more than 300% in Azerbaijan. Concerns about the reporting of the IMR in Caucasus and Central Asia were raised by the former Soviet Central Statistical Administration, which felt the need to apply correction factors to the data reported by those regions in order to ensure comparability with the European republics of the USSR (Andreyev and Ksenofontova, 1991).

The registration process of infant deaths in Azerbaijan is similar to that of other former Soviet Union countries. Currently two official counts of infant deaths exist: one through the Center for Medical Statistics and Information of the Ministry of Health (MOH) and one through the State Committee for Statistics of Azerbaijan (SCS). The MOH receives infant mortality data on aggregate data forms from medical facilities (monthly from maternity hospitals and annually from pediatric wards and polyclinics). The SCS receives mortality data from urban and rural civil registry bureaus; the medical death certificates filled out by physicians in hospitals or ambulatory units are submitted by relatives in order to obtain official death certificates needed for burial. The original medical death certificates are submitted to SCS, which processes demographic data and applies cause-of-death codes according to the 10th revision of the *International Classification of Diseases* (WHO, 1993). It is unclear whether one system is more accurate than another, because both are subject to potential misclassification and underreporting. For example, medical facilities may feel pressured to misclassify very premature babies as miscarriages, because IMR is a classic indicator of evaluating performance of health units. The SCS may be subject to underregistration of both births and deaths because the declaration of these events is performed by a third party (usually a parent), usually within the first 3 months after birth (Jone and Grupp, 1983). Thus, infants born alive who subsequently die before having birth certificates issued would remain unregistered as either live births or infant deaths. The likelihood of escaping registration may be the highest when the death occurs soon after birth and decreases with the increase in the infant's age.

One of the principal objectives of the AZRHS01 was to estimate levels and trends in infant and child mortality. The survey included a series of questions to obtain for each live birth the date of occurrence, sex of the child, survival status and, for children who had died, the 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 were used to calculate mortality levels among respondents' children, namely, infant mortality (i.e., deaths before the first birthday), child mortality (i.e., deaths between 12 and 59 completed months of age), and child-under-5 mortality (i.e., deaths before the

Figure 6.8
Infant, Neonatal, and Post-neonatal Mortality Rates
Between January 1991 and December 2000
Comparison between Official Rates and AZRHS01 Estimates
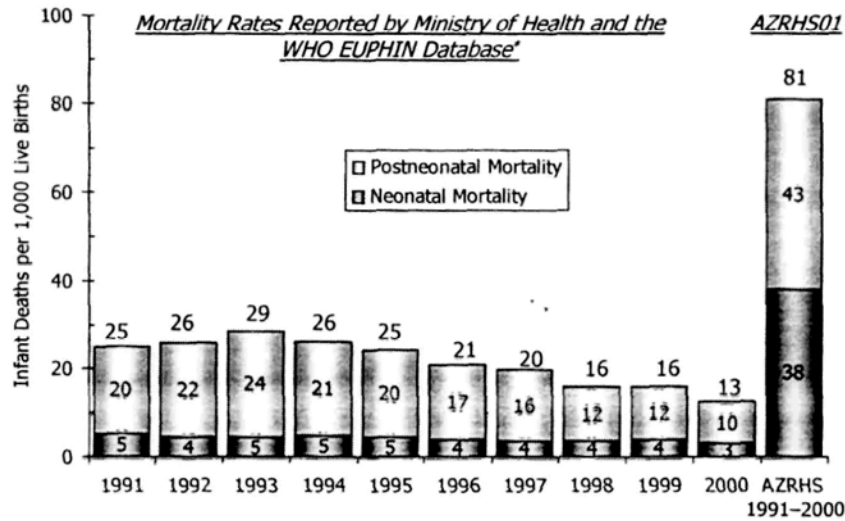
*Neonatal and Postneonatal Mortality Rates for 1997–2000 provided by the Information and Health Statistics Department of the Azerbaijani Ministry of Health; mortality rates for 1991–1996 available at the WHO EUPHIN website.

fifth birthday). Infant mortality was further divided into two periods: neonatal (0-28 days) and postneonatal (29 days to 11 completed months). In the 10-year interval from January 1991 to December 2000, the IMR was estimated at 80.8 per 1,000 live births, and the neonatal and postneonatal mortality rates were 38.1 per 1,000 and 42.7 per 1,000, respectively (see Table 6.8.2 and Figure 6.8). In interpreting these results, the reader should bear in mind that survey data tend to underestimate neonatal mortality to a greater extent than child mortality at older ages. When the death occurs in the first few hours or days of life, some women, especially those with low levels of education and those who have had many births, do not always report their losses as infant deaths because they may not consider their births to be live births. For this reason, the estimated neonatal mortality rate of 38.1 and, implicitly, the IMR of 80.8 should be considered as minimum values for this period of time.

The IMR of 80.8 per 1,000 live births estimated from AZRHS01 for the most recent 10-year period was 3.8 times higher than the average rate of 21.5 infant deaths per 1,000 live births reported by MOH (Table 6.8.2). The statistical standard error (SE) for the survey period estimate was 4.5 percentage points (calculated as SE= [rate/square root of number of deaths]*1.4 where 1.4

103

TABLE 6.8.2
Infant, Neonatal, and Post-neonatal Mortality Rates (Deaths per 1,000 Live Births)
Between January 1991 and December 2000
Comparison between Official Rates and AZRHS01 Estimates

| Year | Official Mortality Rates[*] | | | AZRHS01 | | |
	Neonatal Mortality Rate (NNMR)	Post-neonatal Mortality Rate (PNNMR)	Infant Mortality Rate (IMR)	NNMR	PNNMR	IMR
1991	5.3	19.6	25.0			
1992	4.5	21.5	26.0			
1993	4.6	24.0	28.6	41.2	44.7	85.9
1994	4.8	21.4	26.2·			
1995	4.5	19.8	24.3			
1996	3.8	17.0	20.8			
1997	3.7	15.9	19.6			
1998	3.6	13.0	16.6	34.1	40.3	74.4
1999	4.0	12.6	16.5			
2000	3.2	9.6	12.8			
1991–2000	4.2	17.3	21.5	38.1	42.7	80.8

* Neonatal and Postneonatal Mortality Rates for 1997–2000 provided by the Information and Health Statistics Department of the Azerbaijani Ministry of Health; mortality rates for 1991–1996 available at the WHO EUPHIN website.

represents the design effect needed because the AZRHS01 used a cluster sampling design. Standard errors can be used to calculate confidence intervals around the IMR within which we can say with 95% confidence that the true value of the population IMR lies. Thus, the point estimate of 80.8 per 1,000 should not be considered as the exact value of the IMR; in theory, that would have been possible to calculate if all women of reproductive age had been interviewed. The true rate could be higher or lower; its value lies between a 95% confidence interval from 72.0 to 89.6 per 1,000 (CI=± 1.96*SE).The lower limit of 72.0 was still 3.3 times higher than the average of 21.5 per 1,000 reported by the SCS for 1991-2000.

The survey neonatal death rate of 38.1 per 1,000 was almost 10 times higher than the average official rate of 4.2 per 1,000 for 1991-2000 (ranging from 5.3 per 1,000 in 1991 to 3.2 in 2000). Similarly, the survey found postneonatal mortality of 42.7, which was 2.5 times higher than the official average of 17.3 per 1,000 (ranging from 24 per 1,000 in 1993 to 9.6 in 2000). Thus, the difference between

the survey estimates and the official rates was observed in both neonatal and postneonatal mortality rates, but much more for neonatal deaths. As a result, neonatal deaths contributed to only 19% of the IMR for 1991-2000, according to MOH data, whereas neonatal deaths in respondents' histories accounted for almost half (47%) of the reported deaths during the first year of life. In conclusion, the survey estimates of neonatal deaths were substantially higher than the official data. Presumably, high underreporting of these deaths exists within the vital records reporting system.

Part of the gap between the official rates and survey estimates can be explained through differences in definition of live birth. Respondents in AZRHS01 were asked to report pregnancy outcomes (e.g., stillbirths and live births) according to international definitions that were recently adopted by Azerbaijan. Thus, a live birth was defined as any infant born alive, irrespective of the duration of the pregnancy, that breathes or shows any other signs of life after separation from the mother. The time interval for which survey mortality rates were calculated extends, however, over a period when the former Soviet Union definition of a live birth was largely in use. Under that definition, any infant with signs of life present at the time of delivery but whose weight was less than 1,000 g, had gestational age less than 28 weeks, or measured less than 35 cm and died within the first 7 days of life was classified as a miscarriage or stillbirth (Velkoff and Miller, 1995; Anderson and Silver, 1986). Thus, by applying the WHO definition, the survey recorded a certain number of births with a relatively low survival probability as live births, whereas the same births may have been misclassified in the official statistics as late fetal deaths, particularly if they occurred in the early 1990s.

However, the difference in definition of what constitutes a live birth should only affect mortality rates for the first 7 days of life (i.e., early neonatal mortality), whereas estimates for postneonatal or child mortality should not be affected. If the mortality rates presented in this chapter excluded very preterm babies (i.e., pregnancies terminating at 28 or more weeks of gestation or less) who died during the first week of life, the resulting IMR would be about 2 percentage points lower than if the WHO definition were applied (78.9 vs.80.8 deaths per 1,000 live births); the entire difference between IMRs calculated with the two definitions is due to the decrease in neonatal mortality, from 38.1 per 1,000 to 36.0 per 1,000 (data not shown). Thus, differences in definition clearly do not account for the gap between survey estimates and official rates. Alternatively, underreporting of births and infant deaths to civil registries (particularly for infants who were not delivered in medical facilities) and uneven quality of reporting from local vital record offices to the central level may play a more important role than differences in definition.

Table 6.8.3
Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)
by Selected Characteristics
Among Children Born between January 1991 and December 2000
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Infant Mortality			Child Mortality	Under-5 Mortality	No. of Cases
	Total*	Neonatal	Postneonatal	(1–4 Years)	(0–4 Years)	
Total	80.8	38.1	42.7	11.4	92.2	7,380
Period of Exposure						
January 1991–December 1995	85.9	41.2	44.7	10.9	96.8	4,227
January 1996–December 2000	74.4	34.1	40.3	14.0	88.4	3,153
Residence						
Urban	79.4	44.4	35.0	9.3	88.7	3,347
Rural	82.5	31.3	51.2	13.5	96.0	4,033
Region						
Baku	79.3	48.5	30.8	6.7	86.0	1,277
North & North-East	80.2	24.8	55.4	15.1	95.3	933
West	72.9	41.7	31.2	5.4	78.3	710
South-West	97.5	50.5	47.0	12.4	109.9	2,436
South	61.2	31.3	29.9	15.5	76.7	954
Central	102.7	42.8	59.9	11.3	114.0	1,070
Maternal Age Group (at Birth)						
<20	66.4	27.2	39.2	10.3	76.7	758
20–29	79.6	38.6	41.0	10.0	89.6	5,203
30 or more	93.8	42.7	51.1	18.8	112.6	1,419
Education Level						
Secondary Incomplete or less	92.0	44.9	47.1	15.9	107.9	1.495
Secondary Complete	90.4	35.5	54.9	12.2	102.6	3,892
Technicum	64.1	41.8	22.4	9.8	73.9	1,242
University	40.0	31.9	8.1	0.7	40.7	751
IDP/Refugee Status						
IDP/R	105.9	62.8	43.1	11.3	117.2	1,393
Non-IDP/CA	103.8	47.6	56.2	11.8	115.6	2,970
Non-IDP/NCA	71.5	32.1	39.4	12.6	84.1	3,017
Birth Order						
First Birth	76.6	41.5	35.1	10.4	87.0	2,417
Second Birth	68.9	33.6	35.3	10.6	80.5	2,410
Third Birth	89.0	35.1	53.9	10.9	99.9	1,516
Fourth or higher	108.0	44.3	63.7	13.4	121.4	1,037
Child Gender						
Male	83.6	45.7	38.0	9.9	93.5	3,837
Female	77.8	29.9	47.9	12.9	90.7	3,543

* If children born alive with gestational age under 28 weeks would be excluded from the calculation of IMR, the resulting rate for 1991–2000 is 78.9 deaths per 1,000 live births.

As shown in Table 6.8.2, both IMR and the under-5 mortality declined in the most recent 5-year period compared with the period 1991-1995, consistent with downward trends documented by the official reports. The decline in neonatal mortality was more substantial than the decline in postneonatal mortality (17% vs. 10%), perhaps indicating better intrapartum and neonatal care in the most recent period. Neither infant nor under-5 mortality rates differed significantly by mother's residence. Mortality differentials by age of the mother at the time of birth showed that the highest infant and under-5 mortality rates were found among births to women aged 30 or older (93.8 per 1,000 and 112.6 per 1,000, respectively).

Infant mortality, classified by education level of the mother, was highest among mothers without postsecondary education. The greatest differentials were observed in the levels of postneonatal mortality: Children born to women without postsecondary education were at least 6 times more likely to die between 28-364 days of age than were children born to women with a university education. Better access to preventive and curative health care services and better living standards among women with higher levels of education are probably the likely explanation for the difference.

Infant mortality differentials by IDP/R status illustrate that the rates for infants born to IDP/R women and non-IDP/R women living in conflict-affected areas were almost 50% higher than among non-IDP/R infants living in areas not directly affected by war. No significant differences were found in child mortality by IDP/R status. Thus, the difference in child under-5 mortality rates (which were almost 40% higher among infants born to IDP/R women and non-IDP/R women in conflict-affected areas than among non-IDP/R women in non-conflict-affected areas) were entirely caused by differences in IMRs, particularly neonatal mortality rates.

The infant and child mortality rate among infants born with birth order of four or higher was higher than among those preceded by two or fewer births. Male infant mortality (83.6 per 1,000) was slightly higher than the rate for females (77.8 per 1,000), reflecting the sex differential in neonatal mortality. After the neonatal period, however, female infants had higher probability of dying than male infants.

In conclusion, the levels of infant and child mortality in Azerbaijan are quite high. The relatively high magnitude of this public health problem was not easy to document through official statistics until recently. To improve reporting, the Azerbaijan MOH began applying ICD-10 definitions in 2001 and introduced new birth, death, and perinatal death certificates through Order No. 100, October 2001 (MOH, 2001b). Moreover, the MOH issued specific instructions for medical facilities on how to report such events (Order No. 88, July 2002) and on how to improve medical statistical reporting (Order No. 137, October 2002) (MOH, 2002a and 2002b).

CHAPTER 7

NUTRITIONAL STATUS OF MOTHERS AND CHILDREN

Childhood malnutrition in the population is generally estimated using the indices of height-for-age, weight-for-height, and weight-for-age. A high prevalence of low height-for-age (less than -2.00 height-for-age z score, often referred to as *shortness ox stunting)* is usually an indication of chronic malnutrition in a population. Although chronic malnutrition can be the result of long-term food shortages and disease, it can also be the result of poor socioeconomic conditions. A high prevalence of low weight-for-height (less than -2.00 weight-for-height z-score, referred to as *thinness* or *wasting)* is an indicator of acute malnutrition. Acute malnutrition is usually a reflection of recent food shortages, infections, or diarrhea. General malnutrition is usually indicated by a low weight-for-age z score and can be the result of long-term poor living conditions or the result of a more acute situation. However, a low prevalence of low weight-for-height is most likely a reflection of more chronic conditions (World Health Organization [WHO], 1995).

7.1 Methodology

To assess the nutritional status of children in the population, all children ages 3-59 months in sampled households were measured and weighed at their place of residence. Measurements were taken by nutrition health professionals who had received intensive training on anthropometry assessment and hemoglobin measurements prior to the beginning of fieldwork. Height was measured using the Shorr length/height board for children 3-59 months. The height of children age 2 years or older was measured in the standing position (without shoes), and the recumbent length of children younger than 2 years was measured. The results were recorded to the nearest 0.1 cm on the questionnaire. The weight of all children (wearing only undergarments) was measured using the Uniscale, which is designed to measure adults and children of all ages. Infants and toddlers under age 2 years were weighed with the mother holding the child on the Uniscale (the mother's weight was automatically deducted to get the child's weight). The weight was read and recorded to the nearest 0.1 kg. The child's age was calculated from the mother's report of the child's month and year of birth.

To assess how the nutritional status of children differed from what would be expected in a reference population, the indices were compared with the international growth reference developed by the U.S.

National Center for Health Statistics-Centers for Disease Control and Prevention and WHO (WHO, 1995) to obtain a standardized *z* score. The NCHS/CDC/WHO reference is based on growth data for healthy children in the United States. This reference has been chosen because studies have shown that well-nourished children from most countries follow a similar pattern of growth to that of the reference population. On the basis of this reference, children were classified as malnourished if they had a *z* score level less than 2 standard deviations below the mean of the reference population (i.e., -2.00 *SD)* for any indicator. Children who had a *z* score of less than -3.00 were classified as severely malnourished.

Anthropometry data were available on 2,446 children ages 3-59 months. However, the final sample size for each indicator changed once those who had missing or out-of-range *z* scores were excluded (height-for-age n=2,426, weight-for-height n=2,435, and weight-for-age n=2,442). Using the standard deviation of the mean *z* scores as a measure, the data quality was quite good: height-for-age, mean *z* score = -0.83 (1.1 *SD);* weight-for-height mean *z* score = -0.04 (0.96 *SD);* weight-for-age mean *z* score = -0.058 (1.03 *SD).*

To assess the prevalence of anemia in children in the population, a capillary blood sample was taken by fingerstick for all children aged 12 to 59 months. Written informed consent was obtained from the mother before samples were taken. Hemoglobin measurements were completed immediately after sample collection using a portable HemoCue® hemoglobinometer in the home. Results for each child tested were read and recorded on the mother's questionnaire. Anemia was defined as a hemoglobin of less than 11.0 g/dL, using the WHO anemia criteria for children younger than 5 years old (WHO, 2001) The mother was told immediately if the child was anemic.

To assess the nutritional status of mothers with young children, all sampled women who had children aged 3-59 months living in the household with them and who agreed were weighed and measured, and a capillary blood sample was taken. Mother's weight was measured in the home, in street clothes without shoes, using a portable Uniscale. The weight was read and recorded to the nearest 0.1 kg. The mothers' height was measured without shoes, using the Harpenden Stadiometer with a spirit level, and was recorded to the nearest 0.1 cm. Weight status was assessed using body mass index (BMI), which is defined as weight (kg)/squared height (m^2). Weight status was classified on the basis of the WHO recommendations of weight cutpoints for adults (WHO, 1995). Underweight was defined as BMI of less than 18.5, overweight was defined as BMI of >25. First-degree overweight was defined as BMI of 25.00-29.99, second-degree overweight as BMI of 30.00-39.99, and third-degree overweight as BMI of 40 or greater.

The anemia status of the mother was determined from hemoglobin measured on the HemoCue® hemoglobinometer from a capillary blood sample taken in the home. Anemia was defined according

to the 1998 CDC anemia criteria. The cutpoints were hemoglobin of less than 12.0 g/dL for nonpregnant women and less than 11.0 g/dL for women 1 to 3 months pregnant. The outpoints were 10.6,10.5, 10.7,11.0, 11.4, and 11.9 g/dL for mothers 4,5, 6,7, 8 and 9 months, respectively (CDC, 1998).

7.2 Changes in Levels of Chronic and Acute Malnutrition: 1996 to 2001

Data from the 1996 National Health and Nutrition Survey of the Internally Displaced and Resident Population of Azerbaijan allow for comparison of the change in the prevalence of chronic and acute malnutrition in young Azeri children between 1996 and 2001. Figure 7.2 shows that the prevalence of chronic malnutrition (i.e., low height-for-age) decreased from 22% in 1996 to 13% in 2001. In 1996, Azerbaijan experienced a large increase in the internally displaced person and refugee (IDP/R) population due to the political conflict and economic instability at that time, a situation that could explain this difference. In 1996, the prevalence of low height-for-age in the under-5 age group in the IDP/R population in 1996 was 31%, compared with 22% in the non-IDP/R population, but in 2001, the prevalence in the two populations was similar (15% and 13%, respectively). Note that the nutritional status of the IDP/R population is similar to that of the non-IDP/R population on all the indicators in the 2001 survey. This pattern represents a change from the results of the 1996 survey. The prevalence of acute malnutrition (i.e., low weight-for-height) remained fairly constant between the 1996 and 2001 surveys, at 3% and 2%, respectively.

Figure 7.2
Prevalence of Chronic and Acute Malnutrition in 1996 and 2001
Among Children Aged 3–59 Months
Health and Nutrition Survey (HNS, 1996) and AZRHS01—Azerbaijan
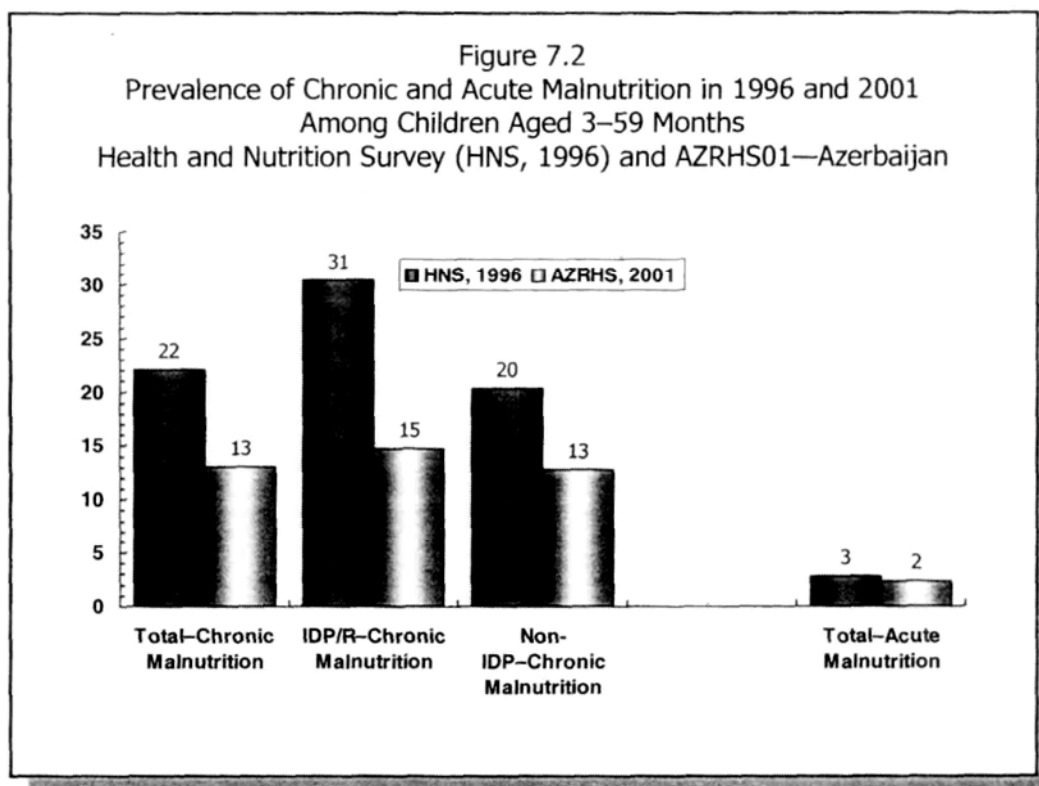
These low rates are close to the expected prevalence in a healthy population, indicating that acute malnutrition is not a public health problem. However, between 1996 and 2001 a slight decrease occurred in the mean weight-for-height z score for the population, from 0.13 (1.02 *SD)* in 1996 to -0.04 (0.96 *SD)* in 2001, indicating a slight downward shift for the population distribution as a whole.

7.3 Chronic Malnutrition

The total prevalence of chronic malnutrition (i.e., low height-for-age) was 13.3% among children younger than 5 years old (Table 7.3) and did not vary significantly among children under age 2 when compared to children 2-5 years of age (13.1% and 13.7%, respectively) (data not shown). The problem of chronic malnutrition was greater among children living in rural areas (15.9%) than among those living in urban areas (10.6%). Regionally, the lowest level of chronic malnutrition was found in the Baku and West regions (9.9% and 10%, respectively), whereas the highest was observed in Southern region (18.3%), followed by 14.7% in the North-Northeast region of Azerbaijan. Although most regions of the country showed fairly low (2%-3%) levels of severe chronic malnutrition (defined as a height-for-age z score of less than 3), the South region had the highest level of severe malnutrition (6.3%). Children whose mother had a complete education (15.3%) or incomplete secondary education (16.1%) were more likely to have chronic malnutrition than were children whose mothers had a university education (4.1%). Chronic malnutrition also varied by SES: children from families of low socioeconomic status (SES) experienced a higher prevalence (17.8%), compared with children from middle SES (8.8%) and high SES (4.1%). The prevalence was more than twofold higher (26.1%) in children who weighed less than 2,500 g at birth (i.e., low birth weight) and in those born prematurely (28.5%) than in children of normal birth weight (10.5%) and those born at full term (12.8%). No gender differences were observed for height-for-age indicator z score level less than -2.00 *SD.*

7.4 Acute Malnutrition

In general, the overall prevalence (2.4%) of acute malnutrition (i.e., low weight-for-height) was no greater among Azeri children younger than 5 years old than expected, based on the reference population (Table 7.4). However, the rate among children under 2 years old was more than 3 times higher than the rate among children 2-5 years old (4.3% and 1.3%, respectively). Moreover, the rates of acute malnutrition among children aged 3-11 months and 12-23 months (4.4% and 4.2%, respectively) were nearly twice the expected rates. Little difference was found between children living in rural areas and those living in urban areas (2.0% vs. 2.7%). Regionally, children living in the North-Northeast and Central regions of Azerbaijan had higher levels of acute malnutrition (3.2% and 3.1%, respectively) than children living in other regions of the country did.

TABLE 7.3
Anthropometric Indicator of Chronic Malnutrition (Height-for-Age) by Selected Characteristics Among Children Aged 3–59 Months
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Height-for-Age z score (HAZ)* | | Unweighted No. of Cases |
	HAZ <−3.00 (Severe Chronic Malnutrition)	HAZ <−2.00 (Chronic Malnutrition)	
Total	3.1	13.3	2,426
Age (months)			
3–11	3.1	8.6	355
12–23	5.2	17.3	473
24–35	2.0	10.4	495
36–47	2.5	13.2	528
48–59	2.8	15.7	575
Residence			
Urban	2.2	10.6	1,056
Rural	3.9	15.9	1,370
Region			
Baku	1.5	9.9	411
North & North-East	2.7	14.7	355
West	1.9	10.0	220
South-West	2.9	12.9	830
South	6.3	18.3	312
Central	3.8	13.2	298
Education Level			
Secondary Incomplete	6.4	16.1	532
Secondary Complete	2.3	15.3	1,284
Technicum	2.8	9.0	354
University	0.4	4.1	256
Socioeconomic Status			
Low	4.3	17.8	1,436
Middle	2.1	8.8	811
High	0.0	4.4	179
IDP/Refugee Status			
IDP/R	2.3	14.7	459
Non-IDP/CA	3.2	12.1	967
Non-IDP/NCA	3.2	13.4	1,000
Premature			
Not-Premature	2.8	12.8	2,354
Premature	11.5	28.5	72
Weight at Birth			
<2,500 grams	8.6	26.1	176
≥2,500 grams	1.8	10.5	1,522
Unknown	5.3	17.8	728
Gender			
Male	2.3	13.1	1,280
Female	4.0	13.6	1,146

* Using NCHS/CDC/WHO as international reference (WHO, 1995). The values are expressed as percentages.

TABLE 7.4
Anthropometric Indicator of Acute Malnutrition and Overweight (Weight-for-Height) by Selected Characteristics among Children Aged 3–59 Months
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Weight-for-Height z score (WHZ)* | | | Unweighted No. of Cases |
	WHZ <−3.00 (Severe Acute Malnutrition)	WHZ <−2.00 (Acute Malnutrition)	WHZ >2.00 (Overweight)	
Total	0.2	2.4	2.6	2,435
Age Group (months)				
3–11	0.5	4.4	3.2	355
12–23	0.6	4.2	4.2	476
24–35	0.0	1.5	2.2	499
36–47	0.1	0.8	1.6	530
48–59	0.0	1.7	2.0	575
Residence				
Urban	0.4	2.7	3.3	1,062
Rural	0.0	2.0	1.9	1,372
Region				
Baku	0.4	2.6	2.8	413
North & North-East	0.2	3.2	3.0	357
West	0.1	1.3	0.8	219
South-West	0.2	2.4	1.7	830
South	0.1	0.8	1.7	313
Central	0.1	3.1	5.0	303
Education Level				
Secondary Incomplete	0.4	2.0	1.1	531
Secondary Complete	0.2	3.2	2.5	1,292
Technicum	0.1	1.3	1.7	356
University	0.0	0.8	6.9	256
Socioeconomic Status				
Low	0.2	2.8	1.2	1,441
Middle	0.3	2.2	3.8	813
High	0.2	0.4	6.0	181
IDP/Refugee Status				
IDP/R	0.0	2.2	1.3	457
Non-IDP/CA	0.3	2.4	3.9	974
Non-IDP/NCA	0.2	2.4	2.4	1,004
Premature				
Not-Premature	0.2	2.4	2.7	2,364
Premature	0.0	0.8	0.0	71
Weight at Birth				
<2,500 grams	0.1	6.4	0.6	178
≥2,500 grams	0.0	2.3	3.1	1,530
Unknown	0.5	1.4		727
Gender				
Male	0.2	2.6	2.4	1,281
Female	0.2	2.1	2.7	1,154

* Using NCHS/CDC/WHO as international reference (WHO, 1995). The values are expressed as percentages.

114

The rate was lowest for children living in the South region (0.8%). Children of mothers who had a secondary or less education (3.2% and 2%) had the highest levels of acute malnutrition. The rate also varied somewhat by SES, showing an inverse relationship. Children of IDP/R families were similar to children of non-IDP/R families. Children who weighed less than 2,500 g at birth (i.e., were low birth weight) had rates of acute malnutrition almost threefold (6.4%) those of their normal birthweight counterparts (2.3%). No gender differences were observed.

The weight-for-height indicator z-score (WHZ) with values greater than 2 (overweight) among children less than 5 years old is also shown in Table 7.4. A total of 2.6% of children had WHZ greater than 2, indicating overweight; 3.8% of children younger than 2 years old were overweight, whereas only 1.9% of children aged 2-5 years old were overweight (data not shown). The groups that had the highest levels of overweight were children aged 12-23 months (4.2%), those living in the urban areas (3.3%), those in the Central region (5.0%), those whose mothers were university educated (6.9%), children from middle (3.8%) and high (6.0%) SES families, and non-IDP/R children living in conflict-affected areas (3.9%). Although those rates are not very high, it is disconcerting that improved SES in this population appears to be related to increased levels of overweight. The health community needs to be conscious of this relationship and move to develop and implement prevention programs to insure that the problem does not increase to epidemic proportions as the country improves socioeconomically. The problem of overweight seems to occur with equal frequency as acute malnutrition among Azeri children under 5 years old.

7.5 General Malnutrition

Low weight-for-age (less than -2.00 *z* score) is used in this report as an indicator of general malnutrition. Usually, a low weight-for-age is considered an indicator of chronic malnutrition when a low prevalence of acute malnutrition exists. Because the total rate of acute malnutrition was low among Azeri children aged 3-59 months, the 6.8% rate of general malnutrition (Table 7.5) is probably a reflection of the higher rate of stunting in this population. The rate of low weight-for-age was slightly higher among children younger than age 2 (8.0%) than among children aged 2-5 years (6.2%). Regionally, children living in the North-Northeast (8.7%), South-West (8.0%), and Southern regions (7.5%) had the highest rates of general malnutrition. Similarly, the Southern and North-Northeast regions also had the highest rates of chronic malnutrition. An inverse relationship was found between general malnutrition and the mother's education level and family income: children whose mother had less than a secondary education (10.9%) were almost 5 times more likely to be malnourished than were those whose mother had a university education (2.3%). Children who were from low-SES families (9.3%) were almost 3 times as likely to be malnourished as children from high-SES families (3.4%). The rate of low weight-for-age among IDP/R children (5.4%) was 2 percentage points lower than that of non-IDP/R children (7.0% and 7.2%). Children who were of low birth weight had a higher rate of general malnutrition (17.6%) than those of normal birth weight (4.8%).

115

TABLE 7.5
Anthropometric Indicator of General Malnutrition (Weight-for-Age) by Selected Characteristics
Among Children Aged 3–59 Months
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Weight-for-Age z score (WAZ)*		Unweighted No. of Cases
	WAZ <-3.00 (Severe General Malnutrition)	WAZ<-2.00 (General Malnutrition)	
Total	0.9	6.8	2,442
Age Group (months)			
3–11	2.6	6.7	357
12–23	1.5	8.9	477
24–35	0.8	6.4	500
36–47	0.4	6.0	531
48–59	0.0	6.2	577
Residence			
Urban	0.5	5.8	1,064
Rural	1.4	7.8	1,378
Region			
Baku	0.4	4.6	414
North & North-East	1.2	8.7	357
West	0.1	4.4	220
South-West	1.0	8.0	834
South	1.9	7.5	314
Central	0.7	6.6	303
Education Level			
Secondary Incomplete	1.0	10.9	534
Secondary Complete	1.4	6.6	1,293
Technicum	0.1	4.6	358
University	0.0	2.3	257
Socioeconomic Status			
Low	1.4	9.3	1,447
Middle	0.5	3.9	816
High	0.2	3.4	179
IDP/Refugee Status			
IDP/R	1.1	5.4	460
Non-IDP/CA	0.6	7.2	976
Non-IDP/NCA	1.0	7.0	1,006
Premature			
Not-Premature	0.9	6.7	2,370
Premature	3.3	9.2	72
Weight at Birth			
<2,500 grams	1.8	17.6	177
≥2,500 grams	0.6	4.8	1,535
Unknown	1.8	9.7	730
Gender			
Male	0.8	5.9	1,289
Female	1.1	7.9	1,153

* Using NCHS/CDC/WHO as international reference (WHO, 1995). The values are expressed as percentages.

116

Similarly, children born prematurely had higher rates of general malnutrition than full-term children did (9.2% vs. 6.7%). The rates among boys and girls were similar (7.9% and 5.9%, respectively).

7.6 Prevalence of Anemia in Children Aged 12-59 Months

Hematology data were available for 2,017 children after excluding those with missing hemoglobin data *(n=69)* and values that were less than 6 g/dL *(n=2)*. The mean hemoglobin level for children aged 12-59 months was 11.4g/dL (1.44 *SD);* children younger than 2 years old had a 1.1 g/dL lower mean hemoglobin (10.6 g/dL [1.53 *SD])* than did children 2-5 years old (11.7 g/dL [1.29 *SD]).* Only four children examined had severe anemia (i.e., hemoglobin less than 7g/dL). Therefore, the anemia observed was primarily moderate (7.0-9.9 g/dL) to mild (10-10.9 g/dL) according to the WHO classification (WHO, 2001). The large variation in the hematology data is illustrated in Figure 7.6. This variation is also demonstrated by the large standard deviations around the means. Large variation in hematology data may reflect true heterogeneity in the population, data reporting errors, or errors related to capillary blood sampling and collection techniques.

The rate of anemia was 31.8% among Azeri children aged 12-59 months (Table 7.6). As seen in other populations, the highest rate of anemia was among children 12-23 months (56.9%). The

Figure 7.6
Hemoglobin Distribution among Children Aged 12–59 Months
AZRHS Survey, Azerbaijan, 2001
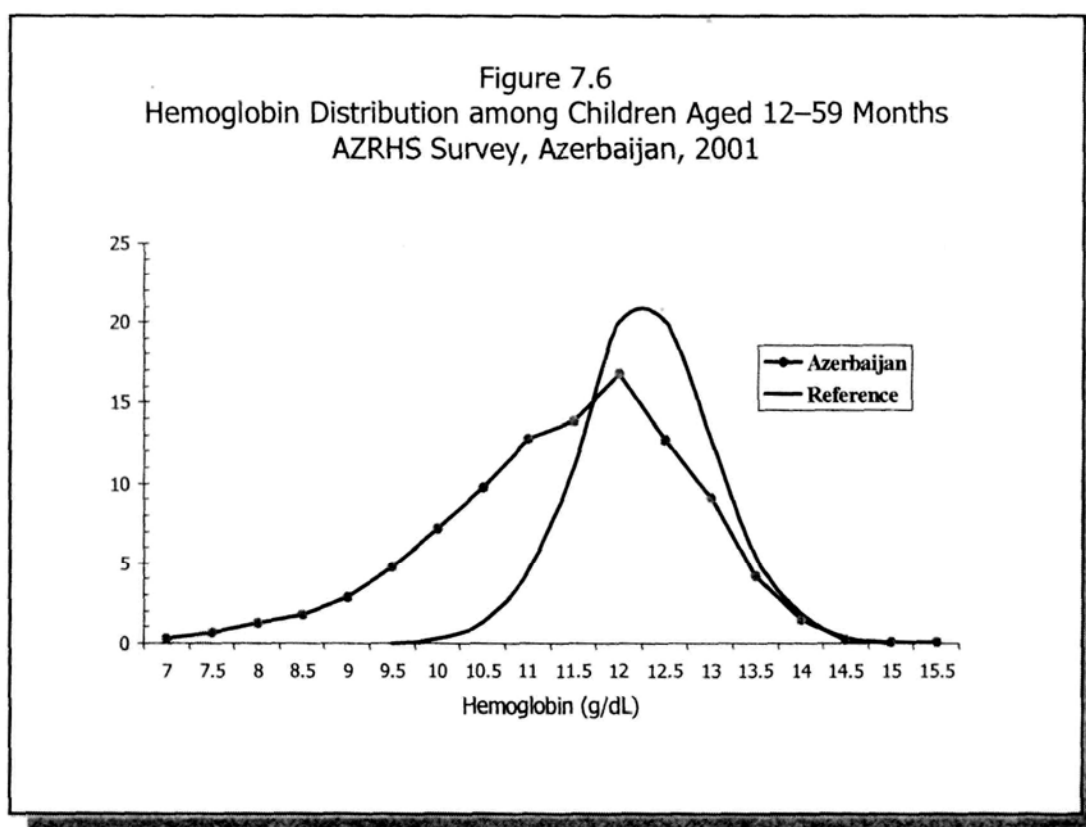
TABLE 7.6
Prevalence of Anemia[*] among Children Aged 12–59 Months by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	% with Anemia (Hemoglobin<11.0 g/dL)	Unweighted No. of Cases
Total	31.8	2,017
Age Group (months)		
12–23	56.9	459
24–35	34.0	487
36–47	20.3	510
48–59	17.6	561
Residence		
Urban	32.4	861
Rural	31.3	1,156
Region		
Baku	29.2	324
North & North-East	33.2	295
West	28.2	176
South-West	35.1	701
South	33.3	260
Central	31.1	261
Education Level		
Secondary Incomplete	34.4	442
Secondary Complete	33.0	1,074
Technicum	26.1	296
University	27.5	205
Socioeconomic Status		
Low	34.3	1,221
Middle	28.7	652
High	28.8	144
IDP/Refugee Status		
IDP/R	32.6	373
Non-IDP/CA	32.5	828
Non-IDP/NCA	31.5	816
Premature		
Not-Premature	31.9	1,955
Premature	27.4	62
Weight at Birth		
<2,500 grams	36.8	144
≥2,500 grams	31.0	1,258
Unknown	32.7	615
Gender		
Male	34.1	1,066
Female	29.2	951
Stunted		
Yes	40.4	298
No	30.3	1,719

* Defined as hemoglobin<11.0 g/dL, according to WHO anemia criteria for children less than 5 years old (WHO, 2001).

anemia prevalence documented in AZRHS01 represents a decrease from the prevalence reported in the 1996 survey (31.8 vs. 43.5%), but the 1996 survey defined anemia using the CDC criteria (Hgb<l 1.0 g/dL for children aged 12-23 months and <11.2 g/dL for children aged 24-59 months). If those criteria would have been applied in AZRHS01, a higher anemia level would be obtained (35.6% vs. 31.8%) (data not shown).

Rates of anemia in this age group exceeding 40% are considered to be of severe public health significance; in such situations, WHO recommends supplementing all children in the population with iron (2 mg/kg of body weight per day). The anemia rate in Azerbaijan was similar for children living in urban as well as rural areas. The rates varied by region, ranging from 28.2% in the West to 35.1 % in the South-West; however, all rates were 5-7 times higher than would be expected (5%).

Low education of the mother appears to be an important determinant of anemia in children; children whose mothers had only a secondary education or less (33:0% and 34.4%, respectively) were more likely to be anemic than those whose mother had a technical or university education (26.1% and 27.5%, respectively). Likewise, children from lower SES families were slightly more likely to be anemic than those from middle- to high-income families (34.3% vs. 28.8%). The rate of anemia was similar for IDP/R and non-IDP/R children. Children who were low birth weight at birth were slightly more anemic than those of normal birth weight. Boys were more likely than girls to be anemic; children who were stunted were also more likely to be anemic.

7.7 Nutritional Status and Anemia Levels among Mothers with Children Aged 3-59 Months

Overweight was more of a problem than underweight among mothers of young children (Table 7.7.1). Only 6.3% of nonpregnant mothers were underweight, whereas 37.5% were overweight (including 12.4% who were second- or third-degree overweight). The highest level of overweight was observed in mothers age 30 or older (44.5%-73.8%), those living in the Baku and Western regions (48.5% and 45.8%, respectively), those who had a postsecondary education (49.7%, 44.0%, respectively), middle or high SES (43.4%-51.8%), and those who were IDP/Rs (47.9%). The lowest levels of overweight were observed among nonpregnant mothers younger than age 25 (17.8%-24.7%) and those living in the Southern region (19.4%).

The anemia rate was 40.2% for nonpregnant mothers and 38.4% for pregnant mothers (Table 7.7.2). The total rate of anemia (40.0%) was slightly but not significantly higher than the rate reported for all women in the 1996 Health and Nutrition Survey (36.1 %) (data not shown). The rates were highest for mothers living in the Central and Southern regions of the country (54.1% and 49.0%, respectively). WHO recommends that 3 months of preventive iron supplementation (60 mg per day with 400ug of folic acid) be considered for nonpregnant women of childbearing age in areas where the prevalence of anemia among this group is greater than 40% (WHO, 2001).

119

TABLE 7.7.1
Prevalence of Underweight and Overweight* among Non-pregnant Mothers of Children Aged 3–59 Months by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Underweight	Overweight				No. of Cases
		Total	**1°**	**2°**	**3°**	
Total	6.3	37.5	25.1	11.6	0.8	1,772
Age Group						
15–19	11.8†	17.8†	14.7†	3.1†	0.0†	46
20–24	7.9	24.7	20.2	3.8	0.7	385
25–29	6.7	33.0	24.8	7.8	0.4	550
30–34	4.5	44.5	27.2	16.3	1.0	493
35–39	6.1	53.4	32.4	19.7	1.3	239
40–44	0.6	73.8	28.6	42.4	2.8	59
Residence						
Urban	4.7	45.0	28.3	15.6	1.1	811
Rural	8.0	29.4	21.6	7.3	0.5	961
Region						
Baku	2.5	48.5	30.4	16.4	1.7	325
North & North-East	7.6	34.1	23.4	10.0	0.7	257
West	2.5	45.8	33.5	12.3	0.0	165
South-West	5.1	38.6	25.7	11.5	1.4	580
South	12.2	19.4	13.1	6.3	0.0	215
Central	7.5	39.7	25.5	13.2	1.0	230
Education Level						
Secondary Incomplete	6.1	34.0	22.6	10.1	1.3	357
Secondary Complete	6.5	33.9	23.6	9.6	0.7	939
Technicum	8.0	49.7	29.6	19.1	1.0	279
University	3.6	44.0	30.2	13.8	0.0	197
Socioeconomic Status						
Low	8.2	30.6	21.5	8.5	0.6	1,006
Middle	5.0	43.4	27.6	14.6	1.2	621
High	1.0	51.8	35.0	16.2	0.6	145
IDP/Refugee Status						
IDP/R	10.2	47.9	28.1	18.0	1.8	326
Non-IDP/CA	6.0	39.7	24.0	15.1	0.6	695
Non-IDP/NCA	5.8	35.6	24.9	10.0	0.7	751

* Overweight and degree of overweight defined by WHO classifications (WHO, 1995).
† Estimates may be unreliable due to small sample size.

TABLE 7.7.2
Prevalence of Anemia* among Mothers of Children Aged 3–59 Months
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Anemia Prevalence	No. of Cases[†]
Total	**40.0**	**1,906**
Pregnancy Status	38.4	157
Pregrant	40.2	1,749
Non-Pregnant		
Age Group		
15–19	46.6	53
20–24	39.4	451
25–29	39.2	598
30–34	39.2	501
35–39	43.5	244
40–44	39.9	59
Residence		
Urban	38.5	859
Rural	41.7	1,047
Region		
Baku	37.0	337
North & North-East	35.1	274
West	33.1	172
South-West	39.2	644
South	49.0	234
Central	54.1	245
Education Level		
Secondary Incomplete	39.8	383
Secondary Complete	42.2	1,019
Technicum	35.8	290
University	36.3	214
Socioeconomic Status		
Low	42.2	1,092
Middle	38.3	661
High	34.9	153
IDP/Refugee Status		
IDP/R	39.0	356
Non-IDP/CA	43.7	759
Non-IDP/NCA	39.3	791

* Anemia defined by CDC criteria (CDC, 1998): the cutpoint for nonpregnant mothers is 12.0 g/dL; the cutpoint for pregnant mothers varies with gestational age (11.0 g/dL for 1–3 months pregnant mothers, 10.6, 10.5, 10.7, 11.0, 11.4, and 11.9 g/dL for mothers 4, 5, 6, 7, 8 and 9 months pregnant, respectively).
† Excludes 15 mothers whose current pregnancy status was unknown.

CHAPTER 8

CONTRACEPTION AWARENESS AND KNOWLEDGE OF USE

Azeri women report three abortions for every live birth. This high rate is due mostly to low use of effective contraception and high reliance on traditional methods, lack of knowledge and mistrust of modern methods, and low access to family planning services. Despite the recent efforts of nongovernmental organizations and donor organizations, much more work is needed to meet the contraceptive needs of all subgroups of the Azeri population. Lack of or misleading information about family planning methods and little knowledge about the places where methods can be obtained are important barriers to consistent and correct use.

An important objective of the AZRHS01 was to explore the level of knowledge of family planning methods and their source of supply among women of reproductive age. Respondents were asked whether they had ever heard about each of 10 modern and traditional contraceptive methods; if yes, from whom; whether they knew when and how to use the method; and whether they knew where the method could be obtained.

8.1 Contraceptive Awareness and Knowledge of Use

Azeri women demonstrated a relatively high level of family planning awareness, in contrast to their low prevalence of modern contraceptive use. Eighty-seven percent of Azeri women had heard about at least one modern method, but on average, they recognized fewer than three modern methods—generally the 1UD, condoms, and the pill (83%, 58%, and 53%, respectively). Almost two-thirds of women had heard of withdrawal (61%) and 39% had heard of periodic abstinence, also known as the rhythm method (39%). Only 38% of women had heard of female contraceptive sterilization (tubal ligation), and few (6%) had heard of vasectomy (Table 8.1.1).

The level of awareness of either modern or traditional methods was slightly higher among urban than among rural women (Table 8.1.1). Urban-rural differences were large for women's awareness about several modern contraceptive methods, ranging from 1.4 to 1.5 times higher for awareness of condoms (69% vs. 45%), tubal ligation (44% vs. 31%), and the pill (61% vs. 44%), to 1.6 to 1.7 times higher for awareness of injectables (12% vs. 7%) and spermicides (14% vs. 8%). The least

known methods (i.e., vasectomy and emergency contraception) were those that had the largest (three fold) urban-rural gap in awareness (9%-10% vs. 3%).

The level of awareness of modern methods was higher in Baku than in the rest of the country (93% vs. 82%-89%), and Baku respondents knew, on average, one more modem method than did women in other regions (3.4 vs. 2.2-2.7 modern methods). Awareness of all modern methods was

TABLE 8.1.1
Percentage of Women 15–44 Years of Age Who Have Heard of Specific Contraceptive Methods by Residence and by Region
Reproductive Health Survey: Azerbaijan, 2001

Contraceptive Method		Residence			Region				
	Total	Urban	Rural	Baku	North North-East	West	South-West	South	Central
Any Method	87.9	90.6	84.7	93.6	85.8	89.8	83.0	83.9	88.6
Any Modern Method	87.1	90.3	83.3	93.3	84.8	89.1	82.2	82.7	87.6
IUD	83.4	85.9	80.5	87.9	79.6	86.3	80.5	80.3	85.5
Condom	58.0	68.8	45.1	80.8	57.7	52.7	47.4	43.4	51.6
Pills	53.1	60.9	43.8	69.0	49.7	56.4	45.0	41.9	48.7
Tubal ligation	37.9	43.5	31.1	46.7	31.9	41.8	27.1	37.2	38.0
Spermicides	11.4	14.2	8.0	16.8	10.0	10.8	9.2	8.3	10.6
Injectables (Depo-Provera)	9.7	11.7	7.3	14.0	8.4	11.6	8.7	6.7	7.6
Emergency contraception	6.7	9.5	3.4	14.5	5.1	4.8	5.3	3.2	4.3
Vasectomy	5.8	8.6	2.5	14.4	3.3	3.8	2.1	2.0	5.2
Average No. of Modern Methods	2.7	3.0	2.2	3.4	2.5	2.7	2.3	2.2	2.5
Any Traditional Method	65.2	67.5	62.4	70.3	63.4	66.7	63.0	60.3	65.6
Withdrawal	61.0	62.1	59.7	62.3	59.7	65.1	60.4	57.0	62.2
Periodic abstinence (rhythm met.)	39.2	46.3	30.8	53.9	31.9	39.1	34.5	32.1	39.8
No. of Cases	7,668	3,832	3,836	1,533	924	766	2,302	950	1,193

highest in Baku, especially awareness of condom, pills, vasectomy, and emergency contraception. Except for the higher level of awareness of periodic abstinence among Baku women, little regional variation was found in women's awareness of traditional methods.

Among survey respondents, the awareness of both modern and traditional methods was directly correlated with the respondent's age (Table 8.1.2). Although only three-fourths of young women (i.e., those aged 15-24 years) were aware of at least one contraceptive method, contraceptive awareness was almost universal at age 25 and older. Awareness of modern methods was 20% higher

and awareness of traditional methods was 2.5 times higher among women aged at least 25 years than among those aged 15-24. The most widely known methods for women aged 25 and older were the IUD (94%-96%), withdrawal (79%-83%), condom (68%-69%), and the pill (63%-64%). Among the youngest women, however, the awareness of condom and the pill ranked second and third, respectively, after IUD awareness, and awareness of withdrawal ranked fourth. Nonetheless, young women knew, on average, fewer than two modern methods, whereas their older counterparts were aware of at least three modern methods, on average.

TABLE 8.1.2
Percentage of Women Aged 15–44 Years Who Have Heard of Specific Contraceptive Methods by Age Group, Marital Status, and IDP/R Status
Reproductive Health Survey: Azerbaijan, 2001

Contraceptive Method	Total	Age Group			Marital Status			IDP/R Status		
		15–24	25–34	35–44	Currently Married	Previously Married	Never Married	Non-IDP/R	Non-IDP/CA	Non-IDP/NCA
Any Method	87.9	74.3	95.9	97.7	99.2	94.0	68.9	89.3	86.1	88.2
Any Modern Method	87.1	73.6	94.8	96.9	98.0	93.4	68.8	88.2	85.4	87.4
IUD	83.4	65.6	93.9	96.1	96.9	91.7	60.6	85.3	83.3	83.2
Condom	58.0	41.8	69.2	67.9	72.2	60.0	35.0	57.0	49.4	60.3
Pills	53.1	37.2	63.8	63.0	65.5	56.6	32.6	52.3	48.4	54.3
Tubal ligation	37.9	20.6	44.8	53.2	47.9	50.5	19.8	34.4	34.3	39.1
Spermicides	11.4	6.9	15.7	12.9	14.8	13.0	5.7	9.4	9.7	12.1
Injectables (Depo-Provera)	9.7	8.5	12.2	8.9	11.3	8.9	7.3	12.4	7.1	10.0
Emergency contraception	6.7	3.0	10.6	7.8	8.9	7.9	3.1	6.9	4.4	7.3
Vasectomy	5.8	3.0	8.0	7.2	7.1	5.0	3.9	4.2	4.1	6.4
Average No. of Modern Met.	2.7	1.9	3.2	3.2	3.2	2.9	1.7	2.6	2.4	2.7
Any Traditional Method	65.2	34.4	83.2	87.0	92.2	75.1	20.3	64.6	63.4	65.7
Withdrawal	61.0	29.9	79.3	83.1	88.9	71.0	14.6	60.0	59.6	61.5
Periodic abstinence(rhythm met.)	39.2	18.1	51.2	54.5	54.3	49.1	13.6	39.0	39.0	39.3
No. of Cases	7,668	2,414	2,689	2,565	5,146	387	2,135	1,272	3,047	3,349

Virtually all currently married women (i.e., women in union), as well as previously married women, had heard of at least one modern method (98% and 94%) and at least one traditional method (92% and 75%). Awareness of modern and traditional methods were greater than 90% among currently

married women; awareness was much higher for modern methods than for traditional methods among never (69% vs. 20%) or previously married women (93% vs. 75%). Awareness of all modern methods, particularly female sterilization, was lower among never-married than among ever-married respondents, however. Because marital status is directly correlated with age and never-married women are more likely to be young, the pattern of knowledge of specific methods among unmarried women resembled that for younger women. Similarly, the number of modern family planning methods recognized was the lowest among never-married respondents (1.7 modern methods). The level of contraceptive awareness did not vary significantly among IDP/R women and non-IDP/R women.

TABLE 8.1.3

Percentage of Women Aged 15–44 Years Who Have Heard of Specific Contraceptive Methods by Education
Reproductive Health Survey: Azerbaijan, 2001

		Education			
Contraceptive Method	**Total**	**Secondary Incomplete or Less**	**Secondary Complete**	**Technicum**	**University & Postgraduate**
Any Method	87.9	78.4	87.4	97.4	97.6
Any Modern Method	87.1	77.7	86.3	96.7	97.6
IUD	83.4	72.4	82.8	95.4	93.6
Condom	58.0	40.4	54.3	75.0	87.7
Pills	53.1	40.0	48.8	67.1	79.7
Tubal ligation	37.9	24.4	35.8	54.9	52.1
Spermicides	11.4	7.1	8.1	18.4	24.7
Injectables (Depo-Provera)	9.7	8.3	7.4	14.7	15.9
Emergency contraception	6.7	3.2	4.9	11.3	15.7
Vasectomy	5.8	1.4	3.1	9.7	20.9
Average No. of Modern Methods	2.7	2.0	2.5	3.5	3.9
Any Traditional Method	65.2	49.3	65.2	80.8	77.8
Withdrawal	61.0	45.8	62.0	74.6	70.7
Periodic abstinence (rhythm met.)	39.2	22.5	35.4	58.6	64.5
No. of Cases	7,668	1,697	3,868	1,215	888

The level of awareness of both modern and traditional methods was directly correlated with women's educational level. Among women with incomplete secondary or lower levels of education, awareness Of specific methods was the lowest (Table 8.1.3). Particularly notable was the much lower awareness of tubal ligation, vasectomy, and emergency contraception among less educated women. For the

126

most widely known methods, the difference between these women and the best educated women ranged from 29% for IUD awareness to more than 100% for the awareness of condom, pill, or tubal ligation. Consequently, the average number of modern methods known by these women was much lower than the average number known by the most educated women (2 vs. 3.9 methods)

Respondents who reported that they were aware of (i.e., "have heard of) a contraceptive method were asked whether they knew how to use the method. Knowledge about how to use any modern or traditional method was lower than the corresponding awareness of it (63% vs. 87% and 58% vs. 65%, respectively) (Tables 8.1.1 and 8.1.4). The proportion of respondents who knew how each method or procedure is used was usually substantially lower than the proportion aware of each method or procedure. For the most widely known modern contraceptive methods (i.e., IUD, condom, the pill, and tubal ligation), a large gap existed between awareness of the methods and knowledge of how they are used (Figure 8.1). Although awareness of IUDs was high (83%), only half of women (51%) said they actually knew how IUDs are used. Additionally, although 53% had heard of the pill, only 24% knew how that method is used. A narrower gap in knowledge was obvious for condoms, tubal ligation, spermicides, injectables, and emergency contraception, further reducing the proportion of women who could start using these methods. The gap between awareness of the method and knowledge about its use was also present for the periodic abstinence method (39% vs. 28%) and, to

Figure 8.1
Awareness and Knowledge of How to Use Contraceptive Methods
Among Women Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001
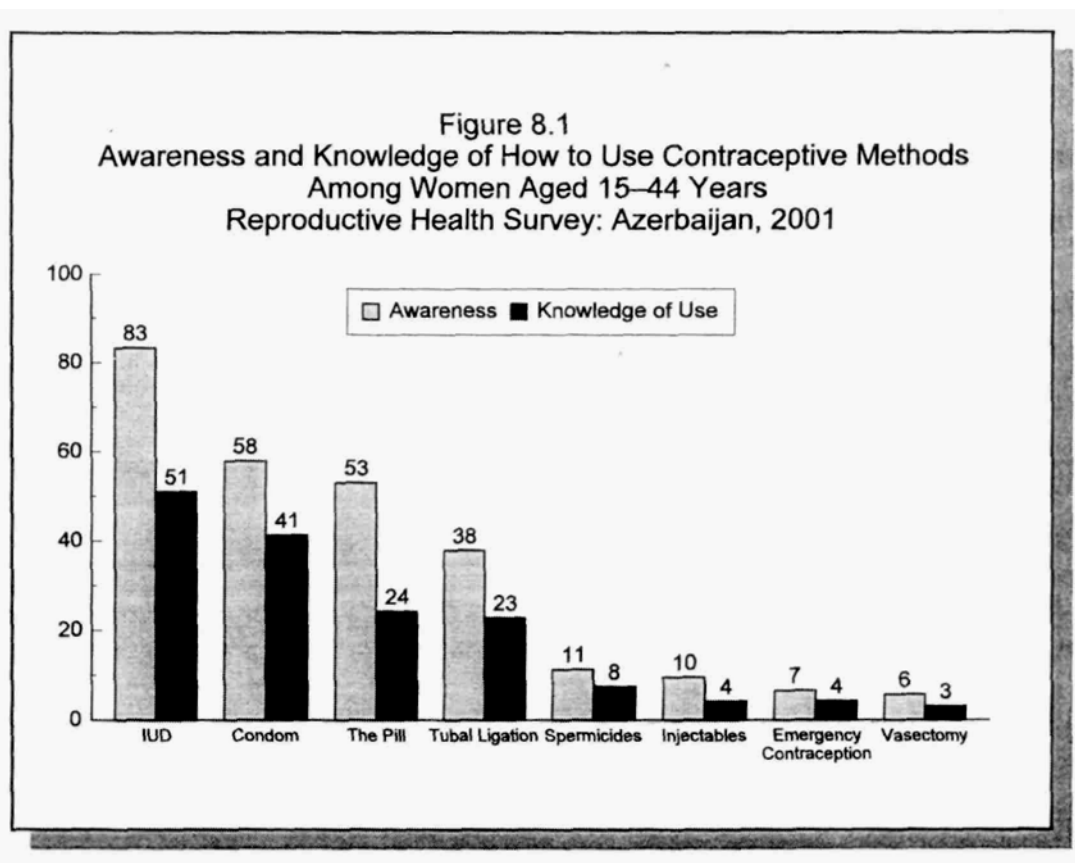
a lesser extent, for withdrawal (61% vs. 54%).

The difference between awareness of and knowledge about use was the greatest among young adults (74% vs. 47%) and diminished with increased age of the respondents (96%-98% vs. 87%—89%) (Tables 8.1.2 and 8.1.4). Again, the age difference in lack of knowledge about how contraception

TABLE 8.1.4
Percentage of Women Aged 15–44 Years Who Say They Know
How Specific Contraceptive Methods Are Used
by Age Group, Marital Status, and IDP/Refugee Status
Reproductive Health Survey: Azerbaijan, 2001

Contraceptive Method	Total	Age Group			Marital Status			IDP/R Status		
		15–24	25–34	35–44	Currently Married	Previously Married	Never Married	IDP/R	Non-IDP/CA	Non-IDP/NCA
Any Method	71.9	46.9	87.2	89.1	93.5	79.1	36.3	69.7	68.0	73.2
Any Modern Method	63.0	42.8	75.5	76.8	79.5	70.3	35.5	59.8	57.8	64.7
IUD	51.1	30.2	62.7	66.7	66.9	59.4	24.7	47.8	48.7	52.2
Condom	41.4	26.6	51.5	50.3	53.6	42.6	21.5	37.4	36.3	43.1
Pills	24.3	13.5	31.8	30.7	33.0	23.9	10.2	24.3	21.9	24.8
Tubal ligation	22.9	10.6	27.7	33.8	29.8	32.1	10.4	20.6	20.7	23.6
Spermicides	7.6	4.1	10.5	9.3	10.1	7.9	3.5	6.1	6.9	8.0
Injectables (Depo-Provera)	4.3	1.6	6.9	5.4	5.8	4.4	1.9	5.0	2.7	4.6
Emergency contraception	4.4	3.1	6.2	4.4	5.6	2.9	2.8	6.0	3.3	4.5
Vasectomy	3.2	1.1	5.0	4.3	4.1	4.1	1.7	2.9	2.3	3.5
Average No. of Modern Met.	1.6	0.9	2.0	2.0	2.1	1.8	0.8	1.5	1.4	1.6
Any Traditional Method	57.6	26.2	75.8	80.0	85.6	61.6	11.9	56.5	56.0	58.1
Withdrawal	54.3	23.9	72.1	75.8	82.0	57.3	9.2	52.1	53.4	54.8
Periodic abstinence (rhythm)	27.7	9.2	37.6	41.8	40.8	30.2	6.2	27.8	27.7	27.7
No. of Cases	7,668	2,414	2,689	2,565	5,146	387	2,135	1,272	3,047	3,349

is used was more pronounced for selected methods. For example, the proportion of women who did not know how IUDs and condoms are used decreased from 70% and 73% among young adult women, to 37% and 48%, among women aged 25-34 years, and to 33% and 50% among those aged 35-44 years. Similarly, the proportion of women who did not know how tubal ligation protects against pregnancy decreased from 89% to 66% between young adults and older women, whereas the percentage of women who did not know how to use the pill decreased from 86% to 69%. Knowledge

about the use of periodic abstinence was more than 4 times higher among women aged 25 years or older then among young adult women. As a result, young adult women, on average, could identify how contraceptive works for, at most, one modern method compared with two modern methods identified by older women.

Differences between awareness of contraceptive methods and knowledge about how they are used were larger among never and previously married women than among currently married women. Never married women were the least likely to have knowledge about contraceptive use and had the largest gap between awareness and knowledge about use (69% vs. 36%), whereas virtually all currently married women knew how at least one contraceptive method works (94%). Little variation was found in the knowledge of contraceptive use by respondents' IDP/R status. The difference between awareness of and knowledge about use diminished with increased education, from 78% vs. 56% among women with less than complete secondary education to 97%-98% vs. 87% among women with postsecondary education (data not shown).

8.2 Knowledge about Contraceptive Source and Effectiveness

Another indicator commonly used to evaluate information, education, and communication efforts is knowledge of source(s) of contraception. The AZRHS01 found that only two-thirds of women could name at least one source for supplied methods of contraception (Table 8.2.1). Respondents were more likely to know a source for the most commonly used modern methods (see Chapter 9). For instance, 59% of women knew where to obtain IUDs, 44% knew a source for condoms, 36% knew a source for pills, and 26% knew where female contraceptive sterilization procedures (tubal ligations) are performed, but very few knew where vasectomies are performed or where to get injectables, spermicides, or emergency contraception. Knowledge about contraceptive sources among women aged 25 years or older was almost double that of young adults (80% vs. 43%), and it was the highest (84%) among currently married women (data not shown). Knowledge of a source was substantially higher among women living in Baku (80%) or other urban areas (71%) than among rural residents (60%), but little difference by IDP/R status was found. Knowledge of a source increased with education, especially for sources of condoms (from 26% among women with less than complete secondary education to 76% among those with university training) and the pill (from 22% to 61%, respectively) (data not shown).

TABLE 8.2.1

Percentage of Women Aged 15–44 Years Who Say They Know Where to Get Specific Contraceptive Methods

by Age Group, Residence, and IDP/R Status

Reproductive Health Survey: Azerbaijan, 2001

Contraceptive Method	Total	Age Group			Residence			IDP/R Status		
		15–24	25–34	35–44	Baku	Other Urban	Rural	Non-IDP/R	IDP/CA	Non-IDP/NCA
Any Modern Method	**68.2**	49.7	80.1	80.4	80.4	71.8	59.7	66.0	60.0	70.5
IUD	**58.5**	37.9	70.7	73.1	64.0	62.2	53.3	55.6	54.1	60.0
Condom	**44.4**	30.2	54.4	52.9	66.9	47.1	31.4	39.8	35.8	47.1
Pills	**35.7**	22.7	45.4	42.8	51.7	38.7	25.7	33.2	30.3	37.3
Tubal ligation	**25.8**	12.4	31.8	37.0	30.8	29.4	20.8	21.7	22.8	27.0
Spermicides	**7.8**	4.2	11.1	9.2	12.8	8.5	4.8	6.2	6.9	8.2
Injectables (Depo-Provera)	**4.9**	1.8	8.1	5.8	11.3	4.4	2.2	5.2	3.1	5.3
Emergency contraception	**4.6**	2.9	6.4	5.1	7.4	4.9	3.1	6.7	3.5	4.6
Vasectomy	**3.6**	1.3	5.4	4.8	9.0	3.3	1.2	3.3	2.6	3.9
No. of Cases	**7,668**	2,414	2,689	2,565	1,533	2,299	3,836	1,272	3,047	3,349

The AZRHS01 included a series of questions in which each respondent was asked to indicate whether specific contraceptive methods (shown on a card) were very effective, effective, or not effective in preventing pregnancy when used consistently and correctly. Answers to the questions are presented in Table 8.2.2, which lists contraceptive methods in descending order of effectiveness, according to their 12-month failure rates (Hatcher et al., 1998). This ranking is based on studies of unintended pregnancies among users of various family planning methods in the first 12 months of using that method (i.e., method failure), with the exception of emergency contraception, for which such analysis does not apply. According to this classification, vasectomy and Norplant (whose effectiveness was not explored in the AZRHS01 because they are largely unavailable in Azerbaijan) are the most effective methods, with a failure rate at 1 year of use of only 0.1 pregnancy per 100 women. Injectables, female sterilization, and IUDs have failure rates between 0.3 and 0.6 pregnancy per 100 women. Combined oral contraceptives have low theoretical failure (0.1 pregnancy per 100 women), but their actual failure rate, as commonly used, is much higher (6-8 pregnancies per 100 women). Condoms and other barrier methods are less effective, with failure rates of 3-6 pregnancies per 100 women during correct use and 14-26 pregnancies per 100 women as commonly used. Periodic abstinence can be moderately effective if used correctly; withdrawal is the least effective method.

TABLE 8.2.2

**Percentage Distribution of Women Aged 15–44 Years by Their Opinion About Contraceptive Effectiveness
if the Method Is Used Correctly and Consistently
Reproductive Health Survey: Azerbaijan, 2001**

Contraceptive Method*	Contraceptive Effectiveness					Total	No. of Cases
	Very Effective	Effective	Less or Not Effective	Do Not Know	Never Heard of the Method		
Tubal ligation	12.5	11.6	1.0	14.1	**60.8**	100.0	7,668
IUD	26.7	28.8	3.1	25.2	**16.2**	100.0	7,668
Pill	5.4	20.8	4.7	22.9	**46.2**	100.0	7,668
Condom	7.8	22.5	3.2	25.1	**41.4**	100.0	7,668
Calendar	3.2	16.0	8.5	12.7	**59.6**	100.0	7,668
Withdrawal	16.5	26.4	9.4	9.7	**38.0**	100.0	7,668

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

No modern method was recognized as being very effective by a majority of women, partly because substantial numbers of women lacked knowledge about how modern methods are used. Even when women who had never heard of a specific method were excluded, no effective method (e.g., tubal ligation or IUD) was correctly recognized as highly effective. For example, if those who had never heard of tubal ligation or IUD are excluded, those methods were correctly identified as being very effective by only 40% and 32% of women. Similarly, only 10% of women who had heard of the pill considered this method to be highly effective, whereas 27% of women who were aware of withdrawal stated that withdrawal is very effective. In fact, most women with contraceptive awareness of specific methods believed that those methods are somewhat effective, rather than very effective; between 4% and 10% of respondents did not know whether those methods were reliable. For the most commonly used modern methods, the percentage of women with awareness who believed that a method is highly effective or effective was 66% for IUD, to 62% for tubal ligation, 51% for condom, and 49% for the pill. At the same time, 69% and 48% of women who had heard of withdrawal and periodic abstinence believed the methods were highly effective or effective (Figure 8.2).

Figure 8.2
Belief That Specific Contraceptive Methods Are *Very Effective* or *Effective* in Preventing Pregnancy
Among Women Aged 15–44 Years Who Have Heard of Specific Methods
Reproductive Health Survey: Azerbaijan, 2001

A bar chart showing percentages by method:
- Withdrawal: 69
- IUD: 66
- Tubal Ligation: 62
- Condom: 51
- Pill: 49
- Periodic Abstinence: 48
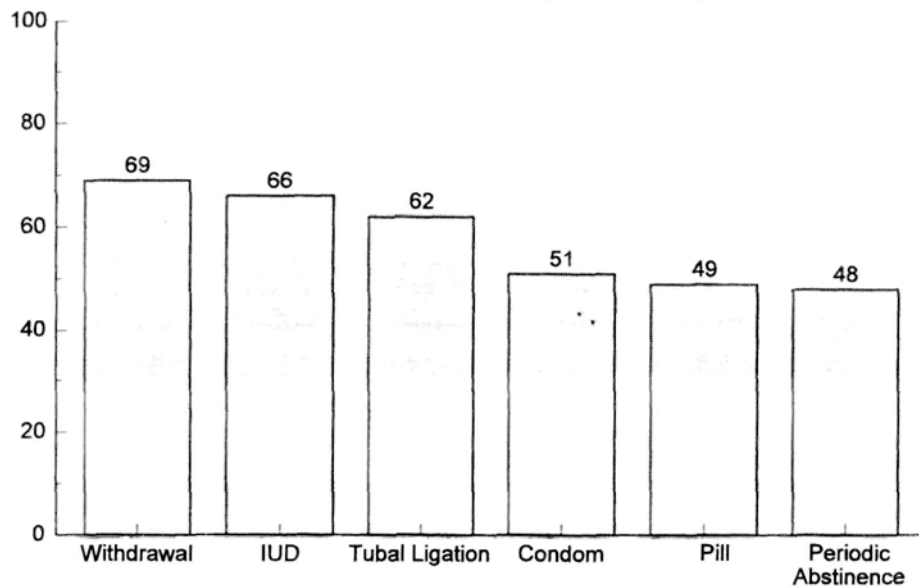
8.3 First Source of Information about Contraception

The AZRHS01 found that among women aged 15-44 years, the main source of information about birth control methods was an acquaintance or a friend (40%), followed by a relative other than a parent (19%), a physician (16%), a partner or boyfriend (11 %), and the mass media (4% audiovisual media, 3% print media, and 3% books) (Table 8.3).

Parents and school were seldom mentioned as sources of contraceptive information (1%). Young women (i.e., those aged 15-24 years) reported similar first sources of information as older women. More than 1 in 3 (38%) young women found out about contraception in discussions with a friend or acquaintance, 25% learned from the mass media or books, and 7% learned from a health care provider. The source of contraceptive information varied only slightly by method; women were most likely to have heard about IUD and tubal ligation from a medical health provider (26% and 24%) and about withdrawal from their partners (48%).These findings explain, in part, the poor quality of

132

contraceptive information (see also [Table 8.2.2](#)), which is often acquired through rumors, and illustrate the need for increasing public health efforts in educating women about the benefits of contraception through official channels (e.g., school, mass media, and health providers).

TABLE 8.3
First Source of Information about Contraception by Specific Method
Women Aged 15–44 Years Who Have Heard about Specific Methods of Contraception
Reproductive Health Survey: Azerbaijan, 2001
(Percent Distribution)

First Source of Information about Contraception	Contraceptive Method						
	Total	IUD	Condom	Pill	Tubal Ligation	Withdrawal	Periodic Abstinence
Peer, colleague	23.0	23.1	21.6	25.1	22.9	19.6	26.4
Relative	19.2	27.4	14.8	19.6	21.3	12.8	23.1
Friend	16.6	15.8	17.7	19.7	15.8	12.8	19.6
Physician	16.0	26.3	9.0	16.0	24.2	2.9	15.4
Partner	10.6	0.2	12.9	1.0	0.4	48.1	1.5
Television, radio	3.9	0.9	13.4	5.4	2.2	0.2	0.5
Brochures, newspapers, magazines	3.4	1.1	4.1	4.1	3.2	1.2	4.5
Books	2.7	1.0	1.9	2.6	4.2	1.2	4.6
Nurse, midwife or pharmacist	2.2	1.1	3.4	3.7	1.8	0.4	2.1
Teacher	1.2	1.0	0.7	1.2	2.3	0.3	1.2
Mother or father	0.9	1.9	0.3	1.0	1.3	0.1	0.7
Other	0.1	0.1	0.0	0.2	0.2	0.1	0.1
Do not remember	0.2	0.1	0.3	0.3	0.2	0.2	0.2
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0

CHAPTER 9

CURRENT AND PAST CONTRACEPTIVE PREVALENCE

At the breakup of the Soviet Union, contraceptive prevalence in the USSR was estimated to be around 30%, lower in the Caucasus and Central Asian republics and higher in the Eastern European republics (Brackett, 1993). Most Soviet-bloc countries of central and Eastern Europe were isolated from the advanced contraceptive technology of the industrialized countries, so the use of modern contraceptives was low and reliance on induced abortion was high. Compared with Western Europe, women in the eastern countries extensively used traditional contraceptive methods, which are highly that are most prone to failure, particularly withdrawal. In most of the former Soviet-bloc countries, the limited availability, access, and acceptance of modern contraceptive methods—as well as the high reliance on traditional, less effective methods—had shifted the role of induced abortion from a minor contributor to the primary determinant of fertility control.

At the beginning of the 1990s, the extremely high rates of induced abortion in several former Soviet-bloc countries appeared the be the principal determinant of fertility decline, because the protracted transition to new political and economic systems in these countries had initially brought little change in contraceptive prevalence. In recent years, however, changes in the balance between contraception and abortion appear to be underway. Thanks to recent efforts by a number of international donors in collaboration with governmental and nongovernmental local counterparts, both the availability of modern methods and the delivery of adequate information on modern contraception seem to be improving. In several countries of the region, such as Romania and Kazakhstan, nationwide sample surveys have documented a recent decline in abortion rates that coincided with an increased number of couples using modern contraceptive methods (Serbanescu et al., 2001; ORC/Macro, 2000).

9.1 Current Contraceptive Prevalence

Before 1990, USSR health statistics reported that the lowest current use of contraception (7%) among the former Soviet Union countries was in Azerbaijan (Brackett, 1993). After independence, data about contraceptive prevalence were scarce and often difficult to interpret. Several small area surveys reported current contraceptive use as low as 47% and as high as 67% (United Nations Population Fund, 1999a; Buchholz, 1999; Claeys et al., 2001; Posner et al., 2001). A recent

nationwide survey conducted by the United Nation's Children's Fund (UNICEF) estimated that 55% of married women aged 15-49 were currently using a contraceptive method; the most commonly used method was withdrawal (31%). Modern methods, mostly IUDs, were used by 16% of married women (UNICEF, 2000).

Table 9.1.1
Current Contraceptive Prevalence Among Currently Married Women of Reproductive Age
Reproductive Health Surveys (RHS) and Demographic Health Surveys (DHS)
In Selected Eastern European and Former Soviet Union Countries, 1993-2001

Country	Type of Survey	Any Method	Modern Method	% Modern Methods of Total Prevalence	Most Used Method
Eastern European Region					
Czech Republic, 1993	RHS	69	45	65	Withdrawal
Romania, 1993	RHS	57	14	25	Withdrawal
Romania, 1999	RHS	64	30	47	Withdrawal
Russia (three oblasts*), 1999	RHS	73	53	73	IUD
Moldova, 1997	RHS	74	50	68	IUD
Ukraine, 1999	RHS	68	38	56	IUD
Caucasus Region					
Georgia, 1999–2000	RHS	41	20	49	Withdrawal
Armenia, 2000	DHS	61	22	36	Withdrawal
Azerbaijan, 2001	RHS	55	12	22	Withdrawal
Central Asian Region					
Kazakhstan, 1995	DHS	59	46	78	IUD
Kazakhstan, 1999	DHS	62	54	87	IUD
Uzbekistan, 1996	DHS	57	53	93	IUD
Kyrgyz Republic, 1997	DHS	60	50	82	IUD
Turkmenistan, 2000	DHS	55	47	85	IUD

* Yekaterinburg, Perm, and Ivanovo.

Source: Goldberg H et al., 1993; KIIS and CDC, 2001; VCIOM and CDC, 1998, 2000; ORC MACRO 1996-2001; Serbanescu F et al. 1995.

Recent reproductive and demographic health surveys conducted in Eastern Europe and the former Soviet Union republics documented a relatively high prevalence of contraceptive use (typically more than 50% among currently married women) but relatively high reliance of methods of lower efficacy, particularly in the Caucasus region (Table 9.1.1). Contraceptive prevalence was highest in Eastern Europe and lowest in the Caucasus region; although in Eastern Europe, almost 3 of every 4 couples were using a contraceptive method, that proportion decreased in the Caucasus region to between 41% in Georgia, 61% in Armenia and in Central Asia, 55% in Turkmenistan, and 62% in

Kazakhstan. The prevalence of modern contraceptive methods was highest among couples in the Central Asian republics (between 47% and 55%) and lowest in the Caucasus region (12%-22%); in many countries, it exceeded the prevalence of traditional methods, sometimes by a considerable margin. In the Central Asian countries, modern methods accounted for more than 80% of contraceptive prevalence. The prevalence of modern methods exceeded that of traditional methods in all countries of Eastern Europe, with the exception of Romania. Conversely, in all countries of the Caucasus region, the prevalence of modern methods was lower than the prevalence of traditional methods. Azerbaijan had the lowest rates of use of modern contraceptive methods (22%).

TABLE 9.1.2
Current Use of Contraception Among All Women, by Marital Status and IDP/Refugee Status
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Use of Contraception	Total	Marital Status			IDP/Refugee Status		
		Currently Married & In Union	Previously Married	Never Married	IDP/R	Non- IDP/CA	Non- IDP/NCA
Currently Using	32.4	55.4	2.1	0.0	32.1	32.3	32.5
Modern Methods	7.0	11.9	1.4	0.0	4.8	5.8	7.5
IUD	3.6	6.1	1.4	0.0	1.8	2.9	4.0
Condom	1.9	3.2	0.0	0.0	1.5	1.1	2.1
Tubal ligation	0.7	1.2	0.0	0.0	0.5	0.7	0.7
Pill	0.6	1.0	0.0	0.0	0.7	1.1	0.4
Spermicides	0.2	0.3	0.0	0.0	0.2	0.0	0.2
Emergency contraception	0.0	0.1	0.0	0.0	0.1	0.0	0.1
Traditional Methods	25.4	43.5	0.7	0.0	27.3	26.5	25.0
Withdrawal	23.7	40.5	0.7	0.0	25.7	25.2	23.1
Periodic abstinence (rhythm)	1.7	3.0	0.0	0.0	1.6	1.3	1.9
Not Currently Using	67.6	44.7	97.9	100.0	67.9	67.7	67.5
Total	100.0	100.0	100.0	100.0	9.4	17.6	73.1
No. of Cases	7,668	5,146	387	2,135	1,272	3,047	3,349

This section focuses on currently married women because they represent the majority of sexually active women (i.e., active within the past 30 days); have greater frequency of intercourse, higher fertility, and more unintended pregnancies; and constitute the common denominator for most national and international studies of contraceptive prevalence. It is important to document, however, the contraceptive behaviors of all women because never-married women may have special contraceptive needs.

Most previously married women and virtually all never-married women who had ever had intercourse were not currently sexually active and therefore not in need of contraception. Not surprisingly, then, they were not using contraception during the month preceding the interviews (Table 9.1.2). Only 2% of previously married women were using contraception at the time of the survey; two-thirds of them were using the IUD, and the remaining third were using withdrawal. By contrast, currently married women were more likely to use a traditional contraceptive method than a modern method. About half (55%) of women currently in legal or formal unions were currently using a method of contraception, but only 12% used modern methods.

The proportion of women in union currently using any form of contraception ranged from 3% (among childless women) to 68% (among women with four or more living children) (Table 9.1.3). For the entire country, the proportion of all currently married contraceptive users who used a modern method was 22%, ranging between 7% (among the minority group of Talish women) and 46% (among those with the highest socioeconomic status [SES] and among Russian women). The proportion of women currently married who used any contraception did not differ substantially by residence, but it increased substantially with age until age group 30-34, rose sharply with the number of living children, and increased moderately with education level. The rate of contraceptive use was not significantly different for IDP/R women and non-IDP/R women. Use of modern contraceptives was twice as high in urban areas as in rural areas (16% vs. 7%); it was highest in Baku (19%) and was higher among 25- to 44-year-olds than among young adults

Figure 9.1
Current Use of Specific Contraceptive Methods
Among Women Aged 15–44 Years Currently Married
Reproductive Health Survey: Azerbaijan, 2001

No Method 45%
Pills 1%
Tubal Ligation 1%
Condom 3%
IUD 6%
Periodic Abstinence 3%
Withdrawal 41%

138
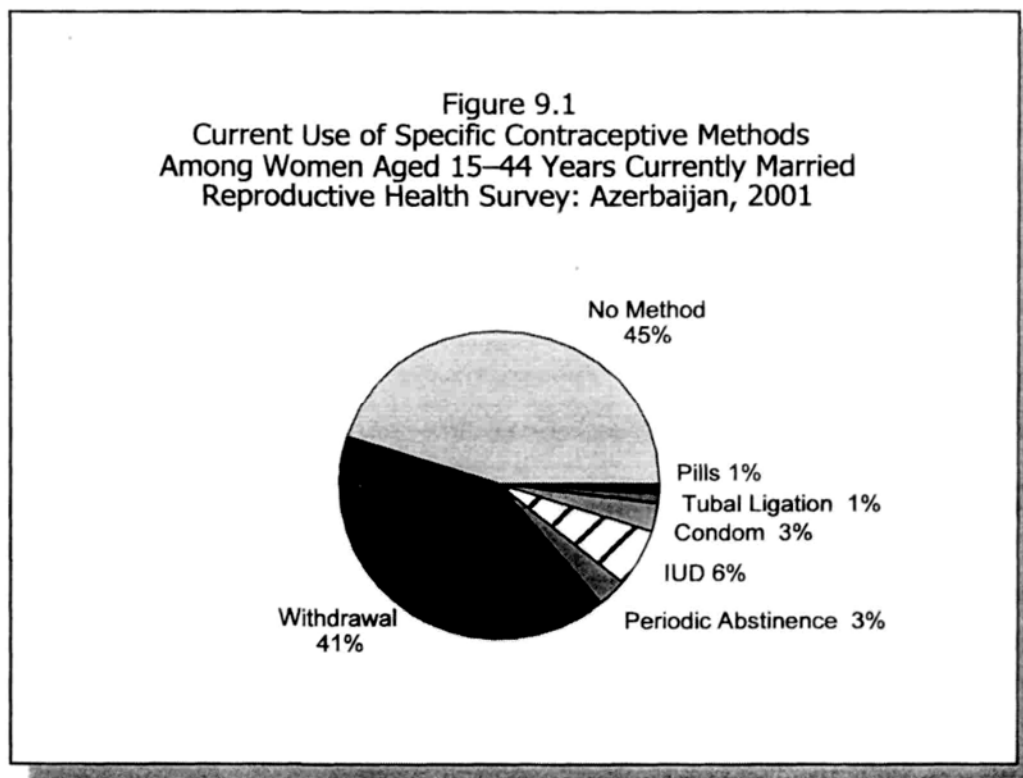
TABLE 9.1.3
Current Use of Modern and Traditional Methods by Selected Characteristics
Currently Married Women Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Any Method	Modern Methods	Traditional Methods	Percentage Using a Modern Method	No. of Cases
Total	55.4	11.9	43.5	22	5,146
Residence					
Urban	53.8	15.5	38.3	29	2,586
Rural	57.2	7.3	49.9	13	2,560
Region					
Baku	53.9	18.8	35.1	35	1,054
North & North East	56.6	7.5	49.1	13	635
West	49.4	10.7	38.7	22	511
South West	54.5	6.2	48.3	11	1,553
South	59.4	13.7	45.7	23	600
Central	57.2	10.3	46.9	18	793
Age Group					
15–19	14.2	1.5	12.7	11	157
20–24	45.0	8.3	36.7	18	638
25–29	57.3	13.4	43.9	24	910
30–34	62.0	12.7	49.3	20	1,301
35–39	61.2	13.9	47.3	23	1,270
40–44	52.7	10.8	41.9	21	870
No. of Living Children					
0	3.3	0.4	2.9	12	432
1	45.4	10.1	35.3	22	680
2	61.8	14.2	47.6	23	1,978
3	63.3	12.9	50.4	20	1,472
4+	67.8	12.6	55.2	18	584
Education					
Secondary incomplete or less	51.1	9.5	41.6	19	980
Secondary complete	54.4	9.5	44.9	17	2,643
Technicum	59.3	12.5	46.8	21	921
University/Postgraduate	59.7	24.1	35.6	40	602
Socioeconomic Status					
Low	56.7	7.2	49.5	13	2,739
Middle	52.6	12.8	39.8	24	1,852
High	58.0	26.6	31.4	46	555
Ethnic Group					
Azeri	55.4	12.0	43.4	22	4,816
Talish	45.1	2.9	42.2	7	88
Lezgi	56.7	8.9	47.8	16	55
Russian	57.4	26.2	31.2	46	36
Tat	61.4	9.2	52.2	15	30
Other	58.0	12.8	45.2	22	121
IDP/Refugee Status					
IDP/R	52.6	7.8	44.8	15	858
Non-IDP/CA	57.6	10.3	47.3	18	2,013
Non-IDP/NCA	55.1	12.7	42.4	23	2,275

TABLE 9.1.4
Current Use of Specific Contraceptive Methods by Selected Characteristics
Currently Married Women Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Any Method	IUD	Condom	Tubal Ligation	Pills	Other Modern	Withdrawal	Periodic Abstinence	No. of Cases
Total	55.4	6.1	3.2	1.2	1.0	0.4	40.5	3.0	5,146
Residence									
Urban	53.8	7.2	5.0	1.3	1.4	0.6	34.1	4.2	2,586
Rural	57.1	4.8	1.0	1.0	0.5	0.0	48.4	1.5	2,560
Region									
Baku	53.9	8.4	6.7	1.0	1.2	1.5	28.3	6.8	1,054
North & North-East	56.6	3.5	2.7	0.9	0.4	0.0	46.4	2.7	635
West	49.4	5.1	2.8	2.1	0.7	0.0	37.0	1.7	511
South-West	54.5	2.6	2.4	0.6	0.6	0.0	46.1	2.2	1,553
South	59.4	10.1	1.3	1.4	0.9	0.0	45.3	0.5	600
Central	57.2	5.6	1.4	1.2	2.1	0.0	45.3	1.6	793
Age Group									
15–19	14.2	0.5	1.0	0.0	0.0	0.0	12.6	0.1	157
20–24	45.0	5.6	1.8	0.3	0.6	0.0	36.1	0.6	638
25–29	57.3	6.3	5.1	0.1	1.4	0.5	42.0	1.9	910
30–34	62.0	6.9	3.8	0.7	1.0	0.3	45.9	3.4	1,301
35–39	61.2	7.1	3.0	1.9	1.5	0.4	43.1	4.2	1,270
40–44	52.7	4.9	2.4	2.7	0.4	0.4	37.7	4.2	870
No. of Living Children									
0	3.3	0.3	0.2	0.0	0.0	0.0	2.6	0.2	432
1	45.5	3.4	4.5	0.8	1.2	0.3	32.9	2.4	680
2	61.7	7.6	3.5	0.9	1.3	0.8	44.1	3.5	1,978
3	63.3	6.8	3.6	1.5	1.0	0.0	47.3	3.1	1,472
4+	67.8	7.2	2.2	2.7	0.5	0.0	51.3	3.9	584
Education									
Secondary incomplete or less	51.0	5.3	1.6	2.0	0.6	0.0	40.4	1.1	980
Secondary complete	54.4	5.3	2.2	1.0	0.7	0.3	42.7	2.2	2,643
Technicum	59.3	5.6	3.8	1.2	1.6	0.3	41.9	4.9	921
University/Postgraduate	59.7	11.4	9.1	0.6	1.7	1.3	29.2	6.4	602
Socioeconomic Status									
Low	56.8	4.2	1.4	1.0	0.6	0.0	48.3	1.2	2,739
Middle	52.6	6.7	3.6	1.3	0.9	0.3	35.3	4.5	1,852
High	58.0	11.4	8.8	1.7	2.7	2.0	26.2	5.2	555
Ethnic Group									
Azeri	55.4	6.2	3.2	1.2	1.0	0.4	40.3	3.1	4,816
Talish	45.1	0.9	1.1	0.0	0.9	0.0	42.2	0.0	88
Lezgi	56.7	4.3	2.3	2.3	0.0	0.0	42.0	5.8	55
Russian	57.4	12.2	5.2	2.6	3.6	2.6	26.0	5.2	36
Tat	61.4	3.1	6.1	0.0	0.0	0.0	49.1	3.1	30
Other	58.0	7.4	3.2	1.0	1.2	0.0	43.4	1.8	121
IDP/Refugee Status									
IDP/R	52.6	3.0	2.5	0.8	1.1	0.4	42.2	2.6	858
Non-IDP/CA	57.5	5.1	1.9	1.2	2.0	0.0	44.9	2.4	2,013
Non-IDP/NCA	55.1	6.7	3.6	1.2	0.7	0.4	39.3	3.2	2,275

and higher among those with at least one living child than among childless couples. The proportion doubled for women with a university education compared with women with lower levels of education. Similarly, it was significantly higher for women living in households with a high SES than for those living in households with a low or middle SES (27% vs. 13% and 7%, respectively). Modern contraceptive use was the highest among Russian women (26%) and the lowest among Talish women (3%). For all subgroups, however, the use of modern methods did not surpass the use of traditional methods and never exceeded 46% in the contraceptive method-mix.

By far the most prevalent method in use among women currently manned was withdrawal (41%), which accounts for 73% of contraceptive prevalence (Table 9.1.4 and Figure 9.1). IUDs, which were used by 6% of women, and condoms (3%) were the next most commonly used methods, accounting for 78% of modern methods used. Contraceptive sterilization, despite an overwhelming desire by most women to have no more children (see Chapter 4), was used by only 1% of women currently married; the pill was also used by only 1% of women in union. Although total contraceptive prevalence varied little by background characteristics (except for childless and adolescent women, who had a much lower prevalence), the choice of a specific method sometimes differed substantially among various subgroups. The use of IUDs was higher than average in urban areas, particularly in Baku (8%); in the Southern region (10%); among women with a university education or with high SES (11%); and among Russian women (12%). Condom use was also higher in urban areas than in rural areas (5% vs. 1%) and in Baku (7%); it increased with education and SES. Withdrawal was the most often used method regardless of the women's background characteristics but was considerably more prevalent among rural residents (48%); women residing in the North, South, and Central regions (45%-46%); among women with three or more children (47%-51%); among women with low SES (48%); and among Tat women (49%).

9.2 Source of Contraceptive Methods

To assess sources of contraceptive methods for currently married women, the AZRHS01 included questions about where current users of contraceptive methods obtained their supplies. The public medical sector was the largest source of contraceptive supplies in Azerbaijan (54%). Hospitals with gynecologic wards and maternity wards supplied 27% of women currently in union with their current method of contraception. Women's consultation clinics (WCCs) supplied 21% of women, whereas polyclinics and village hospitals and dispensaries supplied only 5% of women. Commercial sales, particularly through pharmacies, were the second-largest source of contraceptive supplies (35%). Clinics run by nongovernmental organizations (NGOs) and private clinics constituted an emerging source of contraception, particularly for pills. Other sources, such as partners, friends, and relatives, supplied 9% of users.

TABLE 9.3
Source of Supply for Modern Contraceptive Methods among Currently Married Women Aged 15–44 Years
Currently Using a Modern Method by Specific Methods
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Source	Total*	IDP/R Status			Contraceptive Method			
		IDP/R	Non-IDP/CA	Non-IDP/NCA	IUD	Condom	Pills	Tubal Ligation
Public Medical Sector	**53.9**	**42.7**	**58.8**	**54.1**	**93.8**	**3.1**	**12.4**	**94.5**
Hospital (Ob/Gyn ward)	18.5	12.2	20.1	18.8	30.2	0.4	0.6	54.6
Women's consultation clinic	21.3	9.9	14.7	23.4	42.7	0.3	7.7	0.0
Maternity	8.8	7.6	14.3	8.0	12.7	0.5	1.0	33.7
Polyclinic	1.1	1.6	0.7	1.1	2.3	0.0	0.0	0.0
Rural dispensary ("FAP")	0.9	4.3	1.3	0.5	0.7	0.8	2.5	0.0
Village hospital	3.3	7.1	7.7	2.3	5.2	1.1	0.6	6.2
NGO or Private Clinic/Office	**2.2**	19.3	3.0	0.5	0.5	2.4	7.0	5.5
Commercial Sales	**35.2**	**27.4**	**31.5**	**36.4**	**4.9**	**67.9**	**77.6**	**0.0**
Pharmacy	34.8	24.7	31.5	36.2	4.1	67.9	77.6	0.0
Store/Kiosk	0.4	2.7	0.0	0.2	0.8	0.0	0.0	0.0
Other	**8.5**	**10.6**	**6.6**	**8.5**	**0.7**	**25.4**	**3.0**	**0.0**
Partner	7.2	6.9	4.7	7.6	0.0	23.1	1.9	0.0
Friend or relative	1.3	3.7	1.9	0.9	0.7	2.3	1.1	0.0
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	**807**	118	235	454	370	266	96	52

† Prescription to buy the IUD at a pharmacy and bring it to clinic/maternity for insertion

IDP/R women were less likely than non-IDP/Rs to obtain contraceptive supplies in public hospitals and clinics (43% vs. 54%-59%) and more likely to receive a method from health clinics run by NGOs.

Sources varied greatly according to the contraceptive method used. Public hospitals were the primary source of IUDs (48%) and female contraceptive sterilization (95%). Pharmacies supplied more than two-thirds and three-fourths, respectively, of condoms and pills as well as virtually all other modern methods (i.e., Depo-Provera and spermicides). Pharmacies also supplied 4% of IUDs (with a prescription issued by the ob/gyn), but IUDs must be inserted at a medical facility.

WCCs were the second most common source of IUDs and pills, supplying 43% and 8% of women currently using these methods. Health clinics run by NGOs were the third most commonly used source of pills (7%). Not surprisingly, partners constituted the second source for condoms for women (23% of users). Few women reported obtaining condoms in a hospital or a health clinic, including NGO clinics.

9.3 Dissatisfaction With the Current Method and Preference for Other Methods

AZRHS01 also explored the level of satisfaction with contraception among current users. The proportion of women who were satisfied with their method of contraception was considerably higher (83%) than the proportion who reported having problems or concerns (17%) (see Table 9.3.1).

TABLE 9.3.1
Satisfaction With Currently Used Contraceptive Method by Specific Method Used and Reason for Dissatisfaction, Currently Married Women Aged 15–44 Years Who Are Currently Using Contraception
Reproductive Health Survey: Azerbaijan, 2001

	Total	Current Method					
		IUD	Condom	Pill	Tubal Ligation	Withdrawal	Periodic Abstinence
% Satisfied with Current Method	**82.5**	**83.8**	**84.4**	**75.0**	**86.3**	**82.1**	**83.5**
%Dissatisfied with Current Method and Main Reason of Dissatisfaction*	**17.5**	**16.2**	**15.6**	**25.0**	**13.7**	**17.9**	**16.5**
Not Very Effective, Had Already Failed	5.1	0.0	2.4	3.9	1.2	5.8	10.5
Partner Complains About the Method	4.1	0.0	7.5	1.9	0.0	4.6	3.4
Difficult or Unpleasant to Use	3.7	0.0	2.1	0.0	0.1	4.8	0.7
Health Concerns	3.0	9.4	2.7	6.6	5.7	2.0	0.6
Side Effects	1.1	6.7	0.0	11.4	1.7	0.1	0.0
Access/Cost	0.3	0.0	0.3	1.1	4.9	0.0	1.3
Other	0.2	0.1	0.6	0.1	0.1	0.6	0.0
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**2,937**	296	174	49	66	2,197	155

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

143

The most often mentioned reason for dissatisfaction (5%) was related to concerns about the contraceptive method's effectiveness. Most users had already experienced method failure. Other concerns were related to partner's disapproval (4%), difficulty with using the current method (4%), and fear of or experience with side effects (4%).

Among modem methods, the pill was the method with which respondents were the least satisfied (25%). Most pill users cited experience of side effects (11%) and health concerns (7%) as the main reasons for dissatisfaction. Users of traditional methods were dissatisfied with those methods mainly because they have low effectiveness or are difficult to use (e.g., withdrawal), or their partners complain about the methods. Similarly, women whose partners were using condoms reported that the main reason for dissatisfaction was related to their partner's complaints.

To assess method acceptability, all current users of contraception were asked whether they would prefer to be using some other method of preventing pregnancy. About 1 in 3 users answered positively (Table 9.3.2). The percentages differ considerably, however, depending on the method used. Desire to switch to another method was highest among women whose partners were using condoms (46%), followed by users of traditional methods (33% and 39%), and pill users (30%). The only methods with low proportions of users who preferred other methods were IUD (12%) and female sterilization (0%), consistent with the fact that few users reported problems with those methods and that sterilization reversals are uncommon in Azerbaijan.

TABLE 9.3.2
Currently Married Women Aged 15–44 Years Who Are Currently Using a Contraceptive Method and Would Prefer to Use a Different Method by Current Method Used and Preferred Method
Reproductive Health Survey: Azerbaijan, 2001

Current Method	Total*	Preferred Method					No. of Cases
		IUD	Pill	Condom	Other Modern	Undecided	
Any Method†	35.0	21.6	5.7	1.5	1.7	4.0	2,937
IUD	11.7	0.0	4.2	0.4	1.5	4.9	296
Condom	45.6	27.9	6.5	0.7	6.2	3.6	174
Pills	30.4	17.6	0.0	0.0	6.6	6.2	49
Tubal Ligation	0.0	0.0	0.0	0.0	0.0	0.0	52
Withdrawal	39.0	25.0	6.3	1.8	1.4	4.0	2,197
Periodic Abstinence	33.0	21.8	5.5	1.7	0.2	3.8	155

· * Includes 11 women who said they want to switch to a traditional method.
† Includes 14 women using other modern methods.

TABLE 9.3.3
Currently Married Women Aged 15–44 Years Who Are Currently Using a Contraceptive Method and
Want to Switch to Another Method
by Reason for Not Using the Preferred Method by Preferred Method
Reproductive Health Survey: Azerbaijan, 2001

| Most Important Reason | Total* | Preferred Method | | | | |
		IUD	Pill	Condom	Other Modern	Undecided
Cost	26.9	36.5	22.0	20.3	26.8	0.0
Still Thinking About it	23.2	12.4	27.5	13.2	24.5	57.1
Health Concerns	22.5	27.7	32.8	4.6	19.5	1.8
Doctor Did Not Recommend It	8.2	13.0	4.9	0.0	0.0	0.0
Availability, access	6.0	1.9	11.2	20.9	24.9	3.8
Partner Opposes	4.5	5.5	1.0	21.4	0.0	0.0
Difficult to Use	1.1	0.0	0.6	0.0	4.3	3.1
Other Reasons	7.5	2.9	0.0	19.5	0.0	34.1
Total	100.0	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	430	240	79	25	25	55

* Includes 6 women who would prefer to switch to a traditional method.

Almost two-thirds of women who wanted to switch to another method expressed a preference for the IUD (22% of 35%=63%), particularly, women using male-controlled methods and periodic abstinence. Only a minority of women (2% of 35%=6%) who wanted to switch to another method indicated that they preferred female sterilization.

The three main reasons for which women were unable to switch methods of contraception were the cost associated with their preferred method (27%), health concerns about the preferred method (23%), and indecision (23%) (Table 9.3.3). Only 6% of the respondents mentioned lack of availability of or access to the preferred method; another 5% of respondents reported that their partners were against the preferred method.

Most women preferring the IUD, the method preferred to the greatest extent, said they were not using it either because of its cost (37%) or because they feared side effects (28%). Fear of side effects was also the most important reason for the women who wanted to switch to the pill (33%), followed by indecision (28%) and cost (22%). The most frequently mentioned barriers to condom use were cost, availability or accessibility (41%), and partner opposition (21%).

9.4 Users of Traditional Methods

Every respondent who was currently using any traditional method (i.e., calendar method and withdrawal) was asked whether a number of factors were "important" or "somewhat important" in their decision not to use a more effective method. Those factors included fear of health or side effects that may be associated with the use of modern methods; lack of knowledge about other methods; cost or availability of other methods; partner preference; medical or other person's advice against modern methods; and religious beliefs. As shown in Table 9.4.1 and Figure 9.4.1, most women stated that fear of side effects (90%), lack of or little knowledge about modern methods (71 %), cost (61 %), or availability of or access to modern methods (53%), along with partner preference for traditional methods (49%), were the major factors influencing their decision not to use a modern method.

About 1 in 4 women considered a friend (26%) or a doctor's advice (24%) as important factors in their decision to use traditional methods, and 1 in 7 women mentioned their religious beliefs as a reason to not use a modern method (15%). Among users of nonsupplied (i.e., traditional) methods, few differences in background characteristics were found among those mentioning specific reasons for not using a modern method.

Figure 9.4.1
Most Important Reasons for Not Using Modern Contraceptives
Women Aged 15-44 Currently Using Traditional Methods
Reproductive Health Survey—Azerbaijan, 2001

Reason	Percent
Fear of Side Effects	90
Lack of Knowledge	71
Cost of Other Methods	61
Difficult to Get Other Methods	53
Partner Preference	49
Other Person Advice	26
Doctor Recommendation	24
Religious Beliefs	15

TABLE 9.4.1

Contraceptive Method Users Who Stated that Selected Factors Were Important or Somewhat Important When Deciding To Use a Non-Supplied Method Instead of a Modern Method, by Selected Characteristics Women Aged 15–44 Currently Using Traditional Methods Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Fear of Health/Side Effects	Lack of Knowledge	Cost of Other Methods	Difficult to Obtain Other Methods	Partner Preference	Other Person Advice	Doctor Recommendation	Religious Beliefs	No. of Cases
Total	89.7	70.7	61.2	53.1	48.7	25.6	24.2	14.9	2,352
Method Used									
Withdrawal	89.8	71.4	61.2	53.7	48.0	24.2	23.4	14.1	2,197
Periodic Abstinence	89.3	61.5	60.7	44.3	.58.1	44.7	34.9	26.6	155
Residence									
Urban	88.3	67.3	56.7	47.8	46.9	25.2	22.6	12.9	1,048
Rural	91.1	74.0	65.4	58.1	50.4	26.0	25.7	16.9	1,304
Region									
Baku	82.4	63.6	58.5	48.4	56.8	33.6	24.2	18.8	390
North & North-East	89.6	73.6	69.2	62.9	55.2	33.5	31.3	25.0	315
West	92.6	67.7	42.8	27.6	28.3	5.4	15.8	0.0	219
South-West	93.8	77.7	65.5	60.3	46.9	22.9	29.8	10.9	783
South	94.9	73.0	64.1	58.9	46.9	22.2	19.8	6.2	272
Central	88.7	69.9	59.7	51.8	47.0	23.9	19.3	16.3	373
Age Group									
15–24	87.3	75.8	55.2	49.0	54.4	20.6	22.1	15.9	259
25–34	89.0	71.5	62.6	53.1	49.3	24.1	23.6	13.9	1,079
35–44	91.1	68.6	61.4	54.2	46.6	28.4	25.2	15.7	1,014
Education Level									
Secondary Incomplete	84.6	76.9	67.0	64.1	50.4	21.1	22.5	14.4	425
Secondary Complete	89.5	74.0	63.7	55.3	48.6	28.0	26.0	16.9	1,248
Technicum	94.2	64.3	53.4	45.7	46.2	24.6	23.8	11.5	444
University	91.7	54.6	52.0	34.9	50.8	23.8	18.7	12.8	235
Socio-economic Status									
Low	90.2	74.7	66.1	58.3	47.5	23.3	24.9	13.9	1,380
Middle	90.4	67.4	57.5	48.3	48.7	27.9	23.3	15.3	791
High	83.8	59.4	45.4	40.1	55.5	31.1	22.9	20.2	181
IDP/R Status									
IDP/R	88.2	77.7	67.3	61.3	46.8	25.4	19.8	14.5	404
Non-IDP/CAA	90.6	71.1	61.8	54.1	50.4	24.9	24.9	13.5	979
Non-IDP/NCA	89.7	69.6	60.2	51.7	48.5	25.8	24.6	15.4	969

Generally, each reason was mentioned more often by rural women, those with lower levels of education, and those with low SES. Fear of side effects among users of nonsupplied methods increased with respondent's education and age.

Table 9.4.2 presents the opinions of women using non-supplied (traditional) methods regarding the effectiveness of their current method relative to "modern methods like the IUD or the pill." It is notable that more than two-thirds of women consider their method more effective than (47%) or equally effective (20%) to modern methods and that only 25% recognized that the IUD and the pill are more effective methods of preventing pregnancy. In addition, 8% admitted that they did not know whether their method is more or less effective. Similar findings were documented by reproductive health surveys in other countries of the region: 56% of women currently using traditional methods in Russia and 78% of women in Georgia believed that their traditional methods were as effective as or even more effective than the pill or the IUD (Figure 5.1.3). These findings highlight both the lack of correct information about modern contraceptives and women's trust in traditional methods historically practiced in the region.

Beliefs in high relative effectiveness of traditional methods were not significantly influenced by background characteristics, including education of the respondents. Perceived effectiveness of traditional

Figure 9.2.2
Perceived Effectiveness of Traditional Methods Compared with Modern Methods
(IUD or the Pill)
Women Aged 15-44 Currently Using Traditional Methods—RHS Surveys

148
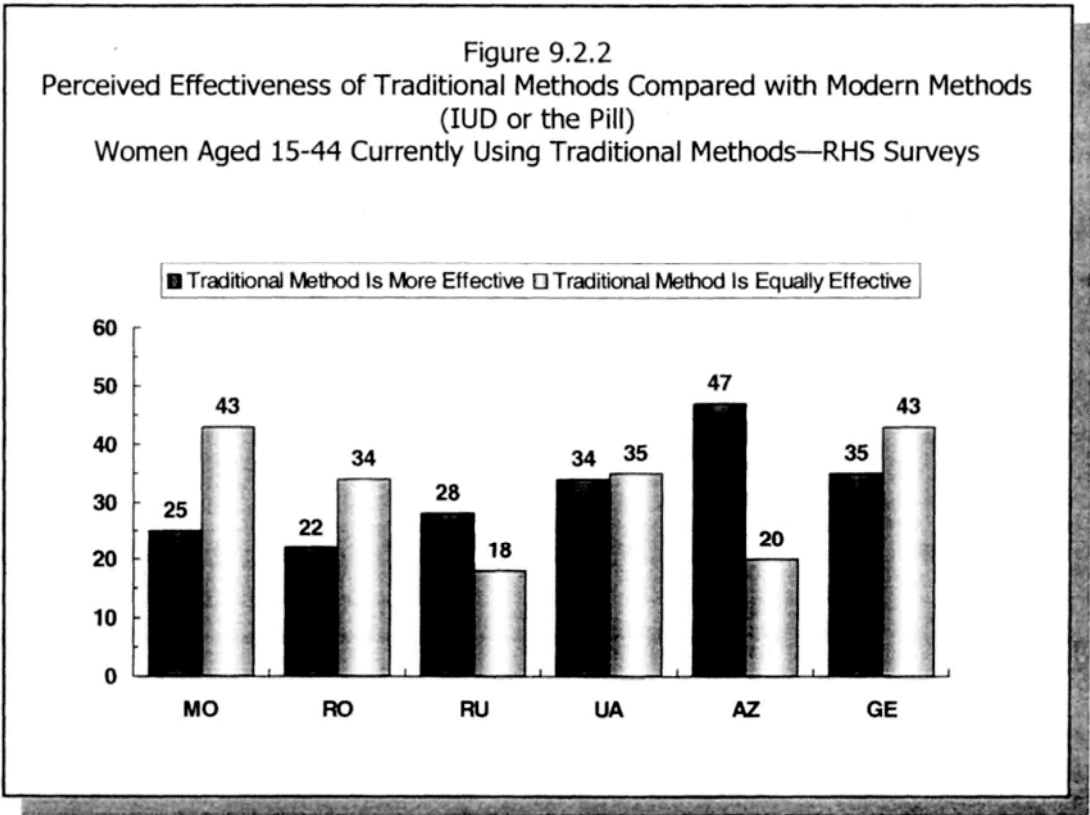
TABLE 9.4.2
Perceived Effectiveness of Traditional Methods Compared to Modern Methods
by Selected Characteristics
Women Aged 15–44 Currently Using a Traditional Method
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Perceived Effectiveness of Traditional Methods Compared to Modern Methods				Total	No. of Cases
	Current Method More Effective	Current Method Equally Effective	Current Method Less Effective	Do Not Know		
Total	46.6	19.9	25.3	8.3	100.0	2,352
Residence						
Urban	45.7	18.5	27.0	8.8	100.0	1,048
Rural	47.4	21.2	23.6	7.8	100.0	1,304
Age Group						
15–24	38.7	22.1	27.3	11.8	100.0	259
25–34	42.8	21.0	27.9	8.3	100.0	1,079
35–44	52.2	18.3	22.2	7.4	100.0	1,014
Education Level						
Secondary Incomplete or Less	42.1	23.8	23.1	11.1	100.0	425
Secondary Complete	48.6	18.8	24.3	8.4	100.0	1,248
Technicum	44.4	19.2	29.4	6.9	100.0	444
University	48.8	19.4	26.3	5.5	100.0	235
Socio-economic Status						
Low	46.6	20.7	23.4	9.3	100.0	1,380
Middle	45.2	20.6	27.5	6.6	100.0	791
High	51.5	11.7	28.0	8.8	100.0	181
IDP/R Status						
IDP/R	45.2	17.5	29.2	8.1	100.0	404
Non-IDP/CA	50.4	21.7	21.3	6.6	100.0	979
Non-IDP/NCA	45.7	19.8	25.7	8.8	100.0	969
Preference for Other Method[†]						
IUD	18.5	23.6	51.3	6.6	100.0	601
Pill	19.8	31.4	39.0	9.8	100.0	169
Other Modern Method	25.1	12.8	55.1	7.1	100.0	89
Undecided	26.4	29.0	29.3	15.3	100.0	97
Does Not Want To Change	62.8	17.1	11.7	8.5	100.0	1,390

† Excludes six women who want to switch to another traditional method.

methods was inversely associated with the desire to use a modern method in the future. Women who did not want to change their current traditional method were more likely to think highly of its effectiveness (63%). Those who said that their preference for a future method would be the IUD or the pill were the least likely to believe that their current method was relatively effective (19%-20%).

9.5 Reasons for Not Using Contraception

Currently married women mentioned a broad variety of reasons for not using contraception. The most common reasons given were related to pregnancy (40%), lack of current sexual activity (19%), and female fecundity impairment, including infecundity (10%) or the presence of pelvic inflammatory disease (5%) ([Table 9.5](#)). Pregnancy-related reasons included a current pregnancy,

TABLE 9.5
Most Commonly Cited Reasons for Not Currently Using Contraception by IDP/R Status and by Age Group
Among Women in Union Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001
(Percent Distribution)

| Reason | Total | IDP/R Status | | | Age Group | | |
		IDP/R	Non-IDP/CA	Non-IDP/NCA	15–24	25–34	35–44
No sexual intercourse within the last month	19.4	10.5	18.5	20.8	7.7	21.8	23.9
Currently pregnant	15.9	17.0	18.8	15.1	35.1	18.9	2.6
Wants to get pregnant soon	14.3	12.0	12.7	15.0	24.4	15.2	7.9
Postpartum/Breastfeeding	10.1	10.2	11.4	9.8	17.3	12.9	3.6
Female infecundity/Subfecundity	9.8	10.3	10.7	9.5	4.2	7.5	14.9
Douching	5.5	9.1	4.0	5.3	1.5	5.7	7.5
Pelvic inflammatory disease (PID)	4.7	4.8	6.7	4.2	1.4	3.1	7.9
Respondent doubts that she can get pregnant	4.3	8.5	4.9	3.6	0.5	2.6	7.9
Approaching menopause	4.1	2.9	3.5	4.4	0.0	0.0	10.0
Dislike	2.4	3.2	1.3	2.6	1.4	1.9	3.5
Fear of side effects	1.8	1.6	0.6	2.1	0.9	1.9	2.3
Neglected to use	1.7	2.5	2.6	1.4	1.2	2.6	1.3
Male infertility	0.4	0.1	0.7	0.4	0.2	0.3	0.6
Lack of access /Cost	0.4	0.4	0.1	0.5	0.8	0.3	0.3
Lack of knowledge of family planning services	0.4	1.0	0.0	0.3	0.4	0.2	0.4
Other reasons	3.5	4.5	2.9	3.6	2.8	3.8	3.8
Does not know	1.2	1.5	0.5	1.3	0.2	1.2	1.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	2,209	374	854	981	475	854	880

breast-feeding, or the respondent's desire for pregnancy. Female fecundity impairment includes surgical and medical causes that prevent pregnancy and failure to conceive after at least 2 years of effort (without using contraception). Few women reported reasons related to family planning as contributing to their decision not to use a method; more common were reasons such as fear of side

effects (2%), personal or partner opposition to contraceptive methods (2%), and lack of access to family planning services or lack of knowledge about contraception (1%). Reasons for not using a method did not vary much between IDP/R and non-IDP/R women, but they differed sharply by age group. Younger women in union were more likely to be pregnant or in the postpartum period (52%) or to be attempting to become pregnant (24%), whereas women aged 35-44 years were more likely to be unable to get pregnant.

9.6 Intention to Use Contraception Among Nonusers

An important use of survey data is estimating the intention to use contraception in the future among nonusers. Most currently married women have an unmet need for modern contraception, but about 1 in 10 women have an unmet need of any contraception (see Chapter 10). In forecasting potential need for family planning services, program managers should take into account not only current users but also prospective users of supplied methods. Some women may be current users of traditional methods, whereas others may be nonusers who desire to start using family planning. Thus, the success of the national family planning program in Azerbaijan would depend equally on its ability both to satisfy current clients of supplied methods (e.g., to make a variety of contraceptive supplies available, accessible, and affordable) and to enroll new clients (e.g., by increasing their awareness of modern contraception and knowledge of a source for supply).

Almost two-thirds of fecund, currently married nonusers of contraception (64%) plan to use a contraceptive method in the future, including 44% who would like to start using contraception within the next 12 months (Table 9.6.1). About 1 in 9 women (11%) were unsure whether they wanted to use contraception in the future. Only 1 in 4 women were opposed to contraceptive use in the future. Intention to use contraception is influenced by the number of living children: nonusers who intend to begin contraceptive use tend to have one or more children and want to start using contraception within the next year. Almost half of childless nonusers (49%), however, plan to use contraception in the future, but few of them would like to start within the next 12 months (8%).

Surprisingly, the survey found that future fertility preferences influence the intention to use contraception in the future among fecund nonusers (Table 9.6.2). The proportion of potential future users did not differ significantly among those who desire more children (i.e., *potential spacers)* compared with those who want to limit fertility (i.e., *limiters)* (69% vs. 60%). Moreover, twice as many limiters as spacers said that they would not use any method of contraception in the future. This finding is probably related to the fact that more than half of limiters are age 35 or older and generally do not believe they can still get pregnant (data not shown).

TABLE 9.6.1
Desire to Use Contraception in the Future by Number of Living Children
Fecund Currently Married Women Aged 15–44 Years Who Are Not Using Contraception
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Desire to Use Contraception	Total	Number of Living Children*				
		None	One	Two	Three	Four or More
Want to Use a Method Within 12 Months	**44.3**	7.7	41.9	52.8	48.9	47.9
Want to Use a Method Later	**19.4**	49.2	33.3	12.9	10.4	3.5
Undecided	**11.0**	25.5	13.3	9.8	6.2	6.0
Do not Want to Use Contraception	**25.4**	17.6	11.6	24.5	34.5	42.7
Total	**100.0**	100.0	100.0	100.0	100.0	100.0
Unweighted No. of Cases	**1,899**	185	390	661	478	185

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

TABLE 9.6.2
Desire to Use Contraception in the Future by Fertility Preferences
Fecund Currently Married Women Aged 15–44 Years Who are Not Using Any Contraception
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Desire to Use Contraception	Total	Desire for (Additional) Children		
		Want More Children	No More Children	Undecided
Want to Use a Method Within 12 Months	**44.3**	31.3	51.4	57.8
Want to Use a Method Later	**19.4**	38.0	8.4	21.3
Undecided	**11.0**	15.6	8.2	13.9
Do not Want to Use Contraception	**25.4**	15.0	32.0	7.0
Total	**100.0**	100.0	100.0	100.0
Unweighted No. of Cases	**1,899**	676	1,184	39

152

Figure 9.6
Percentage of Fecund Currently Married Women Aged 15–44 Who are Not
Using Contraception and Plan to Use Contraception in the Future
by Specific Methods Intended
Reproductive Health Survey—Azerbaijan, 2001
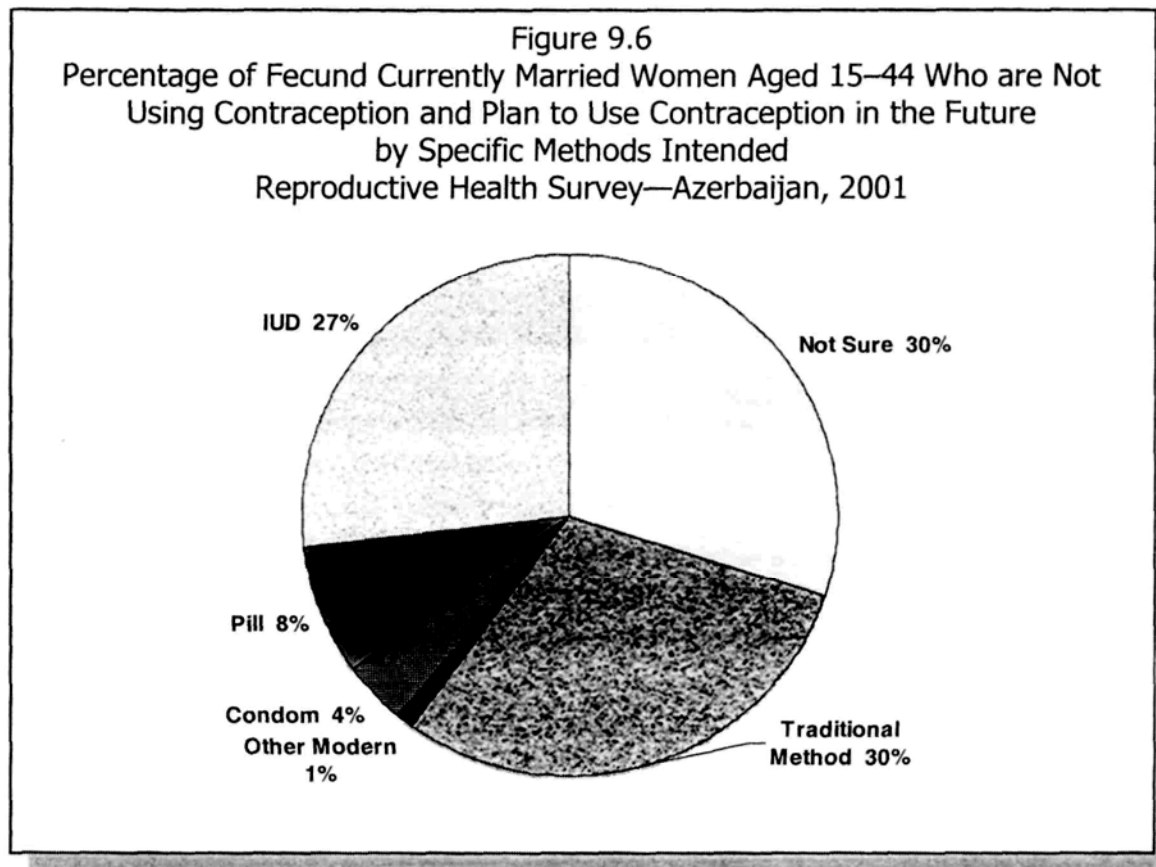
Less than half of the women who plan to use contraception in the future would like to start using a modern method; those who do plan to use a modern method express preference for the IUD (Figure 9.6); 1 in 3 plan to use a traditional method, usually withdrawal. A substantial proportion (30%) do not know what method they will use. Preference for a particular method was not influenced by their fertility preferences.

9.7 Recent Trends in Contraceptive Use

The AZRHS01 questionnaire included a detailed contraceptive "calendar" on which the contraceptive use, pregnancy events, and marital status were recorded monthly, starting with January 1996, up to the date of the interview. As shown in Table 9.7 and Figure 9.7.1, these data were used to compute midyear contraceptive prevalence rates for 1996-2000 using the reported prevalence in the month of July in each year. During this time frame, a steady but relatively moderate increase occurred in contraceptive prevalence among currently married women. Between July 1996 and July 2000, contraceptive prevalence rose from 52% to 56%, a 8% increase. The increase in use was more rapid for modern (from 10% to 12%) than for traditional (from 42% to 44%) methods. As a result,

153

Figure 9.7.1
Mid-Year Prevalence of Traditional and Modern Methods
(July,1996–July, 2000)
Women in Formal or Consensual Union—AZRHS01, Azerbaijan 2001
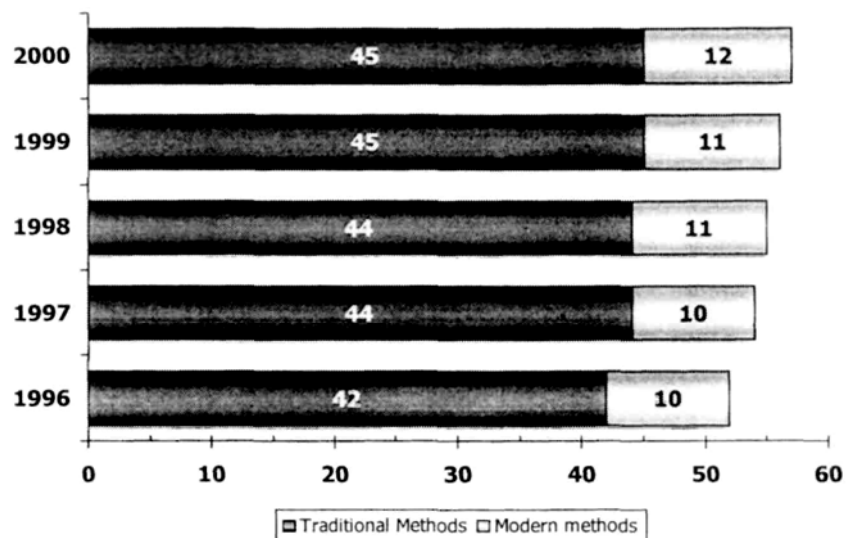
TABLE 9.7
Mid-Year Contraceptive Prevalence At One-Year Interval 1996–2000
Among Currently Married Women Aged 15–44 Years (Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

	1996	1997	1998	1999	2000
Any Method	52.0	53.7	54.8	56.2	57.0
Modern Methods	9.8	10.1	10.5	11.3	12.1
IUD	5.6	5.6	5.5	5.9	6.3
Condom	2.1	2.2	2.5	2.8	3.2
Pill	0.9	1.0	1.2	1.2	1.2
Female Sterilization	1.1	1.1	1.1	1.1	1.1
Other	0.1	0.2	0.2	0.3	0.3
Traditional Methods	42.2	43.6	44.3	44.9	44.9
Withdrawal	39.6	40.8	41.6	42.0	41.8
Periodic Abstinence	2.6	2.8	2.7	2.9	3.1
No Method	48.0	46.3	45.2	43.8	43.0

154

the contribution of modern methods to the mixture of contraceptive methods rose from 19% to 21%. Nearly half of the increase in modern use was due to a net growth in condom use, whose prevalence increased by about 50% (from 2.1% to 3.2%).

These findings are consistent with other reproductive health surveys in the region. Survey results indicate that contraceptive prevalence among either all women or married women (because the contraceptive histories did not always include month-by-month marriage histories, in some counties it was necessary to examine trends for all women, not just those currently married) increased steadily in the years leading up to the survey in several populations for which data were available. Use grew by an average of about 1 to 2 percentage points per year for 5 years in several countries and about twice as fast in Moldova (data not shown). Generally, the increase in use of modern methods was much steeper—ranging from 11% in Russia to 42% in Moldova to 54% in Romania—than the increase in traditional methods (Figure 9.7.2). Thus, most of the growth in contraceptive prevalence resulted from growth in the use of modern methods. In Azerbaijan, the prevalence of modern use among all women increased from 5% to 7%, a 40% increase.

To increase the use of more effective methods, Azerbaijan's national family planning program should concentrate on heightening public awareness of the relative effectiveness of various types of

Figure 9.7.2
Mid-Year Prevalence of Modern Methods for the Last Five Years
Among All Women Aged 15–44 — RHS Surveys in EE and NIS
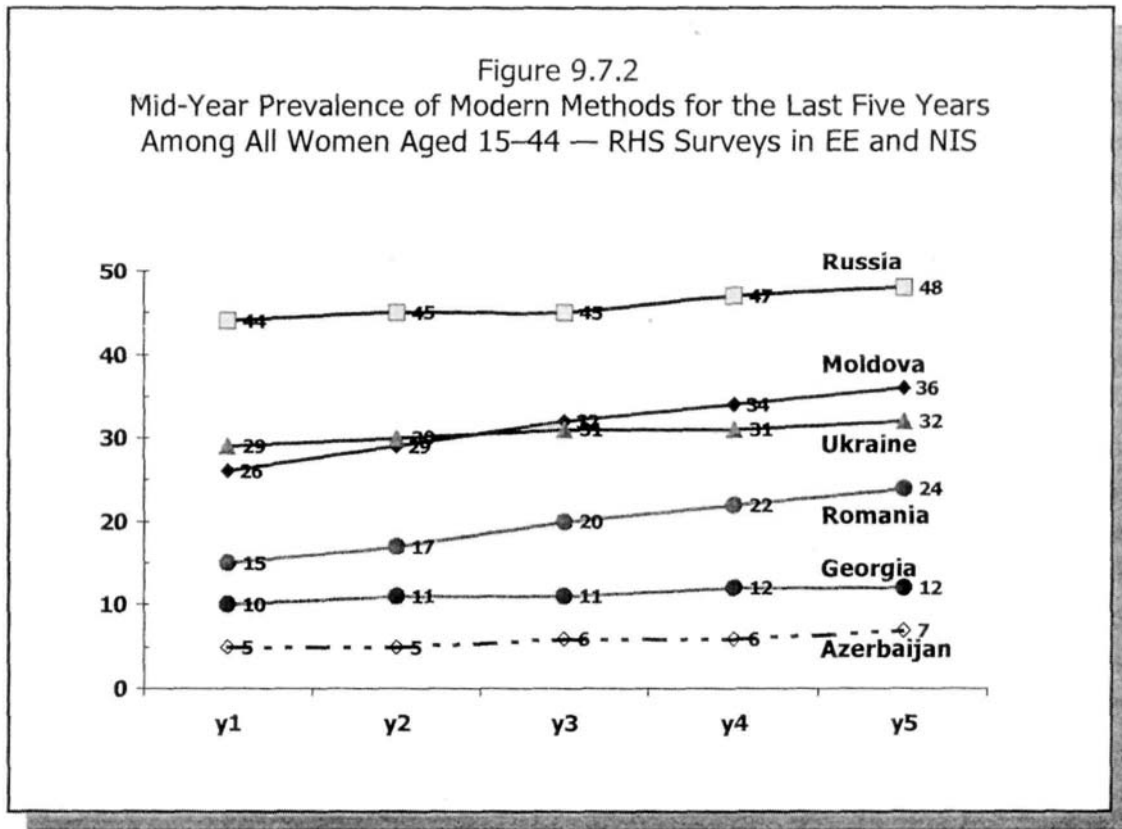
contraception, including contraceptive sterilization; disseminating information about the health effects of various methods, including their health benefits; and improving access to modern methods. Renewed international donors' support is needed to increase information, education and communication (IEC) efforts and train family planning and health care providers.

9.8 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. If, as is usually the case, some women did not report pregnancies ending in abortions and they had been using contraception at the time of conception, failure rates may be underestimated; thus, the true rates are probably somewhat higher than those shown in Table 9.8.1.

Life table analysis of segments of contraceptive use was employed to estimate the monthly probabilities of failure and of discontinuing contraceptive use for all women using a contraceptive method during the observed period (January 1996-March 2001). Linking these probabilities, 12-, 24-, and 36-month contraceptive failure and discontinuation rates can be calculated. These rates represent the proportion of users who stop using their method within the first year, second year, or third year of use for any reason (i.e., the discontinuation rate) or because they become pregnant while using the method (i.e., the failure rate). The 1-, 2-, and 3-year intervals of use refer to uninterrupted use; a new interval starts when a woman begins to use a method for the first time or when she resumes its use after a period in which she had used another or no method. When more than one method had been used during any month, that month's contraceptive experience was assigned only to the more effective of the two methods (e.g., many periodic abstinence users reported use of condoms during the period of maximum fertility and were classified as condom users).

Twenty-three percent of women became pregnant during the first year of using a method, 40% became pregnant after 2 years, and 49% became pregnant after 3 years. Failure rates varied considerably by the contraceptive method used. The IUD had the lowest failure rate at 1, 2, and 3 years: between 0.5% and 2.3% of IUD users became pregnant. The 1-year IUD failure rate was very low, comparable with most recent data published in the literature—0.8 failures per 100 women using the method during the first year of use (Hatcher et al., 1997). Condom users reported failure rates of 21% during the first year and 32% and 38% after 2 and 3 years, respectively. The high failure

TABLE 9.8.1
Contraceptive Failure and Discontinuation Rates after One, Two, and Three Years
For Selected Methods of Contraception
All Segments of Contraceptive Use Initiated since January 1996
Reproductive Health Survey: Azerbaijan, 2001

	Failure Rates					
	All Methods	**Contraceptive Method**				
Duration		**IUD**	**Condom**	**Pill**	**Withdrawal**	**Periodic Abstinence**
One Year	23.2	0.5	20.6	15.2	25.8	30.1
Two Years	40.3	1.1	32.1	24.3	45.7	43.0
Three Years	49.1	2.3	38.4	31.0	55.0	60.8
No. of Segments*	6,865	412	670	332	4,976	357

	Discontinuation Rates					
	All Methods	**Contraceptive Method**				
Duration		**IUD**	**Condom**	**Pill**	**Withdrawal**	**Periodic Abstinence**
One Year	47.6	13.6	67.4	81.6	44.3	57.7
Two Years	68.7	30.5	83.0	93.6	67.8	74.0
Three Years	78.2	43.8	90.1	95.3	78.0	85.6
No. of Segments*	6,865	412	670	332	4,976	357
%Discontinuation due to Method Failure (12 months)	48.7	3.6	30.6	18.6	58.2	52.2

* Includes 118 segments of use of other modern methods.

rate reported for the condom exceeds its reported contraceptive efficacy—14%, according to the same reference—by almost one-third. Similarly, the failure rate for oral contraceptives (15%) was twice as high as the published 1-year failure rates for common use (6%-8%). The highest failure rates at 12, 24, and 36 months of use were reported by users of periodic abstinence (30%, 43%, and 61%, respectively) and withdrawal (26%, 46%, and 55%, respectively), underlining the need for

increased IEC efforts to promote correct use of more effective contraceptive methods.

In addition to higher than average total and method-specific failure rates (excluding users of IUD), the survey data showed considerably high discontinuation rates: 48% of women discontinued their method within 1 year, 69% within 2 years, and 78% within 3 years of use. Almost half of discontinuations after 12 months of use were caused by the method failure (method failures accounted for 23/48 x 100=49% of discontinuations after 1 year). Of the five methods shown in Table 9.8.1, the IUD was the only one with a low discontinuation rate at 1 year (14%), but three times as many IUD users stopped using the method within 3 years (44%). Only 4% of IUD users discontinued the method because of method failure. By contrast, about 4 in 5 (82%) pill users discontinued their method during the first year and only 5% of women continued to use the pill after 3 years, despite its low failure rate. Most often, pill use was discontinued for reasons other than method failure. Condom discontinuation shows a similar pattern: only 1 in 3 women (33%) used the condom for more than 1 year, and fewer than 1 in 5 (18%) used it for more than 3 years. Method failure, however, played a substantial role in the women's decisions to stop using condoms after 1 year, accounting for 31% of the reasons cited for discontinuation. Periodic abstinence and withdrawal were associated with very high discontinuation rates at 1 (37%-40%), 2 (59%-62%), and 3 years (72%-73%); method failure was cited as the reason for almost one-half of discontinuations (52%-58%).

In addition to method failure, women using contraception discontinue their method for many method-specific reasons (Table 9.8.2). After method failure, the most cited reasons for discontinuation, accounting for 9% of discontinuations, were partner related (i.e., partner's objections and partner's temporary or permanent absence). Intention to become pregnant accounted for only 6% of discontinuations.

The main reason for discontinuation varies greatly with the contraceptive method used at that time. IUD discontinuation rate in the first year of use, the lowest among all contraceptive methods, is heavily influenced by side effects or health concerns associated with method use. More than half of IUD users discontinued for this reason; in contrast only 4% discontinued because they got pregnant using the method and 20% because a doctor recommended IUD removal. The experience or fear of side effects was also a principal reason for discontinuing pill use: 54% of women who stopped using the pill (44% of 82%=54%) did so because of side effects. Medical advice against using the pill (23% of 82%=28%) and the high cost or lack of availability of pills (13% of 82%=16%) accounted for most of the other discontinuation reasons for this method. In addition to method failure, which accounted for 31% of condom discontinuations, about 1 in 3 women whose partners were using condoms discontinued use because their partner objected to or stopped using the method. About one-fifth of condom users mentioned the high cost associated with the method or its lack of availability

as the main discontinuation reason. Method failure was by far the most important reason for discontinuation of withdrawal and periodic abstinence. The second most important reason for discontinuation of withdrawal was a partner-related reason, and for periodic abstinence it was the desire to start another method.

TABLE 9.8.2
Contraceptive Discontinuation Rates After 12 Months by Main Reason of Stopping Contraception
For Selected Methods of Contraception
All Segments of Contraceptive Use Initiated Since January 1996
Reproductive Health Survey: Azerbaijan, 2001

Reason For Discontinuing Contraception*	All Methods	Contraceptive Method				
		IUD	Condom	Pill	Withdrawal	Periodic Abstinence
Total†	47.6	13.6	67.4	81.6	44.3	57.7
Method Failure (Became Pregnant Using)	23.2	0.5	20.6	15.2	25.8	30.1
Partner Related Reasons	9.0	0.9	23.0	6.3	8.5	7.9
Desire to Become Pregnant	5.5	0.8	10.5	4.0	5.4	10.0
Neglected to Use (Respondent or her Partner)	3.5	0.0	8.3	13.0	3.1	2.4
Switch to Other Method	3.5	0.0	5.4	6.6	3.2	11.0
Side Effects or Health Concerns	3.1	8.2	0.9	43.9	0.2	0.4
Doctor's Advice	2.0	2.7	1.6	23.0	0.7	2.0
Cost/Availability	1.7	0.0	14.2	12.6	0.0	0.0
Difficult/Inconvenient to Use	1.6	0.0	9.8	1.8	3.7	1.6
Other Reasons	3.5	0.2	4.6	1.5	3.5	6.3
No. of Segments	6,865	412	670	332	4,976	357

* gross discontinuation rates
† net discontinuation rates

CHAPTER 10

NEED FOR CONTRACEPTIVE SERVICES

10.1 Potential Demand and Unmet Need for Contraception

A standard approach to assessing the potential demand for family planning services, other than analysis of contraceptive behaviors among women currently in formal or consensual unions, is to define the contraceptive needs of women in relation to their fecundity and stated reproductive preferences. The total potential demand for contraception .is generally defined as the sum of current contraceptive use (i.e., *met need)* and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births (i.e., *unmet need).* Thus, the unmet need for contraception is a specific estimate that measures the gap between desired fertility and the contraceptive practices adopted to ensure that fertility preferences are met in a population.

The conventional definition of unmet need focuses on married women who are sexually active (i.e., intercourse within the past month), exposed to the risk of pregnancy (i.e., women not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea are excluded), fecund (i.e., neither they nor their partners have any subfecundity conditions), who do not want to become pregnant (at the time of the interview), but are not using any form of pregnancy prevention (Bongaarts, 1991). In this report, the standard formulation of unmet need was extended to all women, not just those in union. Separate estimates for potential demand and unmet need were calculated separately for all women and married women.

The AZRHS01 asked all women questions about their sexual, contraceptive, and reproductive behaviors and about their fertility preferences, thus allowing for a broad examination of unmet need among unmarried respondents. This approach, however, is less useful in countries with strong traditions that emphasize premarital sexual abstinence, such as Azerbaijan. In all countries, the level of unmet need is likely to be much higher among married respondents because they are more likely to be currently sexually active and generally have a higher risk of unintended pregnancy and a higher potential demand for family planning methods.

In addition to the unmet need for any family planning methods, the AZRHS01 estimated the unmet need for modern methods—an indicator used in other Eastern European surveys that expanded the standard definition to include users of nonsupplied methods (i.e., withdrawal, periodic abstinence,

Table 10.1.1
Unmet Need of Contraception among All Women of Reproductive Age[*] and among Married Women Reproductive Health Surveys (RHS) and Demographic Health Surveys (DHS) in Selected Eastern European and Former Soviet Union Countries, 1993–2001

Country	Type of Survey	All Women		Currently Married Women	
		Any Method	Modern Method	Any Method	Modern Method
Eastern European Region					
Czech Republic, 1993	RHS	10	31	15	39
Romania, 1993	RHS	9	39	11	55
Romania, 1999	RHS	5	29	6	39
Russia (three oblasts[†]), 1996	RHS	14	26	NA	NA
Russia (three oblasts[†]), 1999	RHS	11	28	12	33
Moldova, 1997	RHS	7	23	6	29
Ukraine, 1999	RHS	15	37	18	47
Caucasus Region					
Georgia, 1999–2000	RHS	15	27	24	44
Armenia, 2000	DHS	10	34	15	52
Azerbaijan, 2001	RHS	7	31	12	53
Central Asian Region[‡]					
Kazakhstan, 1995	DHS	13	21	19	29
Kazakhstan, 1999	DHS	10	16	15	22
Uzbekistan, 1996	DHS	10	13	14	18
Kyrgyz Republic, 1997	DHS	9	15	13	22
Turkmenistan, 2000	DHS	12	17	19	27

[*] Women aged 15–44 years in RHS surveys and 15–49 years in DHS surveys.

[†] Yekaterinburg, Perm, and Ivanovo.

[‡] Women currently using douching, folk methods, or breast-feeding were classified as having an unmet need for contraception.

Source: Goldberg et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; ORC/MACRO 1996–2001; Serbanescu et al. 1995, 1998, 2001.

and traditional/folk methods) in the category of unmet need. In countries with high use of traditional methods, the standard definition of unmet need masks the real need for more effective contraception because these methods tend to have higher failure rates. For these countries it is more useful to estimate the unmet need for modern contraception, despite the small risk of overstating the unmet need in some cases in which traditional methods are used effectively. For international comparisons, however, both indicators are shown for all women and for women in union. Among all countries in Central and Eastern Europe and the former Soviet Union where population-based reproductive health or demographic health surveys have been recently conducted, Azerbaijan has a relatively low need

for any contraception (7% among all women and 12% among married women) but one of the highest unmet need for modern contraception (31% among all women and 53% among married women) (Table 10.1.1). Unmet meet for a modern method among all women, estimated in other Eastern European and former Soviet Union countries by the Fertility and Family Surveys project was 12% in Hungary, 17% in Latvia, 19% in Slovenia, 23% in Lithuania, and 36% in Bulgaria (Klijzing, 2000). Thus, among all women of reproductive age, the unmet need for modern methods in Azerbaijan ranks the third highest in the region (after 37% in Ukraine and 36% in Bulgaria).

Generally, the level of any unmet need in Eastern Europe and the former Soviet Union was higher among married respondents because they are more likely to be currently sexually active and have a higher risk of unintended pregnancy. Recent reproductive and demographic health surveys showed that levels of unmet need for any method were greatest among married women in Georgia (24%), Turkmenistan (19%), and Ukraine (18%), whereas the levels of unmet need for modern methods were highest among married women in Azerbaijan (53%), Armenia (52%), and Ukraine (47%) (Serbanescu et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000; ORC/MACRO 1996-2001). Unmet need for a modern method was slightly lower in the Central Asian republics, where modern contraceptive prevalence constitutes more than 80% of the total contraceptive prevalence, and the IUD is the most prevalent method.

The AZRHS01 found that about 1 in 3 women (38%) had a potential demand for contraception—defined as the sum of current contraceptive use (i.e., met need) and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed births (i.e., unmet need)—including 7% of current users of modern methods, 25% of current users of traditional methods, and 7% of nonusers at risk of unintended pregnancy (Table 10.1.2). According to the most recent census data, these figures translate into an estimate of 775,000 women aged 15-44 years with a potential demand for family planning services. Because fewer than one-fifth of these women are using a modern contraceptive method, about 630,000 remain at risk of an unintended pregnancy because they do not use any method or they use traditional methods (i.e., have an unmet need for modern contraception).

As might be expected, the potential demand for family planning methods was much higher among women who are currently married or in consensual unions (65%) than among those previously (4%) or never married (0.1%) because they are more likely to be currently sexually active (Table 10.1.2). Potential demand was directly correlated with age, ranging from 11% among young adults to 60% among women aged 35 or older: most young women (74%) were not sexually experienced, and those who were had no need for contraception because of pregnancy-related reasons (i.e., they were already pregnant or wanted to become pregnant). Potential demand was slightly higher among women who were internally displaced persons or refugees (IDP/Rs) (41%) than among non-IDP/R women (37%-38%).

TABLE 10.1.2
Potential Demand for Family Planning (FP) Services by Age Group, Marital Status, and IDP/R Status
Women Aged 15–44 Years
Reproductive Health Survey: Azerbaijan, 2001

Demand for Family Planning Services	Total	Age Group 15–24	Age Group 25–34	Age Group 35–44	Currently Married	Previously Married	Never Married	IDP/R	Non-IDP/CA	Non-IDP/NCA
No Demand (Women Not Currently in Need of FP Services)	61.7	89.5	48.1	40.1	35.2	95.6	99.9	58.8	63.3	62.0
Never had sexual intercourse	36.2	73.5	16.9	7.4	0.0	0.2	99.7	32.9	38.9	36.0
Not currently sexually active*	10.0	2.8	12.5	16.9	9.6	83.9	0.1	9.8	9.3	10.3
Currently pregnant or postpartum	7.7	9.1	11.0	2.8	12.7	5.5	0.0	8.2	8.1	7.6
Seeking to get pregnant†	3.8	3.4	5.2	3.1	6.4	1.5	0.0	3.8	3.3	4.0
Infecund/Subfecund‡	4.0	0.7	2.5	9.9	6.5	4.2	0.1	4.1	3.7	4.1
Potential Demand for FP Services	38.1	10.7	51.9	59.8	64.8	4.4	0.1	41.2	36.7	38.0
Met Need										
Current users of a modern method	6.8	1.5	9.9	10.4	11.4	1.4	0.0	4.7	5.7	7.3
Current users of a traditional method	24.5	7.2	34.6	36.9	41.9	0.7	0.0	26.2	25.6	24.0
Unmet Need of Any Contraception (Nonusers at risk of unintended pregnancy)	6.8	2.0	7.4	12.5	11.5	2.7	0.1	10.3	5.4	6.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Unmet Need for Modern Contraception§	31.3	9.2	42.0	49.4	53.3	3.4	0.1	36.5	31.0	30.7
Unweighted No. of Cases	7,668	2,414	2,689	2,565	5,146	387	2,135	1,272	3,047	3,349

* Within the past month.
† Want to get pregnant right away; includes 33 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.

Both definitions were used to define proportions of all women and married women in need of family planning services and to examine differentials by selected background characteristics (Table 10.1.3 and Figure 10.1). Although only 7% of all women had un unmet need for contraception, almost 5 times as many married women (31%) have such an unmet need. Similarly, more than half of all married women had an unmet for modern contraception compared with about 1 in 8 women in the total population.

TABLE 10.1.3

Women Aged 15–44 Years in Need of Any or More Effective Contraceptive Methods by Marital Status by Selected Characteristics

Reproductive Health Survey: Azerbaijan, 2001

Characteristic	All Women			Married Women		
	Any Method	Modern Method	No. of Cases	Any Method	Modern Method	No. of Cases
Total	6.8	31.4	7,668	11.5	53.3	5,146
Residence						
Urban	9.3	31.2	3,832	15.6	52.6	2,586
Rural	3.9	31.5	3,836	6.4	54.2	2,560
Region						
Baku	10.8	31.0	1,533	17.3	50.7	1,054
North & North-East	5.9	33.6	924	9.7	56.7	635
West	8.9	31.3	766	14.7	51.7	511
South-West	5.7	31.8	2,302	9.9	56.4	1,553
South	3.2	27.9	950	5.8	50.8	600
Central	5.1	31.7	1,193	8.7	54.1	793
Age Group						
15–19	0.6	1.7	1,207	5.2	17.1	157
20–24	3.8	18.7	1,207	8.7	41.7	638
25–29	5.6	35.3	1,156	7.7	48.7	910
30–34	8.9	47.4	1,533	10.9	58.3	1,301
35–39	11.5	50.8	1,531	13.2	59.8	1,270
40–44	13.8	47.7	1,034	16.3	57.9	870
No. of Living Children						
0	0.6	1.0	2,655	4.6	7.0	432
1	8.1	35.2	784	8.8	40.2	680
2	11.5	55.0	2,094	12.0	57.9	1,978
3	12.8	59.7	1,530	13.1	62.6	1,472
4+	13.5	65.4	605	14.1	68.6	584
Education Level						
Secondary incomplete or less	5.1	23.9	1,697	10.4	50.1	980
Secondary complete	7.2	33.5	3,868	11.7	55.0	2,643
Technicum	8.6	39.6	1,215	12.4	57.0	921
University/Postgraduate	6.7	27.4	888	10.9	46.0	602
Socioeconomic Status						
Low	5.2	32.8	4,068	8.8	56.3	2,739
Middle	8.9	31.6	2,770	14.7	53.3	1,852
High	7.0	24.7	830	11.7	41.7	555
IDP/Refugee Status						
IDP/R	10.3	36.5	1,272	16.9	59.8	858
Non-IDP/CA	5.4	31.0	3,047	9.4	55.0	2,013
Non-IDP/NCA	6.7	30.8	3,349	11.2	52.1	2,275

Figure 10.1
Unmet Need for Any Method and for a Modern Method
All Women and among Women in Union Aged 15-44
Reproductive Health Survey—Azerbaijan, 2001
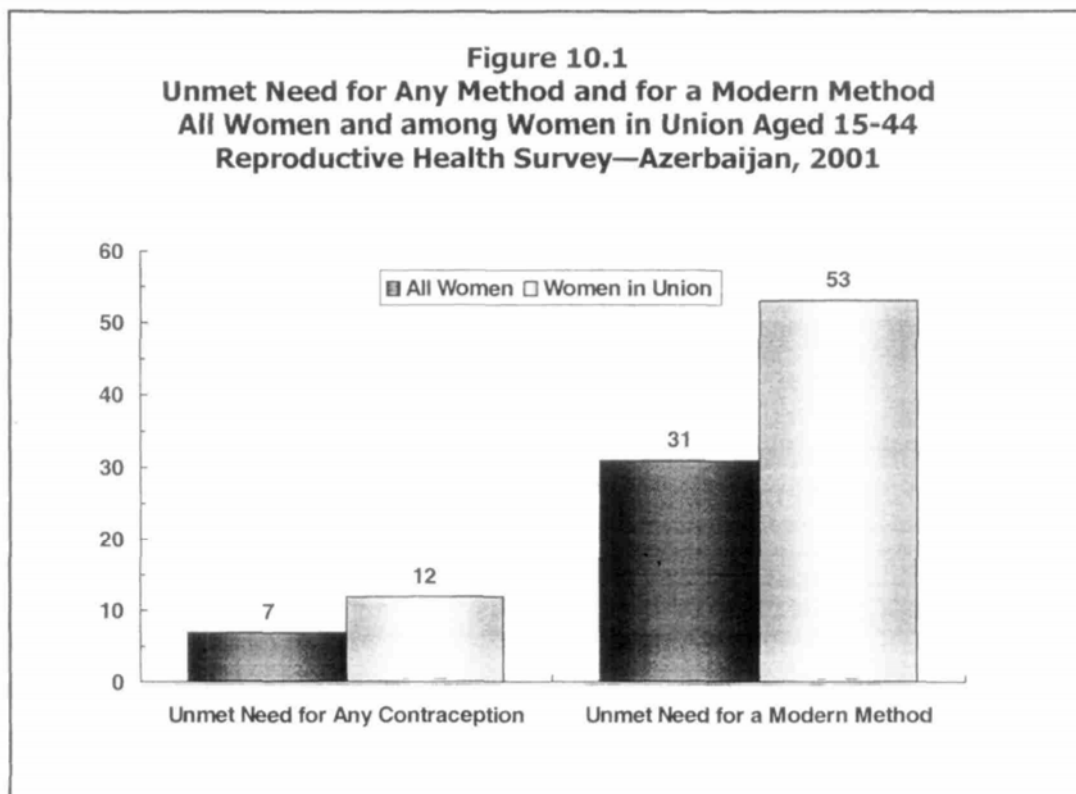
Among married, women, some subgroups of women exhibited much higher levels of unmet need for contraception than others: urban women (16%), including Baku residents (17%); women living in the South-West region (15%); women aged 30 or older (11%-16%); women with at least two children (12%-14%); and lDP/R women (17%). Except for young adult women and childless women (whose need for contraception is low because of pregnancy-related reasons), the unmet need for a modern method ranged from 42% among women living in households with high socioeconomic status to 69% among women with four or more children.

10.2 Potential Demand for Family Planning Services According to Fertility Preferences

In addition to measuring the potential demand for family planning services, the survey allows for estimates of met and unmet need according to respondents' fertility preferences. Among respondents with potential demand for any contraception (i.e., the standard definition) and for a modern method (i.e., the expanded definition), nonusers who did not want to get pregnant right away but wanted to have children at some point in the future (including those who were undecided as to whether to have children) were classified as having unmet need for *spacing* births. Respondents who did not want (any)more children but were not doing anything to prevent pregnancy (or were using less effective

methods) were considered to have an unmet need for *limiting* births. Similarly, respondents whose contraception needs were met (i.e., users of any method or of modern methods) were classified as having met need for spacing and met need for limiting births. Comparative data for several countries in which recent reproductive health surveys allowed an examination of unmet need according to future fertility intentions are shown in [Table 10.2.1](#). Generally, unmet need for limiting is higher than unmet need for spacing, regardless of the definition used and the region studied. Among women currently in union in this region, the unmet need for limiting is 2 to 3 times higher than the unmet need for spacing, concordant with a low ideal family size and a strong desire to terminate childbearing after achieving the ideal number of children. As a result, more than two-thirds of the total unmet need comes from unmet need for limiting births. By contrast, as a result of the low use of long-term and permanent contraceptive methods, the need for limiting is less likely to be satisfied than the need for spacing in most of these countries. The proportion of the total unmet need that

Table 10.2.1

Unmet Need of Contraception among Married Women of Reproductive Age[*] by Future Fertility Preferences
Reproductive Health Surveys (RHS) and Demographic Health Surveys (DHS)
in Selected Eastern European and Former Soviet Union Countries, 1993–2001

Country	Unmet Need for Any Contraception			Unmet Need for Modern Contraception			% Unmet Need for Limiting	
	Total	For Spacing	For Limiting	Total	For Spacing	For Limiting	Any Method	Modern Method
Eastern European Region								
Czech Republic, 1993	15	4	11	39	12	27	73	69
Moldova, 1997	6	3	3	29	9	20	58	68
Romania, 1999	6	2	4	39	9	30	70	76
Russia (three oblasts[†]), 1999	12	2	9	33	7	26	79	78
Ukraine, 1999	18	3	14	47	8	39	81	83
Caucasus Region								
Georgia, 1999–2000	24	6	18	44	10	34	76	78
Armenia, 2000	15	4	11	52	10	42	73	81
Azerbaijan, 2001	12	2	10	53	8	45	84	85
Central Asian Region‡								
Uzbekistan, 1996	19	7	7	18	8	10	50	56
Kyrgyz Republic, 1997	13	5	8	22	9	13	62	59
Kazakhstan, 1999	15	6	9	22	9	13	60	59
Turkmenistan, 2000	14	11	8	27	14	13	42	48

* Women aged 15–44 in RHS surveys and 15–49 in DHS surveys.

† Yekaterinburg, Perm, and Ivanovo.

Source: Goldberg H et al., 1993; KIIS and CDC, 2000; VCIOM and CDC, 1998, 2000; MACRO International 1996–2001; Serbanescu F et al. 1995, 1998, 2001.

Figure 10.2
Unmet Need for Limiting Childbearing as a Proportion of All Unmet Need
Among Women Aged 15-44 Who Have an
Unmet Need for Any Contraception—RHS Surveys in EE and NIS
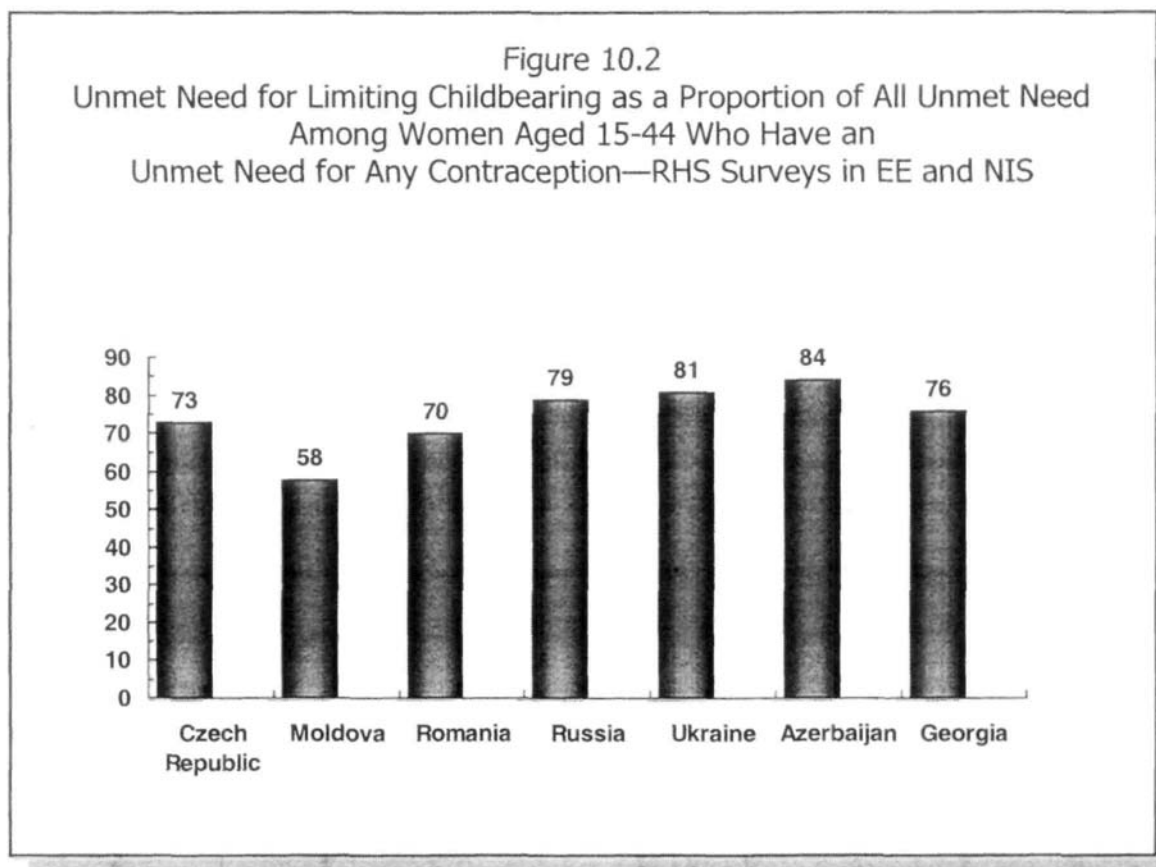
is unsatisfied due to women not using any contraception even though they do not want any more children ranged from 58% in Moldova to 84% in Azerbaijan (Figure 10.2).

In Azerbaijan, both met and unmet need for limiting were higher than met and unmet need for spacing (Table 10.2.2). Among women currently in union, contraceptive use for limiting (45%) was nearly 6 times more prevalent than use for spacing (8%), concordant with the low ideal family size and fertility patterns in Azerbaijan. Similarly, the unmet need for limiting (10%) was 5 times higher than the unmet need for spacing (2%). At first glance, most of the demand for contraception in Azerbaijan (82%)—either for spacing or for limiting—seems to be satisfied, largely as a result of the widespread use of traditional methods. As mentioned at the beginning of the chapter, if the use of nonsupplied methods (i.e., withdrawal and periodic abstinence) is high, the standard definition of unmet need masks the real need for more effective contraception because these methods tend to have much higher failure rates than modern methods. For example, the 12-month failure rate among withdrawal users was 23%; for users of periodic abstinence, it was 30% (see Chapter 9).

In fact, as a result of the low prevalence of long-term and permanent contraceptive methods in Azerbaijan, most of the demand for methods that would effectively help couples limit childbearing

168

is not met. Only 9.6% of married women reported that their need to end childbearing had been satisfied through use of modern methods whereas 45% still had unmet needs for effectively limiting childbearing. Thus, of the 55% of married women who wanted to limit fertility, only about one-sixth (18%) had their demand for modern contraceptives satisfied. Similarly, the unmet need of modern methods for spacing was 4 times as high as the met need (8% vs. 2%). Although the modern contraceptive demand for spacing among married couples was much lower than that for limiting (10% vs. 55%), it was equally likely to be satisfied (18%).

TABLE 10.2.2
Met and Unmet Need for Family Planning Services
Among All Women and Among Married Women Aged 15–44 Years
According to Their Future Fertility Preferences
Reproductive Health Survey: Azerbaijan, 2001

	All Women		Married Women	
	Any Method	**A Modern Method**	**Any Method**	**A Modern Method**
Total Demand for FP	38.2	38.2	64.8	64.8
Demand for Spacing	6.0	6.0	10.0	10.0
Demand for Limiting	32.2	32.2	54.8	54.8
Met Need For FP (Users)	31.3	6.8	53.3	11.4
For Spacing	4.9	1.1	8.2	1.8
For Limiting	26.4	5.7	45.1	9.6
Unmet Need For FP (Non-Users)	6.9	31.4	11.5	53.3
For Spacing	1.1	4.9	1.8	8.2
For Limiting	5.8	26.5	9.7	45.1
% Demand Satisfied	81.9	17.8	82.1	17.6
For Spacing	81.7	18.3	82.0	18.0
For Limiting	82.0	17.7	82.3	17.5
No. of Cases	**7,668**	**7,668**	**5,177**	**5,177**

The distinction between potential demand for spacing and limiting has important programmatic implications for family planning services and programs that aim to increase contraceptive use. Couples who need contraception for spacing (i.e., temporary methods) need a different array of methods from those who need contraception for limiting births (i.e., long-term or permanent

169

methods). In addition, spacers tended to be younger, childless or with one child, and better educated than limiters, who are typically age 30 and older and have two or more children (data not shown). Finally, the motivation for not using contraception is different among potential spacers and potential limiters. Women with unmet need for spacing were more likely to say that they did not use a method because they intended to get pregnant at some point in the future, whereas women with unmet need for limiting fertility believed that they were not at risk of getting pregnant (data not shown).

Thus, to ensure that the newly designed national family planning program can reach the contraceptive needs of couples in Azerbaijan, more effort should be made to expand the availability of a wide variety of effective, high-quality, affordable methods, including long-term and permanent methods, and to increase contraceptive awareness among both spacers and limiters. Because the largest share of unmet need is among women who live in rural areas, are less educated, are less affluent, or have two or more children, indicating that access to services is not equal, the family planning program needs to expand its reach. Satisfying the unmet need for modern contraception will require a substantial increase in programmatic and financial support over current levels of effort.

CHAPTER 11

CONTRACEPTIVE COUNSELING

In Eastern Europe and the former Soviet Union countries, most reproductive health services are provided by doctors who traditionally have received little training in providing client-oriented counseling. An important component of the recent reproductive health strategy—initiated by the United Nations Population Fund (UNFPA), in collaboration with the Ministry of Health—is to develop a comprehensive family planning program and train health professionals to provide a wide array of family planning services, including counseling (UNFPA, 1999a). Although recent training efforts under the UNFPA's initiative included providers' training in contraceptive counseling, an official recommendation for postabortion and postpartum counseling to be included in the standards of care for abortion and deliveries is still pending.

The AZRHS01 included a series of questions designed to capture the interactions between family planning providers and their clients. Specifically, the survey asked about the extent to which health professionals provided basic information and services to women who had used a modern contraceptive method or had an abortion or a birth during the 5 years prior to the interview.

11.1 Communication With Family Planning Providers

Women who had used at least one modern contraceptive method in the previous 5 years were asked who had advised them to use their most recent modem method. If the advice came from a health care provider (i.e., physician, nurse, or midwife), they were asked whether they received any information about other methods, including their effectiveness and the side effects associated with their use. As shown in Table 11.1, 2 of 3 women were advised by a heath care provider to use their current or most recent modern method (65% by an ob/gyn and 2% by a nurse or midwife), and 1 in 4 women started using their last method at the partner's suggestion (22%) or at her own counsel (4%), bypassing any potential medical advice. In 4% of cases, the choice of the method was made at the suggestion of a pharmacist. In the remaining cases, the choice was suggested by a friend (3%) or relative (1%). These data are consistent with results from other reproductive health surveys conducted with the assistance of the U.S. Centers for Disease Control and Prevention in Eastern Europe and the former Soviet Union (Serbanescu et al., 1995, 1998, 2001). The surveys found that the most important source of contraceptive advice was an ob/gyn (Figure 11.1).

The source of advice varied widely by last method used. Almost all IUD users and women with tubal ligation had chosen their method at the advice of a heath care provider (96% and 89%), but only 8% of condom users were advised by a physician or a nurse or a midwife. Most women who had used condoms did so because their partners suggested it (39%) or because they decided to do so themselves. Almost three of four women (70%) were advised by a health care provider to use the pill; the second most important source of advice was a friend (12%). Most spermicide users initiated use at the recommendation of a pharmacist (29%) or a friend (29%).

Health providers' interactions with their family planning clients and the messages conveyed during these interactions can affect client satisfaction with services, continued use of services in the future, and correct use of the method. As shown in the bottom panel of Table 11.1, during provider-client interaction only 40% of women received general information about other contraceptive methods, one in three was counseled about the effectiveness of the method she was using compared with other methods, and 59% reported that the provider had explained possible side effects of the method chosen. Condom users were more likely to be counseled about other contraceptive methods and their effectiveness, although the proportion who received medical advice was rather small (14%). IUD and tubal ligation users were the least likely to receive information about other methods (35% and 33%) and about contraceptive effectiveness (30% and 29%). Women who used lUDs and hormonal contraception were the most likely to have received medical advice on possible side effects (64% and 56%).

Figure 11.1
Percentage of Women Aged 15-44 Who Received Contraceptive Counseling from an OB/GYN at the Time of Starting to Use a Modern Method During the Last 5 Years— RHS Surveys in EE and NIS
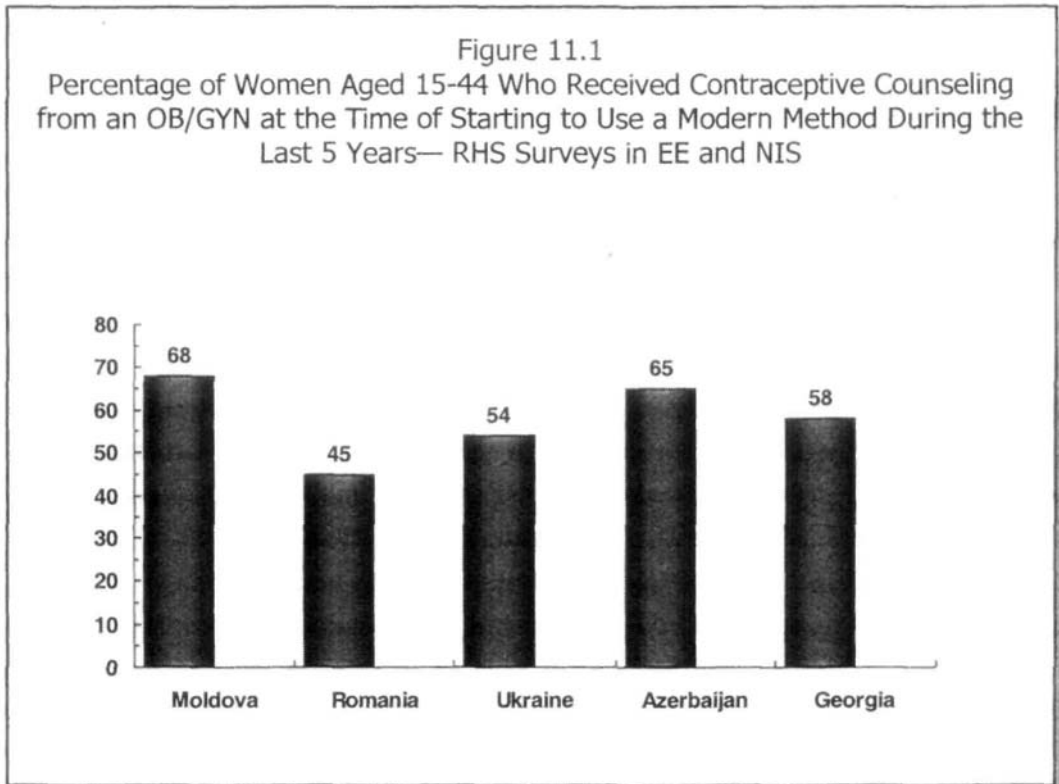
TABLE 11.1
Percentage of Women Who Have Used a Modern Contraceptive Method Within the Past 5 Years
by Who Advised Them to Use the Specific Method and
Type of Counseling Received from a Heath Care Provider
Reproductive Health Survey: Azerbaijan, 2001

| | | IDP/R Status | | | Last Used Contraceptive Method | | | |
| | | | Non- | Non- | | | Hormonal | Tubal |
Who Advised User	**Total**	**IDP/R**	**IDP/CA**	**IDP/NCA**	**IUD**	**Condom**	**Contraception**	**Ligation**
Ob/Gyn[‡]	**64.7**	65.1	69.0	63.9	97.1	13.3	49.5	96.9
Partner	**21.8**	18.2	12.7	23.6	0.0	70.5	1.3	0.0
Nobody	**3.5**	7.7	3.9	3.0	0.1	7.9	5.7	2.8
Friend	**2.9**	0.0	3.3	3.1	0.5	3.0	9.1	0.0
Mother or Other Relative	**1.4**	3.7	1.0	1.3	0.6	1.6	4.4	0.0
Pharmacist	**3.5**	0.6	7.3	3.2	0.0	3.0	21.0	0.0
Nurse/Midwife	**2.2**	4.4	2.7	1.9	1.8	0.7	9.0	0.0
Other	**0.0**	0.3	0.2	0.0	0.0	0.1	0.0	0.3
Total	**100.0**	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	807	118	235	454	370	266	102	52

| | | | Non- | Non- | | | Hormonal | Tubal |
Type of Counseling	**Total[§]**	**IDP/R**	**IDP/CA**	**IDP/NCA**	**IUD**	**Condom**	**Contraception**	**Ligation**
General information about other methods	**40.4**	47.7	42.8	39.2	34.8	76.3	55.5	33.4
Information about method's effectiveness	**33.4**	29.8	37.9	33.0	30.2	54.2	38.8	29.3
Information about possible side effects	**59.3**	51.1	66.9	58.7	64.3	48.0	56.2	38.0
No. of Cases	542	90	170	282	363	56	63	50

* Includes 17 women who said they had used spermicides at the last intercourse.
† Includes women whose last method was either the pill or injectables.
‡ Includes also 5 women advised by general practitioners.
§ Includes only women who were advised by a health professional (an Ob/Gyn, general practitioner, nurse, or midwife).

11.2 Postabortion Counseling

As shown in Chapters 4 and 5, almost three-fourths of fecund women in union do not want an(more) children and a high number of Azeri women resort to legal abortion to delay or avoid having children. Women terminate their pregnancies in abortion and do not adopt an effective contraceptive method afterwards are probably at high risk for another unintended pregnancy and represent an

Figure 11.2
Contraceptive Counseling at the Time of Having an Induced Abortion Women
Aged 15-44 With at Least one Abortion in the Last 5 Years
RHS Surveys in EE and NIS
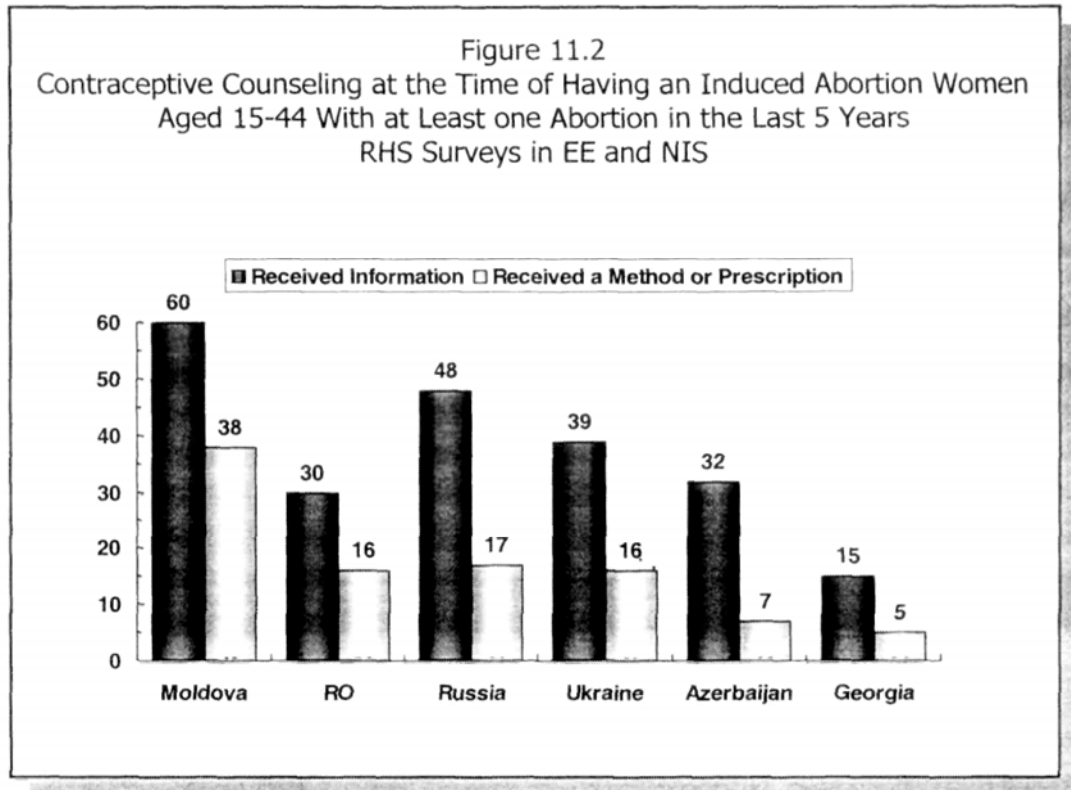
important group whose family planning needs are unsatisfied. A wide range of contraceptive methods, together with accurate information, and/or referral for ongoing family planning care should be made available and accessible to all women who have undergone abortions; both abortion providers and family planning health professionals should be able to offer contraceptive counseling and services. Unfortunately, most abortion providers in Azerbaijan either fail to understand the value of postabortion counseling or lack the time and resources to provide it.

In AZRHS01, all women who have had an abortion in the past 5 years were asked if they received any family planning advice either before or after the abortion procedure, whether they received any contraceptive method or prescription for a method, and whether they were referred to a family planning facility following the procedure. This questions were similar to those asked in other CDC-assisted RHS in the region (Figure 11.2). Similar to other countries of the region, only a minority of Azeri women received family planning counseling (32%) or were offered services before or after abortion (7%). Moldova and Russia were the only countries where half of women with at least one induced abortion in the past 5 years reported contraceptive counseling at the time of abortion.

174

TABLE 11.2
Various Family Planning Services Offered at the Time of Legally Performed Abortions
by Selected Characteristics
Legal Abortions Between January 1996–March 2001
Reproductive Health Survey: Azerbaijan, 2001

Characteristic		Contraception Counseling			Distribution of Contraceptive Methods, Prescriptions for Methods or Referrals			
	Total	Before Abortion	After Abortion	Before and After Abortion	Received a Method	Received Prescription	Offered Referral	No. of Cases
Total	32.3	2.6	24.8	4.9	2.2	4.4	1.7	4,083
Residence								
Urban	33.9	2.8	26.1	5.0	2.5	5.7	2.0	2,064
Rural	30.1	2.2	23.0	4.9	1.7	2.5	1.2	2,019
Region								
Baku	30.7	4.3	21.0	5.4	1.7	5.8	2.8	834
North & North-East	34.4	1.3	27.8	5.3	1.3	6.3	1.5	465
West	32.3	1.8	26.2	4.3	2.1	2.8	0.0	427
South-West	26.2	0.9	21.0	4.3	1.3	0.8	0.8	1,477
South	33.5	3.3	26.4	3.8	2.7	2.9	2.3	320
Central	36.1	3.4	27.2	5.5	4.7	4.1	2.1	560
Age Group								
15–24	33.5	2.7	26.3	4.5	3.1	4.2	2.8	1,161
25–34	31.8	2.0	24.7	5.1	1.7	4.1	0.9	1,906
35–44	32.2	3.4	23.7	5.1	2.0	5.0	1.9	1,016
Education Level								
Secondary Incomplete	30.7	1.9	22.6	6.2	2.2	2.8	1.6	746
Secondary Complete	30.3	2.5	23.6	4.2	1.9	4.4	1.4	2,122
Technicum	37.9	2.7	30.7	4.5	1.7	4.4	2.7	808
University	34.7	4.1	23.4	7.2	4.3	6.6	1.1	407
Socioeconomic Status								
Low	28.8	2.7	21.8	4.3	1.3	3.1	0.9	2,196
Middle	35.8	2.3	27.4	6.1	2.5	5.2	2.3	1,450
High	34.7	3.1	27.9	3.7	4.0	6.6	2.4	437
IDP/Refugee Status								
IDP/R	32.9	3.5	24.8	4.6	3.4	4.0	1.1	828
Non-IDP/CAA	30.7	1.9	22.8	6.0	3.5	2.4	2.2	1,637
Non-IDP/NCAA	32.7	2.6	25.4	4.7	1.6	5.0	1.6	1,618
Place of Abortion*								
Hospital	32.1	2.4	25.3	4.4	2.1	4.3	1.6	2,979
Governmental Clinic	34.1	3.0	24.2	6.9	2.3	4.5	2.1	944
Private Clinic	35.3	10.3	24.4	0.6	10.1	8.3	0.0	44
Year of Abortion								
1996–1997	28.3	0.2	23.9	4.2	1.9	1.9	0.9	604
1998–1999	29.4	2.5	22.3	4.6	1.4	4.5	1.2	1,556
2000–2001	36.3	3.5	27.3	5.5	2.9	5.1	2.4	1,923

* Excludes 116 abortions performed or initiated at respondent's home.

CHAPTER 12

OPINIONS ABOUT CONTRACEPTION AND ABORTION

After becoming an independent nation in 1991, Azerbaijan reported declines in a number of health indicators, including those associated with reproductive health. As the political structure began to stabilize after independence, a number of nongovernmental agencies (NGOs) began operating in Azerbaijan, working in reproductive health and family planning. A number of these activities, which target internally displaced persons and refugees (IDP/Rs), have been supported by the United Nations High Commissioner for Refugees. Other NGOs, such as Relief International, the International Rescue Committee, Children's Aid Direct, and the United Methodist Committee on Relief, helped implement these programs. The United Nations Population Fund (UNFPA), in collaboration with the Ministry of Health (MOH), also led a series of reproductive health intervention programs targeting access to contraceptives and training family planning health care providers (United Nations Development Programme [UNDP], 1999).

The high abortion rate among Azeri women is noteworthy. Trend data from the 2001 Azerbaijan Reproductive Health Survey show that between 1995 and 1999, the total abortion rate increased (from 2.3 to 2.8 abortions per woman). The rate has continued to rise. In 2001, the abortion rate among Azeri women aged 15-44 years was 3.2 (see also Chapter 5). The prevalence of modern contraceptive use began to decrease during the 1990s and continued to decrease in the postindependence period; at the same time, the abortion rate increased (Pathfinder, 1999). Reasons for the decline in use of modern contraceptive methods include "misinformation" and "fear of hormonal methods" (Pathfinder, 1999). A 1999 evaluation of a Medecins Sans Frontieres-Holland (MSF-H) intervention program in Northwest Azerbaijan reported that abortion was used by 33% of those women in the year before the evaluation was conducted (MSF-H, 1999). According to the Pathfinder report, access to contraceptives on the open market was extremely limited. In addition to the MSF-H activities, Pathfinder International collaborated with the MOH and UNFPA to improve the quality and availability of family planning counseling services in certain areas of Azerbaijan. Information, education, and communication (IEC) activities were also conducted.

Both the MSF-H and Pathfinder reports suggest that health care providers (i.e., gynecologists) were unlikely to support the training programs for midwives, activities to increase contraceptive use, and IEC projects (MSF-H, 1999; Pathfinder, 1999). According to the Pathfinder report, women's health

providers in Azerbaijan earn a large percentage of their income from abortion-related care. As a result, they are reluctant to encourage effective (and increased) contraceptive use because it may reduce the abortion rate, and consequently their income.

Each of these reports suggest that surveillance data on a number of health indicators related to contraceptive use are needed. Additionally, to better understand why women fail to use or why they may improperly use contraceptives will require further study. As the reports suggest, contraceptive use and the desire for information about contraception are affected by a number of social and environmental factors. Data from this report may be useful as the MOH (and other agencies) begins developing and implementing more intervention programs.

Survey objectives included determination of which population subgroups need more information about contraception, what kind of information is needed, and which routes could be used to target those subgroups with IEC activities. For this survey, respondents were asked about their interest in obtaining information about contraceptive methods; the most appropriate information sources; their perception of health risks related to pill, IUD, and condom use as well as the risk associated with having an abortion; and the advantages and disadvantages of contraceptive use.

12.1 Interest in More Information on Contraception

The interest in contraceptive information in Azerbaijan was similar to that in other countries such as Moldova (Serbanescu et al., 1998) and Romania (Serbanescu et al., 2001) where 74% and 64% of women of reproductive age, respectively, wanted to receive information. Nearly three-quarters of Azeri women surveyed (73%) wanted more information about contraception (Table 12.1). A greater proportion of women age 20-34 (78%-86%), desired information on contraceptives than did those aged 35 or older (51 %-69%). A high proportion of women who were currently married desired more information on contraception, and the desire for more information on contraception was also higher among users of condoms, IUD, and traditional methods of contraception.

TABLE 12.1
Percentage of Women Who Want More Information about Contraception
by Selected Characteristics
Among Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	% of Women Who Want More Information	No. of Cases
Total	**73.0**	**7,668**
Residence		
Urban	73.8	3,832
Rural	72.4	3,836
Age Group		
15–19	70.4	1,207
20–24	85.5	1,207
25–29	83.0	1,156
30–34	78.1	1,533
35–39	69.2	1,531
40–44	51.1	1,034
Marital Status		
Currently Married/in Union	76.7	5,146
Previously Married	48.2	387
Never Married	71.0	2,135
Education Level		
Secondary Incomplete or less	70.3	1,697
Secondary Complete	73.1	3,868
Technicum	75.7	1,215
University/Postgraduate	76.3	888
Socioeconomic Status		
Low	71.4	4,068
Medium	75.0	2,770
High	74.3	830
IDP/Refugee Status		
IDP/R	75.1	1,272
Non–IDP/ CA	75.4	3,047
Non–IDP/ NCA	72.4	3,349
Current Contraception Use		
IUD	82.0	299
Condom	87.9	175
Other Modern Methods	68.5	115
Traditional Methods	81.8	2,354
Non–Users	69.1	4,725

TABLE 12.2
Women's Opinion on Which Best Source of Contraception Information, by Selected Characteristics
Among Women Aged 15–44 Who Want More Information about Contraception
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Gynecologist	Mass Media	Mother/ Relative	Books	Friend	Other	Total	No. of Cases
Total	67.0	10.2	8.9	6.4	3.8	3.7	100.0	5,787
Residence								
Urban	65.0	12.6	8.0	7.8	2.9	3.7	100.0	2,863
Rural	69.4	7.4	9.9	4.8	4.8	3.7	100.0	2,924
Age Group								
15–19	43.7	11.7	24.4	7.8	7.2	5.1	100.0	868
20–24	60.7	11.4	12.5	7.6	4.5	3.3	100.0	1,026
25–29	74.3	9.4	3.7	6.1	2.5	4.1	100.0	983
30–34	79.8	7.5	2.1	5.0	2.3	3.4	100.0	1,244
35–39	79.3	9.8	0.7	5.8	1.9	2.5	100.0	1,102
40–44	75.7	12.1	1.1	5.2	2.8	3.2	100.0	564
Marital Status								
Currently Married/ in Union	79.2	8.3	1.9	4.6	2.8	3.2	100.0	4,070
Previously Married	71.0	12.0	1.4	7.9	5.4	2.3	100.0	195
Never Married	45.5	13.5	21.6	9.5	5.4	4.6	100.0	1,522
Education Level								
Secondary Incomplete or less	59.5	8.7	15.9	5.2	5.4	5.4	100.0	1,216
Secondary Complete	70.8	8.1	8.6	5.2	4.1	3.2	100.0	2,946
Technicum	71.1	11.8	3.7	7.6	2.2	3.5	100.0	941
University/Postgraduate	61.1	19.5	3.0	12.2	1.5	2.6	100.0	684
Socioeconomic Status								
Low	68.5	6.5	11.4	5.1	4.7	3.7	100.0	3,052
Medium	66.4	12.2	6.9	7.6	3.1	3.8	100.0	2,111
High	63.0	18.2	5.3	7.8	2.5	3.2	100.0	624
IDP/Refugee Status								
IDP/R	71.4	5.8	5.9	5.8	4.3	4.2	100.0	1,011
Non–IDP/ CA	70.8	5.5	7.9	5.5	4.2	4.2	100.0	2,330
Non–IDP/ NCA	65.4	6.8	9.5	6.8	3.6	3.5	100.0	2,446
Current Use of Contraception								
IUD	79.6	10.2	1.8	4.5	0.4	3.4	100.0	241
Condom	77.3	11.3	0.0	5.9	0.8	4.6	100.0	156
Other Modern Methods	69.3	9.8	0.0	11.4	3.8	5.7	100.0	81
Traditional Methods	80.4	8.1	1.2	5.1	2.2	3.0	100.0	1,967
Non–Users	59.8	11.2	13.2	7.1	4.8	3.9	100.0	3,342

12.2 Opinions About the Best Source of Information on Contraception

Respondents were asked what they considered to be the "best" source of information on contraception. The sources mentioned can be grouped into two major categories: medical sources (e.g., gynecologists) and nonmedical sources (e.g., mass media, parents, books, friends, spouse, or partner)(Table 12.2). The most frequently mentioned source of information about contraceptive methods was the gynecologist (67%), followed by the mass media (10%). Among women younger than age 20, gynecologists, their mother or other relatives, and mass media were considered the best sources of information. Seventy-one percent of women with technicum or complete secondary education said the gynecologist was the best source of contraception information. University-educated women and women who had not completed secondary school both reported gynecologists (61%) to be their best source. However, among university-educated women, the mass media was second (20%), followed by books (12%). Mother/relatives (16%), followed by the mass media (9%) were the second- and third-best information sources reported by women who had not completed their secondary education; however, a certain percentage of the latter group may be women younger than age 20 who may still be in secondary school. Although among all respondents the gynecologist was regarded as having the central role in disseminating contraceptive information, IUD users and users of traditional methods more often reported the gynecologist to be the best source of information (80%). Women did not as frequently report other sources as best (e.g., users of modern methods or husband or partners).

Women in the region consistently report gynecologists as the best source of contraceptive information (Figure 12.2). In 1997, 64% of Moldovan respondents said gynecologists were the best information source (Serbanescu et al., 1998). In the 1999 RHS in Romania, 61% of female respondents reported gynecologists as the best information source (Serbanescu et al., 2001). Although gynecologists were the best information source in Georgia (1999), only 46% of women mentioned this source (Serbanescu et al., eds, 2001). Mass media is another source of contraceptive information often mentioned in surveys: in Georgia and Moldova larger proportions of women reported mass media as the best source (36% and 25%, respectively). The proportion was considerably lower in Romania (13%) and lowest in Azerbaijan (10%).

These results suggest that IEC coordinators should work closely with health care providers, particularly gynecologists, and members of the mass media, to gain their support for and participation in development and implementation programs that will effectively increase awareness, enhance knowledge, and change attitudes toward contraception.

12.3 Opinions on the Advantages and Disadvantages of the Pill and IUD

Figure 12.2
First and Second Most Desired Sources of Information about Contraception
Among Women Aged 15-44 Who Want More Information
Selected Countries in Eastern Europe
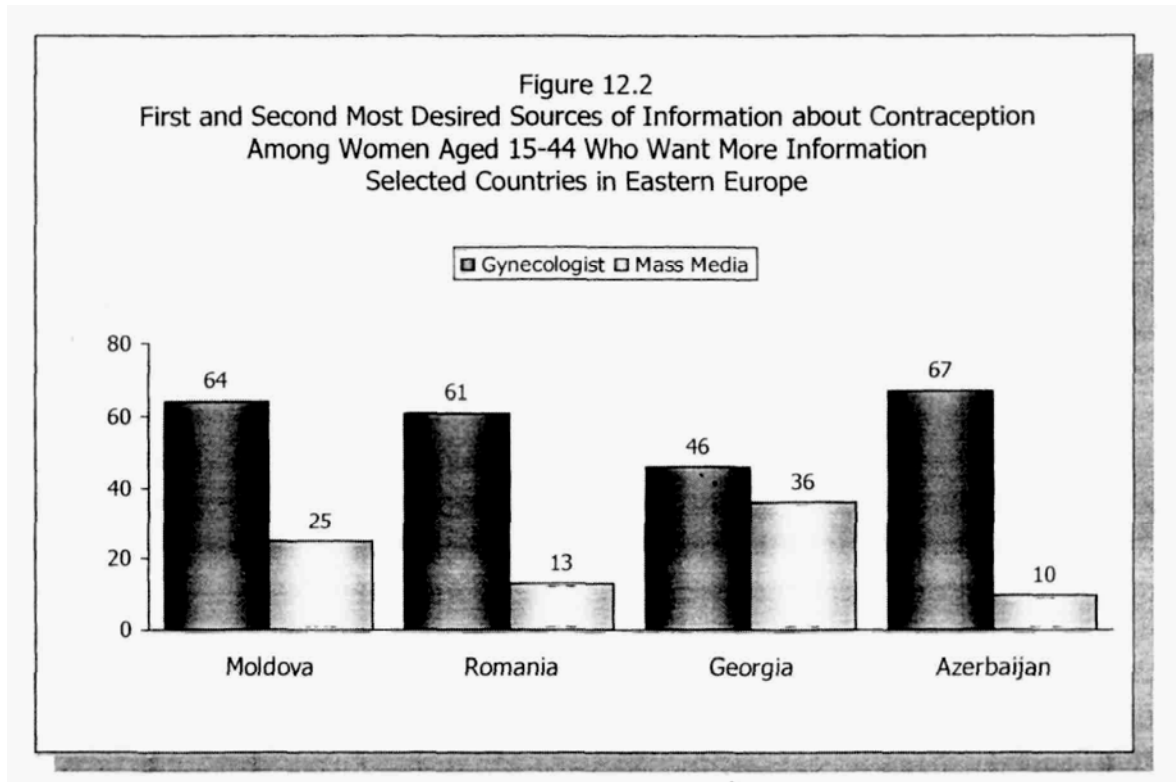
Respondents who had heard of the pill or IUD were asked to agree or disagree with several statements referring to possible advantages and disadvantages of using those methods.

The organization and functioning of family planning services, the geographic and financial access to modern family planning methods, and information are factors that may influence women's opinions about the advantages and disadvantages of the different modern contraceptive methods. As a general observation, the percentage of women able to identify the advantages and disadvantages of the pill and the IUD was higher in urban areas and among women with more education (Tables 12.3.1 and 12.3.2). Women also tended to recognize the advantages and disadvantages that could be identified on the basis of general knowledge rather than those requiring an in-depth knowledge of reproductive physiology and the pharmacology of the pill and IUD.

Among women who had heard of the pill, the advantages most frequently identified for the pill were that it is "easy to use"and "easy to procure"(Table 12.3.1). Twenty-three percent of respondents agreed that the pill "reduces menstrual bleeding," 29% agreed that it "makes menstrual periods more regular," and 20% agreed that it "decreases the risk of getting certain cancers." The most frequently

TABLE 12.3.1

Percent of Agreement with Selected Statements Concerning Advantages and Disadvantages
Associated With Using the Pill, by Residence and Education
Among Women Aged 15–44 Who Have Heard of the Pill
Reproductive Health Survey: Azerbaijan, 2001

| STATEMENTS | Total | Residence | | Education Level | | | |
		Urban	Rural	Secondary Incomplete	Secondary Complete	Technicum	University
Advantages							
Pills Easy to Procure	55.4	61.2	45.6	46.2	53.8	60.5	63.4
Pills Easy to Use	52.9	56.7	46.5	43.2	51.2	56.9	62.9
Pills Regulate Periods	29.2	29.6	28.6	27.5	27.8	31.5	32.0
Pills Decrease Menstrual Cramps	26.4	26.3	26.5	23.3	26.1	30.0	26.2
Pills Decrease Blood Loss	23.3	21.8	25.6	23.1	23.1	25.2	21.7
Pills Protect Against Cancer	19.8	19.2	20.8	19.8	19.5	19.7	20.9
Disadvantages							
Stressful to Remember to Take the Pill	44.6	48.1	38.9	37.4	45.5	46.5	48.1
Pills Make You Gain Weight	31.9	34.7	27.1	26.1	29.0	35.9	40.5
Pills Are too Expensive	26.2	26.1	26.2	25.4	28.7	24.0	23.0
Pills Are Bad for Circulation	20.1	19.7	20.7	18.3	19.1	22.6	21.5
Number of Cases	**4,263**	**2,394**	**1,869**	**725**	**1,981**	**853**	**704**

mentioned disadvantage of using pills was that remembering to take a pill every day is stressful (45%). Approximately one-third of women mentioned that pill use may cause weight gain. One-fourth of women who had heard of the pill considered it "too expensive" and 1 in 5 women thought that it was "bad for blood circulation".

Among currently married women, the IUD was the most commonly used modern contraceptive method in Azerbaijan (see also Chapter 9). In terms of advantages, 35% of respondents said that the IUD was "easy to use," and 34% said that "it is relatively inexpensive"(Table 12.3.2). Among these women, 33% perceived the IUD as decreasing "the risk of an ectopic pregnancy".

TABLE 12.3.2
Percent of Agreement with Selected Statements Concerning Advantages and Disadvantages
Associated With Using an IUD, by Residence and Education
Among Women Aged 15–44 Who Have Heard of the IUD
Reproductive Health Survey: Azerbaijan, 2001

STATEMENTS	Total	Residence		Education Level			
		Urban	Rural	Secondary Incomplete	Secondary Complete	Technicum	University
Advantages							
IUD Easy to Use	34.9	40.1	28.4	27.6	33.5	40.2	45.3
IUD Relatively Inexpensive	33.6	36.9	29.3	25.9	32.6	39.5	41.7
IUD Decreases Risk of Ectopic Pregnancy	33.0	35.5	29.9	24.9	31.2	42.2	40.3
Disadvantages							
IUD May Increase Menstrual Blood Loss	50.3	50.4	50.2	47.0	47.2	53.5	47.3
Increases Risk of Pelvic Inflammatory Disease	49.8	50.7	48.8	45.8	48.4	55.3	54.4
IUD May Increase Painful Menstruation	48.3	46.9	50.0	47.3	49.3	56.8	50.7
IUD May Cause Spotting Between Periods	47.3	48.1	46.4	44.2	45.1	54.1	51.5
Number of Cases	6,688	3,396	3,292	1,324	3,356	1,169	839

About half of respondents who had heard of the IUD, agreed that it may cause an increased risk of pelvic inflammatory disease, that IUD use may increase menstrual blood loss or that the device may increase menstrual pain. For both advantages and disadvantages of IUD use, awareness was higher in urban areas and among women who had completed technicum or university education. In general, the proportion of women who had heard of the advantages of the pill or the IUD was relatively low (Tables 12.3.1 and 12.3.2). Greater efforts are needed to increase women's knowledge about modern contraceptive methods. Women must also be educated to a greater extent about each method's advantages and disadvantages in order to improve their ability to make informed choices about modern contraceptive use.

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

Use of modern contraceptive methods may be related to women's perceptions of the health risks associated with certain contraceptives. Respondents were asked to evaluate the health risk posed by selected contraceptive methods (the pill, IUD, condoms, and tubal ligation) on a scale of low, medium, or high risk.

When asked about the health risk of these methods, high proportions of women "did not know" whether these contraceptive methods posed a risk to a woman's health (40%-75%) (Tables 12.4.1 .- 12.4.4). Users of a method appear to have more information about the risk associated with their selected contraceptive method than non-users. For example, only 2% of IUD users and 4% of condom users responded that they "did not know" when asked about the health risks of their particular method (Table 12.4.2, 12.4.3).

Among the respondents who had an opinion regarding the health risk of using pills, 6 out of 7 thought it posed a medium or high risk (Table 12.4.1). Women were 5 to 6 times as likely to respond that the pill posed at least a medium risk to health, regardless of SES. However, as mentioned above, significantly higher percentages of respondents in rural areas and in lower education and socioeconomic groups "did not know" whether use of modern methods posed a health risk..

Non-users of IUD were more likely to report that the IUD was high risk (17%-25%) compared with IUD users (8%) (Table 12.4.2). About 40% of respondents said they "did not know" whether using an IUD posed a health risk for women. Half of all respondents, or 5 out of 6 of those who had an opinion, thought that using an IUD posed a medium or greater risk to a woman's health. Perception of any risk increased with age and among ever-married women. IUD users split, with slightly more than half attributing low risk to that method, but about 46% rating the method as having medium or greater risk.

Two-thirds of women did not know enough about condoms to be able to assess their health risks. One-quarter of all women, or 75% of those with an opinion felt that condoms posed only a low risk to a woman's health (Table 12.4.3). Lack of knowledge was greatest among rural women, women under age 20, never married women, women with less than complete secondary education or low SES, and those not currently using any method of contraception. The opinion that condoms are low risk was common across age groups, education levels, SES, residence, marital status, IDP/R status, and current method of contraception.

TABLE 12.4.1
Women's Opinion of Degree of Risk to a Woman's Health by Using the Pill
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Low Risk	Medium Risk	High Risk	Don't Know[*]	Total	No. of Cases
Total	**5.4**	**19.4**	**12.0**	**63.1**	**100.0**	**7,668**
Residence						
Urban	6.2	24.1	14.5	55.2	100.0	3,832
Rural	4.5	13.8	9.0	72.6	100.0	3,836
Age Group						
15–19	2.3	9.1	6.4	82.2	100.0	1,207
20–24	7.4	18.8	10.0	63.8	100.0	1,207
25–29	6.2	25.2	12.6	56.0	100.0	1,156
30–34	7.1	21.6	14.8	56.5	100.0	1,533
35–39	6.0	24.5	16.0	53.5	100.0	1,531
40–44	4.7	22.3	14.6	58.4	100.0	1,034
Marital Status						
Currently Married/in Union	6.9	23.9	15.3	53.9	100.0	5,146
Previously Married	3.8	23.4	14.7	58.1	100.0	387
Never Married	3.4	11.7	6.2	78.7	100.0	2,135
Education Level						
Secondary Incomplete or less	3.3	13.2	8.4	75.2	100.0	1,697
Secondary Complete	4.9	16.3	11.8	67.0	100.0	3,868
Technicum	7.0	26.1	16.1	50.8	100.0	1,215
University/Postgraduate	10.0	36.7	15.1	38.3	100.0	888
Socioeconomic Status						
Low	4.1	14.6	9.5	71.9	100.0	4,068
Medium	6.0	22.2	14.7	57.2	100.0	2,770
High	9.3	29.9	13.8	47.0	100.0	830
IDP/Refugee Status						
IDP/R	5.9	20.9	11.9	61.3	100.0	1,272
Non–IDP/ CA	4.9	16.6	8.6	69.9	100.0	3,047
Non–IDP/ NCA	5.5	19.9	12.8	61.7	100.0	3,349
Current Use of Contraception						
IUD	7.4	28.1	15.2	49.3	100.0	299
Condom	10.6	36.5	28.0	24.9	100.0	175
Other Modern Methods	23.6	37.5	11.8	27.0	100.0	115
Traditional Methods	5.9	24.3	15.4	54.4	100.0	2,354
Non–Users	4.6	16.3	10.1	69.0	100.0	4,725

* The majority of those responding in the "don't know" category were those women who had never heard of the method.

TABLE 12.4.2
Women's Opinion of Degree of Risk to a Woman's Health by Using the IUD
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Low Risk	Medium Risk	High Risk	Don't Know*	Total	No. of Cases
Total	**10.1**	**30.5**	**19.1**	**40.3**	**100.0**	**7,668**
Residence						
Urban	12.8	33.1	19.3	34.8	100.0	3,832
Rural	6.8	27.5	18.8	46.9	100.0	3,836
Age Group						
15–19	5.2	14.6	10.2·	69.9	100.0	1,207
20–24	9.2	29.3	17.4	44.1	100.0	1,207
25–29	11.5	38.3	18.4	31.8	100.0	1,156
30–34	12.0	37.7	22.5	27.8	100.0	1,533
35–39	14.0	35.3	24.7	26.1	100.0	1,531
40–44	10.5	35.6	25.1	28.7	100.0	1,034
Marital Status						
Currently Married/in Union	13.1	38.5	23.2	25.2	100.0	5,146
Previously Married	9.2	31.0	26.9	32.9	100.0	387
Never Married	5.4	17.7	11.3	65.6	100.0	2,135
Education Level						
Secondary Incomplete or less	6.7	22.5	16.9	53.9	100.0	1,697
Secondary Complete	9.0	30.6	18.8	41.6	100.0	3,868
Technicum	14.3	36.0	23.3	26.5	100.0	1,215
University/Postgraduate	16.2	39.9	19.3	24.5	100.0	888
Socioeconomic Status						
Low	6.8	26.8	18.8	47.6	100.0	4,068
Medium	12.8	33.4	19.5	34.3	100.0	2,770
High	14.8	36.4	18.8	29.9	100.0	830
IDP/Refugee Status						
IDP/R	10.3	30.8	22.9	36.0	100.0	1,272
Non–IDP/ CA	7.7	26.5	20.2	45.6	100.0	3,047
Non–IDP/ NCA	10.7	31.5	18.3	39.5	100.0	3,349
Current Use of Contraception						
IUD	52.3	37.3	8.3	2.2	100.0	299
Condom	15.1	54.3	18.7	11.9	100.0	175
Other Modern Methods	11.5	42.8	24.8	21.0	100.0	115
Traditional Methods	10.0	40.7	25.4	23.9	100.0	2,354
Non–Users	7.7	25.4	17.2	49.7	100.0	4,725

* The majority of those responding in the "don't know" category were those women who had never heard of the method.

TABLE 12.4.3
Women's Opinion of Degree of Risk to a Woman's Health Associated with Using Condoms
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Low Risk	Medium Risk	High Risk	Don't Know[*]	Total	No. of Cases
Total	24.5	6.8	1.6	67.0	100.0	7,668
Residence						
Urban	32.7	8.2	1.6	57.4	100.0	3,832
Rural	14.7	5.0	1.7	78.6	100.0	3,836
Age Group						
15–19	10.8	2.5	1.0	85.7	100.0	1,207
20–24	26.0	5.6	1.8	67.5	100.0	1,207
25–29	33.1	7.8	1.7	57.4	100.0	1,156
30–34	26.7	9.1	2.2	62.1	100.0	1,533
35–39	32.2	8.1	1.3	58.4	100.0	1,531
40–44	24.2	9.7	2.3	63.8	100.0	1,034
Marital Status						
Currently Married/in Union	31.2	8.9	1.9	58.0	100.0	5,146
Previously Married	25.8	7.6	4.1	6.5	100.0	387
Never Married	13.5	3.2	0.9	82.3	100.0	2,135
Education Level						
Secondary Incomplete or less	12.8	3.8	2.0	81.4	100.0	1,697
Secondary Complete	20.2	6.5	1.3	72.0	100.0	3,868
Technicum	35.6	8.8	2.5	53.1	100.0	1,215
University/Postgraduate	52.1	11.3	1.2	35.4	100.0	888
Socioeconomic Status						
Low	15.6	4.7	1.6	78.2	100.0	4,068
Medium	29.6	8.4	2.0	60.0	100.0	2,770
High	44.3	10.1	0.9	44.7	100.0	830
IDP/Refugee Status						
IDP/R	25.5	7.9	1.2	65.4	100.0	1,272
Non–IDP/ CA	19.8	4.6	1.6	74.0	100.0	3,047
Non–IDP/ NCA	25.5	7.2	1.7	65.6	100.0	3,349
Current Use of Contraception						
IUD	31.9	8.3	0.7	59.0	100.0	299
Condom	87.7	8.2	0.0	4.1	100.0	175
Other Modern Methods	41.0	9.8	3.0	46.2	100.0	115
Traditional Methods	31.3	9.2	2.2	57.2	100.0	2,354
Non–Users	19.5	5.7	1.5	73.4	100.0	4,725

[1] The majority of those responding in the "don't know" category were those women who had never heard of the method.

TABLE 12.4.4
Women's Opinion of Degree of Risk to a Woman's Health Associated with Tubal Ligation
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Low Risk	Medium Risk	High Risk	Don't Know*	Total	No. Of Cases
Total	5.8	6.5	12.2	75.5	100.0	7,668
Residence						
Urban	7.5	7.9	15.1	69.5	100.0	3,832
Rural	3.9	4.8	8.6	82.7	100.0	3,836
Age Group						
15–19	2.5	2.3	4.0	91.3	100.0	1,207
20–24	3.9	5.0	8.4	82.7	100.0	1,207
25–29	7.3	7.7	12.4	72.6	100.0	1,156
30–34	6.5	8.0	16.6	69.0	100.0	1,533
35–39	7.6	8.3	19.1	65.0	100.0	1,531
40–44	9.3	10.1	15.8	64.9	100.0	1,034
Marital Status						
Currently Married/in Union	7.6	8.0	16.0	68.4	100.0	5,146
Previously Married	6.8	9.0	16.4	67.7	100.0	387
Never Married	2.8	3.7	5.4	88.1	100.0	2,135
Education Level						
Secondary Incomplete or less	3.1	3.8	5.5	87.6	100.0	1,697
Secondary Complete	5.2	5.4	12.0	77.5	100.0	3,868
Technicum	7.9	11.0	19.2	61.9	100.0	1,215
University/Postgraduate	11.7	10.8	17.6	59.9	100.0	888
Socioeconomic Status						
Low	4.1	5.0	9.8	81.2	100.0	4,068
Medium	6.7	7.8	13.5	72.0	100.0	2,770
High	10.2	8.4	17.6	64.0	100.0	830
IDP/Refugee Status						
IDP/R	6.0	6.2	12.6	75.2	100.0	1,272
Non–IDP/ CA	5.2	6.2	9.0	79.6	100.0	3,047
Non–IDP/ NCA	6.0	6.6	12.9	74.6	100.0	3,349
Current Use of Contraception						
IUD	8.4	6.9	14.9	69.8	100.0	299
Condom	12.7	14.7	20.3	52.3	100.0	175
Other Modern Methods	40.8	11.5	12.2	35.5	100.0	115
Traditional Methods	6.7	8.3	16.5	68.6	100.0	2,354
Non–Users	4.4	5.5	10.2	79.9	100.0	4,725

* The majority of those responding in the "don't know" category were those women who had never heard of the method.

189

As shown in Table 12.4.4, only 12% of women considered tubal ligation to pose a high risk to a woman's health; however 76% of women did not know enough about the method to have an opinion of the health risk. Perception of risk increased with age, education, SES and urban residence; lack of knowledge decreased in the same circumstances. Clearly, more education on tubal ligation is needed. Intervention programs can be designed to target subgroups reporting less knowledge of and experience with tubal ligation and other contraceptive methods.

Those subgroups with low knowledge of the advantages, disadvantagesand level of health risk associated with the use of modern contraceptive methods should constitute the target population for future IEC activities of family planning programs. Increasing the proportion of the population informed about the benefits and risks associated with modem contraceptive methods may lead to an increase in the number of modern contraceptive users, thereby reducing the occurrence of unintended pregnancy.

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

Abortion has been long accepted in Azerbaijan as a means of avoiding births resulting from unintended pregnancies, as it was legal and available free of charge during the Soviet era. Abortion "acceptability" remains high in Eastern Europe and the former Soviet Union (78%-85%) (see also Chapter 13). Encouraging a shift in behavior from abortion to the use of contraception to prevent unintended pregnancy should be an important program intervention. Half of the women surveyed consider abortion to pose a high risk to a woman's health (Table 12.5). In light of this, Azeri women may well be open to alternative methods of fertility control.

Regardless of characteristics, women were more likely to report abortion as being a high risk than a low or even medium risk. Currently married women, women older than age 24, those with technicum or university education, and women who use any method of contraception were most likely to respond that abortion poses a high risk to a woman's health (57% to 70%). These findings suggest that Azeri women do not necessarily resort to abortion because they prefer it to effective contraception but rather because of its availability.

In contrast to the proportion of women rating abortion as having a high risk of health effects, the proportion of women reporting the risk associated with abortion to be low was small (5%) (Table 12.5). Regardless of characteristics, the proportion of women reporting abortion to be a low risk was small was never greater than 10%, although the least likely to believe abortion to have a low risk of health effect were women under age 20, never married women, women with a university education, and condom users.

TABLE 12.5
Percent Distribution of Women's Opinion of Degree of Risk
that Women's Health Can Be Affected by an Abortion
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Low Risk	Medium Risk	High Risk	Don't Know	Total %	No. of Cases
Total	5.2	12.9	51.4	30.6	100.0	7,668
Residence						
Urban	6.1	14.8	51.2	27.9	100.0	3,832
Rural	4.0	10.5	51.7	33.8	100.0	3,836
Age Group						
15–19	3.7	7.8	31.4	57.2	100.0	1,207
20–24	4.8	13.4	49.1	32.7	100.0	1,207
25–29	4.1	15.5	58.3	22.1	100.0	1,156
30–34	6.1	13.9	60.3	19.7	100.0	1,533
35–39	6.2	15.3	58.7	19.9	100.0	1,531
40–44	6.5	13.6	60.2	19.8	100.0	1,034
Marital Status						
Currently Married/In Union	6.2	15.1	61.8	16.9	100.0	5,146
Previously Married	7.1	11.8	52.4	28.8	100.0	387
Never Married	3.2	9.3	34.6	52.9	100.0	2,135
Education Level						
Secondary Incomplete or less	4.6	10.9	45.2	39.3	100.0	1,697
Secondary Complete	5.2	11.9	50.5	32.5	100.0	3,868
Technicum	7.1	16.2	57.1	19.6	100.0	1,215
University/Postgraduate	3.5	16.6	60.7	19.1	100.0	888
Socioeconomic Status						
Low	4.4	11.1	49.3	35.2	100.0	4,068
Medium	5.7	14.2	52.9	27.2	100.0	2,770
High	6.6	15.3	55.3	22.8	100.0	830
IDP/Refugee Status						
IDP/R	7.3	11.5	51.4	29.8	100.0	1,272
Non–IDP/ CA	5.9	12.1	46.3	35.7	100.0	3,047
Non–IDP/ NCA	4.7	13.2	52.7	29.4	100.0	3,349
Current Use of Contraception						
IUD	6.2	16.2	61.8	15.7	100.0	299
Condom	3.7	18.1	70.0	8.2	100.0	175
Other Modern Methods	10.2	13.3	70.3	6.2	100.0	115
Traditional Methods	6.2	15.2	64.1	14.5	100.0	2,354
Non–Users	4.6	11.6	45.1	38.6	100.0	4,725

Most Azeri women want more information about contraception (73%), and most of those women would prefer to receive that information from a gynecologist (67%). More than half of the women who have heard of the contraceptive pill beieve they are easy to get and use. Remembering to take the pill was the most frequently mentioned disadvantage (45%). Less than a third of women were aware of other advantages or disadvantages of pill use. Approximately half of the women who had heard of the IUD knew of each of the disadvantages while only a third knew any of the advantages of this method. A large proportion of women responded that they did not know whether selected contraceptive methods posed a health risk: pill (63%), IUD (40%), condom (67%), and tubal ligation (76%). However, users of condoms and IUDs were among least likely to report their own method as being high risk. Despite the prevalence of abortion, half of all respondents reported abortion as to be a high risk to a woman's health. Based on these results Azeri women want and need more information on more effective, modern contraceptive methods to control their fertility without fear of risks to their health. While nearly every subgroup could benefit from this information, education efforts should target young, unmarried, less educated women since they will be approaching marriage and childbearing even as they are among the least informed about family planning.

CHAPTER 13

REPRODUCTIVE HEALTH KNOWLEDGES AND ATTITUDES

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

In addition to exploring attitudes about family size and induced abortion, the AZRHS01 included questions related to the attitudes that surround reproductive decision making, pregnancy resolution, and gender roles in Azerbaijan. The results of questions on these topics should prove useful for developing and modifying elements of reproductive health education programs and curricula.

13.1 Ideal Family Size

Respondents were asked their opinion regarding the "ideal" number of children for a young family in Azerbaijan. This question was meant to explore general attitudes of reproductive-age women, not their personal decisions about ideal family size. The mean ideal number of children was 2.6 (Table 13.1). Given the total fertility rate in Azerbaijan of 2.1 births per woman (see also Chapter 4), this finding means that in an ideal situation, women of reproductive age would prefer having more children than they actually have or will have. This difference, no doubt, is related to economic and social constraints that influence couples to limit their family size in practice. In answering this question, respondents may have been affected by their personal experience, because the reported

TABLE 13.1
Mean Ideal Number of Children for a Young Family in Azerbaijan,
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Mean Ideal Number of Children	No. of Cases*
Total	2.6	7,168
Residence		
Urban	2.6	3,618
Rural	2.7	3,550
Age Group		
15–19	2.5	1,142
20–24	2.5	1,144
25–29	2.6	1,085
30–34	2.7	1,434
35–39	2.8	1,421
40–44	2.8	942
Marital Status		
Currently Married/ in Union	2.7	4,810
Previously Married	2.5	369
Never Married	2.5	1,989
Education Level		
Secondary Incomplete or less	2.6	1,563
Secondary Complete	2.6	3,603
Technicum	2.7	1,154
University/Postgraduate	2.6	848
No. of Living Children		
0	2.5	2,460
1	2.5	737
2	2.7	1,967
3	2.8	1,448
4 or more	2.9	556
Socioeconomic Status		
Low	2.6	3,757
Medium	2.6	2,618
High	2.5	793
Ethnicity		
Azeri	2.6	6,719
Non-Azeri	2.6	449
IDP/Refugee Status		
IDP/R	2.7	1,185
Non-IDP/CA	2.7	2,830
Non-IDP/NCA	2.6	3,153

* Excludes 500 women who answered "As many as God gives", "As many as possible" and other non-numeric responses.

194

ideal mean number of children was somewhat higher among women with four or more children (2.9 children) than among women with one child or no living children (2.5 children). In general, there is not a great deal of variation by characteristics of the respondent.

Married women were also asked how many children they desired when they were first married. Fifty-six percent wanted two children, and 17% wanted three children. A comparison of the number of living children reported by married women with the number of children they desired at the time they were married found that one-quarter of those who wanted two children had more than two (24%), and 8% of those who wanted three children had more than three. Although desires regarding family size may change with time, certainly a portion of these percentages represent unwanted fertility.

13.2 Knowledge of the Menstrual Cycle

A relatively small proportion of Azeris have been exposed to sex education; therefore, the survey examined respondents' knowledge of basic concepts regarding reproduction and fertility. Table 13.2 shows respondents' opinions as to when during the menstrual cycle a woman is most likely to get pregnant one of the most common indicators for evaluating sex education.

Only 17% of women answered correctly that the highest risk of becoming pregnant is halfway between two menstrual periods; 47% answered that they did not know, with wide variation between subgroups. The level of knowledge of the menstrual cycle is directly correlated with educational attainment: Almost 5 times as many women with university education answered this question correctly as did those with less than complete secondary education. Women in rural areas and lower socioeconomic groups have much lower levels of knowledge of the most likely time for a woman to become pregnant. Sex education efforts must be targeted toward never-married women and women under age 20, because women in these subgroups were least likely to know the correct answer to this question. Young, unmarried women need this knowledge as they approach marriage and childbearing. Education efforts should also target those women at lower socioeconomic and education levels.

13.3 Knowledge of the Fertility Effect of Breast-Feeding

As with the menstrual cycle, women were asked their opinion on the degree of risk of a woman getting pregnant while breast-feeding, another basic concept of reproduction and fertility. Thirty-six percent of women correctly knew that the risk of pregnancy is lower during breast-feeding (Table 13.3). The data also show that women's knowledge of the fertility reduction effect of breast-feeding increased with age. Women under age 20 were most likely (64%) to say that they did not know

TABLE 13.2
Women's Opinion About the Most Likely Time During the Menstrual Cycle A Woman Can Get Pregnant,
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Week Before Menses	During Menses	Week After Menses	Halfway Between Menses	Anytime	Do Not Know	Total	No. of cases
Total	2.5	0.5	22.7	16.7	10.8	46.8	100.0	7,668
Residence								
Urban	3.0	0.6	22.7	21.3	10.6	41.9	100.0	3,832
Rural	2.0	0.4	22.7	11.1	11.0	52.8	100.0	3,836
Age Group								
15–19	1.9	0.3	6.7	4.1	13.6	73.5	100.0	1,207
20–24	3.0	0.4	18.8	12.3	10.9	54.5	100.0	1,207
25–29	2.6	0.5	27.4	19.4	10.0	40.2	100.0	1,156
30–34	2.3	0.4	29.6	24.2	8.3	35.1	100.0	1,533
35–39	2.4	0.9	32.9	22.8	11.9	29.1	100.0	1,531
40–44	3.3	0.6	27.8	23.3	8.3	36.7	100.0	1,034
Marital Status								
Currently Married/ in Union	3.0	0.6	30.8	23.7	10.0	31.9	100.0	5,146
Previously Married	5.7	1.5	28.5	18.4	8.7	37.3	100.0	387
Never Married	1.3	0.2	8.8	5.3	12.3	72.2	100.0	2,135
Education Level								
Secondary Incomplete or Less	1.9	0.3	16.9	7.7	14.0	59.2	100.0	1,697
Secondary Complete	2.2	0.5	22.7	14.8	10.7	49.1	100.0	3,868
Technicum	3.8	0.9	31.3	23.7	7.4	33.0	100.0	1,215
University/Postgraduate	3.4	0.4	23.8	33.8	8.7	29.9	100.0	888
Socio-Economic Status								
Low	2.1	0.3	22.3	11.7	11.0	52.7	100.0	4,068
Medium	2.9	0.6	23.9	18.8	10.6	43.3	100.0	2,770
High	3.1	0.8	20.7	30.0	10.7	34.7	100.0	830
Ethnicity								
Azeri	2.5	0.5	22.9	16.7	10.8	46.6	100.0	7,189
Non-Azeri	2.6	0.4	20.6	16.4	10.8	49.1	100.0	479
IDP Status								
IDP/R	2.4	0.6	24.6	14.0	13.3	45.2	100.0	1,272
Non-IDP/CA	2.5	0.6	26.1	13.6	10.7	46.4	100.0	3,047
Non-IDP/NCA	2.5	0.5	21.6	17.8	10.4	47.1	100.0	3,349

the answer to this question and to have the lowest level of correct knowledge (19%). A very low percentage of unmarried women (20%) had correct knowledge of the effect of breast-feeding on fertility. Little difference was found among women according to ethnicity, residence, internally displaced person and refugee (IDP/R) status or socioeconomic status (SES).

TABLE 13.3
Women's Opinion on the Risk of Pregnancy When Breastfeeding
Compared to When Not Breastfeeding,
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Higher Risk	Lower Risk	Same Risk	Do Not Know	Total	No. of Cases
Total	1.5	36.3	31.9	30.4	100.0	7,668
Residence						
Urban	2.1	37.5	31.3	29.0	100.0	3,832
Rural	0.7	34.9	32.5	31.9	100.0	3,836
Age Group						
15–19	1.1	18.7	16.0	64.3	100.0	1,207
20–24	1.7	31.4	29.8	37.1	100.0	1,207
25–29	1.4	42.2	35.7	20.7	100.0	1,156
30–34	2.0	45.0	37.8	15.2	100.0	1,533
35–39	1.5	43.8	39.4	15.2	100.0	1,531
40–44	1.1	45.5	39.7	13.7	100.0	1,034
Marital Status						
Currently Married/ in Union	1.8	47.1	40.2	10.9	100.0	5,146
Previously Married	1.6	29.6	43.9	25.0	100.0	387
Never Married	0.9	20.0	16.7	62.4	100.0	2,135
Education Level						
Secondary Incomplete or less	1.3	30.5	29.8	38.4	100.0	1,697
Secondary Complete	1.6	36.0	31.4	31.0	100.0	3,868
Technicum	1.4	44.8	34.2	19.6	100.0	1,215
University/Postgraduate	1.5	38.7	34.9	25.0	100.0	888
Socioeconomic Status						
Low	0.7	35.0	32.6	31.7	100.0	4,068
Medium	1.8	37.4	30.7	30.0	100.0	2,770
High	3.5	38.2	32.5	25.8	100.0	830
Ethnicity						
Azeri	1.4	36.5	31.9	30.3	100.0	7,189
Non-Azeri	2.0	35.1	31.9	31.1	100.0	479
IDP/Refugee Status						
IDP/R	1.2	37.7	33.4	27.8	100.0	1,272
Non-IDP/CA	0.9	34.6	33.1	31.4	100.0	3,047
Non-IDP/NCA	1.6	36.6	31.4	30.4	100.0	3,349

13.4 Attitudes Toward Abortion

Azerbaijan, like all former Soviet Union republics, has a long history of reliance on abortion, which, in combination with traditional methods of contraception, was responsible for the rapid decline in fertility in the 1950s. Legally induced abortion on request was the main method of fertility control in Russia after the Socialist revolution. Even after 1935, when Stalin restricted abortion to narrow

medical indications, clandestine abortion provided by either medical providers or traditional practitioners was widely used to avert unwanted births. In November 1955, abortion performed in the first trimester again became available "on request," when the restrictive legislation was repealed, largely to prevent illegal abortions and their associated complications. The Soviet Union became the country with the highest abortion rate in Europe; the number of pregnancy terminations exceeded the number of births by a factor of 2 or more. For those countries with available data, acceptance of a woman's right to decide about her pregnancy, including abortion, is still high in Eastern Europe and the former Soviet Union (78%-85%) (Figure 13.4).

This long tradition of relying on abortion to control fertility, combined with economic difficulties that pressure couples to limit or delay childbearing; the lack of widespread availability of modern contraception; and relatively high use of traditional, less effective methods, is largely responsible for the continued high rates of abortion and its acceptability in Azerbaijan. However, personal values and reproductive norms could strongly influence abortion and contraceptive behaviors. The respondents' positions on abortion were explored by asking whether "a woman should always have the right to make personal decisions about her pregnancy, including obtaining an abortion" and, for those who disagreed that induced abortion should be an option for pregnancy resolution under any circumstances, whether an abortion should be permitted under six specified circumstances:
1.   "The woman's life is endangered by the pregnancy."
2.   "The fetus has a physical deformity."
3.   "The pregnancy has resulted from rape."
4.   "The woman's health is endangered by the pregnancy."
5.   "The woman is not married."
6.   "The couple cannot afford to have a(nother)child."

Eighty percent of respondents agreed that a woman should always have the right to decide about her pregnancy, including resorting to abortion (Table 13.4.1). Less than 1% of women opposed pregnancy termination under any circumstance, whereas 20% agreed with the acceptability of abortion being used only for certain reasons. Attitudes toward the right to decide about pregnancy resolution varied little. Women whose ideal number of children was 1 to 2 children had the greatest acceptance of abortion for any reason (91%).

Respondents who said that abortion is not always acceptable demonstrated two levels of acceptance under given circumstances that might motivate a pregnant woman to consider abortion (Table 13.4.2). The higher level of abortion acceptability is when continuing the pregnancy endangers the life of the mother (83%) or when the child might be deformed (80%). In the lower level of acceptance, although still representing the majority of the respondents, 70% of women thought

abortion was acceptable if the pregnancy endangered a woman's health, 67% if the pregnancy resulted from rape, 66% is the woman is unmarried, and 65% if the couple cannot afford the child.

Generally, women with technicum education were more likely to approve of abortion in all of the selected circumstances, whereas women under age 25 were least likely to agree that abortion is acceptable in any of the scenarios (Table 13.4.3). Currently married women were more likely than never-married women to agree that abortion is acceptable in these circumstances. No significant difference was observed based on residence, ethnicity, or IDP/R status.

All respondents, regardless of their opinion about "a woman's right to decide about her pregnancy, including obtaining an abortion," were asked, "If a woman has an unwanted pregnancy, should she keep the baby, give the baby up for adoption, or have an abortion?" (Table 13.4.4). Although 80% of women believe abortion to be always acceptable (Table 13.4.1), when presented with these three possibilities in a hypothetical case of unwanted pregnancy, fewer women (71%) agreed that it should be ended by abortion. Twenty-one percent thought that a woman who experienced an unwanted pregnancy should give birth and keep the baby, and only 2% agreed with having the baby adopted.

Figure 13.4
Acceptability of Abortion As a Woman's Personal Decision
Eastern European Countries With Available Data
Women Aged 15-49
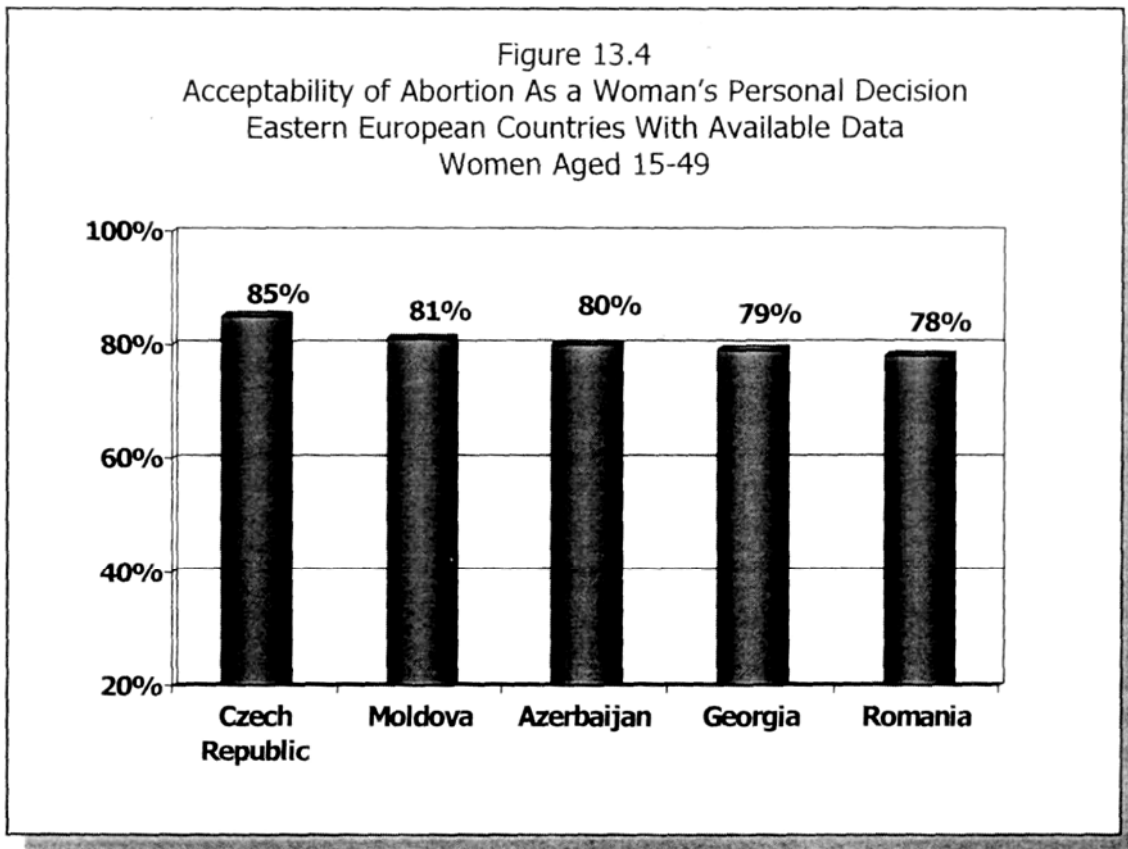
Table 13.4.1
Women's Opinion on Acceptability of Abortion,
by Selected Characteristics
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Always Acceptable	Under Certain Circum stances	Never Acceptable	Total	No. of cases
Total	79.8	20.0	0.2	100.0	7,668
Residence					
Urban	79.8	20.0	0.1	100.0	3,832
Rural	79.8	20.0	0.2	100.0	3,836
Age Group					
15–19	72.6	26.9	0.4	100.0	1,207
20–24	80.3	19.6	0.1	100.0	1,207
25–29	80.5	19.5	0.0	100.0	1,156
30–34	83.2	16.8	0.0	100.0	1,533
35–39	84.2	15.8	0.0	100.0	1,531
40–44	80.7	19.1	0.3	100.0	1,034
Marital Status					
Currently Married/ in Union	82.3	17.6	0.1	100.0	5,146
Previously Married	80.4	19.6	0.0	100.0	387
Never Married	75.7	24.0	0.3	100.0	2,135
Education Level					
Secondary Incomplete or less	78.9	20.9	0.2	100.0	1,697
Secondary Complete	79.5	20.2	0.2	100.0	3,868
Technicum	81.1	18.9	0.0	100.0	1,215
University/Postgraduate	81.1	18.9	0.0	100.0	888
Ethnicity					
Azeri	79.7	20.1	0.2	100.0	7,189
Non-Azeri	80.6	19.3	0.2	100.0	479
IDP/Refugee Status					
IDP/R	78.3	21.7	0.0	100.0	1,272
Non-IDP/CA	78.9	21.0	0.1	100.0	3,047
Non-IDP/NCA	80.2	19.6	0.2	100.0	3,349
Ideal Number of Children					
0–1	79.3	19.9	0.8	100.0	188
1–2	90.6	9.4	0.0	100.0	253
2	80.3	19.6	0.1	100.0	2,899
2–3	77.7	22.2	0.1	100.0	1,002
3	79.4	20.3	0.3	100.0	987
More Than Three	78.9	21.0	0.1	100.0	1,839
As Many As Possible	79.8	19.6	0.7	100.0	415
Don't Know	76.4	23.6	0.0	100.0	85

However puzzling, these answers do not contradict each other. Respondents' perceptions that a woman should always have the right to decide about her pregnancy, including abortion, may reflect

their desire for personal control over fertility. The right to an abortion may be viewed as a necessary right that should be available on request in the absence of unlimited access to modern contraceptive methods. Women's opinions about terminating a hypothetical unwanted pregnancy by means of abortion elicit more ambivalence, probably reflecting the inherent moral difficulty in deciding between carrying the pregnancy to term or ending it in abortion.

TABLE 13.4.2

Women's Agreement or Disagreement
With the Acceptability of Abortion Under Selected Circumstances:
Women Aged 15–44 Who Do Not Believe Abortion is Always Acceptable
(Percent Distribution)
Reproductive Health Survey: Azerbaijan, 2001

	Acceptability of Abortion					
	Acceptable	Not Acceptable	Depends	Don't Know	Total	Cases
If the Pregnancy Endangers Woman's Life	82.6	9.7	4.3	3.5	100.0	1,456
If the Child Might Be Born Deformed	79.8	8.3	6.3	5.6	100.0	1,456
If Pregnancy Endangers Woman's Health	69.7	19.4	5.3	5.6	100.0	1,456
If Pregnancy Resulted from Rape	66.9	12.4	13.9	6.7	100.0	1,456
If the Woman is Not Married	66.0	15.3	11.3	7.4	100.0	1,456
If Family Cannot Afford to Support the Child	65.2	23.6	5.2	6.1	100.0	1,456

As might be expected, age, marital status, and number of living children were the most important determinants of a woman's opinion of what to do in the case of an unwanted pregnancy. Women with no living children (who are younger and more likely to have never been in union) are much more likely to believe that a woman should keep the baby in the case of an unwanted pregnancy than are women with more than one child (27% vs. 18%).

TABLE 13.4.3

Percent of Women Who Agree With the Acceptability of Abortion
Under Selected Circumstances, by Selected Characteristics:
Women Aged 14-44 Who Do Not Believe Abortion Is Always Acceptable
Reproductive Health Survey: Azerbaijan, 2001

	Circumstance						
Characteristic	Woman's Life In Danger	Fetus Deformed	Woman's Health In Danger	Pregnancy Resulted From Rape	Woman Unmarried	Cannot Afford Child	No. of Cases
Total	82.5	79.8	69.7	66.9	66.0	65.2	1,456
Residence							
Urban	85.5	81.8	71.8	68.7	63.3	64.7	765
Rural	79.0	77.5	67.2	64.8	69.4	65.7	691
Age Group							
15–24	78.2	73.3	63.5	60.5	61.6	56.8	549
25–34	87.7	83.7	73.6	74.9	70.4	73.9	472
35–44	85.0	87.4	76.6	70.3	69.5	71.2	435
Marital Status							
Currently Married/ in Union	85.4	86.0	74.9	74.4	72.6	73.7	878
Previously Married	68.9	83.6	51.0	54.8	55.5	53.6	67
Never Married	80.7	72.1	65.7	59.6	59.6	56.6	511
Education Level							
Secondary Incomplete or less	74.4	70.7	61.8	55.9	65.9	60.4	321
Secondary Complete	84.4	80.8	69.3	70.9	70.6	68.2	737
Technicum	86.6	90.6	81.2	73.1	61.5	72.4	232
University/Postgraduate	87.9	82.7	74.8	66.7	51.9	53.5	166
Ethnicity							
Azeri	82.9	79.6	70.0	66.6	66.2	64.9	1,363
Non-Azeri	79.5	81.3	66.8	70.1	64.9	67.7	93
IDP/Refugee Status							
IDP/R	83.3	84.5	73.4	74.2	70.0	74.2	247
Non-IDP/CA	84.5	84.1	73.8	67.3	71.7	70.9	557
Non-IDP/NCA	81.9	78.0	68.1	65.8	64.0	62.4	652

TABLE 13.4.4
Women's Opinion of What a Woman Should Do If a Pregnancy is Unwanted, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| | What Should A Woman Do If A Pregnancy Is Unwanted | | | | | No. of |
Characteristic	Have An Abortion	Give Birth And Keep The Baby	Give Birth And Have Baby Adopted	Don't Know	Total	Cases
Total	71.2	20.9	1.8	6.1	100.0	7,668
Residence						
Urban	73.4	20.6	1.9	4.0	100.0	3,832
Rural	68.6	21.1	1.7	8.5	100.0	3,836
Age Group						
15–24	64.0	24.0	2.2	9.8	100.0	2,414
25–34	75.2	19.6	1.4	3.7	100.0	2,689
35–44	76.6	18.1	1.8	3.6	100.0	2,565
Marital Status						
Currently Married/ in Union	79.0	17.2	1.6	2.2	100.0	5,146
Previously Married	72.2	21.0	1.8	5.0	100.0	387
Never Married	58.5	26.7	2.3	12.5	100.0	2,135
No. Of Living Children						
None	59.4	26.5	2.4	11.7	100.0	2,655
One	76.1	21.3	1.4	1.2	100.0	784
Two	79.3	17.3	1.4	2.0	100.0	2,094
Three	84.6	12.2	1.7	1.5	100.0	1,530
Four or More	78.4	17.9	1.1	2.7	100.0	605
Education Level						
Secondary Incomplete or less	66.2	21.4	2.0	10.4	100.0	1,697
Secondary Complete	70.1	22.5	1.9	5.6	100.0	3,868
Technicum	78.2	17.5	2.1	2.3	100.0	1,215
University/Postgraduate	77.5	17.5	1.0	4.0	100.0	888
Ethnicity						
Azeri	72.1	20.1	1.9	5.8	100.0	7,189
Non-Azeri	63.4	27.3	1.1	8.2	100.0	479
IDP/Refugee Status						
IDP/R	78.0	13.5	2.0	6.6	100.0	1,272
Non-IDP/CA	73.2	19.6	1.5	5.6	100.0	3,047
Non-IDP/NCA	69.9	22.1	1.9	6.1	100.0	3,349

13.5 Attitudes and Perceptions About Reproductive Norms and Gender Roles

Adherence to traditional reproductive norms and gender roles for women and men can play a major role in couples' reproductive and contraceptive decisions. The AZRHS01 reports the proportion of women who hold selected views toward nine reproductive norms or gender roles (Table 13.5).

203

TABLE 13.5
Percentage of Women Aged 15–44 Who Agree With Statements on Reproductive Norms,
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Woman Should Be Virgin at Marriage	Need Husband's Permission To Work	All People Should Marry	Men Have Final Say In Family	Husband Should Help With Chores	Can Become Pregnant at First Sex	Child-care Isa Woman's Job	If Woman Works, All Money to Husband	Main Job of Woman is Housework
Total	**95.9**	**94.1**	**93.6**	**90.5**	**84.1**	**75.7**	**70.4**	**65.8**	**64.5**
Residence									
Urban	93.9	91.3	91.2	86.2	83.0	78.6	65.6	50.9	53.2
Rural	98.4	97.5	96.5	95.6	85.5	72.3	76.1	83.8	78.0
Age Group									
15–24	95.3	94.0	91.4	88.8	79.8	58.3	72.2	61.3	67.2
25–34	95.7	94.4	94.3	91.6	85.8	86.1	71.0	66.8	62.5
35–44	97.0	94.0	95.7	91.6	88.0	87.8	67.4	70.7	62.8
Marital Status									
Currently Married/ in Union	97.0	95.0	96.0	92.6	86.4	90.1	70.8	69.0	65.1
Previously Married	92.5	91.7	90.8	85.7	86.8	87.7	63.3	66.1	63.9
Never Married	94.7	93.1	90.2	87.8	80.0	50.9	70.7	60.7	63.5
No. Of Living Children									
0	94.9	93.3	90.7	88.6	80.7	55.9	70.2	62.0	64.1
1	93.2	92.1	91.4	87.6	86.3	90.2	70.9	59.7	64.7
2	95.9	94.1	95.6	91.8	86.8	91.4	69.4	65.6	60.6
3	99.3	96.3	97.2	92.9	86.1	91.3	69.2	72.1	65.1
4 or More	98.0	96.8	98.5	96.1	88.5	88.6	75.8	82.2	76.5
Education Level									
Secondary Incomplete or less	97.0	97.1	95.9	93.5	79.2	66.3	79.4	77.6	80.4
Secondary Complete	97.3	95.9	94.8	93.5	84.5	74.8	72.9	71.2	70.4
Technicum	95.8	92.1	93.0	86.9	88.1	87.7	62.8	56.7	48.1
University/Postgraduate	88.6	83.6	84.7	76.6	87.7	83.3	51.2	31.1	28.3
Socio-Economic Status									
Low	98.3	97.7	96.6	95.0	85.1	72.1	75.7	80.2	76.5
Medium	94.9	92.8	92.2	88.3	83.3	78.4	65.7	56.8	56.5
High	89.7	84.2	85.7	79.2	82.9	81.8	64.0	36.9	41.3
Ethnicity									
Azeri	96.7	94.5	94.0	90.6	83.6	75.7	70.3	65.4	63.6
Non-Azeri	89.3	91.0	90.0	89.3	88.5	76.1	70.8	69.2	71.6
IDP/Refugee Status									
IDP/R	98.9	96.5	96.3	94.9	80.6	70.2	72.0	76.9	71.2
Non-IDP/CA	98.0	97.3	96.9	94.2	85.9	73.7	69.7	76.8	68.0
Non-IDP/NCA	95.1	93.1	92.4	89.1	84.1	76.9	70.3	61.7	62.7

Women in Azerbaijan are generally conservative in their views. More than 9 out of 10 women surveyed agreed that a woman should be a virgin when she marries, that a woman needs her husband's permission to get a job, that all people should marry, and that men have the final say in the family. More than two-thirds believe that child care is a woman's job. Two-thirds think that a woman's main job is to care for the house and cook for her family and that if she works outside the home, she should give her money to her husband. However, three-quarters of respondents knew that a woman could become pregnant the first time she has sex, and 84% felt that if a woman is employed, her husband should help with the chores.

Ninety-six percent of women expressed conservative views about sexual experience prior to marriage. The importance of premarital chastity declined somewhat with increased education and socioeconomic status, but still represented 90% of women with these characteristics. Women of Azeri ethnicity were more likely than women of other ethnic groups to value postponement of sexual experience until after marriage.

Ninety-four percent of women believed that a woman needs her husband's permission to work outside the home. The proportion of women agreeing with this statement fell as education and SES increased, and it was somewhat higher for rural women. Sixty-six percent of women agreed that if a woman does have a job, she should give her money to her husband. The proportion of women agreeing with this statement was higher among rural women, married women, IDP/Rs, and non-IDP/R women living in conflict-affected areas. The belief that a woman should give the money she has earned to her husband increased with age and number of children, but it was inversely related to education and SES.

The idea that all people should marry was held by 94% of respondents. University-educated women and women with a high SES were less likely to endorse marriage for all.

Nine out of 10 women (91%) felt that men should have the final say in all family matters. Respondents were less likely to agree with this statement as education and SES increased. Rural women and women with four or more children were more likely to feel that the man is in charge of the family.

Even with the strong agreement with conservative beliefs about family and the marital relationship, a large number of women agreed that if a woman is employed, her husband should help her with the household chores (84%). The percentage of women advocating a husband's assistance increased with age, education, and number of living children. Married women were more likely than unmarried women to agree that a husband should help a working wife.

Three-quarters of all women knew that a woman can become pregnant the first time she has sex (76%). However, the proportion was much lower among women with less than a complete secondary education (66%), women under age 25 (58%), women with no children (56%), and never-married women (51%). These are the very subgroups who are in greater need of this knowledge, because they will be getting married and having their first sexual experience.

Child care is a woman's job, according to 70% of respondents. Rural women and women with more than three children were more likely to agree with this description. Agreement declined as age, education, and SES increased.

Nearly two-thirds (65%)of respondents agreed that the main job for a woman is to take care of the home and cook for her family. Rural women were much more likely than urban women to identify housework as the primary responsibility of a woman, as were women with at least four children. Agreement that a woman's main concern is cooking and cleaning decreased with higher levels of education and SES.

CHAPTER 14

HEALTH BEHAVIORS

In both the developed and developing world, cancer is a leading cause of death in women. Breast and cervical cancer are the most common reproductive system cancers. A substantial proportion of these cancers in Eastern Europe and the former Soviet Union republics are detected at an advanced and incurable stage, due to the low perception of being at risk, lack of awareness of the symptoms of the disease, a fatalistic attitude toward cancer generally, lack of information or mistrust about the possibility of a cure, lack of or inefficient screening services, and a low priority for women's health issues. Generally, women of the region have limited access to preventive health services, mainly because they lack awareness about screening and health providers fail to recommend the tests. Among these services, access to cervical cancer screening is particularly deficient.

Other serious and increasing health risks for women include the increased use of tobacco and alcohol. In response to restricted opportunities and declining markets in Western societies, the transnational tobacco companies have concentrated their efforts, including manufacturing, distribution, and advertising, in less developed countries and Eastern Europe, in which smoking-related diseases are on the increase. The prevalence of smoking is rising most rapidly among young women in many countries, including those of Eastern Europe. A recent worldwide review estimated that smoking prevalence was highest in Europe and Central Asia, (53% among men and 16% among women). Globally, among women aged 15-49 years, more than 40% of smokers are young adults (Jha et al., 2002). Smoking poses specific risks to women in addition to lung cancer and cardiovascular diseases: It increases both the risk of cervical cancer and the risks, for older women, associated with taking the contraceptive pill. It also affects women's reproductive health by increasing the risk of early menopause, miscarriage, and low birth weight babies.

To examine these health issues, the AZRHS01 included questions regarding the following specific health behaviors: prevalence of routine gynecologic visits, breast self-exam, cervical cancer screening, infertility and pelvic inflammatory disease (PID), self-reported health conditions, and cigarette smoking.

14.1 Prevalence of Routine Gynecologic Visits

Before the dissolution of the Soviet Union, breast and cervix uteri cancers had the first- and the third-highest incidence of all neoplasms among women, accounting for 20% and 9% of cases, respectively. With uterine and ovarian cancer representing 13% of cancers among women, gynecologic cancers accounted for more than 42% of the total neoplasm rate among women in the former USSR (Zaridze and Basieva, 1993). Among the USSR republics, Azerbaijan, Georgia, and several Central Asian republics had some of the lowest all-site cancer incidence rates, according to incidence data reported through cancer registries in 1989 (Morabia and Levshin, 1992). The reported incidence rate of breast cancer in Azerbaijan rose slightly in 1990 to 31.8 new cases per 100,000, but it plummeted to 16.2 per 100,000 in 2000; in all other countries of the former Soviet Union, the rate increased or remained constant (WHO Health for All Database [HFA], 2002). Similarly, between 1990 and 2000, the reported incidence of cervical cancer decreased substantially, from 10.3 new cases per 100,000 to 5 per 100,000. Generally, data on gynecologic cancer incidence, particularly comparisons between countries, should be interpreted with caution, because of serious underreporting in countries with limited screening practices, where women are registered in cancer registries only in the advanced stages of their disease (Parkin, Pisani. and Ferlay, 1993). Mortality-related indicators are more reliable, although in some countries of the former USSR, the coding of underlying causes of deaths and underregistration of deaths may still affect between-countries comparisons (WHO HFA Database, 2002).

Important factors that can limit access to preventive health care visits include limited resources within the health system, inadequate number of health care providers or their maldistribution, and physician barriers (e.g., knowledge, attitudes, and beliefs about routine screening; lack of time or expertise; restrictive hours of service availability; and miscommunication between provider and patient). In addition, patients' attitudes and behaviors regarding health care visits are important determinants of whether they receive routine screening, including cervical and breast cancer screening (Wilcox and Mosher, 1993). Therefore, the AZRHS01 included a series of questions aimed at exploring preventive reproductive health practices among women of childbearing age.

In the United States and Western Europe, it is recommended that women of reproductive age have a routine (i.e., not pregnancy-related) gynecologic examination every year. The AZRHS01 asked each respondent whether she had had "a routine gynecologic exam" that was not pregnancy related. Only about 1 in 2 (57%) sexually experienced women had ever been examined by a gynecologist during a routine exam, and only 22% had been examined in the previous 12 months (Table 14.1). Additionally, 15% of women had undergone an exam between 1 and 3 years prior to the survey; for 21 % the exam had been more than 3 years ago. Rural residents, women living in the South and West, younger women, women with lower levels of education, and those not currently employed were more likely to have never received preventive gynecologic exams.

TABLE 14.1
Time since Last Routine Gynecologic Examination by Selected Characteristics
Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Time of Last Routine Gynecologic Examination					
	Within Past Year	Within 1–3 Yrs.	>3 Yrs. Ago	Never Had	Total	No. of Cases
Total	22.1	14.6	20.8	42.5	100.0	5,540
Residence						
Urban	25.9	14.3	21.2	38.6	100.0	2,823
Rural	17.2	15.0	20.2	47.5	100.0	2,717
Region						
Baku	28.3	16.8	19.0	35.9	100.0	1,145
North & North-East	21.8	15.4	20.8	42.1	100.0	674
West	20.0	11.8	21.1	47.1	100.0	568
South-West	23.3	15.6	19.2	41.9	100.0	1,647
South	15.6	12.2	23.9	48.2	100.0	640
Central	20.5	14.5	20.9	44.1	100.0	866
Age Group						
15–19	21.2	6.9	0.1	71.8	100.0	160
20–24	25.6	13.2	7.6	53.7	100.0	674
25–29	26.1	17.8	14.1	42.0	100.0	951
30–34	22.4	15.2	19.2	43.2	100.0	1,393
35–39	21.4	15.2	26.9	36.5	100.0	1,391
40–44	17.1	13.0	32.6	37.3	100.0	971
Marital Status						
Currently Married, in Union	22.5	14.7	20.1	42.8	100.0	5,146
Previously Married, in Union	17.2	14.3	28.4	40.1	100.0	385
Never Married	*	*	*	*	*	9
Education Level						
Secondary Incomplete or less	18.2	12.2	20.2	49.4	100.0	1,057
Secondary Complete	19.7	14.8	20.1	45.4	100.0	2,845
Technicum	26.0	14.4	24.8	34.8	100.0	989
University/postgraduate	32.4	18.0	18.4	31.2	100.0	649
Employment						
Currently Employed	25.1	15.1	24.1	35.7	100.0	1,227
Not Currently Employed	21.2	14.5	19.8	44.6	100.0	4,313
IDP/Refugee Status						
IDP/R	22.3	12.0	19.6	46.1	100.0	929
Non-IDP/CA	21.5	15.9	20.9	41.8	100.0	2,151
Non-IDP/NCA	22.2	14.7	20.9	42.2	100.0	2,460

* Fewer than 25 cases in this category.

Figure 14.1
Prevalence of Routine Gynecologic Exam (Lifetime and Within the Last Year)
Women Aged 15–44 Who Have Had Sexual Intercourse
RHS and DHS Surveys in EE and NIS
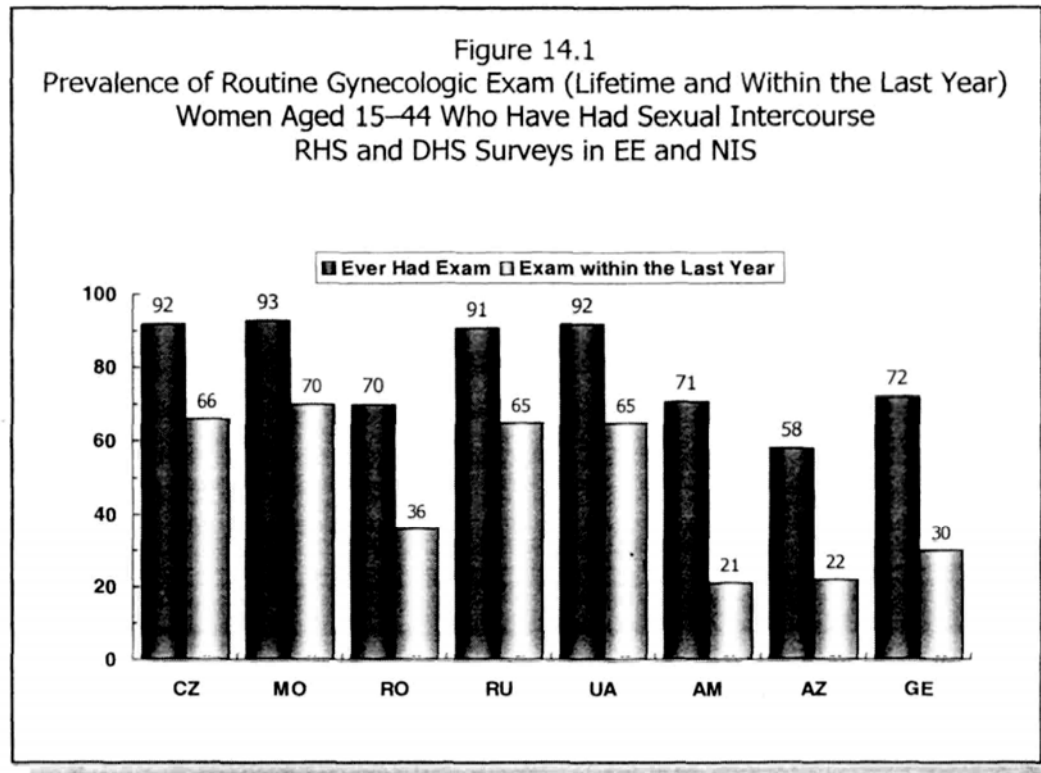
Similar data from other reproductive health and demographic health surveys conducted in Eastern Europe and former Soviet Union countries are shown in Figure 14.1. Between 58% and 93% of sexually experienced women in those countries reported that they had been examined by a gynecologist during a routine exam, but only 22% to 70% had been examined in the previous 12 months. Prevalence of routine exams within the past year was highest in Eastern Europe (65%-70%), with the exception of Romania (36%). The Caucasus region had much lower rates: 21% in Armenia, 22% in Azerbaijan, and 30% in Georgia. The low prevalence of routine exams could have a substantial negative impact on reproductive health screening, counseling, and education for women in these countries.

14.2 Breast Self-Examination

Methods for early detection of breast cancer that can be used as screening tests include breast self-examination (BSE), clinical breast examination (CBE), and mammography (Last et. al., 1986). While clinical trials have shown that mammographic screening can reduce breast cancer mortality in women over age 50 by 25%, there is insufficient evidence at the present time that BSE or CBE alone are effective in reducing mortality and morbidity from breast cancer (Latthe PM and Shafi MI, 2001). However, in populations where mammography is not readily available or is too expensive (and thus unsuitable to be used in population-wide screening), BSE and CBE are responsible for detection of breast cancer in most women (Aubard Y et al, 2002; Rebentish DP et al., 1995). BSE is a simple

TABLE 14.2
Awareness of Breast Self-Examination (BSE) and Frequency of BSE by Selected Characteristics
Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Awareness Total	Frequency of BSE				Total	No. of Cases
		Every Month	Every 3–5 Months	1–2 Times per Year or Less	Never		
Total	29.5	6.3	1.8	2.1	89.9	100.0	5,540
Residence							
Urban	36.6	8.6	2.0	2.6	86.8	100.0	2,823
Rural	20.7	3.3	1.5	1.4	93.8	100.0	2,717
Region							
Baku	48.5	13.2	2.9	4.7	79.2	100.0	1,145
North & North-East	27.8	4.0	2.1	1.4	92.4	100.0	674
West	17.9	2.9	0.6	1.5	94.9	100.0	568
South-West	19.1	3.6	1.1	0.9	94.4	100.0	1,647
South	19.0	1.8	1.7	0.8	95.7	100.0	640
Central	30.8	8.3	1.0	1.5	89.2	100.0	866
Age Group							
15–19	11.0	1.4	0.0	1.7	96.9	100.0	160
20–24	19.5	2.3	1.2	0.5	96.0	100.0	674
25–29	26.5	5.4	1.7	2.3	90.6	100.0	951
30–34	30.9	6.6	1.4	2.4	89.5	100.0	1,393
35–39	36.4	6.9	2.1	1.8	89.2	100.0	1,391
40–44	31.5	9.1	2.6	2.8	85.5	100.0	971
Marital Status							
Currently Married, in Union	29.7	6.4	1.7	2.0	89.8	100.0	5,146
Previously Married, in Union	27.9	3.9	2.2	2.3	91.6	100.0	385
Never Married	*	*	*	*	*	*	9
Education Level							
Secondary Incomplete or less	19.8	3.8	0.7	0.7	94.8	100.0	1,057
Secondary Complete	26.0	4.0	1.7	1.9	92.4	100.0	2,845
Technicum	35.8	9.5	1.3	2.6	86.6	100.0	989
University/postgraduate	51.1	15.0	4.5	4.1	76.4	100.0	649
Employment							
Currently Employed	39.1	10.1	2.6	2.5	84.9	100.0	1,227
Not Currently Employed	26.7	5.1	1.5	1.9	91.4	100.0	4,313
Routine Gynecologic Exam							
Ever	33.8	8.3	2.5	2.3	86.9	100.0	3,213
Never	23.8	3.5	0.8	1.8	93.9	100.0	2,327
IDP/Refugee Status							
IDP/R	26.1	5.0	2.0	0.8	92.2	100.0	929
Non-IDP/CA	25.5	6.1	1.4	1.4	91.1	100.0	2,151
Non-IDP/NCA	30.9	6.5	1.8	2.4	89.3	100.0	2,460

* Fewer than 25 cases in this category.

211

self-care procedure that can detect early modifications of the breast and can be performed by women in the privacy of their homes after minimal instruction. Appropriate follow-up by a physician should be available and accessible for women who detect breast changes through self-examination.

The AZRHSO1 explored only the level of awareness about BSE and its frequency of use. Fewer than 1 in 3 (30%) sexually experienced women of childbearing age had ever heard about this technique, and only 1 in 10 women (10%) had ever performed BSE (Table 14.2). Among survey respondents, awareness of BSE was higher among urban residents than among rural residents (37% vs. 21%) and among women residing in Baku (49%), increased with age and educational level, and was higher among women currently employed and those who underwent routine gynecological exams. Both the prevalence of BSE and monthly practice of the exam were generally low; older age, postsecondary education, being currently employed, and having had routine gynecological exams were characteristics associated with higher monthly practice of the exam.

14.3 Cervical Cancer Screening

Data from large screening programs have shown that annual Pap smear screening reduces the probability of developing invasive cancer by 93.3%, screening every 3 years reduces the probability by 91.2%, and screening every 5 years reduces it by 83.6% (Miller AB, 1986). Based on these estimates, most experts recommend that women who are sexually active or at least 18 years old have

Figure 14.3.1
Prevalence of Cervical Cancer Screening (Lifetime and Within the Last Year)
Women Aged 15–44 Who Have Had Sexual Intercourse
Selected RHS Surveys in EE and NIS
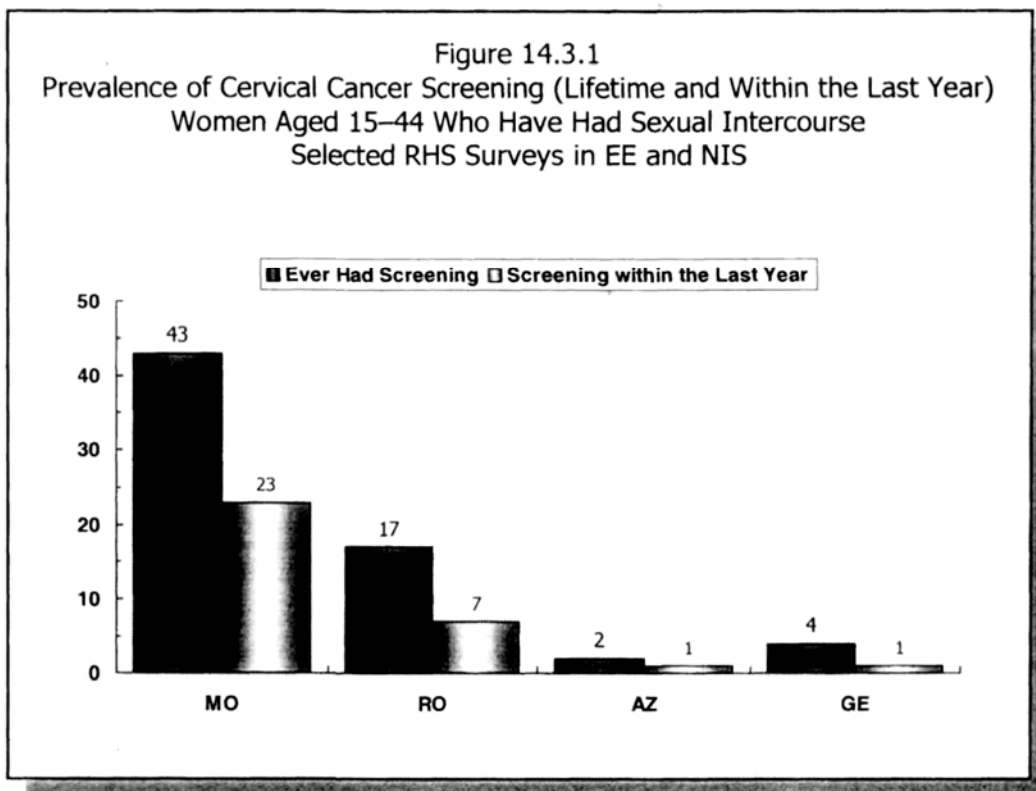
TABLE 14.3
Frequency of Cervical Cancer Screening by Selected Characteristics
Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Frequency of Cervical Cancer Screening Test					
	Within Past Year	1-3 Years Ago	>3 Years Ago	Never Had	Total	No. of Cases
Total	0.6	0.5	0.7	98.2	100.0	5,540
Residence						
Urban	0.9	0.5	0.9	97.7	100.0	2,823
Rural	0.2	0.5	0.5	98.8	100.0	2,717
Region						
Baku	1.9	1.1	·,1.6	95.4	100.0	1,145
North & North-East	0.3	0.0	0.8	99.0	100.0	674
West	0.0	0.0	0.0	100.0	100.0	568
South-West	0.4	0.9	0.7	98.0	100.0	1,647
South	0.0	0.6	0.6	98.8	100.0	640
Central	0.3	0.4	0.0	99.2	100.0	866
Age Group						
15–19	0.0	0.0	0.0	100.0	100.0	160
20–24	0.7	0.0	0.0	99.3	100.0	674
25–29	0.6	0.2	0.4	98.7	100.0	951
30–34	0.5	0.2	0.8	98.5	100.0	1,393
35–39	0.6	0.7	0.8	97.9	100.0	1,391
40–44	0.6	1.2	1.2	96.9	100.0	971
Marital Status						
Currently Married, in Union	0.6	0.5	0.7	98.2	100.0	5,146
Previously Married, in Union	0.6	0.2	0.8	98.4	100.0	385
Never Married	*	*	*	*	*	9
Education Level						
Secondary Incomplete or less	0.4	0.6	0.2	98.8	100.0	1,057
Secondary Complete	0.2	0.3	0.9	98.6	100.0	2,845
Technicum	0.9	0.6	0.5	98.0	100.0	989
University/postgraduate	2.0	0.9	1.2	95.8	100.0	649
Employment						
Currently Employed	0.7	0.6	1.2	97.4	100.0	1,227
Not Currently Employed	0.5	0.5	0.5	98.5	100.0	4,313
Routine Gynecologic Exam						
Ever had	1.0	0.9	1.2	96.9	100.0	3,213
Never had	0.0	0.0	0.0	100.0	100.0	2,327
IDP/Refugee Status						
IDP/R	0.4	0.6	0.0	99.0	100.0	929
Non-IDP/CA	0.5	0.8	0.4	98.3	100.0	2,151
Non-IDP/NCA	0.6	0.4	0.9	98.1	100.0	2,460

* Fewer than 25 cases in this category.

a Pap test annually or every 3 years, followed by the option of reducing the frequency of screening in women over age 65 who have been regularly screened with normal results. Although the self-reported rates of Pap testing are likely to be less accurate than examination of medical records, survey results are often the only estimate available to assess the extent of cervical cancer screening in the general population. The AZRHS01 included a series of questions for all respondents regarding Pap test history: "Have you ever had a cervical smear test (Papanicolaou screening test)?" "When did you have your last cervical smear test?" and, for those who had never had a test, "What is the main reason you have never had a Pap smear?"

Only 2% of sexually experienced women reported that they had ever had a Pap smear (Table 14.3 and Figure 14.3.1) and less than 1% had had their last test within the past 3 years. As in other countries of the region, the prevalence of cervical cancer screening was extremely low and did not allow the study of potential determinants of preventive practices. It is worth noting, however, that the percentages of respondents not having a Pap test in the previous 3 years did not vary significantly with women's age.

This finding may be of concern, because cervical cancer in situ is diagnosed most often in women aged 30-39, and invasive cervical cancer is diagnosed most often in women older than age 40

Figure 14.3.2
Most Common Cited Reasons for Never Having a Cervical Cancer Screening Test among Sexually Experienced Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001

Never Heard of Cervical Cancer Screening 76%

Other 2%
Negligence 2%
No Need to Have Cervical Cancer Screening 3%
Doctor Never Recommended 17%

214
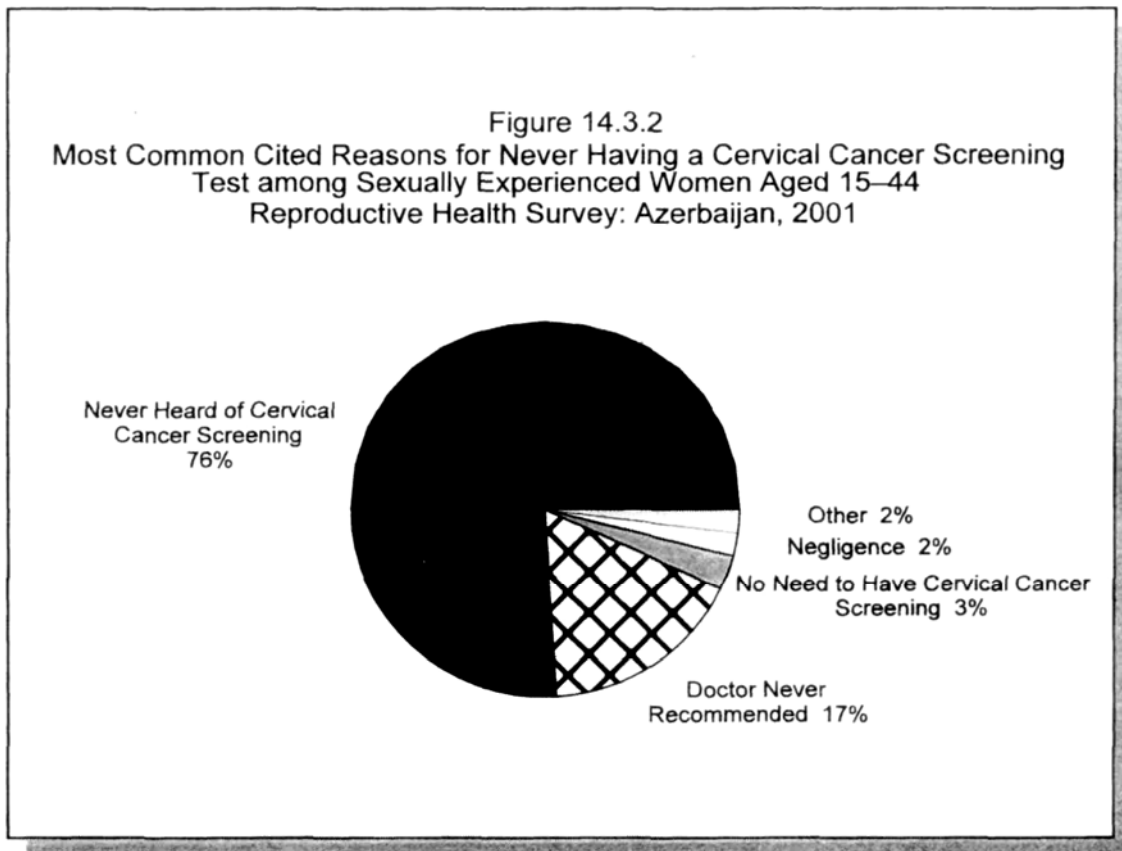
(Brinton and Fraumeni, 1986). The very low prevalence (3%) of cervical screening among women seeking routine gynecologic exams is equally disturbing. Gynecologic routine visits should be viewed as opportunities to educate patients about healthy lifestyle choices and to promote appropriate screening for diseases such as cervical cancer.

The most important reasons for not having a cervical cancer screening test are shown in Figure 14.3.2. For 76% of respondents, the most important reason was the lack of knowledge of such screening; the second most common reason was lack of recommendation of the test by a health provider (17%). Few respondents (just 3%) reported that they had not had screening because they did not need such a test, and 2% of women reported that they neglected to undertake the test. These findings underscore the lack of awareness of gynecologic screening procedures among women of reproductive age in Azerbaijan and the concomitant need for sustained educational campaigns for the public and changes in the practice of health care providers.

14.4 Prevalence of Selected Health Problems

All respondents were asked, "Has a doctor ever told you that you have had (selected health problems)?" The health problems listed were anemia, urinary infection, high blood pressure, hepatitis B, malaria, and toxoplasmosis. In addition, the prevalence of P1D, was determined by asking women if they "had ever been treated for an infection of the fallopian tubes, uterus, or ovaries, also called pelvic infection or PID?" Results are shown in Table 14.4.

Obviously, these results are minimum estimates of the true prevalence of these health problems in the population of women of childbearing age. They probably underrepresent the real prevalence because self-reporting of health conditions implies that women had access to health care facilities, had visited those facilities, and had been told by physicians about their health. Thus, the self-reported occurrence of health problems among different subgroups should be interpreted with caution because background characteristics may affect both access to the health care system and reporting. Furthermore, these are lifetime estimates, do not reflect current health status, and cannot be temporally associated with other events. For all these reasons, the survey data about health problems among women may serve only as proxy estimates in the absence of official statistics based on medical records or hospital discharge data.

The most common condition reported by women of reproductive age was anemia: 37% of all women and 44% of currently married women reported they had been told by a doctor that they had anemia. More than half (57%) had anemia outside a pregnancy (data not shown). The prevalence of anemia was higher among ever-married women and increased with age and with the number of living children (data not shown). The anemia levels found in AZRHS01 (from blood samples collected from women with children under age 5) were consistent with the self-reported levels. Forty percent of nonpregnant women with at least one child under age 5 were anemic (i.e., had hemoglobin [Hb]

TABLE 14.4

TABLE 14.4
Percentage of Women Aged 15–44 Years Who Have Been Told by a Doctor
That They Have Selected Health Problems by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Anemia	PID	High Blood Pressure	Urinary Infection	Toxo-plasmosis	Malaria	Hepatitis B	No. of Cases
Total	**36.5**	**26.8**	**17.7**	**14.0**	**5.1**	**4.6**	**1.7**	**7,668**
Residence								
Urban	38.6	28.5	18.9	14.5	6.6	1.5	2.0	3,832
Rural	34.0	24.7	16.2	13.3	3.3	8.3	1.4	3,836
Region								
Baku	39.5	29.9	19.7	12.9	8.2	0.4	2.6	1,533
North & North-East	38.7	24.2	14.5	12.4	3.8	2.2	1.7	924
West	38.0	30.0	20.5	17.7	2.7	2.0	1.7	766
South-West	38.9	28.2	21.3	17.8	6.9	13.3	2.1	2,302
South	27.2	22.7	13.1	12.8	3.5	5.0	0.5	950
Central	35.7	26.8	19.9	13.6	5.7	11.5	1.4	1,193
Age Group								
15–19	23.0	1.8	3.8	6.1	0.4	3.1	2.3	1,207
20–24	37.3	16.7	12.4	12.6	5.1	4.9	1.8	1,207
25–29	43.0	31.3	15.0	14.2	6.6	6.0	1.4	1,156
30–34	42.9	39.2	23.1	18.4	8.0	5.5	1.2	1,533
35–39	44.1	44.0	25.7	19.8	7.5	4.2	1.4	1,531
40–44	33.6	38.8	32.9	15.5	5.1	4.7	2.0	1,034
Marital Status								
Currently Married, in Union	44.2	42.0	24.3	18.0	8.2	4.9	1.6	5,146
Previously Married, in Union	46.0	41.1	21.2	15.8	6.1	2.7	3.3	387
Never Married	22.7	0.2	6.5	7.2	0.1	4.4	1.7	2,135
Education Level								
Secondary Incomplete or less	34.8	19.6	14.0	11.5	2.4	7.2	0.9	1,697
Secondary Complete	35.7	27.1	18.1	15.3	5.3	4.9	2.1	3,868
Technicum	40.2	35.5	22.5	12.9	7.0	2.1	1.3	1,215
University/postgraduate	38.7	29.3	17.1	14.8	7.9	1.3	2.5	888
Employment								
Currently Employed	41.1	31.4	22.6	14.4	6.5	3.3	1.5	1,600
Not Currently Employed	35.4	25.6	16.4	13.8	4.8	5.0	1.8	6,068
No. of Lifetime Partners								
Never had intercourse	22.6	0.0	6.5	7.2	0.1	4.4	1.7	2128
1	44.3	41.9	23.9	17.7	8.0	4.8	1.6	5389
2	47.3	45.4	27.6	20.3	8.6	4.7	3.8	122
3+	41.2	59.1	12.6	19.8	8.0	0.0	2.7	29
IDP/Refugee Status								
IDP/R	40.0	28.6	20.8	16.5	6.1	10.5	1.2	1272
Non-IDP/CA	35.7	27.6	20.7	16.0	6.1	11.8	1.3	3047
Non-IDP/NCA	36.3	26.4	16.5	13.1	4.8	2.1	1.9	3,349
Routine Gynecologic Exam								
Ever Had	47.6	63.8	26.9	21.5	9.9	4.7	2.0	3,270
Never Had	29.8	4.6	12.1	9.4	2.3	4.6	1.5	4,398

levels under 12.0 g/dL); most of these women (31% of 40%=78%) had mild anemia (Hb 10.0-11.9 g/dL) and less than 1 percent had severe anemia (Hb<7g/dL).

These findings are consistent with the anemia levels measured among women with children under age 5 in the 1996 Azerbaijan Health and Nutrition Survey (Branca et al., 1996). Although not statistically different, the prevalence of anemia in AZRHS01 was slightly lower among internally displaced persons and refugees (IDP/Rs) than among non-IDP/Rs (38% vs. 41%).

The second most common condition reported was PID: 27% of all women and 42% of ever-married women reported the problem. However, PID was nonexistent among women who had never had sexual intercourse, and it was almost nonexistent among adolescent women, who are least likely to be sexually experienced. The PID levels among adolescent (aged 15-19 years) and young adult (aged 20-24 years) women remained lower than the levels among women older than age 24, after controlling for the absence of sexual experience (data not shown). However, age differences in reports of ever having had PID among sexually experienced women were likely to be confounded by the length of exposure, because older women had had a longer time to be exposed to the risk of a genital infection. Those most likely to report PID were women who had ever had a routine gynecologic exam (64%).

Other health conditions were reported as follows: 1 in 6 women reported that she had been told by a doctor that she had high blood pressure; 14% reported urinary tract infection; 5% reported toxoplasmosis; 5% (as high as 12%—13% in the South-West and Central regions) reported episodes of malaria; 2% had been diagnosed with hepatitis B; and a very few women had been told that they had diabetes (1%).

14.5 Impaired Fecundity

The AZRHS01 is the first reproductive health survey conducted with the assistance of the U.S. Centers for Disease Control and Prevention in Eastern Europe and the former Soviet Union countries to include 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 Azerbaijan are increasing, anecdotical evidence leads to widespread beliefs that Azeri 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, AZRHS01 included a series of questions about service attendance, content of infertility visits, and time spent in the hospital for infertility treatments.

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 2 years of exposure to unprotected intercourse. As shown in Table 14.5.1, 10% of currently married women or their husbands had been diagnosed with impaired fecundity. Seven percent of women reported current fecundity impairment. The proportion of women with such diagnosis was slightly higher in urban areas than in rural areas, probably because urban women have better access to medical services that can diagnose fecundity impairment. Fecundity impairment increased directly with age, from 4% among 15- to 19-year-olds to 11% among women aged 25 or older. A higher proportion of nulliparous women reported impaired fecundity (also known as primary impaired fecundity). The proportion of women with impaired fecundity was 4 times higher among women who had had episodes of PID than among those without PID.

Patterns of seeking medical help to become pregnant and the type of help received are presented in Table 14.5.2 and Figure 14.5. Among all married women, about 12% attended infertility services at

Figure 14.5
Attendance of Infertility Services and Type of Services Received
Among Married Women Aged 15–44—AZRHS Survey, Azerbaijan, 2001
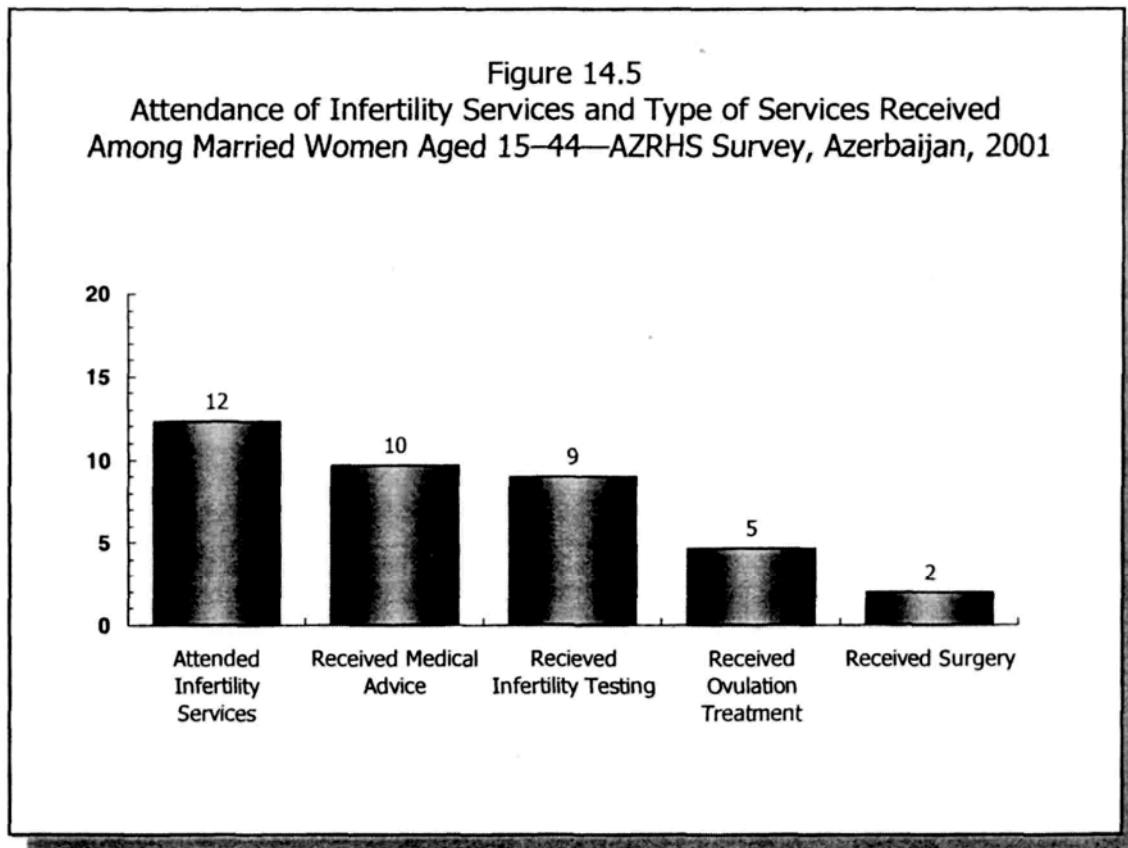
TABLE 14.5.1
Percentage of Currently Married Women Aged 15–44 Years Who Reported Fecundity Impairment by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	% Ever Had Impaired Fecundity	% Current Impaired Fecundity*	No. of Cases
Total	**10.0**	**7.1**	**5,146**
Residence			
Urban	11.4	7.4	2,586
Rural	8.2	6.7	2,560
Age Group			
15–19	3.5	0.4	157
20–24	7.9	3.5	638
25–29	11.1	2.6	910
30–34	9.7	4.2	1,301
35–39	11.0	8.1	1,270
40–44	10.7	17.2	870
No. of Living Children			
0	32.6	20.0	432
1	14.2	6.5	680
2	7.5	4.9	1,978
3+	5.5	6.4	2,056
Education Level			
Secondary Incomplete or Less	9.7	7.9	980
Secondary Complete	9.8	7.3	2,643
Technicum	9.6	5.5	921
University	11.8	7.3	602
Socioeconomic Status			
Low	7.3	6.3	2,739
Middle	12.0	7.3	1,852
High	14.0	9.5	555
IDP/Refugee Status			
IDP/R	8.6	7.3	858
Non-IDP/CA	8.6	7.0	2,013
Non-IDP/NCA	10.5	7.1	2,275
Experienced PID			
Ever Had	18.1	8.2	2,289
Never Had	4.1	6.3	2,857

* Include 18 women who reported anatomical malformations or surgical subfecundity and 6 women with toxoplasmosis.

some time and received various types of help. Most of those women received medical advice, such as timing the sexual intercourse, and testing for infertility (either female or male testing). Less than half received treatment to improve ovulation, and about 1 in 4 women received surgical treatment.

TABLE 14.5.2
Percentage of Currently Married Women Aged 15–44 Years Who Reported Attendace of Infertility Services and Type of Services Received by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Attended Infertility Services	Received Medical Advice	Received Infertility Testing	Received Ovulation Treatment	Received Surgery	No. of Cases
Total	12.3	9.7	9.0	4.7	1.5	5,146
Residence						
Urban	13.5	10.4	10.0	5.2	2.1	2,586
Rural	10.8	8.8	7.8	4.1	0.7	2,560
Region						
Baku	15.8	11.7	11.7	6.4	3.4	1,054
North & North-East	12.4	11.1	10.0	4.9	1.3	635
West	9.3	7.5	5.5	2.3	1.2	511
South-West	10.3	8.3	7.7	4.4	0.7	1,553
South	12.0	8.5	8.3	4.6	1.0	600
Central	10.8	8.6	8.3	4.2	0.1	793
Age Group						
15–19	4.4	4.3	3.4	3.1	0.2	157
20–24	11.6	10.0	8.7	4.9	1.3	638
25–29	13.0	10.9	10.5	6.4	0.8	910
30–34	11.2	8.2	9.0	4.3	0.9	1,301
35–39	13.3	10.6	9.3	4.2	2.7	1,270
40–44	13.7	10.1	8.7	4.4	1.7	870
No. of Living Children						
0	36.9	30.3	33.1	11.2	6.5	432
1	16.9	14.0	13.7	8.0	2.9	680
2	9.6	7.8	6.6	4.1	1.1	1,978
3+	7.4	5.2	4.0	2.6	0.2	2,056
Education Level						
Secondary Incomplete or Less	11.9	8.3	8.2	4.0	1.7	980
Secondary Complete	12.1	9.4	8.5	4.4	1.2	2,643
Technicum	12.4	10.8	9.9	5.7	1.1	921
University	13.4	11.6	11.3	5.6	3.1	602
Socioeconomic Status						
Low	9.8	7.6	6.9	4.2	0.9	2,739
Middle	13.9	10.8	10.4	4.9	1.5	1,852
High	16.7	14.4	13.2	5.7	3.8	555
IDP/Refugee Status						
IDP/R	10.4	7.6	6.9	3.9	0.7	858
Non-IDP/CA	10.7	8.8	7.7	3.6	0.6	2,013
Non-IDP/NCA	12.9	10.2	9.6	5.0	1.8	2,275
Experienced PID						
Ever Had	22.6	17.8	17.0	9.1	3.0	2,289
Never Had	4.8	3.8	3.3	1.5	0.4	2,857

14.6 Cigarette Smoking

Tobacco is a potent human carcinogen that has been shown to be related to many cancers, including those of the respiratory and digestive tracts, bladder, cervix, and kidney. Worldwide, cigarette smoking accounts for 87% of lung cancer deaths and 30% of all cancer deaths. Smoking is also a risk factor for atherosclerosis, which is a major risk factor for heart attacks, strokes, and blood clots of the legs and lungs. Smoking also contributes to the large number of people with asthma, emphysema, pneumonia, and osteoporosis. Maternal smoking has been linked to low birth weight babies, preterm deliveries, miscarriages, sudden infant death syndrome, and respiratory problems of infants (DiFranza and Lew, 1996).

Tobacco use in Eastern Europe has increased since 1990, concurrent with the transition to a market economy and the arrival of the international tobacco industry, whose promotional campaigns have thrived in the absence of legislative regulations. Facing increasing restrictions in the United States and Western Europe, transnational tobacco companies have been expanding rapidly through local manufacturing and aggressive advertising in Eastern Europe and the former Soviet Union republics. Currently, tobacco control policies in former Communist countries are neither comprehensive nor strongly enforced. Restrictions on tobacco advertising and promotion have been recently imposed in some countries, but no systematic efforts have been made to ensure prohibition of smoking in public places, preserving smoke-free environments, restricting cigarette sales to children and teenagers, developing health promotion campaigns, and promoting smoking cessation services (National Tobacco Information Online System [NATIONS], 2001).

The AZRHS01 included several questions for determining cigarette smoking status: "Have you ever tried cigarette smoking?" "Have you smoked at least 100 cigarettes in your entire life?" and, for those who ever smoked 100 cigarettes, "During the last 30 days did you smoke every day, almost every day, some days, or not at all?" Additional questions explored the number of cigarettes smoked by current smokers and the age of smoking initiation. As shown in Table 14.6, cigarette smoking among Azeri women is uncommon. Only 4% of women reported ever trying smoking, and 1% had smoked at least 100 cigarettes during their lifetime (i.e., ever smokers), including 0.6% who smoked daily or almost daily during the 30 days preceding the survey (i.e., current smokers).

Women residing in urban areas were more likely than rural women to have ever smoked (1.6% vs. 0.4%) and to be current smokers. The highest percentage of ever and current women smokers reside in Baku (3% and 2%, respectively). Women aged 20-34 reported higher rates of smoking. Previously married respondents were more likely than those currently married and those who had never been married to have ever smoked or to smoke currently (4% and 3%, respectively). Smoking was directly correlated with educational and socioeconomic status. Respondents who were currently employed

TABLE 14.6
Percentage of Women Aged 15–44 Years Who Have Ever Smoked and Who Currently Smoke by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

	Cigarette Use			
Characteristic	% Ever Tried Smoking	% Ever Smoked 100 Cigatettes	% Currently Smoke	No. of Cases
Total	**4.4**	**1.0**	**0.6**	**7,668**
Residence				
Urban	6.0	1.6	1.0	3,832
Rural	2.5	0.4	0.2	3,836
Age Group				
15–19	6.4	.0.3	0.3	1,207
20–24	6.3	1.6	0.8	1,207
25–29	3.6	1.3	0.8	1,156
30–34	3.3	1.6	1.0	1,533
35–39	2.7	0.9	0.6	1,531
40–44	3.0	0.7	0.5	1,034
Marital Status				
Currently Married/in Union	3.6	1.1	0.7	5,146
Previously Married/in Union	5.1	3.6	2.8	387
Never Married or in Union	5.6	0.5	0.3	2,135
Education Level				
Secondary Incomplete or Less	4.4	0.7	0.4	1,697
Secondary Complete	2.9	0.6	0.4	3,868
Technicum	5.2	1.7	1.0	1,215
University	9.3	2.7	1.9	888
Socioeconomic Status				
Low	2.6	0.4	0.2	4,068
Middle	4.6	1.2	0.8	2,770
High	11.2	3.2	2.0	830
Employment Status				
Employed	5.9	1.2	0.9	1,600
Unemployed	4.0	1.0	0.6	6,068
IDP/Refugee Status				
IDP/R	1.9	0.0	0.0	1,272
Non-IDP/CA	3.5	0.2	0.1	3,047
Non-IDP/NCA	5.0	1.4	0.9	3,349

currently employed (and, presumably, older) were twice as likely as those not employed to have ever smoked and to be current smokers. IDP/R women reported the lowest rates of smoking, and practically none of them was a current smoker.

Figure 14.6
Prevalence of Smoking Daily or Almost Daily Among Women Aged 15–44
Reproductive Health (RHS) and Demographic Health (DHS) Surveys in
Eastern Europe and Former Soviet Union Countries
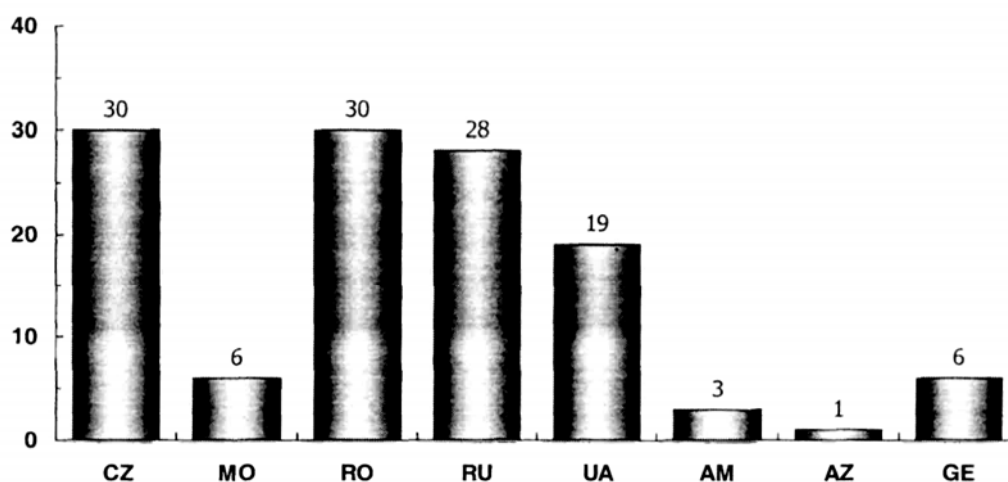
Reproductive and demographic health surveys conducted in the region showed that smoking prevalence among women of reproductive age varies from about 1% in Azerbaijan, to 6% in Georgia and Moldova, to 30% in Romania and the Czech Republic (Figure 14.6) (Serbanescu et al., 2001; VCIOM and CDC, 2000; KIIS and CDC, 2000; ORC/MACRO 2001). In all the surveyed countries, women residing in urban areas were significantly more likely than rural women to be current smokers, and previously married women were most likely to smoke. Age interacted with smoking prevalence differently across countries. Smoking decreased with age in Russia; increased with age in the Czech Republic, Armenia, and Georgia; peaked among 20- to 29-year-olds in Moldova and Ukraine and among 25- to 34-year-olds in Romania and Azerbaijan (data not shown).

CHAPTER 15

FAMILY LIFE EDUCATION

In recent decades, concerns about teenage sexuality, pregnancy, and sexual health have been mounting worldwide. Prevention programs designed to reduce the rate of adolescent pregnancy and sexually transmitted infections (STIs) require a multifaceted approach, and school-based sex education is one important component of a broad effort. A number of studies have demonstrated that high-quality sex education programs can lead to higher levels of abstinence, later initiation of sexual activity, increased use of contraception, and fewer sexual partners (Dawson, 1986; Kirby, 1999; Kirby et al., 1994). Health education interventions are widely seen as appropriate strategies for promoting young people's sexual health, particularly when information among young people about sexuality, reproduction, contraception, and STIs is lacking. Family life education (FLE) has been part of the school curriculum in many countries, although teaching about birth control methods is often omitted. In countries with well-established FLE curricula, the course is often taught with age-appropriate teaching materials from 1st to 12th grade as a component of the health and physical education curriculum. The course usually includes information on selected aspects of human reproductive biology, STIs, AIDS prevention, contraception, and abstinence. Fears that sex education programs encourage or increase sexual activity appear to be unfounded; in fact, some programs are associated with a delay in the initiation of intercourse and an increased likelihood of condom use (Grunseit, 1997; Grunseit et al., 1997).

During the Soviet regime, elements of reproductive biology were taught in high school in biology and human anatomy classes. For a short time *Bases of Ethics of Family Life,* a middle-school course, was taught in Azerbaijan as well as in other Soviet republics. The course covered principles of family life, gender interrelations, ways of coping with family conflicts, and a 3-hour curriculum devoted to sex education. Sex education topics included basic knowledge of reproductive biology, pregnancy, and ethical aspects of sexual life. The course was only taught for a short while because it was highly criticized by parents and teachers *{Bases of Ethics of Family Life,* 1993; Kalimov, 1999). After the collapse of Soviet regime, the need to introduce FLE in school was repeatedly emphasized in mass media. However, political instability, economic decline, and war with Armenia made this theme irrelevant.

Currently in Azerbaijan, FLE is not systematically included in the school curriculum. After 1990,

with the continuous support of several international agencies, local and international nongovernmental agencies (NGOs) trained volunteers to lecture about reproductive health, family planning, and STIs both outside and inside school facilities. These initiatives were concentrated in limited areas in which particular NGOs are active and varied from one area to another. For example, Pathfinder International, in collaboration with the United Nations Population Fund (UNFPA), initiated FLE curriculum development and implementation in five high schools in Baku (Aliyeva et al., 1999). Red Cross began an educational program among schoolchildren of Baku with United Nations Development Programme support in 1994 (Stepanov, 1996). The International Rescue Committee (IRC), in collaboration with the United Nations High Commissioner for Refugees and UNFPA, initiated health education activities in internally displaced person and refugee (IDP/R) settlements as a component of its Women's Health Project between 1998 and 2000 (IRC, 2000). However, efforts to introduce elements of FLE in Azerbaijan were not standardized, lacked national coverage, and often were limited in scope and time frame.

To improve the health knowledge and behavior of Azeri adolescents, it is essential to provide high-quality FLE curricula in schools. Curricula should cover, in addition to reproductive physiology and biology, information on STIs (including HIV/AIDS), methods of contraception, and the psychological and social considerations of sex roles and sexual relationships. These courses, however, need to factor in the religious background of the Azeri population, which is predominantly Muslim. Although Azerbaijan is a secular Muslim country, the principles of Islam concerning family and the education of girls may play an appreciable role in designing and implementing a FLE curricula. Under Islamic tradition, nonpermanent methods of contraception are generally permitted. Islam literature mentions some form of sex education given to the Prophet's followers and the possibility of obtaining advice on selected aspects of reproductive health topics from Aisha, the Profet's wife (Hassanein, 1999).

One of the objectives of the AZRHS01 was to examine whether reproductive-age women in Azerbaijan favor FLE in schools and to explore their opinions about the best age at which to start such education. In addition, the survey was designed to explore young adult women's exposure to FLE in school and at home and their most common sources of information on sexual matters. Data on exposure to FLE and knowledge of young adults could be used for designing formal school curricula and projecting the need for training of teachers.

15.1 Opinions About Family Life Education in Schools

A total of 3 in 4 Azeri women of reproductive age supported FLE in schools, regardless of age, residence, marital status, parity, education, or socioeconomic status (SES). Residents of the South and West regions were slightly less likely than residents of other regions to agree with FLE (Table

15.1.1). When asked about specific topics of FLE, between 71% and 75% of women felt that reproductive biology, birth control methods, and STI topics should be part of the school curriculum.

Among the 25% of women who did not agree that sex education should be taught in school, beliefs that it "may give adolescents the idea to begin sexual activity earlier" were almost universal (89%). Moreover, 71% of such women thought that sex education should be only taught at home, 54% thought that those who teach sex education in schools are not qualified to do so, and 50% opposed sex education because it contravened their religious beliefs (data not shown).

Women who agreed on the need for school-based FLE were also asked their opinion about the best grade level at which to start each topic of sex education (Figure 15.1 and Table 15.1.2). Seventy-three percent wanted FLE classes about "how pregnancies occur" before age 16, including 19% of respondents who supported such courses before age 13 (i.e., sixth grade or earlier). Of those who believed that this topic should be introduced before age 16, the majority favored age 14 or 15 (i.e., grades 8 and 9) as the right time to start lectures. Residents of urban areas, including those living in Baku; those aged 35 or older; those with postsecondary education; and those with high SES were slightly more likely than others to say that sex education should be taught before age 16.

Figure 15.1
Opinions about the Best Time to Start FLE in School by Specific Topics
Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001
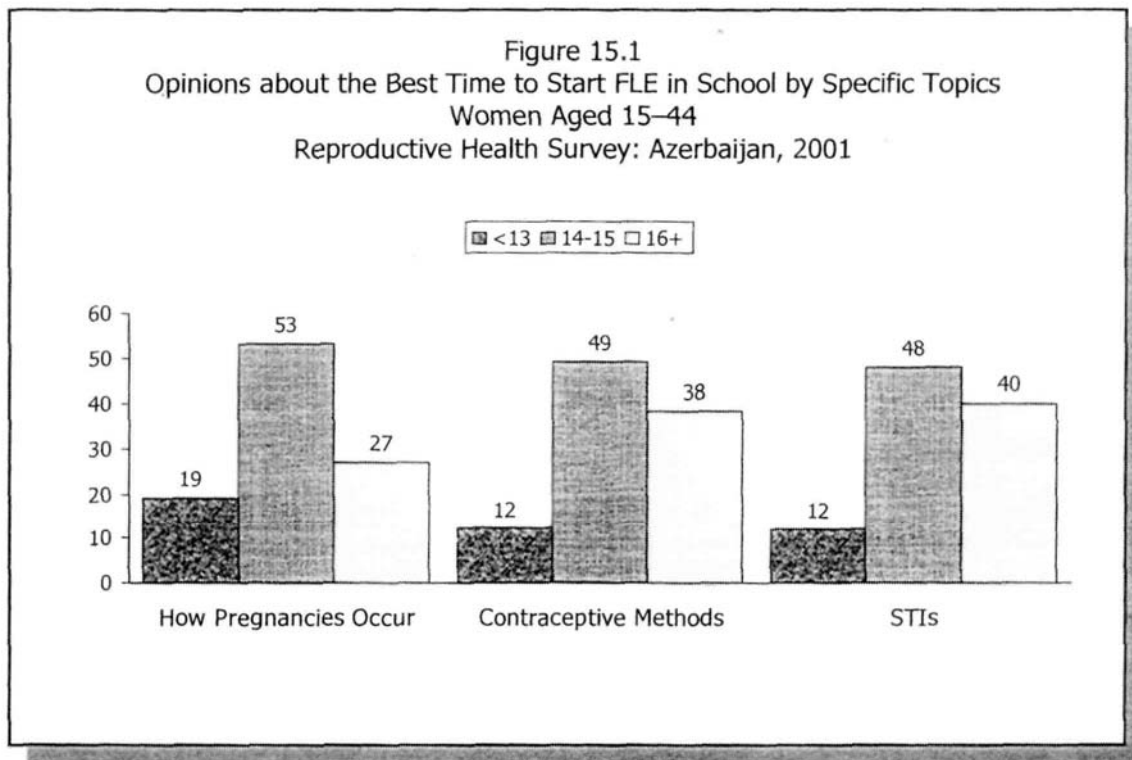
TABLE 15.1.1
Percent of Women Aged 15-44 Who Agree Certain Sex Education Topics Be Taught in School
By Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Any Topic | Sex Education Topic | | | No. of Cases |
		How Pregnancies Occur	Contraception	Sexually Transmitted Diseases	
Total	74.5	74.5	72.7	71.4	7,668
Residence					
Urban	75.8	75.8	73.8	72.2	3,832
Rural	73.0	73.0	71.3	70.4	3,836
Region					
Baku	79.6	79.5	76.4	74.2	1,533
North & North-East	82.3	82.3	80.0	79.5	924
West	61.2	61.2	59.7	58.0	766
South-West	74.1	74.1	72.4	71.6	2,302
South	63.3	63.3	63.1	61.7	950
Central	79.0	79.0	77.7	76.5	1,193
Age Group					
15–24	73.9	73.9	72.1	70.3	2,414
25–34	76.4	76.4	74.0	73.5	2,689
35–44	73.5	73.5	72.1	70.5	2,565
Number of Living Children					
0	75.0	75.0	72.9	71.5	2,655
1	76.7	76.7	75.3	74.1	784
2	75.4	75.3	73.6	72.1	2,094
3 or more	72.0	72.0	70.3	69.3	2,135
Education Level					
Secondary Incomplete or less	69.4	69.4	67.2	66.1	1,697
Secondary Complete	74.0	74.0	72.0	70.5	3,868
Technicum	78.6	78.6	77.8	75.8	1,215
University/Postgraduate	82.1	82.1	80.2	80.0	888
Socioeconomic Status					
Low	71.0	71.0	69.2	68.3	4,068
Medium	77.1	77.1	75.2	73.7	2,770
High	80.6	80.6	78.5	76.0	830
IDP/Refugee Status					
IDP/R	73.6	73.3	70.8	69.9	1,272
Non-IDP/CA	77.1	77.1	75.5	74.8	3,047
Non-IDP/NCA	74.1	74.1	72.2	70.7	3,349

TABLE 15.1.2

Opinions on Best Age To Start School-Based Courses on "How Pregnancies Occur"
Among Women Who Agreed with Sex Education in School by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Best Age to Start Courses on "How Pregnancies Occur"					Best Age to Start Courses on "Contraceptive Methods"				
	≤13	14–15	16+	Total	No. of Cases	≤13	14–15	16+	Total	No. of Cases
Total	19.3	53.4	27.2	100.0	5,763	12.3	49.3	38.4	100.0	5,537
Residence										
Urban	20.4	54.1	25.5	100.0	2,943	12.3	50.5	37.1	100.0	2,803
Rural	17.9	52.6	29.4	100.0	2,820	12.3	47.7	40.1	100.0	2,734
Region										
Baku	22.2	57.7	20.1	100.0	1,221	13.4	52.6	34.0	100.0	1,144
North & North-East	17.1	55.5	27.4	100.0	764	9.5	51.5	39.0	100.0	733
West	14.6	49.3	36.1	100.0	475	9.2	41.6	49.2	100.0	453
South-West	14.3	52.0	33.7	100.0	1,738	9.1	44.4	46.5	100.0	1,693
South	25.6	42.2	32.2	100.0	584	19.9	42.4	37.7	100.0	570
Central	19.7	57.1	23.2	100.0	981	12.9	54.8	32.2	100.0	944
Age Group										
15–19	15.2	52.1	32.7	100.0	873	9.0	46.2	44.8	100.0	816
20–24	19.0	53.1	27.9	100.0	920	13.0	47.8	39.2	100.0	893
25–34	19.2	53.7	27.1	100.0	2,054	13.1	48.1	38.8	100.0	1,976
35–44	22.6	54.3	23.1	100.0	1,916	13.5	53.3	33.2	100.0	1,852
No. of Living Children										
0	18.3	53.4	28.3	100.0	1,979	12.1	48.6	39.3	100.0	1,885
1	22.7	47.8	29.6	100.0	612	15.0	44.6	40.4	100.0	589
2	19.2	54.7	26.1	100.0	1,598	12.6	49.5	37.8	100.0	1,536
3 or more	20.0	54.6	25.3	100.0	1,574	11.2	52.1	36.7	100.0	1,527
Education Level										
Secondary Incomplete or less	18.5	53.9	27.6	100.0	1,172	13.2	49.4	37.4	100.0	1,114
Secondary Complete	17.8	54.9	27.2	100.0	2,902	11.2	50.8	38.0	100.0	2,781
Technicum	19.8	49.9	30.3	100.0	967	10.6	49.1	40.3	100.0	938
University/Postgraduate	25.7	51.5	22.8	100.0	722	16.8	43.5	39.7	100.0	704
Socioeconomic Status										
Low	16.8	54.0	29.2	100.0	2,961	11.0	48.9	40.1	100.0	2,862
Medium	19.9	52.7	27.3	100.0	2,138	12.2	49.2	38.6	100.0	2,046
High	26.5	53.5	20.0	100.0	664	17.5	50.7	31.8	100.0	629
IDP/Refugee Status										
IDP/R	18.6	53.3	28.1	100.0	995	10.6	46.0	43.4	100.0	959
Non-IDP/CA	18.0	53.2	28.8	100.0	2,246	12.1	49.5	38.3	100.0	2,177
Non-IDP/NCA	19.8	53.5	26.7	100.0	2,522	12.6	49.6	37.8	100.0	2,401

TABLE 15.1.3
Opinions of Best Age to Begin Teaching School-based Courses on Sexually Transmitted Diseases
Women 15–44 Who Think Schools Should Teach Family Life Education, by Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Opinion of Best Age To Begin Teaching on Sexually Transmitted Diseases | | | | |
	≤ 13	14–15	≥16	Total	No. of Cases
Total	**12.1**	**47.9**	**40.0**	**100.0**	**5,580**
Residence					
Urban	12.3	48.5	39.2	100.0	2,857
Rural	11.9	47.0	41.1	100.0	2,723
Region					
Baku	13.6	49.1	37.2	100.0	1,173
North & North-East	9.8	50.5	39.7	100.0	739
West	8.6	40.3	51.1	100.0	460
South-West	8.6	43.0	48.4	100.0	1,683
South	19.2	41.6	39.2	100.0	574
Central	11.9	55.3	32.8	100.0	951
Age Group					
15–19	8.9	46.2	44.9	100.0	827
20–24	13.0	45.9	41.1	100.0	897
25–34	12.3	47.3	40.3	100.0	1,992
35–44	13.5	50.7	35.7	100.0	1,864
No. of Living Children					
0	11.7	47.9	40.4	100.0	1,896
1	14.9	44.1	41.0	100.0	595
2	12.3	47.5	40.2	100.0	1,563
3 or more	11.3	49.8	38.8	100.0	1,526
Education Level					
Secondary Incomplete or less	12.4	48.5	39.1	100.0	1,116
Secondary Complete	10.8	49.8	39.4	100.0	2,799
Technicum	11.1	46.5	42.4	100.0	952
University/Postgraduate	17.6	41.4	41.0	100.0	713
Socioeconomic Status					
Low	10.7	47.6	41.7	100.0	2,856
Medium	12.0	47.5	40.5	100.0	2,079
High	17.2	49.9	32.9	100.0	645
IDP/Refugee Status					
IDP/R	10.0	46.7	43.3	100.0	964
Non-IDP/CA	10.9	49.4	39.6	100.0	2,171
Non-IDP/NCA	2.6	47.6	39.7	100.0	2,445

Opinions of reproductive-age women on the best time to start FLE courses about methods of contraception and STIs are shown in Figure 15.1 and in Tables 15.1.2 and 15.1.3. Respondents who supported school-based education on those topics tended to prefer starting the courses before age 16 (62% and 60%, respectively), including 12% who supported seeing the courses introduced before age 13. Similarly, respondents who favored the early onset of school-based courses about contraception and STIs were more likely to be urban residents, to live in Baku, to be at least 35 years old, to have postsecondary education, and to have high SES.

15.2 Discussions about FLE Topics With Parents

To examine the impact of FLE on reproductive health knowledge and sexual and contraceptive behaviors, we explored young women's exposure to FLE topics separately at home and in school. All 15- to 24-year-olds were asked whether, before they reached age 18, they had ever talked to parent about the menstrual cycle, abstinence before marriage, how pregnancy occurs, contraceptive methods, or HIV/AIDS and other STIs. Data for 15- to 17-year-olds are truncated because they had not yet reached age 18; thus, prevalence of FLE topics discussed at home or taught in school for this age group should be treated as minimum estimates only.

A total of 56% of young women had talked about at least one FLE topic with a parent (Table 15.2 and Figure 15.2). Young women living in urban areas, including Baku (70%), and in higher SES groups (67%) were slightly more likely to have had such conversations with a parent. Adolescent (i.e., 15- to 19-year-olds) were more likely than young adults (i.e., 20- to 24-year-olds) to report discussing any of these topics with a parent, either because such conversations have recently become more likely or because differences in recall exist between adolescents and young adults.

When FLE topics were discussed with a parent before age 18, the discussions consisted of, for the most part, talking about the menstrual cycle. Conversations about abstinence before marriage, how pregnancies occur, STIs, HIV/AIDS, and contraception were substantially less prevalent: only about 1 in 5 young women (22%) talked to a parent about abstinence, 1 in 10 talked about how pregnancies occur, less than 6% discussed about HIV/AIDS or other STIs, and 4% talked about contraceptive methods.

Parental conversations on sex education topics cannot be interpreted without taking into account the exposure to sex education in schools. Young women who received FLE in schools were also more likely to have talked to a parent about FLE topics (67% vs. 48%), suggesting that when young women receive school-based sex education, either they or their parents may be stimulated to initiate conversations about sexual topics (data not shown). Although the increase was obvious for all FLE

TABLE 15.2
Percentage of Young Adult Women Aged 15–24
Who Discussed Certain Family Life Education Topics With a Parent Before They Reached Age 18
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Any Topic	Menstrual Cycle	Abstinence Before Marriage	How Pregnancies Occur	HIV/ AIDS	Other Sexually Transmitted Diseases	Contraception	No of Cases
Total	55.5	48.6	22.2	10.8	5.5	4.3	4.1	2,414
Residence								
Urban	60.3	51.8	26.9	11.3	8.4	5.8	4.7	1,155
Rural	50.2	45.0	16.9	10.2	2.3	2.6	3.5	1,259
Region								
Baku	69.5	59.3	37.5	13.0	14.7	10.3	7.0	481
North & North-East	55.0	49.0	20.3	12.8	3.8	4.7	5.5	308
West	52.4	44.4	17.6	6.5	1.4	0.0	1.8	261
South-West	46.5	40.2	17.3	7.9	1.5	1.4	2.7	709
South	47.5	44.2	12.3	8.4	2.1	1.8	2.1	341
Central	53.5	45.9	22.0	13.1	5.7	3.3	3.0	314
Age Group								
15–17	61.1	55.4	20.2	8.5	5.6	3.5	3.2	747
18–19	60.3	54.6	20.3	13.4	6.0	4.7	3.7	460
20–24	48.7	40.2	24.7	11.4	5.3	4.7	5.1	1,207
Education Level								
Secondary Incomplete	54.2	46.8	20.0	10.1	4.4	2.9	4.1	807
Secondary Complete	55.8	49.3	21.1	10.4	4.6	3.7	3.3	1,167
Technicum	58.0	50.1	24.2	11.3	6.1	4.2	5.7	203
University	56.7	50.2	33.3	14.6	13.6	11.8	6.7	237
Socioeconomic Status								
Low	50.5	44.1	16.4	9.4	2.3	2.6	3.3	1,238
Medium	57.9	50.8	26.4	10.7	6.5	5.1	4.4	883
High	67.1	58.6	31.4	16.3	14.9	8.0	6.4	293
IDP/Refugee Status								
IDP/R	56.7	43.7	27.4	7.3	6.6	3.7	3.9	362
Non-IDP/CA	47.8	41.4	17.0	8.6	2.2	2.1	3.0	950
Non-IDP/NCA	57.0	50.6	22.8	11.6	6.1	4.8	4.4	1,102
Sexual Experience								
Ever Had	49.8	40.3	28.1	14.4	4.2	4.0	5.4	834
Never Had	57.6	51.6	20.0	9.5	6.0	4.4	3.7	1,580

Figure 15.2
FLE Topics Discussed at Home or Taught in School
Azerbaijan, 2001—Young Adult Women 15-24
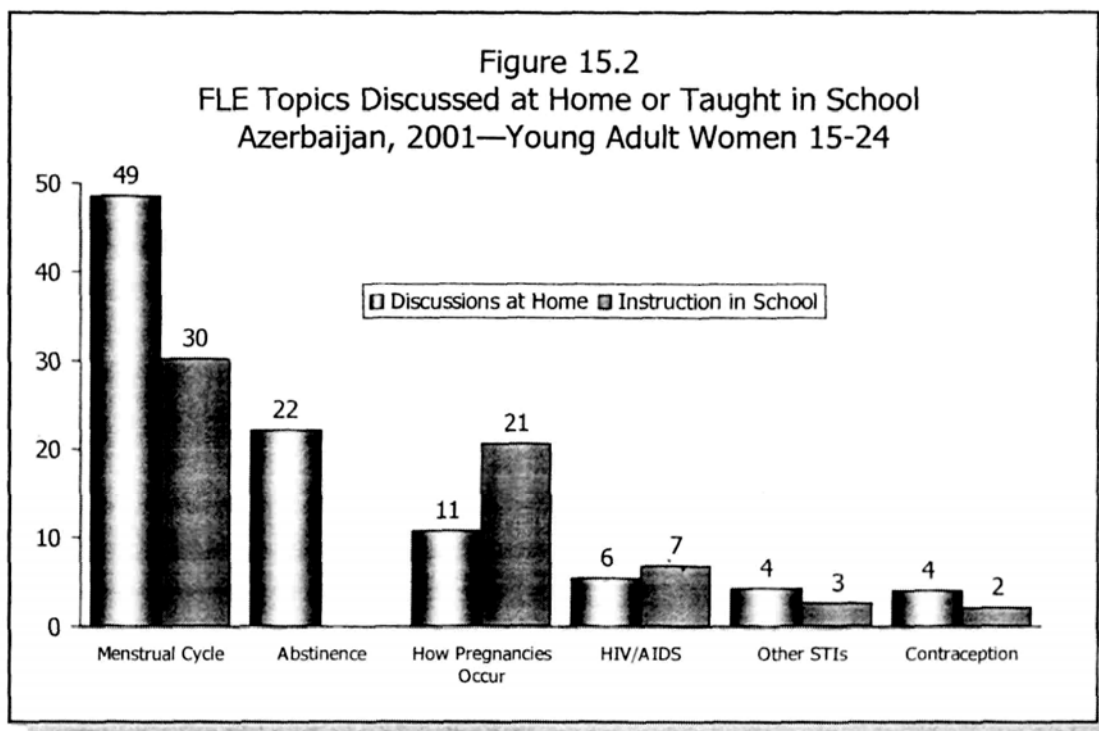
topics, particularly striking was the increase in parent-child conversations about STIs and contraception. Young women who reported school classes on HIV/AIDS prevention, other STIs, and methods of birth control were approximately 7 times more likely to report parent-child conversations about those topics than were those who did not have classes on those topics (data not shown).

15.3 FLE Instruction in School

Young women were also asked whether, before they reached age 18, they had ever received formal or informal instruction in school about the topics listed in Table 15.3.1. Those who reported exposure to instruction in school were then asked the age at which they first had a class on each topic. Like the data on discussions with parents, the data for FLE for 15- to 17-year-olds in schools are truncated because the respondents had not yet reached age 18.

Only 40% of young women had at least one school-based course or FLE class (Table 15.3.1). However, they were much more likely to have received lectures on female and male reproductive biology, the menstrual cycle, and how pregnancies occur (30%, 25%, and 21%, respectively) than lectures on HIV/AIDS, other STIs, and contraceptive methods (7%, 3%, and 2%). Urban residents, particularly those living in Baku, were more likely than rural residents to have received FLE in school on any topic. In fact, with the exception of residents of Baku and the North-Northeast regions,

courses about STIs other than HIV/AIDS and contraception were practically nonexistent. Baku was the only area in which more than 12% of respondents received a course on HIV/AIDS in school.

Young women with only a primary education were significantly less likely to have taken an FLE course in school (3%) because most FLE courses may not be offered until secondary school. This points to the need for out-of-school FLE education for those who never entered secondary school. Similarly, a significantly lower proportion of young women in the lowest SES had ever taken a school-based FLE course. Young women living in areas affected by war (both IRP/Rs and non-IDP/Rs) were less likely to have received FLE topics in school. Exposure to FLE in school was slightly higher among young women who had never had sexual intercourse than among those who reported sexual activity.

The study of age patterns for FLE courses demonstrates that, regardless of topic, no FLE courses were provided before age 11 (data not shown). Only courses related to reproductive biology are started before age 15—that is, prior to high school (Table 15.3.2). Between 12% and 16% of young women had received formal FLE about menstrual cycle, female and male reproductive biology, and "how pregnancies occur"before high school. If they did not receive an FLE course before age 15, most students received one in the first or second year of high school. Few reported such courses after age 17.

Lectures about HIV/AIDS, other STIs, and contraception were significantly less prevalent than lectures on human reproduction by each successive birthday, but the age at first lecture on those topics follows a pattern similar to that of lectures on human reproduction. The least taught topic was methods of birth control: the cumulative proportion of young women reporting formal instruction about this topic was less than 1% by age 15, 1% by age 16, and 2% by age 18. For each successive age, the probability of having received contraceptive instruction was 10 to 15 times lower than the probability of having received instruction about human reproduction. Similarly, formal instruction before age 18 about HIV/AIDS and other STIs was 4 to 7 times less prevalent than instruction on reproductive biology.

Regardless of topic, most FLE instruction in school was delivered by teachers (Table 15.3.3). Between 1% and 8% of young women received school-based instruction from a health professional, particularly on the STI topics. Volunteers and NGO personnel were responsible for 4%-6% of courses about HIV/AIDS and other STIs and for 12% of courses about contraception.

TABLE 15.3.1

Percentage of Young Adult Women Aged 15–24
Who Had Family Life Education Topics in School Before They Reached Age 18
According to Specific Family Life Education Topic, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

				Family Life Education Topic					
Characteristic	Any Topic	Female Reproductive Biology	Male Reproductive Biology	Menstrual Cycle	How Pregnancies Occur	HIV/ AIDS	Other STIs	Contraception	No. of Cases
Total	39.9	29.8	30.2	24.8	20.7	6.8	2.7	2.2	2,414
Residence									
Urban	49.7	36.9	38.8	31.6	27.0	9.0	3.2	2.7	1,155
Rural	28.9	21.9	20.6	17.2	13.6	4.3	2.2	1.5	1,259
Region									
Baku	59.2	42.0	44.2	37.0	35.1	12.1	4.8	4.2	481
North & North-East	46.7	34.5	37.3	25.8	21.1	6.4	3.8	3.4	308
West	33.1	26.0	23.3	23.9	14.1	3.4	0.5	0.8	261
South-West	30.3	21.5	23.1	17.8	15.2	3.5	0.7	0.8	709
South	20.9	17.7	15.9	14.7	12.7	4.0	1.5	1.0	341
Central	33.3	26.1	24.1	21.6	17.3	8.7	2.7	0.2	314
Age Group									
15–17	39.2	28.5	27.6	24.0	20.6	10.1	3.2	2.2	747
18–19	36.3	26.9	27.0	22.5	19.6	5.7	3.8	2.4	460
20–24	42.2	32.2	33.8	26.6	21.2	4.7	1.8	2.0	1,207
Education Level									
Primary	3.4	1.9	3.4	0.0	3.0	1.1	0.0	0.0	139
Secondary Incomplete	30.3	21.5	22.7	16.3	16.4	5.2	2.2	2.3	668
Secondary Complete	42.2	31.6	31.1	26.2	20.1	8.1	2.6	1.3	1,167
Technicum	58.7	45.6	48.6	39.0	30.7	6.8	2.9	4.0	203
University	61.6	48.0	47.3	45.2	37.0	8.9	6.0	5.5	237
Socioeconomic Status									
Low	28.6	21.5	22.5	17.3	13.3	3.5	1.0	0.8	1,238
Medium	48.6	36.0	36.5	30.6	26.5	9.2	4.0	3.2	883
High	56.5	42.4	40.2	35.6	31.0	12.2	5.2	4.0	293
IDP/Refugee Status									
IDP/R	32.1	23.0	26.0	20.2	16.7	3.5	1.2	0.9	362
Non-IDP/CA	28.7	21.9	21.5	19.1	14.5	4.2	1.0	0.7	950
Non-IDP/NCA	43.1	32.2	32.5	26.5	22.4	7.7	3.2	2.6	1,102
Sexual Experience									
Ever Had	37.8	28.8	28.8	24.9	20.0	5.2	2.6	2.0	834
Never Had	40.7	30.2	30.7	24.8	20.9	7.4	2.8	2.2	1,580

TABLE 15.3.2
Percent of All Young Adult Women 15–24
Who Have Taken Courses in School on Selected Family Life Education Topics by Certain Ages
Reproductive Health Survey: Azerbaijan, 2001

Family Life Education Topic	Percent Who Have Taken Course By Age:					No. of Cases
	≤14	≤15	≤16	≤17	≤18	
The Menstrual Cycle	1.4	11.1	25.0	31.5	32.1	2,414
Female Reproductive Biology	1.3	10.9	23.5	30.9	31.6	2,414
Male Reproductive Biology	0.7	9.2	19.4	26.0	26.5	2,414
How Pregnancies Occur	0.6	6.1	15.5	21.7	22.3	2,414
HIV/AIDS	0.1	1.2	3.9	6.3	7.7	2,414
Other Sexually Transmitted Diseases	0.0	0.3	1.1	2.6	3.2	2,414
Contraceptive Methods	0.0	0.6	1.3	2.2	2.4	2,414

TABLE 15.3.3
Main Source of School-Based Family Life Education Among Young Women Aged 15–24
Who Received Family Life Education in School by Selected Topics
Reproductive Health Survey: Georgia, 1999/2000

Family Life Education Topic	Source of School-Based Family Life Education				Total	No. of Cases
	Teacher	Doctor/ Nurse	Volunteer	Other		
Menstrual Cycle	96.2	2.8	1.0	0.0	100.0	698
Female Reproductive Biology	97.6	1.6	0.8	0.0	100.0	674
Male Reproductive Biology	98.7	1.1	0.2	0.0	100.0	568
How Pregnancies Occur	98.0	1.1	0.8	0.0	100.0	473
HIV/AIDS	93.1	2.7	1.5	2.6	100.0	141
Other Sexually Transmitted Diseases	85.8	8.0	0.6	5.6	100.0	54
Contraceptive Methods	84.4	3.9	4.7	7.0	100.0	45

TABLE 15.4
**Opinion on the Most Important Source of Information about Sexual Matters
Among Young Adult Women Aged 15–24 by Selected Characteristics
Reproductive Health Survey: Georgia, 1999/2000**

						Opinion on the Most Important Source of Information About Sexual Matters					
Characteristic	Friends Peers	Other Relatives	A Parent	Media	Books	Teacher	Partner/ Husband	Doctor	Other	Total	No. of Cases*
Total	39.1	23.6	9.6	9.1	7.1	5.4	4.5	1.5	0.2	100.0	2,372
Residence											
Urban	38.2	16.8	11.1	12.4	8.7	6.8	3.8	2.0	0.3	100.0	1,136
Rural	40.1	31.2	8.0	5.3	5.2	3.8	5.4	0.9	0.0	100.0	1,236
Region											
Baku	30.6	12.8	13.2	18.9	10.6	7.0	3.7	2.5	0.7	100.0	471
North & North-East	41.6	19.1	10.9	9.5	5.7	9.5	3.2	0.4	0.0	100.0	304
West	48.0	26.3	6.8	2.8	6.3	0.1	8.0	1.7	0.0	100.0	257
South-West	38.2	30.4	7.8	5.1	8.0	4.4	5.1	0.7	0.1	100.0	702
South	38.1	39.2	4.8	2.5	5.6	3.0	5.7	1.0	0.0	100.0	339
Central	40.7	21.5	12.5	10.5	5.9	3.9	2.2	2.7	0.0	100.0	299
Age Group											
15–17	44.8	22.7	11.8	6.0	6.2	6.7	0.3	1.1	0.4	100.0	730
18–19	39.8	21.2	10.0	11.5	5.1	6.3	5.3	0.8	0.0	100.0	455
20–24	34.3	25.6	7.7	10.3	8.7	3.9	7.5	2.0	0.0	100.0	1,187
Education Level											
Secondary Incomplete	41.8	28.7	10.6	4.8	4.6	4.0	4.7	0.8	0.0	100.0	795
Secondary Complete	40.5	24.8	9.4	8.7	5.5	4.7	5.0	1.2	0.3	100.0	1,140
Technicum	35.4	10.3	8.1	16.3	8.6	11.9	4.3	5.0	0.0	100.0	202
University	26.5	11.3	8.3	20.1	21.7	7.9	1.8	1.9	0.3	100.0	235
Socioeconomic Status											
Low	41.1	30.5	8.1	5.4	5.2	3.6	4.8	1.2	0.0	100.0	1,214
Medium	39.6	17.8	10.6	9.7	8.3	7.6	4.9	1.1	0.3	100.0	870
High	30.2	15.0	12.4	21.1	10.1	5.1	2.4	3.5	0.2	100.0	288
IDP/Refugee Status											
IDP/R	34.6	26.7	9.9	6.7	9.4	4.2	4.7	3.7	0.1	100.0	360
Non-IDP/CA	40.8	24.4	11.8	6.7	6.6	3.6	4.3	1.7	0.1	100.0	930
Non-IDP/NCA	39.2	23.1	9.1	9.8	6.9	5.9	4.6	1.2	0.2	100.0	1,082
Sexual Experience											
Ever Had	31.5	30.1	7.6	4.0	5.1	2.4	16.6	2.8	0.0	100.0	821
Never Had	41.9	21.3	10.4	10.9	7.8	6.4	0.2	1.0	0.2	100.0	1,551

* Excludes 41 women who had no opinion.

15.4 Sources of Information on Sexual Matters

Young women aged 15-24 were asked who, in their opinion, had been their most important source of information on topics related to sexual matters. The most important source for this type of information was friends and peers (39%) (Table 15.4). One-third of young women named a relative, including 10% who said that a parent was the most important source of information. Less than 10% named the media, less than 5% named a teacher, and less than 2% named a doctor as the most important source of information. Urban residents, including those living in Baku; those with high education level and high SES; and 20- to 24-year-olds named the media as a somewhat more important source of information on sexual matters.

15.5 Impact on Knowledge About Fertility Issues and Contraception

Knowledge of the most fertile time in a woman's menstrual cycle is an important measure of a woman's ability to assess the risk of pregnancy during unprotected intercourse, and therefore is an indicator of her potential to prevent unintended pregnancies. Only 12% of young women were able to correctly identify the most fertile time during a woman's menstrual cycle, whereas more than 2 in 3 women (65%) did not know whether there is a specific time during the menstrual cycle when a woman is more fertile (Table 15.5). The proportion with correct knowledge was 3 times as high for 20-to 24-year-olds (12%) as for 15-to 19-year-olds (4%) (data not shown). Knowledge increased significantly with education, from 1% among respondents with primary education to 8% among those with complete secondary education and 18% among university students (data not shown). Table 15.5 also shows the percent distribution of young women according to their knowledge about the time during the menstrual cycle when conception is most likely to occur, by whether they had ever discussed the menstrual cycle with their parents or taken a school-based FLE course on this topic. Both discussions with a parent(s) and formal instruction about the menstrual cycle had relatively greater knowledge about the topic, but the difference was far less than expected. Thus, although between 1 in 2 and 1 in 3 women had exposure, either at home or in school, to information about the most likely time to become pregnant during menstrual cycle, that exposure had little influence on their correct knowledge..

Knowledge about the contraceptive effect of breast-feeding was also low (24%) and increased with age (from 19% among 15- to 19-year-olds to 31% among 20- to 24-year-olds) and with educational level (from 15% among the least educated women to 40% among those with highest educational level) (data not shown). Knowledge that women can get pregnant at their first sexual relationship was comparatively widespread (58%) and also was positively correlated with age and education. Both parental discussions and formal instruction on "how pregnancies occur," however, did not play any apparent role in young women's knowledge about these reproductive health issues, suggesting that other sources (e.g., friends or peers) may have provided correct knowledge.

TABLE 15.5
Knowledge of Young Adult Women Aged 15–24
About Selected Reproductive Health Issues
by Whether or Specific FLE topics Were Discussed with a Parent or Taught in School
Reproductive Health Survey: Azerbaijan, 2001

Most Likely Time to Become Pregnant During Menstrual Cycle	Total	Discussed Menstrual Cycle with Parents		Taught About Menstrual Cycle in School	
		Yes	No	Yes	No
Halfway Between Periods	7.7	9.1	6.3	10.9	6.3
The Week Before or during or Just After the Menstruation	14.7	14.8	14.6	16.4	13.9
Anytime	12.4	12.4	12.4	12.5	12.4
Don't Know	65.2	63.7	66.7	60.3	67.4
Total	100.0	100.0	100.0	100.0	100.0
Number of Cases	2,414	1,332	1,082	1,716	698

	Total	Discussed "How Pregnancies Occur" with Parents		Taught About "How Pregnancies Occur" in School	
		Yes	No	Yes	No
Risk of Getting Pregnant While Breastfeeding					
Lower Risk	24.3	28.3	23.8	26.6	23.6
Same Risk as if not Breastfeeding	22.0	23.4	21.8	25.5	21.1
Higher Risk	1.3	3.8	1.0	2.2	1.1
Do not Know	52.4	44.5	53.3	45.7	54.1
Total	100.0	100.0	100.0	100.0	100.0
Possibility of Getting Pregnant at First Intercourse					
Possible	58.3	72.6	56.6	64.9	56.6
Not Possible	8.3	9.9	8.1	7.5	8.5
Do not Know	33.3	17.6	35.3	27.6	34.8
Total	100.0	100.0	100.0	100.0	100.0
Number of Cases	2,414	246	2,167	473	1,941

CHAPTER 16

SEXUAL AND CONTRACEPTIVE EXPERIENCE OF YOUNG ADULTS

The Young Adult module of the AZRHS01 included questions for women aged 15-24 years about attitudes toward condom use, age and partner at first sexual intercourse, and use of contraceptive methods as well as questions about current sexual partners. This chapter reviews the findings, which constitute the first population-based data on young adults in Azerbaijan.

Although a small percentage of young women in Azerbaijan, a Muslim country, were expected to report premarital sexual experiences, it was possible to classify the first sexual relation as premarital or marital, as has been done in other surveys in Eastern Europe (Serbanescu et al., 1995,1998, 2001; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000). This classification was obtained from two specific questions in the survey instrument: the date of the first sexual relation and the relationship to the partner at the time of this first sexual experience. If the partner was the respondent's husband, the dates of first sexual experience and first marriage were compared to determine whether the first sexual experience was marital or premarital. If the first sexual experience occurred at least 1 month prior to the date of marriage, it was classified as premarital.

16.1 First Sexual Intercourse

Young women were asked for the date (month and year) of their first sexual intercourse as well as their date of birth and age at the time of the interview. As Table 16.1.1 demonstrates, more than half of the respondents remain virgins throughout most of their young adulthood. Of the 2,414 young women, more than two-thirds (74%) reported that they had not had sexual intercourse. This table also shows that virtually all young adult women who were sexually experienced had their first sexual experience after marriage (25.3% of 26.5%=95%). Only within the 22-24 age group do more than half of women report sexual experience, with 6% (3.2% of 54.9%) reporting their first sexual encounter before marriage. The prevalence of premarital sex is extremely low; approximately 1% report sexual intercourse before marriage. This pattern is in stark contrast to all neighboring Eastern European countries except Georgia (see section 16.4).

TABLE 16.1.1
Reported Sexual Experience of Young Women Aged 15–24 Years
and Marital Status at Time of First Sexual Experience by Current Age Group
Reproductive Health Survey: Azerbaijan, 2001

| | Reported Sexual Experience | | | Marital Status at First Intercourse | | |
| | No Sexual | Sexual | | | | No. of |
Current Age Group	Experience	Experience	Total	After Marriage	Before Marriage	Cases
Total (15–24)	73.5	26.5	100.0	25.3	1.2	2,414
15–17	95.5	4.5	100.0	4.5	0.0	747
18–19	80.2	19.8	100.0	19.6	0.1	460
20–21	63.1	36.9	100.0	35.0	1.9	453
22–24	45.1	54.9	100.0	51.7	3.2	754

TABLE 16.1.2
Reported Sexual Experience of Young Women Aged 15–24 Years
by Marital Status at Time of First Sexual Experience by Residence
Reproductive Health Survey: Azerbaijan, 2001

| | Reported Sexual Experience | | | | |
| | No Sexual | After | Before | | Unweighted |
Current Age & Residence	Experience	Marriage	Marriage	Total	No. of Cases
All Women					
15–19	89.8	10.2	0.1	100.0	1,207
20–24	52.5	44.9	2.7	100.0	1,207
Total	73.5	25.3	1.2	100.0	2,414
Urban					
15–19	93.3	6.6	0.1	100.0	569
20–24	59.0	38.3	2.8	100.0	586
Total	78.1	20.7	1.2	100.0	1,155
Rural					
15–19	85.9	14.1	0.0	100.0	638
20–24	44.9	52.6	2.6	100.0	621
Total	68.4	30.5	1.1	100.0	1,259

As shown in Table 16.1.2, the proportion of women reporting sexual experience is slightly lower among urban residents than rural residents (22% and 32% respectively); this finding reflects the earlier age of marriage in rural areas because almost all reported sexual experience is marital. As in most countries, women in rural areas are inclined to marry at young ages for various social and economic reasons. In addition, the increased opportunity for young women in urban areas to continue their education may delay the age at marriage and, as a result, the age at first sexual experience.

The marital status of young women at first sexual experience by current age group and education is described in Table 16.1.3. No real statistical differences are evident by education or age group, except that fewer 20- to 24-year-old women with technical school or university education reported sexual experience, a pattern associated with their later age at marriage.

Married and unmarried respondents who were sexually experienced were asked whether they or their partner used any contraceptive method during their first sexual experience. Only 1% of sexually experienced young women reported that they or their partner used any contraception at that time. Among women whose first sexual experience was marital, less than 1% reported contraceptive use; however, 14% of the women reporting premarital sex said that they or their partner used contraception at first intercourse. The respondents who did not use contraception at first intercourse were asked for their reasons for not using contraception; most (85%) said they did not use contraception because they wanted to get pregnant (Table 16.1.4). The second most cited reason for not using contraception was that they "did not think about it" (7%). These reasons also were the two most commonly cited reasons among women in union (86% and 7%, respectively).

Despite the small sample size of sexually experienced women not in union who did not use contraception at first sex, the main reason for non-use was the desire to become pregnant (49%), followed by unexpected intercourse (27%). About 50% of unmarried women who wanted to become pregnant at first intercourse dated their partner for more than 1 year (data not shown). The desire for pregnancy appears to be a major concern for many women in this age group independent of marital status. Given that most young women in Azerbaijan have their first sexual experience after marriage and have a strong desire to have children once they are married, the demand for family planning among young married women is minimal until they have their first child. Reproductive and maternal and child health programs can concentrate on helping women space future children to improve maternal and infant health; programs also should provide appropriate counseling on contraceptive use during prenatal and postnatal care.

TABLE 16.1.3
Reported Sexual Experience of Young Women Aged 15–24 Years
by Marital Status at Time of First Sexual Experience by Education
Reproductive Health Survey: Azerbaijan, 2001

| Current Age & Education | Reported Sexual Experience | | | | |
	No Sexual Experience	After Marriage	Before Marriage	Total	Unweighted No. of Cases
All Women					
15–19	89.8	10.2	0.0	100.0	1,207
20–24	52.5	44.9	2.7	100.0	1,207
Total	**73.5**	**25.3**	**1.2**	**100.0**	**2,414**
Secondary Incomplete or less					
15–19	88.0	12.0	0.0	100.0	494
20–24	47.6	49.7	2.8	100.0	313
Total	**74.4**	**24.7**	**0.9**	**100.0**	**807**
Secondary Complete					
15–19	90.2	9.7	0.1	100.0	605
20–24	44.4	52.5	3.1	100.0	562
Total	**71.5**	**27.2**	**1.3**	**100.0**	**1,167**
Technical School					
15–19	94.2	5.8	0.0	100.0	52
20–24	62.0	36.2	1.8	100.0	151
Total	**71.9**	**26.9**	**1.3**	**100.0**	**203**
University					
15–19	96.1	3.9	0.0	100.0	56
20–24	74.5	23.6	2.0	100.0	181
Total	**80.8**	**17.8**	**1.4**	**100.0**	**237**

TABLE 16.1.4

Most Commonly Cited Reasons for Not Using Contraception at First Sexual Intercourse
Among Sexually Experienced Young Women Aged 15–24
by Marital Status at First Sexual Intercourse
Reproductive Health Survey: Azerbaijan, 2001

		Marital Status at First Intercourse	
Main Reason for Not Using Contraception	**Total**	**Married or in Union**	**Not Married**
She Wanted to Get Pregnant	84.6	86.0	48.5
She Did Not Think About Using a Method	7.0	6.6	16.3
She Did Not Know About Contraception	3.7	3.5	8.2
Other	2.1	2.2	0.6
Respondent Too Embarrassed to Use a Method	1.4	1.4	0.0
Sexual Intercourse Was Unexpected	1.3	0.3	26.5
Total	**100.0**	**100.0**	**100.0**
Unweighted No. of Cases	**821**	**787**	**34**

TABLE 16.1.5

Age Difference Between Married Partners at First Sexual Intercourse
by Age at First Sexual Intercourse
Reproductive Health Survey: Azerbaijan, 2001

Age at First Sexual Experience	**Less than 5 Years**	**5 Years or Greater**	**Total**	**Unweighted No. of Cases**
Total	**65.7**	**34.4**	**100.0**	**793**
13–15	83.3	16.7	100.0	60
16	78.6	21.4	100.0	109
17	81.5	18.5	100.0	160
18	60.7	39.3	100.0	147
19	57.0	43.1	100.0	119
20–21	49.4	50.6	100.0	133
22–24	36.7	63.3	100.0	65

As seen in Table 16.1.5, about one-third of partners (34%) at first marriage are more than 5 years older than the woman. Among women marrying at age 20-24, more than half of their partners are 5 years or older, as is true for about 40% of those marrying at age 18 and 19.

16.2 Current Sexual Activity

Sexually experienced respondents were asked when they last had intercourse (Table 16.2.1). As mentioned in the previous section, most young adult women (74%) have never had sex. The majority of the sexually experienced women had had sexual intercourse in the past month (14% of 26%=53%); 9% of women were identified as currently pregnant or postpartum at the time of the interview. Thirty-six percent of women currently married or in union and 15% of previously married women were identified as pregnant or postpartum (for a total of 9% of the respondents reporting pregnancy or postpartum). Conversely, among women who have never been married, essentially 100% reported never having had sexual intercourse. By age group, almost 90% of women aged 15-19 have never had sexual intercourse; however, about one-half of women aged 20-24 have had a sexual experience (53%); about 1 in 4 women (27%)— more than half (56%) of sexually experienced, nonpregnant women— had intercourse in the past month.

TABLE 16.2.1
**Current Sexual Activity Status Among Women Aged 15–24 Years
by Current Marital Status and by Age Group
Reproductive Health Survey: Azerbaijan, 2001**

Sexual Activity Status	Total	Marital Status			Age Group	
		Married/ In Union	Previously Married	Unmarried	15–19	20–24
Never Had Intercourse	73.5	0.0	0.0	99.8	89.8	52.5
Ever Had Intercourse	26.5	100.0	100.0	0.2	10.2	47.5
• Within the Last Month	13.9	55.4	6.2	0.1	3.9	26.8
• 1-3 Months Ago	1.6	5.8	9.3	0.0	1.2	2.1
• Over 3 Months Ago but Within Last Year	1.0	3.0	15.9	0.1	0.5	1.7
• One Year or Longer	0.9	0.1	53.7	0.0	0.1	1.9
• Currently Pregnant or Postpartum	9.1	35.8	14.9	0.0	4.6	14.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	2,414	795	33	1,586	1,207	1,207

Most sexually experienced women (64%) did not use contraception at their most recent sexual intercourse (Table 16.2.2). The likelihood of using contraception was lower among young women who were not currently married (9%) than among those who were currently married (38%). Among the sexually experienced women using contraception, traditional methods were more common than modern methods: 30% and 6%, respectively. The IUD is the most common modern method (4%), and withdrawal is by far the most common traditional method as well as the most common of all methods (29%) used.

TABLE 16.2.2
Use of Contraception at Most Recent Sexual Intercourse by Current Marital Status
among Sexually Experienced Young Women Aged 15–24 Years
Reproductive Health Survey: Azerbaijan, 2001

Use of Contraception	Total	Marital Status			Not Currently Married
		Currently Married			
		Total	15–19	20–24	
Currently Using	**36.0**	**37.9**	**14.2**	**44.8**	**8.9**
Modern Methods	**6.3**	**6.7**	**1.5**	**8.2**	**1.6**
IUD	4.1	4.4	0.5	5.6	0.0
Condom	1.6	1.6	1.0	1.8	1.6
Pills	0.4	0.4	0.0	0.6	0.0
Female Sterilization	0.2	0.2	0.0	0.3	0.0
Traditional Methods	**29.7**	**31.3**	**12.7**	**36.6**	**7.2**
Withdrawal	29.3	30.8	12.6	36.1	7.2
Periodic Abstinence	0.4	0.5	0.1	0.6	0.0
Not Currently Using	**64.0**	**62.1**	**85.8**	**55.2**	**91.1**
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
No. of Cases	**834**	**795**	**157**	**638**	**39**

TABLE 16.2.3
Most Commonly Cited Reasons for Not Using Contraception
Among Young Married Women by Age Group
Reproductive Health Survey: Azerbaijan, 2001

Main Reason for Not Using Contraception	Total	Age Group (15–24)	
		15–19	20–24
Currently Pregnant	35.1	38.9	33.5
Wants to Get Pregnant	24.4	37.9	18.3
Currently Postpartum or Breastfeeding	17.3	13.2	19.1
Not Sexually Active	7.7	6.7	8.2
Infertility/subfecundity	4.9	0.5	6.9
Thought Douching Was a Contraceptive	1.5	0.0	2.2
Pelvic Inflammatory Disease	1.4	0.0	2.1
Dislikes Contraception	1.4	1.8	1.2
Did Not Think about It/negligence	1.2	0.0	1.7
Other Reasons	5.1	1.2	5.9
Total	100.0	100.0	100.0
Unweighted No. of Cases	475	127	348

The reasons cited for not using contraception reported by young married women having intercourse are shown in Table 16.2.3. The most commonly cited reason was current pregnancy, followed by the desire to get pregnant and current postpartum or breast-feeding. Thus, 3 out of 4 young married women are not using contraception for reasons associated with pregnancy, regardless of their age.

Sexually experienced respondents were asked to recall the number of sexual partners that they had had in the past 3 months (Table 16.2.4); 87% of sexually experienced women reported having had only one partner, and the other 13% reported no partner. Less than 1% had had two or more partners. All young married women reported having no partner or one partner in the past 3 months. Among previously married young women, 94% have had no partners and 6% have had one partner in the past 3 months. These respondents were also asked to recall their lifetime sexual partners. Ninety-eight percent of all young women reported one sexual partner in their lifetime. Almost all currently married young women reported having only one partner in their lifetime (99%), and only 8% of previously married young women reported more than one partner in their lifetime.

TABLE 16.2.4

Number of Sexual Partners Reported in Last Three Months and in Lifetime by Current Marital Status Among Sexually Experienced Young Women Aged 15–24 Years

Reproductive Health Survey: Azerbaijan, 2001

Number of Sexual Partners	Total	Marital Status		
		Currently Married/in Union	Previously Married	Never Married
Three months				
None	13.1	7.9	93.8	*
One	86.8	92.1	6.2	*
Two or more	0.1	0.0	0.0	*
Total	100.0	100.0	100.0	
Lifetime				
One	98.2	99.0	92.0	*
Two or more	1.8	1.0	8.0	*
Total	100.0	100.0	100.0	
No. of Cases	834	795	33	6

* Fewer than 25 observations in this category

16.3 Opinions and Attitudes About Condoms and Condom Use

Sexually experienced young women were categorized into women who had ever used and those who had never used condoms; they were asked to agree or disagree with statements about condoms and condom use (Table 16.3.1). Among nonusers, the proportion of women with an uncertain response (e.g., "don't know") was 50% or higher for each statement. This finding is probably due to this group's lack of exposure to using condoms or to discussing topics related to condom use. Many more users of condoms responded and either agreed or disagreed with the statements, and few were uncertain. Most users of condoms agreed that using a condom with one's partner is a good idea (71%). Almost two-thirds believe that women should ask their partners to use condoms (60%). Most condom users disagree with the notion that condoms can be used more than once (83%) or the belief that people who use condoms sleep around a lot (82%). These findings suggest that women who have used condoms with their partners generally disagree with societal myths that may act as barriers to using condoms. Sixty-one percent of condom users disagreed that it is embarrassing to ask for

condoms in family planning clinics or pharmacies. Only about 1 in 4 nonusers of condoms agreed that using condoms with partners is a good idea (29%), compared with 71 % of users. Fewer nonusers than users agreed that "women should ask their partners to use condoms" (25% vs. 59%) and that "it is easy to discuss condoms with a prospective partner" (15% vs. 55%). A high proportion of both women who have used condoms (49%) and women who have not used condoms (35%) agreed that condoms are not necessary "if you know your partner."

TABLE 16.3.1
Agreement with Statements about Condoms and Condom Use by Condom Experience
Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Azerbaijan, 2001

Statement	Ever Users (N=97)			Never Users (N=737)		
	Agree	Disagree	Do Not Know	Agree	Disagree	Do Not Know
Using Condoms with your Partner is Smart Idea	70.8	7.1	22.0	28.6	8.5	62.9
Condoms Diminish Sexual Enjoyment	66.9	24.9	8.2	18.4	1.8	79.9
Women should Ask Their Partners to Use Condoms	59.0	33.4	7.6	24.7	14.2	61.1
It is Easy to Discuss Condom Use with a Prospective Partner	54.6	18.9	26.4	15.1	19.5	65.5
Condoms are not necessary if you know your partner	48.6	36.7	14.8	34.8	8.5	56.7
It Is Embarrassing to Ask for Condoms in FP Clinics or pharmacies	33.8	61.1	5.1	24.2	22.1	53.6
Same Condoms Can be used more than Once	14.8	82.5	2.7	5.1	28.4	66.5
People Who Use Condoms Sleep Around A lot	9.7	81.5	8.8	18.3	23.2	58.5

Less than one-quarter of all sexually experienced women (20%) have talked to a partner about using condoms (Table 16.3.2). Eighty-five percent of women who have ever used condoms have spoken with their partner about using condoms, whereas only 12% of women who have never used condoms have spoken with their partner. This finding suggests that the partners' ability to discuss condom use is associated with use. Also, 3 times as many women who have used withdrawal (30%) have discussed condom use as women who have not used withdrawal (11%); this intent to prevent pregnancy by using withdrawal appears to be related to discussing condoms. Among all sexually experienced women, women who have discussed condom use with their partner tend to be urban, to be aged 20-24, and to have attended technical school or university. Twenty-seven percent of urban women have ever talked about condoms with their partner, compared with only 14% of rural women.

TABLE 16.3.2
Percent of Women Who Have Ever Talked to a Partner about His Using Condoms by Selected Characteristics of Sexually Experienced Women 15–24 Years of Age
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	All Sexually Experienced Women	
	%	N
Total	19.8	834
Residence		
Urban	27.3	367
Rural	14.0	467
Age Group		
15–19	8.6	160
20–24	22.9	674
Education Level		
Secondary Completed or less	17.4	691
Technical School/University	32.5	143
IDP/refugee Status		
IDP/R	26.2	132
Non-IDP/NCA	19.9	381
Non-IDP/CA	16.1	321
Ever Used Condoms		
Yes	84.8	97
No	12.0	737
Ever Used Withdrawal		
Yes	30.2	424
No	9.3	410

251

TABLE 16.3.3
Agreement With Specific Statements Regarding Interpersonal Impact of Condom Use
Sexually Experienced Women Aged 15–24 Years
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Safe from Getting Pregnant	Safe from Getting HIV/AIDS	Safe from Getting Other STIs	Angry	Insulted	Worried You Have Done Something Wrong	Suspicious of Partner's Behavior	No. of Cases
Total	47.4	32.6	36.9	22.2	21.7	20.9	17.7	834
Residence								
Urban	59.1	44.3	49.1	25.0	22.7	21.9	20.3	367
Rural	38.2	23.5	27.4	20.1	20.9	20.1	15.6	467
Region								
Baku	67.7	58.1	59.7	25.8	22.0	24.2	25.8	156
North-Northeast	49.7	32.6	39.7	20.6	23.4	22.7	18.4	113
West	38.6	20.1	26.7	26.0	23.8	18.2	15.3	101
Southwest	43.6	26.9	28.2	20.0	20.7	16.5	13.3	261
South	36.1	23.8	26.3	19.5	19.8	21.8	15.1	103
Central	39.5	24.5	29.1	19.7	17.4	17.2	12.1	100
Age Group								
15–19	36.3	17.8	21.7	21.5	17.2	21.3	16.8	160
20–24	50.3	36.7	41.1	22.4	22.9	20.8	17.9	674
Education Level								
Secondary Incomplete or less	43.3	24.3	31.2	22.4	21.4	22.4	17.1	268
Secondary Complete	43.7	31.3	34.3	22.0	22.5	20.3	17.0	423
Technical School/University	67.4	54.3	57.2	22.8	20.1	19.4	20.9	143
Talked about Condoms with Partner								
Ever Talked	86.5	62.5	65.7	21.9	16.0	21.4	23.8	184
Never Talked	37.7	25.2	29.8	22.3	23.1	20.7	16.1	650
Know How Condom Is Used								
Yes	73.7	52.2	56.8	32.5	30.2	29.6	27.0	377
No	25.3	16.1	20.3	13.7	14.6	13.5	9.8	457
Ever Used Condom								
Yes	85.6	67.3	72.3	20.6	11.3	15.7	28.0	97
No	42.8	28.4	32.7	22.4	23.0	21.5	16.4	737

Almost one-half of women (47%) agreed that they would feel safe from getting pregnant if their partner asked to use a condom with them (Table 16.3.3). These positive feelings were more common among women who live in urban areas (59%), attend technical school or university (67%), have

talked to their partner about condoms (87%), know how to use a condom (74%), or have ever used a condom (86%). Only about one-third of women agreed that they would feel safe from HIV/AIDS (33%) and safe from getting other STIs (37%). Eighteen percent of women agreed that they would be suspicious of their partner's behavior if he wanted to use condoms with her, and one-fifth (21%) would be worried that she had done something wrong. About one-fifth (22%) of women would feel insulted or angry.

16.4 Regional Comparisons

The differences in reported premarital sexual experience and use of contraception at first premarital sex among young women aged 15-24 in Eastern Europe are summarized in Table 16.4, which compares data from similar reproductive health surveys conducted in the Czech Republic, Moldova, Russia, Romania, Ukraine, Georgia, and Azerbaijan (Serbanescu et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000). Among women aged 15-24, Czechs have the highest level of reported premarital sexual experience: more than 90% of 20- to 24-year-old women have had premarital sex in the Czech Republic. Russia has the next highest proportion of young women initiating sexual intercourse before marriage. Almost 90% of 20- to 24-year-olds in the Russian survey reported having had premarital sex, followed by 74% in Ukraine. The lowest proportions of women reporting premarital sexual intercourse in all age groups are in Azerbaijan and Georgia, two of the three countries that make up the Caucasus Region. In those two countries, reported premarital sexual experience is less than 1% among 15- to 19-year-olds and just l%-2% among 20- to 24-year-olds, strikingly different from all other Eastern European countries. These findings reflect the conservative nature of Azerbaijan's society; religion may have a strong influence on the acceptability of premarital sex among young adults.

The use of contraceptives in the countries surveyed also demonstrates marked differences between Azerbaijan and neighboring countries. Romania and the Czech Republic have the highest proportions of young women aged 15-24 using contraceptives at first sexual intercourse. Except for Ukraine and Russia, where modern methods are more common, traditional methods and modern methods are relatively equally used in Romania and the Czech Republic. In contrast, Georgian women report a contraceptive use rate of only 3% at first sexual intercourse before marriage, and Azerbaijan women have an initial contraceptive use rate of less than 1%.

Economic, political, and social changes in Eastern Europe since the fall of the Soviet Union and the Soviet bloc have resulted in societies that are less isolated and more exposed to Western culture and mass media.. These changes have affected cultural norms that relate to reproductive health, sexual behaviors, and family values. The rates of premarital sexual experience and contraceptive use have

been substantial in most of the countries listed in Table 16.4, with the exception of Georgia and Azerbaijan. The survey findings in these two countries suggest that widespread changes in cultural norms have not yet influenced women's sexual behaviors, their ability to speak openly about their behaviors, or both.

TABLE 16.4

Percentage of Young Women Aged 15–24 Years Reporting Premarital Sexual Experience (PSE) and Contraceptive Use at First PSE

Reproductive Health Surveys, Eastern Europe: 1993–2001

Country	Year of RHS	% of Young Women Aged 15–24 Reporting PSE			% of Young Women Aged 15–24 Using Contraception at First PSE		
		15–24	15–19	20–24	Total	Modern Methods	Traditional Methods
Czech Republic	1993	78	36	93	57	28	29
Moldova	1997	26	14	40	33	14	19
Russia*	1999	71	49	87	46	33	12
Romania	1999	41	22	58	58	28	30
Ukraine	1999	48	27	74	47	30	16
Georgia	1999/2000	1	†	2	3	3	0
Azerbaijan	2001	1	†	1	14	7	7

* Three oblasts: Ivanovo, Ekaterinburg and Perm
† Less than 0.5%

CHAPTER 17

KNOWLEDGE AND EXPERIENCE OF SEXUALLY TRANSMITTED INFECTIONS

Since the early 1990s, many newly independent states (NIS) of the former Soviet Union have experienced major epidemics of sexually transmitted infections (STIs), particularly syphilis. The extent of the increase in reported cases of syphilis, however, varies widely among those countries. The reported incidence of new cases of syphilis in several NIS countries increased by factors of 45 to 165 during 1990-1998; the steeper increases were reported in Kazakhstan (from 1.4 to 231.4 new cases per 100,000), Kyrgyz Republic (from 2 to 144.4 new cases per 100,000), Belarus (from 2.7 to 164 new cases per 100,000), and the Russian Federation (from 5.3 to 225.6 new cases per 100,000). However, the rates in the countries of the Caucasus region, although higher than in 1990, remained low by comparison (Riedner et al., 2000).

The reported rate of new cases of syphilis in Azerbaijan registered a threefold increase between 1990 and 1998, from 2.7 per 100,000 population to 8.2 per 100,000 population. Between 1997 and 1998, the number of congenital syphilis cases increased from 7 to 12 cases, and the total number of births decreased. One factor that may have been responsible for this increase is the low attendance at antenatal care clinics, which reduces the likelihood of active case finding and early treatment of syphilis among pregnant women. Interestingly, the reported incidence of gonorrhea started to increase in 1992, reached a peak in 1996 (26.4 new cases per 100,000 population), declined thereafter, and stabilized at around 12 new cases per 100,000 in 1998-2000 (Ministry of Health and State Committee of Statistics of the Azerbaijan Republic, 2001). The recent drop in the reported incidence of gonorrhea is attributed more to underreporting and changes in case-finding policies and procedures than to a real decrease in incidence (Joint United Nations Programme on HIV/AIDS [UNAIDS], 1999).

As is the case with most former Soviet Union countries, Azerbaijan inherited a centrally controlled STI surveillance system centered on venereal disease (VD) clinics. Because of limited laboratory resources, few VD clinics have the ability to provide a wide array of laboratory testing and treatment. STI reporting is believed to be seriously affected by the general lack of resources that has plagued health care services during the past decade. As in other countries of Eastern Europe and the former Soviet Union, women with STI symptoms are more likely to seek gynecological care in women's consultation clinics, and gynecologists seldom report those patients to the VD network, although they are required to do so (UNAIDS, 1999).

Because of scarce and competing health resources, STI prevention and education needs should become a focal component of the strategy for STI control. Preventive efforts should include dissemination of information on means of transmission of all STIs, including HIV/AIDS; promotion of safer sex; and risk-reduction practices. However, information must not convey needless threats to people with a very low risk of becoming infected.

To effectively target their educational efforts, policy makers and program managers should be aware of the level of STI knowledge among various population groups and identify population subgroups in greater need of primary prevention messages. In addition, they need to identify factors that influence correct knowledge and must understand misconceptions about HIV transmission. The AZRHS01 collected detailed information about the level of awareness of the most common STIs, the source of information about STIs, and the accuracy of knowledge about HIV transmission and prevention of HIV infection among women of reproductive age. In addition, for the most common STIs, the survey explored women's exposure to STI testing, self-reported lifetime prevalence, and perceived risk for STIs.

17.1 Awareness of STIs and Knowledge of STI Symptoms

When asked whether they had ever heard of nine specific STIs, a high percentage of women had heard of HIV/AIDS (74%), but significantly fewer women had heard of syphilis (41%) and gonorrhea (35%) (Table 17.1.1 and Figure 17.1).

Figure 17.1
Awareness of Certain Sexually Transmitted Infections Among All Women 15-44
Reproductive Health Survey: Azerbaijan, 2001
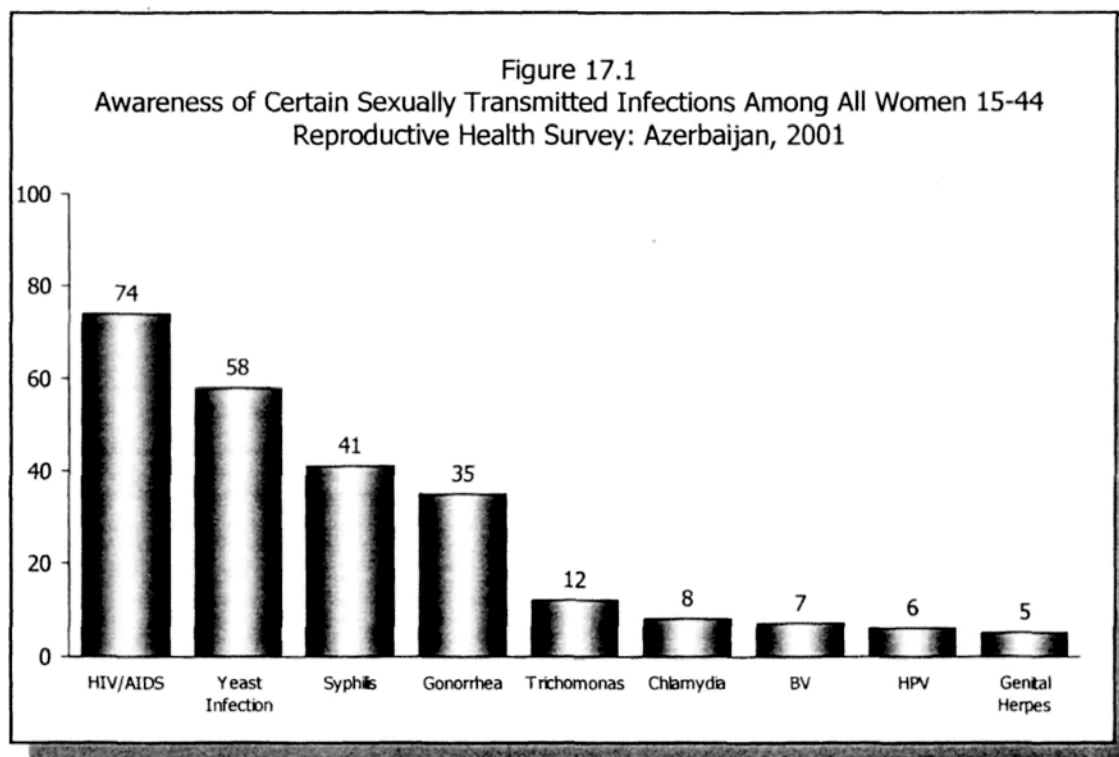
TABLE 17.1.1
Percentage of Women Aged 15–44 Years Who Have Heard of Specified Sexually Transmitted Infections
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	HIV/ AIDS	Yeast Infection	Syphilis	Gonorrhea	Trichomonas	Chlamydia	Bacterial Vaginosis	Genital Warts	Genital Herpes	No. of Cases
Total	74.1	57.8	41.4	34.5	12.4	8.4	7.4	6.1	5.3	7,668
Residence										
Urban	85.1	67.8	55.4	41.8	19.5	12.5	10.8	8.6	7.5	3,832
Rural	61.0	45.8	24.5	25.8	3.8	3.6	3.2	3.0	2.7	3,836
Region										
Baku	93.1	76.8	69.0	46.8	30.4	18.5	16.0	12.6	11.4	1,533
North & North-East	77.6	55.4	40.5	29.5	9.7	6.2	5.4	5.0	5.0	924
West	70.4	52.8	38.5	30.0	7.8	7.2	4.4	3.8	3.5	766
South-West	62.9	47.2	22.8	28.0	4.6	4.2	3.7	3.9	2.5	2,302
South	55.4	44.5	22.7	29.8	3.6	3.8	3.1	2.7	2.3	950
Central	70.7	58.9	35.8	37.6	8.0	5.6	7.3	5.3	3.3	1,193
Age Group										
15–19	55.7	33.2	14.2	13.0	2.8	2.4	3.3	3.0	2.1	1,207
20–24	77.3	53.3	37.0	28.9	10.0	7.9	6.9	5.2	5.3	1,207
25–29	82.3	64.0	47.9	37.5	15.9	10.2	9.4	7.6	7.1	1,156
30–34	81.8	68.2	47.5	41.6	14.7	10.8	9.5	8.9	7.0	1,533
35–39	79.2	70.1	57.0	48.3	17.5	11.9	8.8	7.1	6.1	1,531
40–44	76.3	69.6	57.8	47.6	18.2	9.9	8.3	6.1	5.8	1,034
Marital Status										
Currently Married, in Union	80.3	68.3	51.1	42.9	15.5	10.7	8.3	6.8	6.1	5,146
Previously Married, in Union	78.8	64.3	51.8	36.7	18.5	11.0	8.0	8.0	4.6	387
Never Married	63.7	40.1	24.3	20.6	6.5	4.4	5.8	4.6	4.1	2,135
No. Of Living Children										
0	65.4	43.4	26.8	22.8	7.4	5.8	6.1	5.1	4.5	2,655
1	82.3	67.3	50.6	41.9	19.5	16.1	11.9	8.9	7.1	784
2	84.5	72.2	57.0	44.8	19.5	12.1	9.5	8.0	7.7	2,094
3	80.8	69.9	52.1	44.5	13.7	7.4	7.2	6.1	4.7	1,530
4+	67.6	58.2	42.2	38.7	6.7	4.9	3.0	2.7	1.5	605
Education Level										
Secondary Incomplete or less	54.5	39.6	22.2	19.1	2.4	1.8	2.0	1.4	1.8	1,697
Secondary Complete	72.8	54.0	34.7	29.9	6.6	5.0	4.2	3.5	2.5	3,868
Technicum	92.5	79.6	67.0	54.9	27.3	16.5	14.6	11.8	9.2	1,215
University/Postgraduate	96.6	83.0	75.3	59.1	37.3	25.9	22.0	19.0	18.9	888
No. of Lifetime Partners										
0	63.5	39.9	24.1	20.5	6.4	4.3	5.7	4.6	4.1	2,128
1	80.1	67.8	50.5	41.9	14.9	10.3	8.0	6.7	5.8	5,389
2+	83.1	74.6	75.7	60.6	44.1	24.8	18.1	15.5	13.2	151
IDP/Refugee Status										
IDP/R	69.6	54.3	38.1	32.8	7.4	6.9	7.5	5.1	3.0	1,272
Non-IDP/CA	66.9	54.0	29.8	33.7	7.0	4.5	4.9	4.8	3.1	3,047
Non-IDP/NCA	76.5	59.2	44.6	34.9	14.3	9.6	8.0	6.5	6.1	3,349

The levels of awareness about other STIs was much lower: Only 12% of women had heard of trichomonas, 8% had heard of chlamydia, 7% were aware of bacterial vaginosis, and 6% and 5%, respectively, knew that genital warts and genital herpes are transmitted sexually. About 4 of 5 women (81%) had heard of at least one STI, including HIV/AIDS, but only 2% were able to recognize all STIs when prompted. The average number of STIs of which a woman was aware was 2.5, a number that increased with age, education, socioeconomic status (SES), and the number of lifetime sexual partners (data not shown).

The level of STI awareness varied slightly by characteristics. Rural and young women aged 15-19, never-married women, women without sexual experience, and women with the least educational attainment were least likely to have heard of HIV/AIDS and other STIs. STI awareness did not vary significantly among women who were internally displaced persons and refugees (IDP/Rs) and non-IDP/Rs.

Awareness of HIV/AIDS did not necessarily mean that the respondents had detailed information about the disease. Of the 5,623 respondents who had heard of HIV/AIDS, only slightly more than 1 in 4 (28%) knew that the disease could be present with no symptoms (data not shown). This fact is particularly important because women who do not know the virus can be present without symptoms could put themselves at risk if they have sexual intercourse with an apparently healthy HIV-infected individual. Similarly, awareness of other STIs does not accurately reflect the level of knowledge of specific STI symptoms. STIs are frequently asymptomatic, or the symptoms may be episodic. A critical issue in the epidemiology of STIs is the synergistic effect they may have on each other, particularly the predisposing effect they have on HIV/AIDS transmission. Although concurrent STIs share common sexual risk factors, epidemiologic and biologic evidence show that classic STIs can exacerbate HIV transmission, whereas HIV infection and related immunodeficiency may enhance susceptibility to other STIs (Laga et al., 1991; Wasserheit, 1992). Thus, adequate knowledge of the early symptoms of STIs is an important factor in preventing their spread and seeking diagnosis and treatment. Thus, all respondents in AZRHS01 were asked whether they knew any symptoms that an STI other than HIV/AIDS may cause in a woman.

As shown in Table 17.1.2, two-thirds of women (66%) had heard of at least one STI other than HIV/AIDS. Although 34% of women had no knowledge of an STI, only 30% of women were able to mention at least one symptom, including 20% who were able to mention two or more symptoms. About 2% of women were able to mention six or more symptoms (data not shown).

Even among respondents who reported that they were aware of at least one STI, only 45% were able to name at least one symptom of an STI in a woman (30%÷56%=45%). Awareness of an STI and knowledge of symptoms were more common among urban residents, particularly among those

TABLE 17.1.2

Knowledge of Symptoms Associated with STIs other than HIV/AIDS in a Woman
among All Women Aged 15–44
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Heard of at Least one STI other than HIV/AIDS		Knowledge of Symptoms of STIs in a Woman					
	%	N	No Awareness of STIs	No Symptoms Known	One Symptom	Two or more Symptoms	Total	No. of Cases
Total	**66.0**	**7,668**	**34.0**	**36.0**	**9.7**	**20.3**	**100.0**	**7,668**
Residence								
Urban	75.9	3,832	24.1	37.0	10.5	28.5	100.0	3,832
Rural	54.0	3,836	46.0	34.7	8.8	10.5	100.0	3,836
Region								
Baku	85.1	1,533	14.9	27.9	12.3	44.8	100.0	1,533
North & North-East	64.6	924	35.4	45.4	5.4	13.8	100.0	924
West	60.5	766	39.5	37.2	9.3	14.0	100.0	766
South-West	54.1	2,302	45.9	36.8	7.7	9.6	100.0	2,302
South	52.6	950	47.4	27.7	11.6	13.3	100.0	950
Central	66.5	1,193	33.5	39.9	12.4	14.2	100.0	1,193
Age Group								
15–19	38.9	1,207	61.1	26.6	4.8	7.6	100.0	1,207
20–24	62.2	1,207	37.8	35.3	8.5	18.4	100.0	1,207
25–29	73.3	1,156	26.7	38.2	11.1	24.1	100.0	1,156
30–34	76.4	1,533	23.6	38.1	13.7	24.6	100.0	1,533
35–39	79.0	1,531	21.0	37.7	12.2	29.1	100.0	1,531
40–44	78.7	1,034	21.3	45.1	9.9	23.7	100.0	1,034
Education Level								
Secondary Incomplete or less	48.5	1,697	51.5	33.6	6.8	8.1	100.0	1,697
Secondary Complete	62.7	3,868	37.3	37.7	9.3	15.8	100.0	3,868
Technicum	86.2	1,215	13.8	38.2	14.3	33.7	100.0	1,215
University/Postgraduate	89.7	888	10.3	31.1	11.6	47.0	100.0	888
Socioeconomic Status								
Low	54.4	4,068	45.6	34.9	8.9	10.7	100.0	4,068
Medium	74.7	2,770	25.3	38.6	9.9	26.2	100.0	2,770
High	84.6	830	15.4	31.8	12.2	40.5	100.0	830
No. of Lifetime Partners								
0	47.2	2,128	52.8	29.2	5.6	12.4	100.0	2,128
1	76.5	5,389	23.5	40.2	12.2	24.1	100.0	5,389
2+	84.2	151	15.8	28.6	6.0	49.6	100.0	151
IDP/Refugee Status								
IDP/R	63.9	1,272	36.1	31.7	9.2	22.9	100.0	1,272
Non-IDP/CA	60.6	3,047	39.4	37.6	10.2	12.8	100.0	3,047
Non-IDP/NCA	67.6	3,349	32.4	36.1	9.6	21.8	100.0	3,349

living in Baku. Both awareness of and knowledge of symptoms increased with age, education, - SES, and the number of lifetime sexual partners, but it was not significantly different for IDP/R and non-IDP/R respondents.

17.2 Most Important Source of Information and Mass Media Messages About STIs

The AZRHSO1 also included questions about the source of information regarding any STIs (Figure 17.2 and Table 17.2.1). It is likely, however, that most respondents equated the most important source of information about STIs with the source of AIDS information because media coverage about the worldwide HIV/AIDS epidemic is generally more extensive than coverage of other STIs (see also Table 7.2.2).

Overwhelmingly, Azeri women identified mass media as playing the most important role in increasing their level of awareness of STIs. Almost two-thirds (62%) of respondents mentioned mass media as the most important source of information, and little variation by background characteristics was found. In women's opinions, friends and peers were the second most important source of information (14%). Women living in rural areas, residents of the West and Southwest regions, and women with low educational attainment or low SES were more likely to value information on STIs from friends and peers, perhaps because they have less access to mass media than women in the other subgroups. Only 8% of women believed that a doctor was an important source of information about STIs, presumably because STI counseling is very limited in Azerbaijan. Only 6% of respondents mentioned that parents or other relatives played an important role in their knowledge about STIs. Few women (2%), most of them young adults aged 15-24 years, thought that teachers were their best source of information about STIs; sex education in Azeri schools is fairly recent, and the STI curriculum is seldom taught (see also Chapter 15).

Because the survey found that mass media are unanimously considered to be such an important source of information about STIs, public health efforts aimed at health promotion should actively involve the mass media in implementing behavioral interventions aimed at decreasing exposure to and transmission of STIs. Compelling evidence in the literature indicates that behavioral changes can be positively influenced by well-designed media campaigns.

The survey included questions about recent mass media exposure (i.e., within the 6 months prior to the interview) to messages related to HIV/AIDS and other STIs (Table 17.2.2 and Figure 17.2). Most respondents mentioned that messages on STIs distributed through audiovisual media were more often about HIV/AIDS than about other STIs (54% vs. 13%). Irrespective of the STI message, rural residents, young adults, women from lower educational and socioeconomic levels,
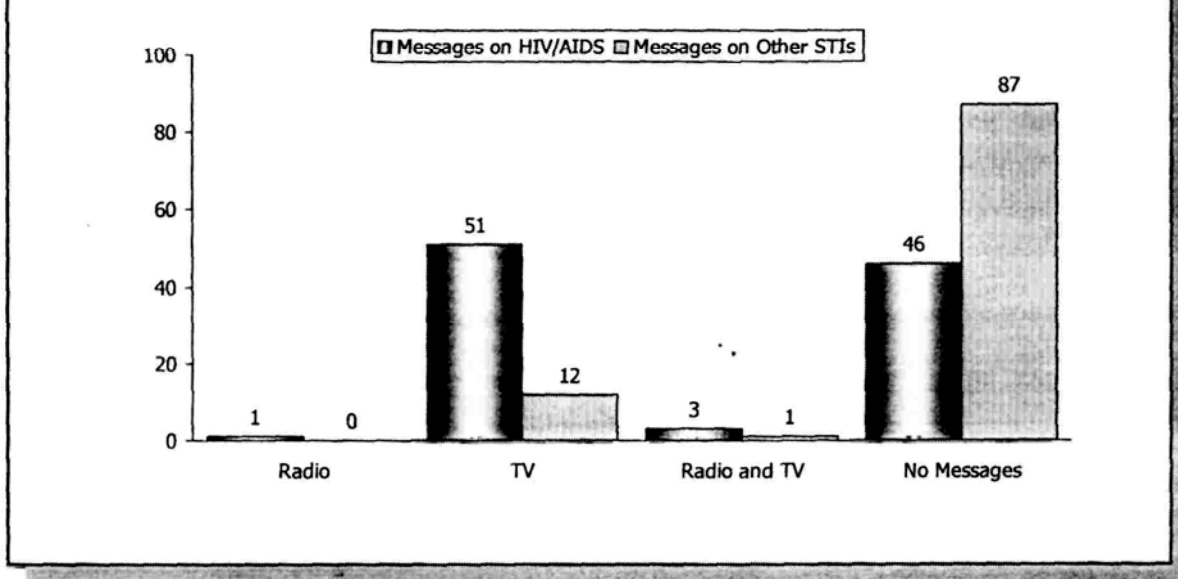
TABLE 17.2.1
**Opinion about Most Important Source of Information Received on Sexually Transmitted Infections
Among Women Aged 15–44 Who Have Heard of at Least One STI
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001**

| Characteristic | Most Important Source of Information about STIs | | | | | | | | | | No. of |
	Mass Media	Friends	Doctor	A Parent or Relative	Books	School	Partner	Other	Do not Remember	Total	Cases
Total	**61.7**	**13.7**	**8.3**	**5.8**	**4.3**	**2.4**	**1.0**	**1.9**	**0.9**	**100.0**	**6,223**
Residence											
Urban	63.4	11.6	9.2	5.0	5.1	2.9	1.1	0.8	0.9	100.0	3,421
Rural	59.2	16.8	6.9	7.0	3.2	1.6	1.0	3.5	0.8	100.0	2,802
Region											
Baku	65.5	6.7	12.5	4.5	5.7	2.4	0.9	0.5	1.3	100.0	1,471
North & North-East	65.3	10.7	8.0	6.0	3.4	3.7	0.6	1.6	0.7	100.0	788
West	53.7	24.3	3.5	7.1	5.5	1.9	1.5	2.2	0.4	100.0	615
South-West	59.3	19.6	5.2	6.7	2.7	1.3	1.4	3.6	0.3	100.0	1,755
South	59.3	15.5	6.3	8.1	4.0	0.9	1.6	3.2	1.1	100.0	654
Central	59.7	16.7	9.0	4.3	3.7	2.5	0.8	2.2	1.0	100.0	940
Age Group											
15–19	60.1	11.7	4.6	8.9	4.0	7.1	0.7	2.2	0.9	100.0	728
20–24	62.9	11.6	7.0	6.5	4.8	4.1	1.2	1.3	0.6	100.0	970
25–29	64.2	12.3	9.4	4.0	4.9	1.8	0.7	1.5	1.3	100.0	1,000
30–34	60.9	14.7	9.2	7.0	3.9	0.6	1.7	1.2	0.7	100.0	1,329
35–39	61.5	13.1	11.5	4.8	4.0	0.4	1.1	2.4	1.3	100.0	1,313
40–44	61.1	19.6	7.6	3.2	4.7	0.0	0.7	2.7	0.4	100.0	883
Marital Status											
Currently Married, in Union	60.9	14.5	10.1	5.3	3.8	0.9	1.4	2.1	0.9	100.0	4,441
Previously Married, in Union	59.9	17.0	10.5	5.0	3.7	0.2	1.8	1.5	0.4	100.0	320
Never Married	63.6	11.4	4.0	7.0	5.7	5.9	0.1	1.4	0.8	100.0	1,462
Education Level											
Secondary Incomplete or less	56.7	19.4	6.3	8.3	1.4	2.0	1.1	3.1	1.8	100.0	1,112
Secondary Complete	64.0	13.8	8.2	6.7	2.1	1.4	1.2	1.9	0.8	100.0	3,091
Technicum	58.6	10.8	10.5	3.2	9.0	5.1	0.7	1.5	0.6	100.0	1,149
University/Postgraduate	65.2	9.1	8.4	2.9	10.1	2.7	0.9	0.6	0.2	100.0	871
Socioeconomic Status											
Low	57.6	18.9	7.5	7.2	2.5	1.0	1.2	3.1	1.0	100.0	2,975
Medium	65.0	10.1	8.5	5.0	5.1	3.4	0.8	1.1	0.9	100.0	2,464
High	64.3	8.7	9.9	4.2	7.8	3.3	1.1	0.3	0.4	100.0	784
No. of Lifetime Partners											
0	63.6	11.4	4.0	7.0	5.7	5.9	0.1	1.4	0.8	100.0	1,453
1	61.0	14.7	10.0	5.3	3.7	0.9	1.5	2.1	0.9	100.0	4,644
2+	57.8	14.1	15.8	4.7	6.1	0.0	1.3	0.3	0.0	100.0	126
IDP/Refugee Status											
IDP/R	57.3	15.3	13.2	6.0	2.2	0.9	1.7	2.4	0.9	100.0	999
Non-IDP/CA	59.8	16.4	7.5	5.6	3.8	2.2	1.1	2.8	0.9	100.0	2,310
Non-IDP/NCA	62.7	12.9	7.8	5.9	4.7	2.6	0.9	1.6	0.9	100.0	2,914

TABLE 17.2.2
**Percentage of Women of Reproductive Age Who Had Received Radio and Television Messages About
HIV/AIDS and Other STIs During the Past Six Months
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001**

Characteristic	Received Messages about HIV/AIDS				Received Messages about other STIs					No. of
	Radio	TV	Radio and TV	Neither Radio nor TV	Radio	TV	Radio and TV	Neither Radio nor TV	Total	Cases
Total	0.5	51.3	2.5	45.7	0.2	12.2	0.8	86.7	100.0	7,668
Residence										
Urban	0.9	61.0	3.8	34.3	0.4	15.8	1.4	82.4	100.0	3,832
Rural	0.1	39.7	0.8	59.4	0.0	7.9	0.2	91.9	100.0	3,836
Region										
Baku	1.6	66.0	7.2	25.2	0.7	19.5	2.7	77.0	100.0	1,533
North & North-East	0.5	55.2	1.9	42.5	0.2	15.5	0.5	83.8	100.0	924
West	0.0	46.3	1.1	52.5	0.0	6.0	0.3	93.7	100.0	766
South-West	0.1	43.4	0.1	56.4	0.0	7.8	0.0	92.2	100.0	2,302
South	0.2	35.7	0.6	63.5	0.1	4.5	0.3	95.1	100.0	950
Central	0.2	49.5	0.9	49.5	0.0	12.9	0.1	87.0	100.0	1,193
Age Group										
15–19	0.7	36.0	2.0	61.3	0.1	5.5	0.8	93.6	100.0	1,207
20–24	0.7	52.9	3.1	43.4	0.4	12.0	1.0	86.5	100.0	1,207
25–29	0.1	61.0	2.5	36.4	0.5	12.8	0.8	85.8	100.0	1,156
30–34	0.6	56.0	2.4	41.0	0.0	15.1	0.7	84.1	100.0	1,533
35–39	0.6	56.2	2.8	40.5	0.2	15.4	1.0	83.5	100.0	1,531
40–44	0.4	52.9	2.1	44.5	0.2	15.3	0.6	83.9	100.0	1,034
Marital Status										
Currently Married, in Union	0.3	56.7	2.1	40.9	0.2	14.5	0.8	84.5	100.0	5,146
Previously Married, in Union	1.1	53.7	1.8	43.4	0.0	12.4	0.8	86.7	100.0	387
Never Married	0.9	42.4	3.1	53.7	0.3	8.6	0.9	90.3	100.0	2,135
Education Level										
Secondary Incomplete or less	0.5	34.1	1.3	64.1	0.2	5.0	0.5	94.3	100.0	1,697
Secondary Complete	0.3	50.9	1.9	47.0	0.1	11.0	0.7	88.2	100.0	3,868
Technicum	0.5	66.5	3.3	29.7	0.6	20.1	0.9	78.4	100.0	1,215
University/postgraduate	1.6	69.1	6.3	23.0	0.5	22.0	1.9	75.6	100.0	888
Socioeconomic Status										
Low	0.3	39.3	0.8	59.7	0.1	6.7	0.3	92.8	100.0	4,068
Medium	0.6	61.5	3.5	34.4	0.2	15.8	1.3	82.7	100.0	2,770
High	1.6	67.3	5.8	25.3	0.9	22.8	1.3	76.0	100.0	830
IDP/Refugee Status										
IDP/R	0.2	50.8	2.2	46.8	0.4	10.9	0.8	87.9	100.0	1,272
Non-IDP/CA	0.2	46.4	0.6	52.9	0.0	11.1	0.0	88.8	100.0	3,047
Non-IDP/NCA	0.7	52.6	3.0	43.8	0.3	12.7	1.0	86.0	100.0	3,349

Figure 17.2
Recent Exposure to Mass Media Messages
on HIV/AIDS and Other STIs
All Women of Reproductive Age—Azerbaijan, 2001

☐ Messages on HIV/AIDS ☐ Messages on Other STIs

	Radio	TV	Radio and TV	No Messages
HIV/AIDS	1	51	3	46
Other STIs	0	12	1	87

sexually inexperienced women, and IDP/R women were less likely to have been recently exposed to STI messages through audiovisual media.

In 1998, the Azeri MOH, along with various UN agencies headed by the United Nations Development Programme, established a national working group on STI management and STI guidelines (Claeys et al., 2001). One task of the working group is to increase STI knowledge among Azeri women and men of reproductive age. Proper education of the population requires collaboration between public health organizations, nongovernmental organizations, and media organizations. Public health programs that aim to educate women about STI risk, transmission, and prevention should closely collaborate with audiovisual media to expand their reach. In designing education campaigns, public health organizations need to ensure that no misconceptions or needless threats are disseminated by radio or television programming, because media imagery may be difficult to offset. They also need to be aware that some groups of women are particularly important to target. Younger and sexually inexperienced women should be educated about the potential of STI infection to deter them from partaking in risky sexual behavior in the future. Rural residents, who are less likely to gain knowledge through mass media campaigns, may require distribution of STI-related materials and education through a health care provider. Women of lower SES may not have immediate access to health care providers and may require specific targeted educational campaigns.

17.3 Self-Reported STI Testing and Diagnosis

The STI public health surveillance network collects information only from the VD clinics. Cases seen by gynecologists or other doctors are seldom reported. Although population-based surveys could represent an important addition to data gathered by STI surveillance systems, they too are vulnerable to underreporting. Individual reports about STI testing and diagnosis are also likely to underestimate the true magnitude of STI levels because of lack of awareness, recall bias, and underreporting of sensitive information. Furthermore, surveys can produce prevalence estimates but are less useful in examining incidence levels. Despite their limitations, surveys complement surveillance data with estimates representative of the general population and various subgroups and allow for correlation of STIs with reproductive-related information and health risk behaviors.

The reported levels of testing and diagnosis for the eight most common STIs in Azerbaijan are shown in Table 17.3.1. Respondents were not asked about HIV diagnosis and treatment. According to women's responses, the most often diagnosed STIs were yeast infection and trichomoniasis. Of all women aged 15-44, 5% reported having had a yeast infection and 1% had had trichomonas infection. For these two STIs, women living in Baku (12% and 3%), women with university education (12% and 3%), and women with two or more lifetime sexual partners (22% and 9%) were more likely to report positive testing, but differences in positive reports may be due to differences in health-seeking behaviors and access to health services. A history of other STIs was seldom reported: Only 0.3% of women had been diagnosed with chlamydia; 0.2% with gonorrhea; and 0.1% with genital warts, genital herpes, or bacterial vaginosis.

In interpreting these results, it should be kept in mind that laboratory testing resources in Azerbaijan are quite limited, and for most STIs, without testing there can be no diagnosis. Furthermore, the differences in awareness of specific STIs (which are influenced by background characteristics) may affect the level of reporting of both testing and confirmed diagnosis. Some STIs are better known than others and may be reported more accurately. Also, some STIs (e.g., syphilis and gonorrhea) require mandatory notifications to the VD network, and respondents may be reluctant to acknowledge such infections, despite the assured confidentiality of the interviews.

Only 1 in 5 sexually experienced women (19%) had ever been tested for STIs (Table 17.3.2). The most frequently tested (13%) and reported (7%) STI among sexually experienced women was yeast infection. Only 7% of women reported being tested for syphilis, but practically none of them reported that they had been diagnosed with the disease. Similarly, few women (3%) reported gonorrhea testing, and less than 1 % reported a diagnosis. Trichomonas testing was reported by 4% of women, and the positivity rate was about 50% among those tested. Chlamydia was reported by 2% of women, with a positivity rate of 25%. According to women's reports about viral STIs, tests for genital warts and genital herpes were seldom conducted (0.5% and 0.6%, respectively),

TABLE 17.3.1
Percentage of Women Aged 15–44 Years with a Diagnosis of
Specified Sexually Transmitted Infections by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Yeast Infection	Trichomonas	Chlamydia	Gonorrhea	Genital Warts	Genital Herpes	Bacterial Vaginosis	Syphilis	No. of Cases
Total	**5.0**	**1.1**	**0.3**	**0.2**	**0.1**	**0.1**	**0.1**	**0.0**	**7,668**
Residence									
Urban	7.1	1.6	0.4	0.3	0.2	0.1	0.2	0.0	3,832
Rural	2.4	0.4	0.2	0.1	0.1	0.0	0.0	0.0	3,836
Region									
Baku	11.8	2.8	0.8	0.5	0.4	0.3	0.4	0.0	1,533
North & North-East	2.6	0.7	0.2	0.1	0.0	0.1	0.0	0.0	924
West	2.5	0.6	0.1	0.1	0.0	0.0	0.0	0.0	766
South-West	1.9	0.1	0.3	0.4	0.0	0.0	0.0	0.0	2,302
South	3.0	0.1	0.4	0.1	0.0	0.0	0.0	0.1	950
Central	5.0	1.0	0.1	0.1	0.2	0.0	0.0	0.0	1,193
Age Group									
15–19	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1,207
20–24	2.2	0.4	0.7	0.3	0.2	0.0	0.1	0.1	1,207
25–29	7.8	1.7	0.4	0.3	0.2	0.2	0.2	0.0	1,156
30–34	6.2	1.1	0.4	0.5	0.1	0.3	0.1	0.1	1,533
35–39	8.7	2.4	0.3	0.3	0.2	0.0	0.1	0.0	1,531
40–44	7.1	1.3	0.3	0.1	0.2	0.0	0.0	0.0	1,034
Marital Status									
Currently Married, in Union	7.8	1.6	0.5	0.3	0.2	0.2	0.2	0.0	5,146
Previously Married, in Union	5.5	1.8	0.4	1.2	0.0	0.0	0.0	0.5	387
Never Married	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,135
No. Of Living Children									
0	1.3	0.2	0.3	0.1	0.0	0.1	0.0	0.0	2,655
1	10.8	2.5	1.2	0.5	0.1	0.0	0.5	0.1	784
2	8.3	2.3	0.3	0.3	0.5	0.2	0.2	0.1	2,094
3	7.4	0.9	0.0	0.6	0.0	0.0	0.0	0.0	1,530
4+	3.2	0.8	0.0	0.0	0.0	0.0	0.0	0.0	605
Education Level									
Secondary Incomplete or less	2.6	0.2	0.1	0.1	0.0	0.0	0.0	0.0	1,697
Secondary Complete	3.8	0.8	0.3	0.3	0.1	0.1	0.1	0.1	3,868
Technicum	7.3	1.8	0.1	0.3	0.2	0.1	0.0	0.0	1,215
University/Postgraduate	11.9	3.0	1.2	0.3	0.4	0.4	0.5	0.0	888
No. of Lifetime Partners									
0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2,128
1	7.2	1.4	0.5	0.3	0.2	0.1	0.1	0.0	5,389
2+	21.7	8.5	1.2	1.2	0.8	1.2	1.7	1.0	151
IDP/Refugee Status									
IDP/R	2.9	0.4	0.3	0.4	0.3	0.0	0.0	0.0	1,272
Non-IDP/CA	4.3	0.8	0.1	0.4	0.2	0.0	0.0	0.0	3,047
Non-IDP/NCA	5.4	1.2	0.4	0.2	0.1	0.1	0.1	0.0	3,349

TABLE 17.3.2
Level of Awareness, Testing, Diagnosis, and Treatment for STIs among Women Aged 15–44 Years
Who Have Ever Had Sexual Intercourse by Specified Sexually Transmitted Infections
Reproductive Health Survey: Azerbaijan, 2001

Specific STIs	Awareness of the STI	Testing for the STI	Diagnosis of the STI	Treatment for the STI	Number of Cases
HIV/AIDS	80.2	4.5	*	*	5,540
Syphilis	51.2	7.4	0.1	0.0	5,540
Yeast Infection	68.0	12.6	7.6	7.5	5,540
Gonorrhea	42.5	2.7	0.4	0.4	5,540
Trichomonas	15.8	4.0	1.7	1.7	5,540
Chlamydia	10.8	2.4	0.5	0.5	5,540
Bacterial Vaginosis	8.3	0.9	0.1	0.1	5,540
Genital Warts	7.0	0.5	0.2	0.2	5,540
Genital Herpes	6.0	0.6	0.1	0.1	5,540
Any STIs	**87.9**	**19.1**	**9.1**	**8.9**	5,540

* Respondents were not asked about the results of HIV testing.

because diagnosis is usually based on clinical examination. Almost 5% of women reported having been tested for HIV/AIDS, but data on testing results were not collected by the survey. Thus, levels of self-reported STIs seem to be much lower than the official reports.

17.4 Self-Reported STI Symptoms

In an attempt to assess the prevalence of STI symptoms among the general population, the survey included a series of questions about recent history of vaginal discharge and the presence or absence

TABLE 17.4

**Reports of Vaginal Discharge or Genital Ulcers During 12 Months Prior to the Interview and
Reports of Other Symptoms Associated with Vaginal Discharge by Selected Characteristics
Sexually Experienced Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001**

| Characteristic | Vaginal Discharge or Genital Ulcer | | | Symptoms Associated with Vaginal Discharge | | | | |
	Vaginal Discharge	Genital Ulcer/Sores	N	Abdominal Pain	Vaginal Prurit	Pain During Intercourse	Dysuria	N
Total	**32.1**	**1.6**	**5,540**	**77.9**	**51.1**	**43.2**	**37.1**	**1,973**
Residence								
Urban	32.0	2.1	2,823	73.8	47.4	37.6	30.6	935
Rural	32.2	0.9	2,717	82.9	55.7	50.2	45.1	1,038
Region								
Baku	29.3	2.2	1,145	63.0	36.7	34.2	22.2	342
North & North-East	30.6	0.8	674	79.4	46.1	44.4	36.2	207
West	40.0	2.1	568	83.9	57.2	48.7	38.0	240
South-West	43.7	1.6	1,647	85.4	60.6	53.0	50.3	718
South	26.4	1.3	640	82.1	60.1	39.9	42.9	186
Central	29.6	1.8	866	79.8	57.0	42.1	43.4	280
Age Group								
15–19	28.0	0.0	160	65.4	45.1	41.6	38.0	52
20–24	36.1	1.1	674	72.8	42.4	41.9	37.8	232
25–29	35.5	2.5	951	81.2	47.4	47.9	32.6	350
30–34	37.4	1.7	1,393	79.0	49.1	40.7	35.4	560
35–39	30.8	1.7	1,391	79.7	62.1	45.8	41.0	498
40–44	22.8	1.3	971	76.3	50.9	39.4	38.1	281
Marital Status								
Currently Married, in Union	31.9	1.7	5,146	78.1	52.0	46.7	37.8	1,839
Previously Married, in Union	33.1	0.4	385	75.1	39.5	5.5	27.4	128
Never Married	*	*	9	*	*	*	*	6
Education Level								
Secondary Incomplete or less	32.4	1.0	1,057	80.2	57.7	47.8	43.9	388
Secondary Complete	31.6	1.7	2,845	80.4	52.7	43.3	38.5	1,010
Technicum	31.7	1.6	989	73.3	51.6	47.4	35.8	348
University/Postgraduate	34.1	2.3	649	70.7	33.5	29.9	22.5	227
No. of Lifetime Partners								
1	31.9	1.6	5,389	78.6	51.7	43.6	37.5	1,916
2+	39.3	1.6	151	57.9	35.4	32.8	26.3	57
IDP/R Status								
IDP/R	36.7	2.4	929	84.9	67.7	49.7	47.9	386
Non-IDP/CA	35.2	1.8	2,151	81.9	60.5	48.4	48.1	826
Non-IDP/NCA	30.7	1.4	2,460	75.7	45.9	40.8	32.4	761
Any STI Testing								
Ever Had	39.4	3.5	963	68.5	48.8	41.7	30.8	406
Never Had	30.4	1.1	4,577	80.7	51.8	43.7	39.0	1,567
Any STI Diagnosis								
Ever Had	48.6	4.7	476	65.7	50.4	43.7	27.9	245
Never Had	30.4	1.3	5,064	79.8	51.2	43.1	38.5	1,728

* Fewer than 25 observations in this category.

of any genital sores or ulcers. Almost 1 in 3 sexually experienced women reported abnormal vaginal discharge, and 2% reported "sores, warts, or ulcers in the genital area" (Table 17.4). Reports of STI symptoms did not vary significantly by respondents' background characteristics. Reports of vaginal discharge and sores were higher among women who had ever been tested for an STI or had had one diagnosed, an indication that their STI symptoms were severe enough to seek medical care. Among women who had recently experienced vaginal discharge, 78% also reported low abdominal pain, 51% reported vaginal itching, 41% reported pain during sexual intercourse, and 37% reported painful urination (i.e., *dysuria).*

This information could be used to decide whether a syndromic approach for the case management of STIs among a female population is warranted. Syndromic case reports do not require laboratory diagnostic tests and are based on the identification of a combination of symptoms and signs (i.e., *syndromes)* suggestive of selected STIs. Syndromic case management combines the identified syndromes with knowledge about the most common causative organisms and their most appropriate treatment. However, the syndromic approach is not suitable for assessment of STI incidence and prevalence or for measurement of the impact of STI prevention programs. In addition, treatment based on syndromic case definitions leads to overtreatment, thereby promoting antimicrobial resistance and incurring social costs related to mislabeling individuals as being infected with an STI. These drawbacks should be carefully balanced against the costs associated with STI complications; continued and potentially increased transmission of HIV infection; and medical costs, such as laboratory testing and clinical diagnosis (van Dam et al., 1998).

17.5 Perceived Risk of STIs

The rate of spread of STIs in a population is basically determined by three factors: (1) exposure to infection, (2) the probability of acquiring the infection, and (3) the duration of time in which infected individuals can spread the infection (Eng and Butler, 1997). Although awareness of HIV/AIDS is high among Azeri women, awareness of other STIs is often lacking. A third of Azeri women have never heard of an STI, and more than two-thirds cannot name any STI symptoms and therefore may not be aware if and when they are getting infected. As a result, Azeri women may **not** be aware of their potential risk of infection, may misjudge their symptoms, and may unknowingly spread an STI. Even when they have heard of STIs and STI-related symptoms, many women will probably underestimate their STI risk.

When asked about their potential risk of acquiring an STI, the majority of sexually experienced women thought that they had little risk or no risk at all (Table 17.5).

TABLE 17.5
Percent Distribution of Women Aged 15–44 Who Have Heard of at Least One Sexually Transmitted Infection
by Their Self-Perceived Risk of Acquiring an STI by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Self-Perceived Risk | | | | | |
	High or Medium Risk	Low Risk	No Risk	Do Not Know	Total	No. of Cases
Total	2.1	4.8	86.6	6.5	100.0	4,498
Residence						
Urban	2.5	5.1	88.0	4.4	100.0	2,745
Rural	1.4	4.1	84.0	10.6	100.0	1,753
Region						
Baku	3.1	7.5	86.5	2.9	100.0	1,300
North & North-East	2.1	2.4	87.8	7.7	100.0	586
West	1.4	4.4	86.0	8.3	100.0	414
South-West	1.3	4.2	87.4	7.0	100.0	1,114
South	1.2	4.3	85.8	8.7	100.0	408
Central	1.7	3.7	85.7	8.9	100.0	676
Age Group						
15–19	0.4	1.4	90.7	7.5	100.0	360
20–24	1.7	3.6	87.3	7.4	100.0	631
25–29	4.0	5.5	86.2	4.2	100.0	760
30–34	1.8	6.6	85.4	6.3	100.0	1,018
35–39	3.1	6.4	83.5	7.0	100.0	1,028
40–44	1.2	3.3	88.9	6.5	100.0	701
Education Level						
Secondary Incomplete or less	2.1	3.7	83.5	10.7	100.0	607
Secondary Complete	1.9	3.9	86.6	7.5	100.0	2,116
Technicum	1.5	5.7	89.0	3.7	100.0	995
University/Postgraduate	3.3	6.7	86.4	3.5	100.0	780
Socioeconomic Status						
Low	1.1	3.9	85.2	9.7	100.0	1,867
Medium	2.1	4.3	88.3	5.2	100.0	1,936
High	4.3	7.7	85.2	2.9	100.0	695
No. of Lifetime Partners						
0	0.3	0.8	92.5	6.3	100.0	842
1	2.6	5.6	85.4	6.4	100.0	3,544
2+	6.5	19.2	62.5	11.8	100.0	112
IDP/Refugee Status						
IDP/R	2.6	2.8	89.0	5.5	100.0	656
Non-IDP/CA	1.7	5.4	83.8	9.2	100.0	1,543
Non-IDP/NCA	2.1	4.8	86.9	6.1	100.0	2,299

Among women with awareness of STIs, concerns about exposure to the risk of STIs were similar to concerns about acquiring HIV/AIDS: About 7% of women believed they have any risk of getting either HIV/AIDS or other STIs, including 2% who thought that their risk is moderate or high (data not shown).

Perceived risk of getting infected with an STI other than HIV/AIDS increased with the increase in the number of recent sexual partners. Background characteristics did not strongly influence this perception.

CHAPTER 18

KNOWLEDGE OF HIV/AIDS TRANSMISSION AND PREVENTION

The HIV/AIDS epidemic has infected more than 40 million people worldwide. Almost half of the infected adults, more than 18.5 million cases, are women. During the year 2001 alone, AIDS claimed the lives of an estimated 1.1 million women and 580,000 children under age 15. The infection poses a serious risk to women's reproductive health globally (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2002).

Eastern Europe is one of the last regions of the world to be challenged by an HIV/AIDS epidemic. Until mid-1995, Eastern Europe and the former Soviet Union did not seem threatened by a substantial HIV epidemic. Of the 450 million residents in the region, HIV infections were estimated at less than 30,000 cases. However, between 1995 and 1997, the estimated number of cases of HIV increased more than fivefold in this region. UNAIDS and the World Health Organization (WHO) estimated that two-thirds of those infections had occurred in the last 12 months of this time period (Dehne et al., 1999). Eastern Europe and Central Asia are now estimated to have 1 million people infected with HIV; intravenous drug use is the main transmission route (UNAIDS, 2001).

HIV case reporting in the 15 successor states of the Soviet Union entails two stages: the recording of the screening test and the referral to a health care institution for an epidemiologic history. The second stage is particularly important because that is where patients are classified by transmission route and source of infection (Dehne et al., 1999). This method of reporting is still used in Azerbaijan. An estimated 401 men, women, and children in Azerbaijan are infected with HIV, and 32 have been diagnosed with AIDS (Ministry of Health [MOH], 2002). These statistics seem quite low compared with those of other countries (UNAIDS/WHO, 2002). The largest proportion of HIV infections (59%) is among injecting drug users, and more than one-third (36%) are due to sexual intercourse (mostly heterosexual); however, cases may be underreported. Vertical transmission from pregnant mother to baby represent only 2% of the cases, and for 3% of the cases the source of infection is unknown (UNAIDS/WHO, 2002).

HIV surveillance has been carried out in Azerbaijan since 1987. The first case of HIV infection in Azerbaijan was detected in 1987 in a foreign visitor, and in 1992 in a citizen of Azerbaijan. In 1990 the National Center in Response to AIDS (National AIDS Center) was established as the only MOH

institute responsible for the coordination and supervision of activities for the prevention of HIV in the Republic. The Center has 12 regional offices (MOH, 2002).

In 1996 the President of the Azerbaijan Republic signed a Decree establishing the "Law on prevention of HIV/AIDS distribution" (Azerbaijan Republic Law # 61-IQ, April 16, 1996, with amendments # 282-IQD on April 25, 1997, and November 15, 2001). In 1997 the Cabinet of Ministers approved the National Program on AIDS Prevention, although the program has not yet been fully funded. According to the law, HIV testing is mandatory for blood donors and donors of other biological liquids, organs, and tissues. The law also reserves the right of the state to conduct epidemiologic screening for HIV . Although a shortage of test kits has forced Azerbaijan to reduce the scope of such surveillance, limited screening is still carried out among men who have sex with men, intravenous drug users, and patients with sexually transmitted infections (STIs) (Dehne et al., 1999). Since May 1957, the National AIDS Center has offered anonymous consultation and testing 24 hours per day. They also have a confidential telephone hotline (MOH, 2002).

Infection rates in Azerbaijan may be underreported, as STIs in general have been shown to be (Claeys et al., 2001). The high proportion of infections among injecting drug users may indicate a serious potential of spreading to the general population via sexual transmission. Effective prevention efforts initiated at the beginning stages of the epidemic may confine the extent of the disease because future infections may depend on this link between injecting drug users and the rest of the population. However, this window of opportunity for public health prevention efforts will be limited; focusing these efforts on specific subgroups is vital and requires population-based surveillance data, as featured in this chapter, to better target prevention programs.

18.1 Knowledge of HIV/AIDS

Respondents were asked whether they had ever heard of HIV/AIDS (Table 18.1.1). Most (74%) of Azeri women have heard of HIV/AIDS. This awareness varied by characteristics of respondents. Rural women and women with no sexual experience were less likely to have heard of HIV/AIDS. Respondents under age 20 (56%), those who had not completed secondary education (55%), and women living in the South region (55%) had the lowest levels of awareness of HIV/AIDS. However, awareness of HIV/AIDS did not necessarily mean that the respondents had detailed information about the disease.

All 5,623 individuals who had heard of HIV/AIDS were asked whether they believed a person could be infected with the HIV virus and be asymptomatic. The proportion of those with such knowledge was calculated for all women, not just those who had heard of HIV/AIDS. Those who never heard of HIV/AIDS were categorized as not knowing that HIV could be asymptomatic. Only 1 in 5 (21 %)

TABLE 18.1.1

Percentage of Women Aged 15–44 Who Have Heard of HIV/AIDS,
Know HIV Infections Can Be Asymptomatic, Know Where HIV Tests Are Provided,
and Have Been Tested for HIV, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Heard of HIV/AIDS	Know HIV Can Be Asymptomatic	Know Where HIV Tests Are Provided	Have Been Tested for HIV	Number of cases
Total	74.1	20.5	15.6	3.0	7,668
Residence					
Urban	85.1	26.4	21.3	4.9	3,832
Rural	61.0	13.3	8.6	0.8	3,836
Region					
Baku	93.1	34.3	29.8	9.0	1,533
North &North-East	77.6	19.9	15.5	2.4	924
West	70.4	16.7	9.0	0.6	766
South-West	62.9	13.7	7.8	0.7	2,302
South	55.4	12.0	9.5	0.7	950
Central	70.7	17.4	11.6	1.2	1,193
Age Group					
15–19	55.7	12.7	7.8	0.3	1,207
20–24	77.3	23.0	16.3	2.0	1,207
25–29	82.3	25.4	21.4	6.0	1,156
30–34	81.8	22.9	18.9	4.6	1,533
35–39	79.2	21.6	17.9	4.2	1,531
40–44	76.3	20.7	14.5	2.3	1,034
Marital Status					
Currently Married/In Union	80.3	22.3	17.4	4.6	5,146
Previously Married	78.8	23.2	20.7	3.4	387
Never Married	63.7	17.1	11.8	0.4	2,135
Education Level					
Secondary Incomplete or Less	54.5	9.9	6.8	0.8	1,697
Secondary Complete	72.8	17.8	11.7	1.6	3,868
Technicum	92.5	28.9	26.5	5.5	1,215
University/Postgraduate	96.6	42.3	35.1	9.8	888
Socioeconomic Status					
Low	61.5	13.5	8.8	1.1	4,068
Medium	84.0	24.6	20.1	4.2	2,770
High	93.1	35.4	28.2	6.7	830
IDP/Refugee Status					
IDP/R	69.6	17.6	13.7	1.8	1,272
Non-IDP/CA	66.9	15.4	10.1	1.2	3,047
Non-IDP/NCA	76.5	22.1	17.1	3.6	3,349
No. of Lifetime Partners					
0	63.5	17.1	11.7	0.3	2,128
1	80.1	22.1	17.4	4.2	5,389
2+	83.1	31.1	29.9	14.2	151

of all women knew that the disease could be present with no symptoms. This fact is particularly important because women who do not know the virus could be present without symptoms could put themselves at risk if they have sexual intercourse with an apparently healthy HIV-infected individual.

The respondents' knowledge of asymptomatic HIV varied by their sociodemographic characteristics. Women of rural residence (13%), incomplete secondary education (13%), and low socioeconomic status (SES) (14%) had less knowledge of asymptomatic HIV than women of urban residence (26%), university education (42%), and high SES (35%). Knowledge that HIV infection can be asymptomatic increased with the number of sexual partners. In no category did more than 42% of women know that HIV can be asymptomatic.

Urban setting, higher education, and higher SES had an effect on increased knowledge that HIV/AIDS exists and that it can be asymptomatic. Health education programs may be most beneficial to women in rural settings, from lower education and SES levels, and women living in the South region of the country. Information should stress the risk potential in having sexual relations with asymptomatic HIV-positive individuals. One-sixth (16%) of all respondents said that they know where HIV tests are provided, including 3% who had been tested for HIV/AIDS. These percentages are similar to those reported earlier (United Nation's Children's Fund [UNICEF], 2000). The proportion of women who knew where to get an HIV test was significantly lower among rural women, women outside Baku, women under age 20, and women with lower education or lower SES, and never-married women. Differences between internally displaced persons and refugees (IDP/Rs) and non-IDP/R women are not noteworthy.

18.2 Knowledge of HIV/AIDS Transmission

To assess knowledge of HIV/AIDS transmission, respondents were asked to agree or disagree with 13 statements on how the AIDS virus may be transmitted. Respondents were classified as lacking knowledge of a particular mechanism of transmission if they answered "no" or "don't know," when the method of transmission was a known route for HIV infection. A "no" answer on an incorrect mechanism of transmission was classified as rejecting an incorrect mechanism of transmission. If a respondent answered "yes" or "don't know" to an incorrect mechanism of transmission, they were grouped together as failing to reject a misconception about HIV transmission.

The transmission route that was least known by respondents was homosexual intercourse (58%) (Table 18.2.1). Vertical transmission from mother to baby by nursing (48%), heterosexual intercourse (46%), nonsterile needles (44%), and transmission from mother to baby in utero (43%)

TABLE 18.2.1
Percentage of Women Aged 15–44 Who Do Not Know Important Ways of HIV Transmission
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Homosexual Intercourse	MTCT Breasfeeding	Blood Transfusion	Heterosexual Intercourse	MTCT in Utero	Non-Sterile Needles	No of cases
Total	57.9	48.3	46.2	43.8	43.1	36.9	7,668
Residence							
Urban	44.7	40.5	32.7	30.1	32.3	24.4	3,832
Rural	73.8	57.7	62.5	60.2	56.1	52.0	3,836
Region							
Baku	33.0	35.1	20.8	17.3	23.1	15.3	1,533
North and North-East	57.2	44.6	45.9	44.9	41.4	35.0	924
West	64.1	52.3	49.2	50.1	45.1	38.4	766
South-West	73.4	57.9	59.7	58.0	55.5	49.3	2,302
South	74.6	60.0	65.1	60.4	58.4	54.8	950
Central	63.1	52.1	53.5	49.0	50.0	44.3	1,193
Age Group							
15–19	76.4	64.5	62.2	65.9	61.0	55.8	1,207
20–24	55.0	48.1	46.6	42.9	42.5	33.8	1,207
25–29	50.6	44.6	38.2	34.2	37.7	29.6	1,156
30–34	52.8	40.0	39.9	34.7	35.6	29.6	1,533
35–39	50.8	42.7	39.9	35.7	35.5	31.5	1,531
40–44	53.9	43.1	43.4	39.4	38.7	33.0	1,034
Marital Status							
Currently Married/ in Union	51.0	41.4	40.6	34.6	35.9	30.5	5,146
Previously Married	51.4	41.6	40.2	39.7	38.3	32.4	387
Never Married	69.9	60.4	56.2	59.0	55.3	47.8	2,135
Education Level							
Secondary Incomplete or Less	76.8	64.3	67.4	64.5	62.9	57.0	1,697
Secondary Complete	61.7	48.6	50.1	47.6	44.8	40.1	3,868
Technicum	41.1	32.3	24.7	22.5	23.8	16.6	1,215
University/Postgraduate	25.3	34.8	14.3	12.6	19.9	8.4	888
Socioeconomic Status							
Low	73.2	58.3	60.6	59.6	56.2	50.8	4,068
Medium	47.5	40.6	35.5	32.1	33.4	26.4	2,770
High	29.8	33.0	22.5	17.4	21.6	14.6	830
IDP/Refugee Status							
IDP/R	62.3	51.3	50.9	47.9	46.4	40.0	1,272
Non-IDP/CA	67.3	55.4	56.5	52.7	53.2	47.8	3,047
Non-IDP/NCA	55.1	46.2	43.1	41.1	40.2	33.9	3,349
No. of Lifetime Partners							
0	70.1	60.5	56.4	59.2	55.5	48.0	2,128
1	51.4	41.5	40.8	35.4	36.5	30.9	5,389
2+	35.5	39.3	27.5	21.2	23.9	22.0	151

TABLE 18.2.2

Percentage of Women Aged 15–44 Who Correctly Reject Misconceptions About HIV Transmission by Selected Characteristics

Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Shaking Hands	Public Toilet	Manicure/ Haircut	Sharing Objects	Mosquito Bites	Kissing	Medical/ Dental	Never Heard of HIV/AIDS	No. of Cases
Total	31.9	16.9	15.8	15.7	13.5	13.4	5.1	25.9	7,668
Residence									
Urban	44.0	24.5	20.5	22.9	18.8	19.3	6.7	14.9	3,832
Rural	17.4	7.8	10.2	7.0	7.0	6.3	3.2	39.0	3,836
Region									
Baku	56.9	33.5	22.0	31.2	25.3	28.0	7.7	6.9	1,533
North & North-East	29.8	16.7	17.7	14.0	15.1	12.4	6.1	22.4	924
West	25.1	9.8	13.5	11.8	6.6	7.7	2.9	29.6	766
South-West	20.9	7.8	11.5	9.3	7.4	7.7	3.4	37.1	2,302
South	19.1	10.0	12.2	7.2	7.3	6.4	3.5	44.6	950
Central	24.7	12.2	12.2	11.7	9.7	9.4	4.5	29.3	1,193
Age Group									
15–19	28.4	12.6	19.1	11.3	14.4	11.9	7.1	44.3	1,207
20–24	37.1	19.4	22.0	18.1	15.9	15.4	6.8	22.7	1,207
25–29	38.3	20.8	16.1	19.8	15.6	16.5	5.5	17.7	1,156
30–34	31.2	16.5	13.6	13.4	11.8	11.5	4.6	18.2	1,533
35–39	31.8	19.7	12.0	18.4	12.9	15.4	3.2	20.8	1,531
40–44	25.7	14.1	9.9	15.0	9.3	9.9	2.4	23.7	1,034
Marital Status									
Currently Married/ in Union	31.7	17.6	14.1	15.5	12.2	13.0	4.0	19.7	5,146
Previously Married	31.1	13.9	10.1	16.7	11.1	10.5	3.6	21.2	387
Never Married	32.4	16.4	19.4	15.8	15.8	14.4	7.1	36.3	2,135
Education Level									
Secondary Incomplete or Less	18.7	8.4	12.1	7.7	7.5	6.7	4.2	45.5	1,697
Secondary Complete	26.5	12.4	14.5	11.2	10.3	9.4	4.5	27.2	3,868
Technicum	43.2	24.0	20.0	20.7	16.8	19.4	6.0	7.5	1,215
University/Postgraduate	66.7	44.2	23.4	44.1	34.3	35.5	8.2	3.4	888
Socioeconomic Status									
Low	18.5	9.3	11.0	7.7	7.5	6.2	3.6	38.5	4,068
Medium	40.4	20.3	20.0	20.2	16.8	17.3	5.8	16.0	2,770
High	58.4	37.0	21.7	33.2	26.9	29.7	8.9	7.0	830
IDP/Refugee Status									
IDP/R	28.3	13.2	16.1	15.3	10.4	13.9	5.6	30.4	1,272
Non-IDP/CA	22.0	10.6	11.3	10.3	9.0	7.9	3.9	33.1	3,047
Non-IDP/NCA	34.8	18.9	16.9	17.0	14.9	14.7	5.3	23.5	3,349
No. of Lifetime Partners									
0	32.2	16.3	19.4	15.7	15.8	14.2	7.1	36.5	2,128
1	31.4	17.0	13.9	15.3	11.9	12.5	3.9	19.9	5,389
2+	42.6	27.3	11.0	26.3	21.4	25.7	6.5	16.9	151

followed. Blood transfusion (37%) was the most known form of HIV transmission. Correct knowledge of HIV transmission varied between having no knowledge (32%) and knowing all six main routes of transmission (28%), with a mean of 3.2 known ways of transmission (data not shown).

Rural residents, younger women, women with lower educational and SES, and women living in the South and Southwestern parts of the country were less likely to have knowledge of HIV transmission. Women who were not sexually experienced or who had never been married were also less likely to have knowledge of HIV transmission. Similarly, these women were the most likely to be unable to identify any correct means of HIV transmission.

The percentage of all women (not just those who have heard of HIV/AIDS) who correctly rejected misconceptions about HIV/AIDS transmission is highlighted in Table 18.2.2. None of the behaviors noted in this table have been identified scientifically as a source of HIV transmission. The women who rejected these as possible ways for contracting HIV are classified by their characteristics. In no case did more than one-third of women reject misconceptions about HIV transmission; just 32% rejected shaking hands as a mode of transmission. From 13% to 17% rejected incorrect modes of transmission not related to medical and dental care; only 5% of women said that attending medical services does not facilitate HIV transmission.

Women in rural areas, with lower educational and SES, and in the South and South-West regions were more likely to reject misconceptions. Knowledge of misconceptions is positively related to both education and SES, except for those related to medical and dental treatment. For example, only 8% of women with university education and 9% of women with high SES rejected the idea that medical or dental treatment could transmit the HIV virus.

Several possible explanations exist for the low percentage of women who knew that they could not contract HIV by simply receiving medical or dental treatment. HIV transmission is often associated with sharp objects, particularly needles. As discussed later in this chapter, a large percentage of Azeri women have a high level of distrust of the health care system and view health care services as a significant source of risk for contracting HIV. The relatively large percentage of older, more educated women who believed that medical treatment was a possible route of HIV transmission, leads to the inference that this is a broad misconception among the population, one that may take significant public health education to overcome. This misconception is not specific to Azerbaijan; it has been reported in other Eastern European countries (Serbanescu et al., 1998, 2001). However, receiving HIV-infected blood products or medical treatment with contaminated needles would be a risk for HIV infection.

Broad beliefs about HIV transmission through sharp objects were also noted in women's opinions about beauty salons, where they go for manicures, pedicures, and haircuts. Only 1 in 6 women (16%) knew that manicures and pedicures do not carry the potential for HIV transmission. Respondents who were older, highly educated, from a higher SES, and resided in urban settings were unlikely to reject this as a mode of transmission. It is possible that better educated, wealthier urban women are more likely to frequent beauty parlors and therefore to be concerned about them as a source of infection.

UNAIDS Knowledge Indicator 2 and the factors that go into its calculation: knowledge that a person can be infected with HIV and show no symptoms, and rejection of the two most prevalent misconceptions about HIV transmission are shown in Table 18.2.3 (UNAIDS, 2000). In Azerbaijan, those misconceptions are that HIV can be spread by kissing and by medical or dental treatment. This indicator is calculated as a proportion of all women surveyed, not just those who have heard of HIV/AIDS, to give an estimate of knowledge among the entire population. As mentioned earlier, only about 1 in 5 women knew that HIV infection could be asymptomatic. Thirteen percent of women knew that HIV could not be transmitted through kissing, and 5% knew that medical or dental treatment could not transmit HIV. Only 1% of all women correctly answered all three questions.

The high level of misconceptions pertaining to HIV transmission illustrates the need for public health education programs. Although mosquitos and other vectors have not been known to transmit the HIV virus, few women knew that to not be a matter of concern (14%). HIV cannot be found in large amounts of saliva, but only 1 in 7 respondents knew it carried no risk (14%). Shaking hands or sharing objects with an infected person does not pose a risk for HIV transmission, yet only 16% of respondents were aware of this fact. Misconceptions on possible HIV transmission through blood donation, dental treatment, and beauty parlors seem to be widespread. Educational programs on the most likely routes of HIV transmission are urgently needed. Women of all educational and socioeconomic levels require education on verifiable transmission sources, particularly those relating to use of blood products.

TABLE 18.2.3
Percentage of Women Aged 15–44 Who Know HIV Can be Asymptomatic And Is Not Spread by Kissing or Medical Treatment, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

| Characteristic | Know HIV Can be Asymptomatic | Know That HIV is Not Spread by: | | UNAIDS Knowledge Indicator 2* | Number of cases |
		Kissing	Medical or Dental Treatment		
Total	20.5	13.4	5.1	0.9	7,668
Residence					
Urban	26.4	19.3	6.7	1.1	3,832
Rural	13.3	6.3	3.2	0.6	3,836
Region					
Baku	34.3	28.0	7.7	1.4	1,533
North and North-East	19.9	12.4	6.1	1.2	924
West	16.7	7.7	2.9	0.3	766
South-West	13.7	7.7	3.4	0.3	2,302
South	12.0	6.4	3.5	0.7	950
Central	17.4	9.4	4.5	0.6	1,193
Age Group					
15–19	12.7	11.9	7.1	0.9	1,207
20–24	23.0	15.4	6.8	1.2	1,207
25–29	25.4	16.5	5.5	1.1	1,156
30–34	22.9	11.5	4.6	0.9	1,533
35–39	21.6	15.4	3.2	0.7	1,531
40–44	20.7	9.9	2.4	0.2	1,034
Marital Status					
Currently Married/ in Union	22.3	13.0	4.0	0.7	5,146
Previously Married	23.2	10.5	3.6	0.0	387
Never Married	17.1	14.4	7.1	1.3	2,135
Education Level					
Secondary Incomplete or Less	9.9	6.7	4.2	0.6	1,697
Secondary Complete	17.8	9.4	4.5	0.6	3,868
Technicum	28.9	19.4	6.0	1.3	1,215
University/Postgraduate	42.3	35.5	8.2	2.1	888
Socioeconomic Status					
Low	13.5	6.2	3.6	0.4	4,068
Medium	24.6	17.3	5.8	0.9	2,770
High	35.4	29.7	8.9	2.6	830
IDP/Refugee Status					
IDP/R	17.6	13.9	5.6	1.2	1,272
Non-IDP/CA	15.4	7.9	3.9	0.4	3,047
Non-IDP/NCA	22.1	14.7	5.3	0.9	3,349
No. of Lifetime Partners					
0	17.1	14.2	7.1	1.2	2,128
1	22.1	12.5	3.9	0.7	5,389
2+	31.1	25.7	6.5	0.6	151

* Indicator 2: percentage of all women with correct knowledge that HIV could be asymptomatic, is not spread by kissing, or through medical treatment.

18.3 Knowledge of HIV/AIDS Prevention

A two-part question was used to identify women's knowledge of HIV prevention (Table 18.3.1). Respondents were asked what a person can do to reduce risk of HIV infection. Individuals who spontaneously answered a correct prevention mechanism were coded "Yes (Spontaneously)". In part two, the women were asked about the mechanisms that they did not answer spontaneously ("Probed").

More than one-third of all respondents spontaneously mentioned that limiting the number of sexual partners (6%), "being monogamous" (14%), "avoiding sex with promiscuous partners" (6%), or "avoiding sex with prostitutes" (10%) is protective against HIV/AIDS transmission. Only 1 in 12 women (8%) noted the use of condoms as a possible preventive behavior, but that percentage increased to 40% after probing. Less than 1 in 10 women (9%) spontaneously mentioned "sterilize needle" as a way to avoid HIV infection. Similarly, more than half of the women correctly identified this preventive behavior after probing (67%). Less than 3% of the women identified the use of HIV testing as a form of prevention, yet after probing an additional 57% recognized testing as a prevention mechanism.

Nearly 3 out of 4 women (72%) could not spontaneously state any main way of avoiding HIV infection, and fewer than 1% could name three or more preventive behaviors (data not shown). Lack of any preventive knowledge is higher among rural residents (84%), residents outside Baku, women younger than age 20 (83%), ever-married and sexually inexperienced women (78%), respondents with less than complete high school education (84%), women with a low SES (82%),and non-IDP women in conflict-affected areas (83%).

The proportion of all women who know the means of preventing HIV spontaneously or after probing from the interviewer is shown in Table 18.3.2, which combines categories similar to those shown in Table 18.3.1. Women who responded with either monogamy or limiting the number of sex partners were combined into one category (69%). A large number of respondents recognized sterilizing or not sharing needles (68%) as a mechanism of preventing HIV transmission. Women who identified avoiding sex with any one of the high-risk groups (i.e., injection drug users, bisexuals, prostitutes, or men with many sex partners) were categorized as "avoid risky sex partners"(67%). More than half of all women acknowledged asking a partner to be tested for HIV (59%) as a prevention mechanism. Forty-four percent of women identified avoiding either blood transfusions or injections as a way to reduce the risk of HIV. Only 40% of respondents mentioned condom use. Abstaining from sex was recognized as a method of prevention by only 35% of women, a finding that may be due to the perception that this method is not practical. Having a lack of knowledge in HIV prevention mechanisms was associated with rural residence, youth, lower educational level,

TABLE 18.3.1
Percent Distribution of Women Age 15–44 Who Mentioned Possible Means
of Preventing HIV/AIDS Spontaneously and After Probing
Reproductive Health Survey: Azerbaijan, 2001

Possible Means	Mentioned		Did Not Mention	Have Not Heard of HIV/AIDS	Total
	Spontaneously	Probed			
Monogamy	14.0	53.0	7.2	25.9	100.0
Avoid Sex with Prostitutes	10.0	57.5	6.6	25.9	100.0
Sterilize Needles	9.3	56.7	8.2	25.9	100.0
Use Condoms	8.0	32.4	33.8	25.9	100.0
Limit Number of Sexual Partners	6.4	58.4	9.4	25.9	100.0
Avoid Sex with Promiscuous Partners	5.5	61.0	7.7	25.9	100.0
Avoid Sharing Razor Blades or Needles	2.5	61.2	10.5	25.9	100.0
Ask Partner to Be Tested for HIV	2.4	56.6	15.2	25.9	100.0
Avoid Blood Transfusions	2.3	36.8	35.1	25.9	100.0
Abstain From Sex	2.0	33.0	39.2	25.9	100.0
Avoid Injections	1.7	36.4	36.0	25.9	100.0
Avoid Sex with IV Drug Users	1.3	63.3	9.6	25.9	100.0
Avoid Sex with Bisexuals	1.1	42.7	30.4	25.9	100.0

lower SES, being unmarried, and lack of sexual experience.

UNAIDS Knowledge Indicator 1 is calculated as the proportion of all women, not just those who have heard of HIV/AIDS, who identify both monogamy and condoms as ways in which a person may reduce the risk of contracting HIV (Table 18.3.3). Sixty-seven percent of women identified monogamy, 65% identified limiting the number of sex partners, and 40% identified condoms. Forty percent of women were able to identify both monogamy and condoms as methods of prevention. As with the other measures of prevention knowledge, Knowledge Indicator 1 was reported more frequently among urban women (52%), women in Baku (65%), women older than age 19, women of higher education and SES, and currently married and sexually experienced women.

Educational messages should target young women and emphasize mechanisms to protect oneself against HIV transmission, particularly the use of condoms and abstinence. Messages should stress that HIV can be transmitted through casual, unprotected sexual relations with heterosexual or bisexual individuals. Focusing on young women who are sexually inexperienced could prevent future behavior that may lead to HIV infection.

TABLE 18.3.2

Percentage of Women Aged 15–44 Who Know Possible Means of Preventing HIV/AIDS Transmission Spontaneously and After Probing, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Monogamy/ Limit Number of Partners	Sterilize Needles/ Avoid Sharing Needles	Avoid Risky Sex	Ask Partner to Be Tested	Avoid Blood Transfusions & Injections	Use Condoms	Abstain from Sex	No. of Cases
Total	68.5	67.7	66.7	59.0	44.2	40.3	35.0	7,668
Residence								
Urban	81.1	80.5	79.6	70.3	53.0	53.3	42.1	3,832
Rural	53.3	52.2	51.2	45.4	33.7	24.7	26.4	3,836
Region								
Baku	88.9	87.9	87.9	76.1	59.6	67.4	45.7	1,533
North & North-East	72.1	71.0	68.8	62.4	46.8	40.6	40.8	924
West	65.3	64.4	64.6	54.6	32.8	33.5	22.8	766
South-West	56.2	56.0	55.0	47.4	32.1	26.6	24.1	2,302
South	49.3	49.1	47.1	41.7	33.8	20.1	25.7	950
Central	63.4	62.2	61.8	57.4	46.5	35.7	37.5	1,193
Age Group								
15–19	50.0	49.0	49.1	42.9	29.7	19.6	26.7	1,207
20–24	71.6	70.8	69.6	60.3	41.9	44.0	31.4	1,207
25–29	76.2	75.3	74.0	65.3	48.6	50.4	38.6	1,156
30–34	75.7	75.1	74.2	66.7	51.3	46.7	38.6	1,533
35–39	73.3	72.5	71.4	63.0	51.7	48.5	40.4	1,531
40–44	72.3	71.6	69.7	62.7	48.5	41.2	37.9	1,034
Marital Status								
Currently Married/ in Union	75.1	74.6	72.7	64.4	50.1	49.0	38.4	5,146
Previously Married	72.7	72.6	71.3	65.0	49.5	40.9	40.5	387
Never Married	57.2	55.9	56.5	49.4	34.1	26.3	28.6	2,135
Education Level								
Secondary Incomplete or less	48.6	47.9	46.4	40.5	29.1	19.9	23.6	1,697
Secondary Complete	66.2	65.1	63.9	56.6	45.5	35.2	36.6	3,868
Technicum	87.7	87.6	86.8	77.6	59.8	61.5	47.2	1,215
University/Postgraduate	94.4	93.6	94.5	82.9	50.2	75.9	36.0	888
Socioeconomic Status								
Low	54.5	53.8	52.4	46.1	33.8	26.0	26.4	4,068
Medium	79.2	78.6	77.6	68.9	52.5	48.8	43.1	2,770
High	90.3	88.8	89.2	79.2	59.7	70.7	43.4	830
IDP/Refugee Status								
IDP/R	63.8	64.1	62.9	55.7	43.2	39.3	30.9	1,272
Non-IDP/CA	59.4	58.7	58.1	52.1	40.0	30.9	31.2	3,047
Non-IDP/NCA	71.3	70.3	69.3	61.1	45.4	42.7	36.4	3,349
No. of Lifetime Partners								
0	57.1	55.8	56.4	49.3	34.1	26.1	28.6	2,128
1	74.8	74.3	72.4	64.3	50.1	47.8	38.9	5,389
2+	81.3	81.3	80.8	70.8	47.7	65.1	27.2	151

*Risky sex includes having sexual partners who use IV drugs, are bisexual, commercial sex workers, or have many sex partners.

TABLE 18.3.3
Percentage of Women Aged 15–44 Who Believe HIV Can Be Prevented By Limiting the Number of Sexual Partners, Being Monogamous, And Using Condoms, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Monogamy	Limit Number of Sexual Partners	Condoms	UNAIDS Knowledge Indicator 1*	No of Cases
Total	**64.7**	**67.0**	**40.3**	**39.5**	**7,668**
Residence					
Urban	77.6	79.5	53.3	52.1	3,832
Rural	49.3	51.9	24.7	24.4	3,836
Region					
Baku	83.8	86.5	67.4	65.3	1,533
North & North-East	66.4	70.3	40.6	40.0	924
West	63.5	64.2	33.5	33.4	766
South-West	52.7	55.5	26.6	26.5	2,302
South	47.4	49.0	20.1	19.9	950
Central	60.7	61.3	35.7	34.9	1,193
Age Group					
15–19	45.6	48.3	19.6	19.2	1,207
20–24	67.8	69.9	44.0	43.0	1,207
25–29	72.6	74.4	50.4	48.9	1,156
30–34	71.8	74.8	46.7	46.4	1,533
35–39	70.3	71.8	48.5	47.7	1,531
40–44	68.8	70.7	41.2	40.3	1,034
Marital Status					
Currently Married/ in Union	72.2	74.0	49.0	48.2	5,146
Previously Married	69.1	71.7	40.9	39.8	387
Never Married	52.2	55.0	26.3	25.5	2,135
Education Level					
Secondary Incomplete or Less	44.3	47.8	19.9	19.8	1,697
Secondary Complete	62.1	64.4	35.2	34.6	3,868
Technicum	85.1	86.5	61.5	60.4	1,215
University/Postgraduate	91.3	91.8	75.9	73.4	888
Socioeconomic Status					
Low	51.0	53.4	26.0	25.8	4,068
Medium	75.4	77.6	48.8	47.8	2,770
High	85.9	87.4	70.7	68.3	830
IDP/Refugee Status					
IDP/R	61.2	63.5	39.3	38.6	1,272
Non-IDP/CA	56.7	57.8	30.9	30.3	3,047
Non-IDP/NCA	67.1	69.6	42.7	41.9	3,349
No. of Lifetime Partners					
0	52.0	54.8	26.1	25.3	2,128
1	71.8	73.7	47.8	47.1	5,389
2+	79.2	80.5	65.1	64.5	151

·* Indicator 1 represents the percentage of all women who identify both monogamy and condoms as prevention measures against HIV.

Due to Azerbaijan's increasing incidence of HIV infection among intravenous drug users, awareness should be raised of the dangers of unclean needle use and of having unprotected sexual relations with a drug user. Drug prevention efforts should target younger, lower educated women, and low-SES women.

18.4 Beliefs About the Risk of HIV/AIDS and Self-Perceived Risk of HIV/AIDS

Current scientific knowledge of the HIV virus and its transmission has determined that individuals who partake in certain risky behaviors are at higher risk of contracting the disease. The risky behaviors include unsafe sex, numerous sexual partners, trading sex for money, and intravenous drug use.

Respondents were asked to rate their own risk of contracting HIV/AIDS (on a scale of high, moderate, low, or no risk) (Table 18.4.1). Information on groups who believe they are at higher risk of HIV is useful in targeting resources that may assist in preventing individuals from engaging in risky behavior.

Less than 1% of all women believed they were at high risk of contracting HIV and less than 5% believed they had moderate or little risk of contracting HIV. Sixty-one percent of the women believed they were at no risk of HIV infection, and the rest had never heard of HIV/AIDS or did not know whether they had any risk. Women who responded that they had any risk of HIV were more often urban residents. Perception of risk increased with sexual experience. Perception of high risk does not vary significantly by background characteristics. Younger, lower educated, lower SES, never married, and sexually inexperienced women were the least likely to perceive themselves as having any HIV risk; however, women in these subgroups were also more likely to never have heard of HIV. Lack of knowledge of HIV and its means of transmission and methods of prevention may affect a woman's ability to correctly assess her own risk of contracting the disease.

The 5% of women who believed that they had some level of risk were asked why they considered themselves to be at risk; their opinions on their main risk factor for contracting HIV (Table 18.4.2). Almost half (47%) of the women who considered themselves to have any risk of HIV believed that they were at risk of HIV due to utilization of health care services. Additionally, 2% of women who received blood transfusions believed that their HIV-risk is higher, bringing the proportion whose perceived risk of infection is medical related to 49%.

TABLE 18.4.1
Percent Distribution of Women Aged 15–44 by Self-Perceived Risk of Contracting HIV/AIDS by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Great Risk	Moderate Risk	Little Risk	No Risk	Don't Know	Have Not Heard of HIV/AIDS	Total	No. of cases
Total	0.4	1.0	3.6	60.9	8.3	25.9	100.0	7,668
Residence								
Urban	0.5	1.5	4.5	73.1	5.5	14.9	100.0	3,832
Rural	0.3	0.5	2.4	46.2	11.6	39.0	100.0	3,836
Region								
Baku	0.2	1.9	7.1	80.9	2.9	6.9	100.0	1,533
North & North-East	1.0	0.9	2.8	62.8	10.0	22.4	100.0	924
West	0.4	0.8	3.7	53.3	12.1	29.6	100.0	766
South-West	0.3	0.9	2.0	51.1	8.5	37.1	100.0	2,302
South	0.2	0.5	1.0	45.8	8.0	44.6	100.0	950
Central	0.1	0.5	3.1	57.0	10.1	29.3	100.0	1,193
Age Group								
15–19	0.1	0.6	1.8	46.2	7.0	44.3	100.0	1,207
20–24	0.2	0.8	3.8	63.1	9.5	22.7	100.0	1,207
25–29	1.0	1.4	4.8	67.8	7.5	17.7	100.0	1,156
30–34	1.0	1.4	3.9	66.2	9.4	18.2	100.0	1,533
35–39	0.2	1.3	4.0	65.1	8.6	20.8	100.0	1,531
40–44	0.3	0.9	4.1	63.3	7.7	23.7	100.0	1,034
Marital Status								
Currently Married/ in Union	0.7	1.3	4.2	65.5	8.6	19.7	100.0	5,146
Previously Married	0.3	0.0	3.5	66.5	8.5	21.2	100.0	387
Never Married	0.1	0.7	2.6	52.6	7.6	36.3	100.0	2,135
Education Level								
Secondary Incomplete or Less	0.7	1.1	2.0	42.3	8.4	45.5	100.0	1,697
Secondary Complete	0.4	0.9	2.1	60.1	9.3	27.2	100.0	3,868
Technicum	0.1	0.7	5.5	79.0	7.2	7.5	100.0	1,215
University/Postgraduate	0.2	1.6	10.3	79.2	5.2	3.4	100.0	888
Socioeconomic Status								
Low	0.4	0.8	2.3	47.5	10.6	38.5	100.0	4,068
Medium	0.4	0.9	4.0	72.5	6.3	16.0	100.0	2,770
High	0.6	2.3	7.2	77.7	5.3	6.9	100.0	830
IDP/Refugee Status								
IDP/R	1.0	0.7	3.2	59.5	5.2	30.4	100.0	1,272
Non-IDP/CA	0.1	0.5	2.7	53.7	9.9	33.1	100.0	3,047
Non-IDP/NCA	0.4	1.2	3.8	62.8	8.3	23.5	100.0	3,349
No. of Lifetime Partners								
0	0.1	0.7	2.5	52.7	7.7	36.5	100.0	2,128
1	0.6	1.2	3.9	65.8	8.5	19.9	100.0	5,389
2+	0.9	1.7	12.6	56.5	11.3	16.9	100.0	151

TABLE 18.4.2
Opinions About the Main Risk Factor of Contracting HIV/AIDS Among Women 15-44 Who Have Heard about HIV/AIDS and Believe They Have Any Risk of Contracting HIV/AIDS
Reproductive Health Survey: Azerbaijan, 2001

Possible Means	Women Who Believe They Have a Risk
Medical/Dental Treatment	46.8
Does Not Trust Partner	21.2
Manicure/Haircut	13.8
Received Many Blood Transfusions/ Products	1.7
Unprotected Sex With Casual Partners	1.1
Many Sexual Partners/ Trade Sex for Money	0.2
Used IV Drugs	0.0
Other	9.6
Don't Know/Refused to Answer	5.7
Total Number of Cases	360

Less than one-quarter of women believed that they are at risk of HIV due to sexual behaviors, either theirs (1%) or their partners (21%); risky sexual behaviors include unprotected intercourse and having a partner who has "sex with other women." None of the respondents cited past intravenous drug use as a possible source for contracting HIV. Fourteen percent of women believe that they are at risk of getting infected because they use beauty parlors (for manicures, pedicures, or haircuts). These concerns may come from the association of sharp objects with possible HIV infection and transmission.

For several possible reasons, a high percentage of women believe that the health care system carries a risk for HIV transmission. First, the economic crisis in Azerbaijan has had a deep impact on the health infrastructure and utilization of health services (which often lack electricity, heat, and running water). State health expenditures represented less than 2% of gross domestic product in 1999; the average number of visits to primary care providers has fallen from more than nine per person in 1985 to just five in 1999; health-seeking behaviors are generally low (see also Chapter 13), partly because of a widespread mistrust in the quality of the health care system (WHO, 2001). Similar misconceptions about the risk of HIV transmission through using the health care system have been noted in other population-based studies in Russia, Romania, and Moldova (Amirkhanian, 2001; Serbanescu et al., 1998, 2001). Individual risk behaviors, rather than health-seeking behaviors, are the primary mechanisms of contracting and transmitting HIV (CDC, 1999). The misconception that health care services put a person at higher risk of contracting HIV may cause women to put less emphasis on their own behavior in preventing the disease. Proper education of the population requires collaboration between public health organizations, nongovernmental organizations (NGOs), and media organizations.

The 80% of women who had heard of AIDS and who believed that they did not have any risk of contracting HIV/AIDS were asked why they thought they had no risk of the disease (Table 18.4.3). Forty percent of the women responded that they had trust in their partner. More than one-third of the women (36%) responded that they were not sexually active, and 20% responded that they were monogamous. Less than 1% of the respondents claimed using condoms lowered their risk of infection. Abstinence was more common in younger women, whereas monogamy and a trustworthy partner were more often reported by older, married, and sexually experienced women. These values did not vary across residence or socioeconomic levels.

In conclusion, this study reveals that particular subgroups of women in Azerbaijan are less educated about HIV/AIDS transmission and possible means of preventing HIV transmission . Younger women, rural residents, women from lower educational and socioeconomic levels, and sexually inexperienced women were less informed about HIV infection. It is particularly important for HIV prevention and education campaigns to target these groups of women. Younger and sexually inexperienced women should be educated about the potential of HIV infection to help them avoid partaking in risky behavior in the future. Rural residents are less likely to gain knowledge through mass media campaigns and will likely require a health care provider to obtain HIV/AIDS-related materials and education that are culturally sensitive. Women of lower SES may not have immediate access to health care providers and may require a specific educational campaign. Although these less knowledgeable women may be in greatest need of education about HIV/AIDS, all women need HIV information because knowledge is poor throughout the population. Although the survey is of women, education about HIV transmission and prevention for men is important as well.

Azerbaijani women require education on the potential risk of HIV infection due to their own or their partner's behavior as well as increased education to correct the notion that utilization of health care services will put a person at risk of HIV infection. Misconceptions of HIV risk due to health care utilization need to be corrected by accentuating the usefulness of the health care system in preventing and controlling infectious diseases.

Azerbaijan's rising incidence of AIDS among intravenous drug users requires additional attention to drug abuse prevention efforts in the country. According to data on source of transmission, 59% of the HIV cases in Azerbaijan are due to intravenous drug use (UNAIDS/WHO, 2002). Men account for 74% of HIV cases (MOH, 2002c). It is important to provide men with drug prevention education and resources. Education on transmission and prevention of HIV should emphasize condom use. One study has shown that women with STIs in Azerbaijan are generally infected by nonmonogamous husbands rather than through risky behaviors of their own (Claeys et al., 2001). Early prevention programs could limit the potential of an epidemic and avert a possible major shift in HIV transmission from intravenous drug use to transmission by sexual intercourse.

TABLE 18.4.3
Opinions About the Main Factor that Protects from Contracting HIV/AIDS Among Women Aged 15–44
Who Have Heard of HIV/AIDS and Believe That They Have
No Risk of Contracting HIV/AIDS, by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Trust in Partner	Not Sexually Active	Monogamy	Use Condoms	Other	Don't Know	Total	Number of Cases
Total	40.3	36.2	20.1	0.2	0.2	3.0	100.0	4,658
Residence								
Urban	40.7	37.7	18.4	0.3	0.3	2.5	100.0	2,782
Rural	39.4	33.3	23.3	0.1	0.0	3.9	100.0	1,876
Region								
Baku	41.7	36.5	17.7	0.7	0.7	2.8	100.0	1,243
North & North-East	30.3	36.8	28.8	0.0	0.0	4.1	100.0	596
West	53.5	34.0	11.9	0.0	0.0	0.6	100.0	429
South-West	41.8	35.1	19.2	0.1	0.2	3.5	100.0	1,237
South	44.1	35.5	17.6	0.0	0.0	2.9	100.0	455
Central	39.7	37.6	19.6	0.2	0.0	3.0	100.0	698
Age Group								
15–19	7.6	86.1	2.2	0.0	0.0	4.1	100.0	533
20–24	25.5	53.9	16.3	0.2	0.3	3.8	100.0	727
25–29	50.2	23.4	22.6	0.4	0.2	3.2	100.0	772
30–34	53.6	17.5	26.6	0.3	0.1	1.9	100.0	983
35–39	56.0	15.4	25.3	0.4	0.4	2.5	100.0	982
40–44	49.6	19.0	28.6	0.1	0.3	2.3	100.0	661
Marital Status								
Currently Married/ in Union	64.0	1.1	31.8	0.3	0.2	2.7	100.0	3,298
Previously Married	0.4	96.3	2.6	0.1	0.0	0.6	100.0	253
Never Married	0.1	95.5	0.0	0.1	0.3	4.0	100.0	1,107
Education Level								
Secondary Incomplete or Less	34.2	46.3	14.4	0.1	0.2	4.8	100.0	702
Secondary Complete	40.2	34.5	21.9	0.2	0.1	3.1	100.0	2,278
Technicum	45.8	28.4	22.9	0.1	0.1	2.6	100.0	964
University/Postgraduate	40.1	40.1	17.2	0.8	0.9	0.9	100.0	714
Socioeconomic Status								
Low	40.2	33.8	22.0	0.1	0.0	3.8	100.0	2,026
Medium	41.1	37.1	18.6	0.3	0.3	2.6	100.0	1,986
High	37.8	39.3	19.7	0.6	0.5	2.0	100.0	646
IDP/Refugee Status								
IDP/R	44.4	30.7	20.2	0.3	0.9	3.4	100.0	741
Non-IDP/CA	39.6	38.1	18.5	0.2	0.0	3.5	100.0	1,655
Non-IDP/NCA	39.9	36.5	20.4	0.2	0.2	2.8	100.0	2,262
No. of Lifetime Partners								
0	0.0	95.7	0.0	0.0	0.3	4.0	100.0	1,103
1	58.7	8.8	29.6	0.3	0.2	2.5	100.0	3,470
2+	57.7	17.9	18.5	3.1	0.0	2.8	100.0	85

288

CHAPTER 19

PHYSICAL AND SEXUAL ABUSE

In recent years, violence against women has gained visibility as a significant public health problem with serious consequences for women's health and for society. The United Nations defines it as "any act of . . . physical, sexual, or psychological harm . . . including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (UN General Assembly, 1993). Violence against women includes a wide range of behaviors and acts perpetrated against women, but its most common form occurs between men and their female partners. Often referred to as "domestic violence," "battering," or "intimate partner violence" (IPV), this form of violence occurs in all cultures and affects women of all ages, socioeconomic status (SES), and educational backgrounds. Gender stereotypes, women's economic dependence on men, cultural acceptability, loose or nonexistent legislation to protect women's fundamental human rights, and lack of preventive measures for victims are some of most widely recognized factors that contribute to IPV. Because IPV affects women's physical, sexual, psychological, economic, and social well-being, it implicitly affects women's health, including their reproductive health. Women subjected to IPV may be unable to use contraception effectively and consistently, may lack control or negotiation skills that will enable them to avoid sexually transmitted infections; plan pregnancies; and attend preventive health services, such as prenatal care.

Most data on the impact of IPV on women's health are compiled from studies targeting small population subgroups (e.g., women attending prenatal care clinics and women in shelters), and population-based, representative data on this subject are scarce. To address this need, nationwide reproductive health surveys conducted with the assistance of the U.S. Centers for Disease Control and Prevention (CDC) in Latin America and Eastern Europe have been collecting data on IPV since the mid-1990s. The surveys provide an unique opportunity to study characteristics of battered women and linkages with reproductive health. Moreover, because the violence indicators collected in CDC-assisted reproductive health surveys are similar, they allow for a regional examination of risk factors and prevalence of IPV.

In addition to documenting IPV in the context of maternal and child health, survey findings can be used to raise awareness at the individual and community level, to educate law enforcement and social service agencies, to influence current public health policies, to develop laws to protect and benefit
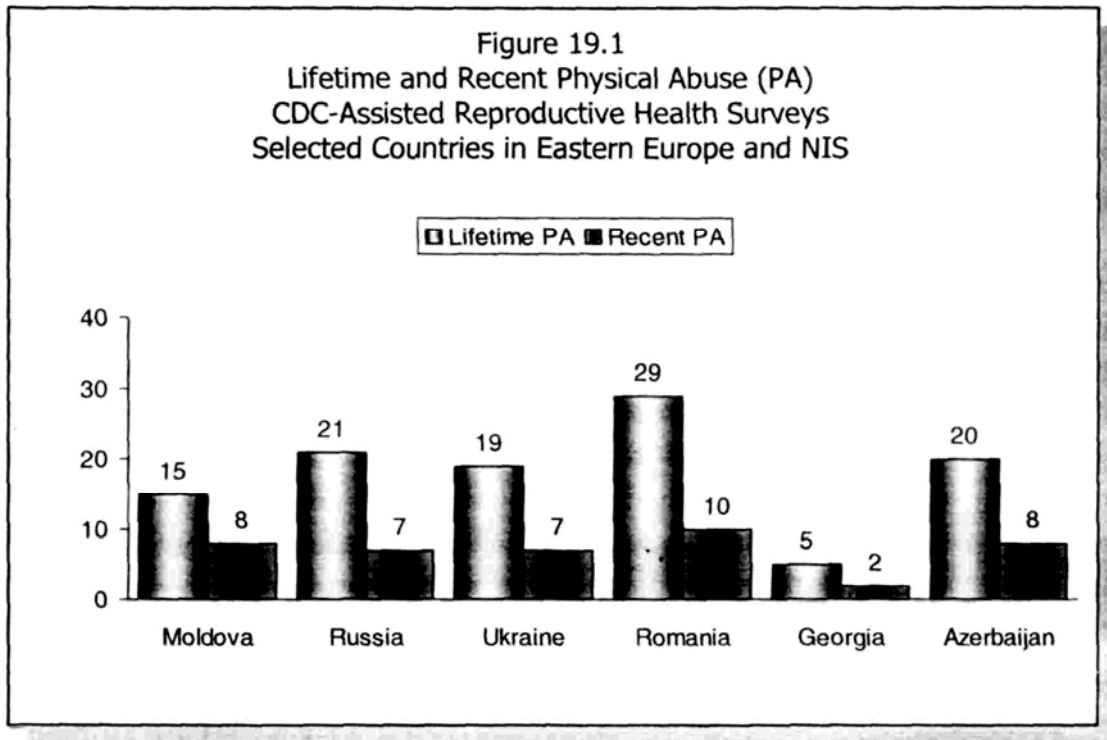
battered women and, ultimately, to project the need for support services and interventions for abused women.

The questions included in the AZRHS01 focus principally on two types of violence against women: (1) IPV and (2) sexual coercion (at any point in a woman's life). Violence by an intimate partner was explored using a modified, eight-item, Conflict Tactic Scale (Straus et al., 1979). IPV was defined as verbal, physical, and sexual abuse among ever-married (whether legally or consensually) women. Female respondents were asked a series of questions related to past and present (i.e., within the past year) abuse. Verbal abuse includes insults, curses, verbal threats, and gestures with the intent of physical harm. Physical violence, further classified into moderate and severe violence (O'Campo et al., 1994), includes pushing, shoving, and slapping (moderate violence) and kicking, hitting with the fist or an object, being beaten up, and being threatened with a knife or other weapon (severe violence). Women who experienced recent physical abuse were further asked about the severity of physical injuries and whether they sought help from law enforcement agencies, family, friends, or health care providers. Sexual abuse by an intimate partner was defined by asking whether "a partner ever 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; all female respondents, irrespective of their marital experience, were asked about their lifetime exposure to sexual coercion, defined as "being forced by a man to have sexual intercourse against your will." Furthermore, questions about age at first forced intercourse and relationship with the perpetrator at first forced intercourse were also included.

19.1 Comparative Findings on Intimate Partner Violence in Eastern Europe

Most countries of the region share similarities with regard to legal status of women and gender roles; they all experienced in the same Communist efforts to promote gender equality, only to see them replaced by recent political and social changes aimed at relegating women to traditional roles. None of these countries have yet established laws and mechanisms to protect women from spousal abuse. The questions included in the AZRHS01 are similar in scope to those asked in other CDC-assisted reproductive health surveys conducted in Eastern Europe and Former Soviet Union countries (Figure 19.1) (Serbanescu et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000; KIIS and CDC, 2000). In all the countries, with the exception of Russia (whose survey was limited to three, mostly urban, oblasts), the survey data produced the first population-based information on violence against women available at the national level.

The estimates presented here are likely to underestimate the true prevalence of IPV in the Azeri population because, for both psychological and practical reasons, some women may have understated or not reported their abuse history, despite assurances of maintaining confidentiality. Moreover,

Figure 19.1
Lifetime and Recent Physical Abuse (PA)
CDC-Assisted Reproductive Health Surveys
Selected Countries in Eastern Europe and NIS

□ Lifetime PA ■ Recent PA

40

30

20

10

0

15   8   21   7   19   7   29   10   5   2   20   8

Moldova   Russia   Ukraine   Romania   Georgia   Azerbaijan

cross-cultural data on spousal abuse can be difficult to interpret because cultural definitions or perceptions of abuse may differ from one country to another. Reported lifetime experience with spousal physical abuse ranged from 5% in Georgia to 29% in Romania, whereas physical abuse during the past 12 months ranged from 2% in Georgia to 10% in Romania. With the exception of Georgia, the ranges of lifetime and recent prevalence of physical abuse in the countries surveyed were similar (Serbanescu et al., 1995, 1998, 2001; VCIOM and CDC, 1998, 2000; K1IS and CDC, 2000).

19.2 History of Witnessing or Experiencing Parental Physical Abuse

In the literature on violence against women, experiencing and witnessing parental abuse as a child have been identified as strong independent predictors of being in an abusive union relationship as an adult. Several studies have linked childhood exposure to family violence with emotional and behavioral problems during childhood (Edleson, 1999; Kolbo and Blakely, 1996), child and adolescent violent behaviors (Song et al., 1998), and physical abuse during adulthood (Hotaling and Sugarman, 1986).

The prevalence of witnessing or experiencing abuse as a child was relatively high in all the countries of the region, except for Georgia; prevalence of witnessing domestic abuse as a child ranged from a high of 30% in Russia to 26% in Romania, 19% in Ukraine, and 9% in Georgia. Experience of

parental abuse as a child ranged from 41% in Romania to 29% in Ukraine, 26% in Russia, and 21% in Georgia (data not shown).

As shown in Table 19.2, an average of 26% of respondents reported having heard or seen abuse between their parents. Between 28% and 38% of women reported that they had experienced parental physical abuse; the average was 33%. There were no significant differences in recall of witnessing parental abuse by respondent's characteristics. The highest prevalence of experiencing parental abuse (38%) was reported by women with less than complete secondary education (who are also the youngest women in the sample), whereas the lowest occurrence (28%) was reported by women with postgraduate education and those aged 35—44.

TABLE 19.2
Percentage of Women Aged 15–44 Who Witnessed or Experienced Parental Abuse
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Witnessed Abuse	Experienced Abuse	No. of Cases[*]
Total	25.9	32.7	7,575
Residence			
Urban	25.8	32.5	3,794
Rural	26.2	33.0	3,781
Region			
Baku	26.3	33.2	1,528
North & North East	26.1	32.8	910
West	24.9	32.4	752
South West	23.2	35.8	2,270
South	27.6	32.7	940
Central	26.0	30.3	1,175
Age Group			
15–24	27.7	37.5	2,384
25–34	25.5	31.7	2,654
35–44	24.2	27.6	2,537
Education Level			
Secondary Incomplete or less	30.7	38.1	1,672
Secondary Complete	24.2	32.5	3,820
Post-secondary	24.7	28.4	2,083
Socio-economic Status			
Low	27.1	34.0	4,010
Medium	24.9	32.4	2,739
High	24.8	28.6	826
IDP Status			
IDP	23.0	34.9	1,254
Non-IDP/CA	25.1	32.3	3,007
Non-IDP/NCA	26.5	32.6	3,314

* Excludes 93 women who reported that they did not grow up with their parents

19.3 Verbal, Physical, and Sexual Abuse by a Partner or Ex-Partner
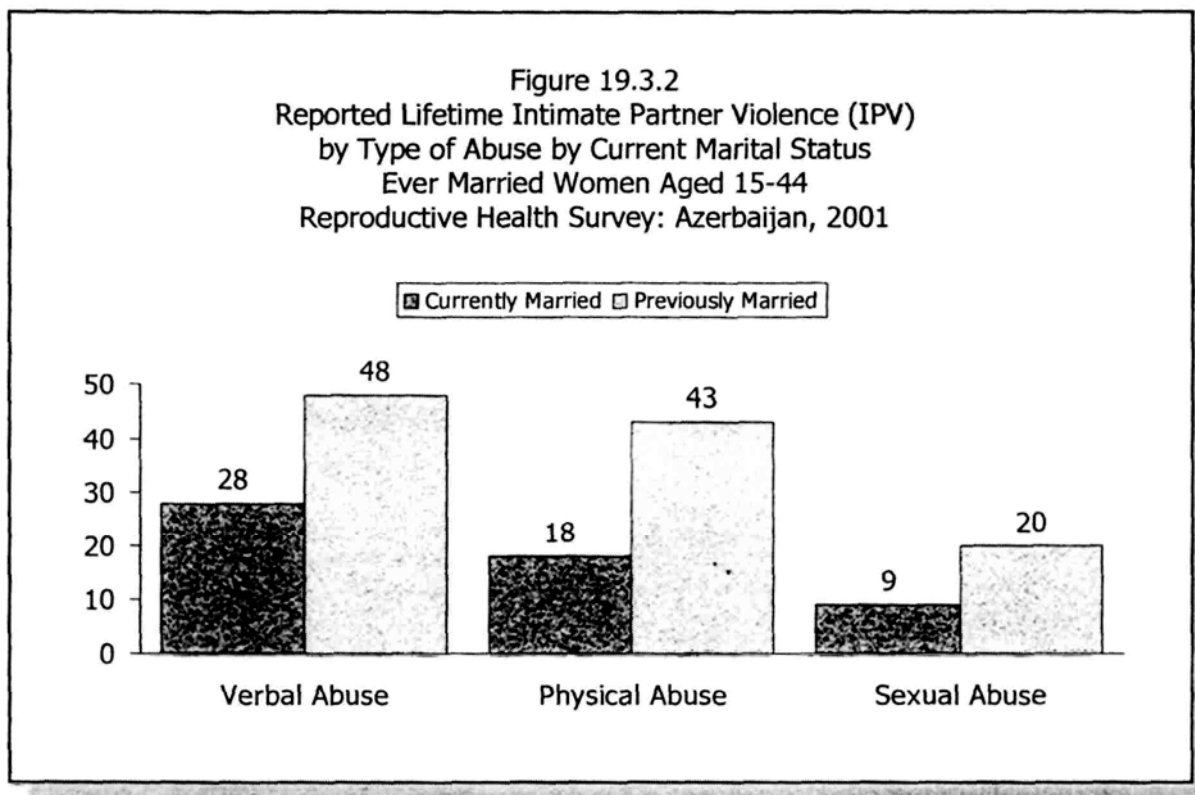
To measure the lifetime prevalence of IPV, women who ever had had a marital partner (either formal or consensual) were asked if they had ever been verbally, physically, or sexually abused by a partner or ex-partner. The terms "partner" and "ex-partner" include a current or former spouse (legal or common-law) or other partner with whom the respondent may have cohabited for any length of time.

Figure 19.3.1 and Table 19.3.1 show that almost 1 in 3 (30%) women reported verbal abuse, 1 in 5 reported physical abuse, and 1 in 10 reported sexual abuse by a partner or ex-partner at some time in their life. Among women who reported verbal abuse, all reported insults and most reported threats of violence. Not surprisingly, considerable overlap was found with the three types of abuse; the majority of women (84%) who have been subjected to physical violence said that the physical abuse was accompanied by verbal abuse (data not shown). Similarly, sexual abuse was frequently associated with other acts of physical harm: 64% of women who had been sexually abused also reported other acts of physical violence (data not shown).

Figure 19.3.1
Reported Lifetime and Recent Abuse
Ever Married Women Aged 15-44
Reproductive Health Survey: Azerbaijan, 2001

293
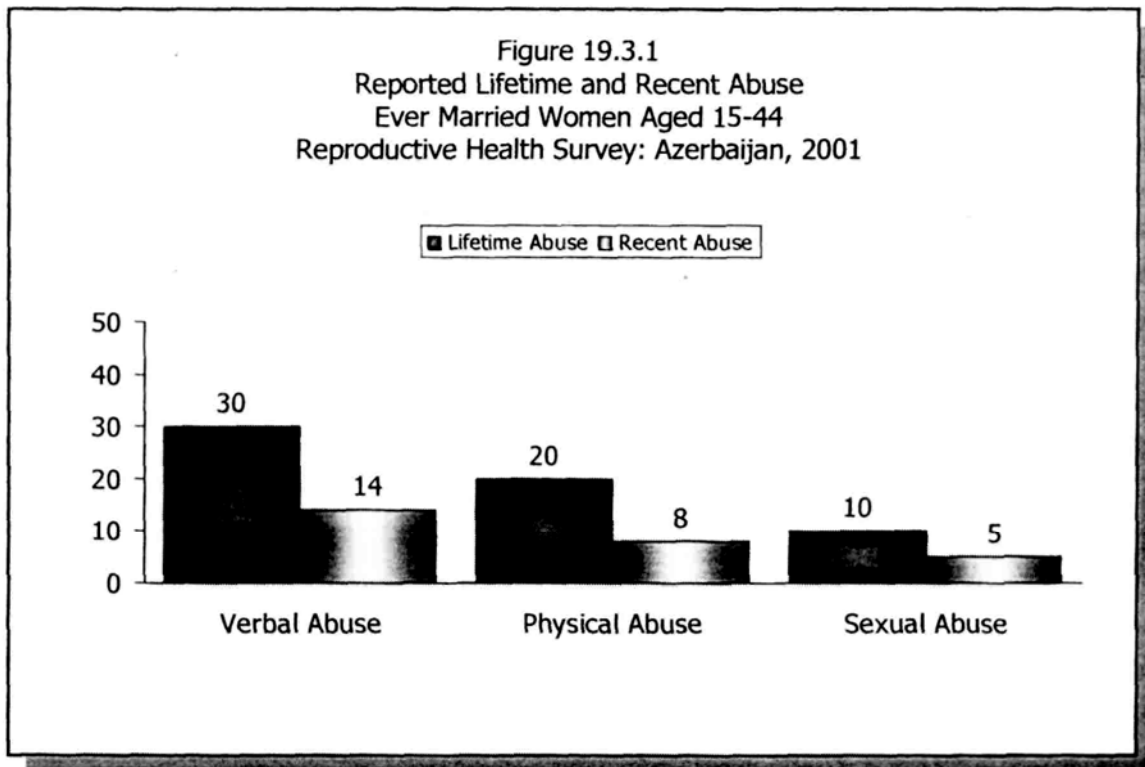
TABLE 19.3.1
**Percentage of Women Who Reported Intimate Partner Violence (IPV) in Their Lifetime and
Percentage Who Reported Intimate Partner Violence in the Last Year
by Type of Abuse by Selected Characteristics
Ever Married Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001**

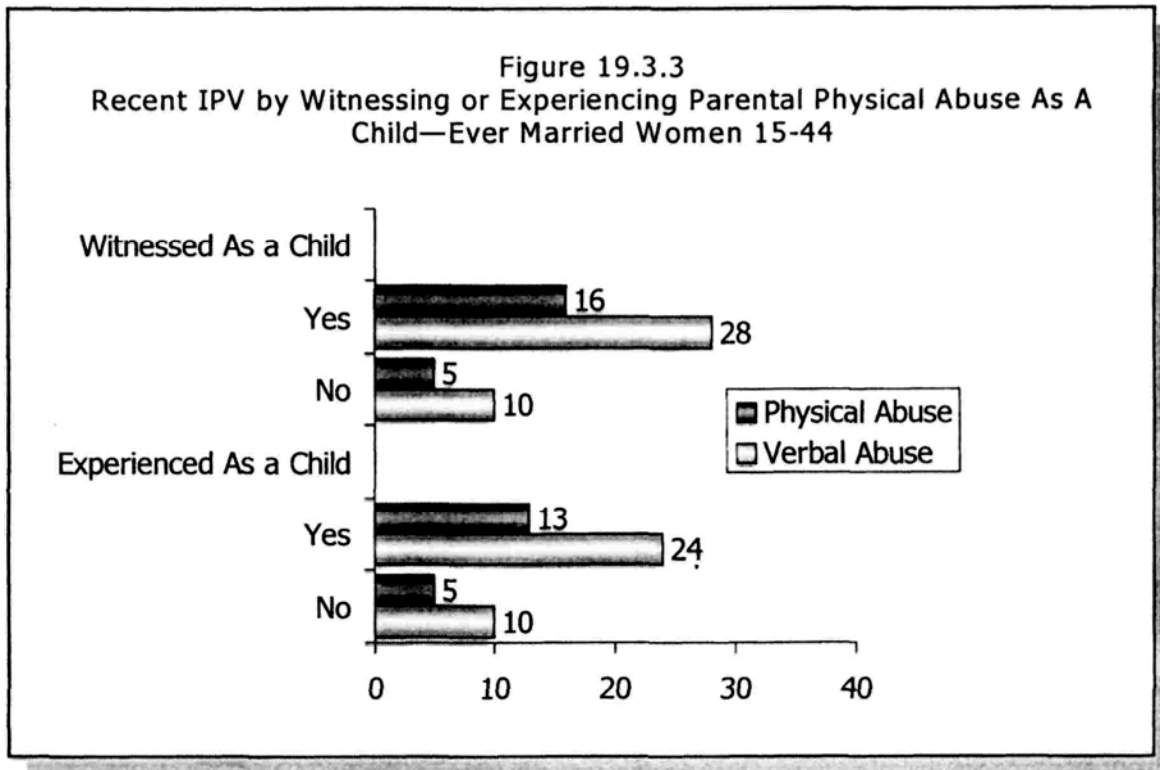| Characteristic	Lifetime IPV				IPV During the Last Year			
	Verbal Abuse	Physical Abuse	Sexual Abuse	No. of Cases	Verbal Abuse	Physical Abuse	Sexual Abuse	No. of Cases
Total	29.8	20.1	9.9	5,533	14.3	7.6	4.9	5,533
Residence								
Urban	28.0	19.4	9.7	2,816	13.3	7.0	4.6	2,816
Rural	32.0	21.0	10.0	2,717	15.7	8.4	5.3	2,717
Region								
Baku	23.9	16.2	9.6	1,136	13.1	7.3	4.7	1,136
North & North East	33.9	23.1	10.5	674	14.0	7.7	4.0	674
West	33.2	23.3	9.7	568	18.0	10.0	5.4	568
South West	31.6	20.9	10.7	1,648	16.3	8.5	6.7	1,648
South	27.0	21.2	6.9	640	11.9	8.2	3.5	640
Central	30.7	16.9	11.9	867	14.4	4.5	6.7	867
Age Group								
15–24	27.6	20.7	10.1	828	19.5	12.8	6.1	828
25–34	31.6	21.6	10.0	2,345	16.4	9.0	5.1	2,345
35–44	29.0	18.7	9.6	2,360	10.7	4.5	4.4	2,360
Marital Status								
Currently Married/In Union	28.1	18.1	8.9	5,146	14.9	7.8	5.2	5,146
Previously Married	48.8	42.6	20.2	387	8.3	5.9	2.3	387
No. of Living Children								
None	27.9	20.6	11.3	520	13.0	6.8	4.1	520
One	29.6	20.6	8.2	784	15.9	9.0	3.4	784
Two	28.7	19.8	10.5	2,094	15.9	8.4	5.2	2,094
Three or More	31.5	20.2	9.4	2,135	12.6	6.6	5.5	2,135
Education Level								
Secondary Incomplete or less	37.6	26.9	14.5	1,057	18.8	11.4	7.7	1,057
Secondary Complete	29.7	19.8	9.3	2,843	13.9	7.2	4.9	2,843
Post-secondary	24.8	16.3	7.7	1,633	12.2	5.7	3.1	1,633
Socio-economic Status								
Low	33.0	23.5	10.6	2,956	15.5	9.1	5.9	2,956
Medium	27.9	18.1	9.7	1,996	13.5	6.5	4.1	1,996
High	22.7	13.4	7.1	581	12.5	5.2	3.9	581
IDP/Refugee Status								
IDP/R	28.5	20.6	12.1	928	15.4	9.2	7.0	928
Non-IDP/CA	32.9	19.1	11.3	2,153	16.7	7.2	6.9	2,153
Non-IDP/NCA	29.3	20.3	9.2	2,452	13.7	7.5	4.2	2,452

Figure 19.3.2
Reported Lifetime Intimate Partner Violence (IPV)
by Type of Abuse by Current Marital Status
Ever Married Women Aged 15-44
Reproductive Health Survey: Azerbaijan, 2001

To document some of the risk factors for abuse, the prevalence of different types of abuse was analyzed by selected characteristics of the respondents. The prevalence of all types of abuse (verbal, physical, and sexual) was slightly higher among rural residents than among urban residents; was little influenced by age, number of living children, and internally displaced person and refugee (IDP/R) status; and was inversely correlated with education and SES levels.

When physical abuse by a partner or ex-partner was analyzed by the respondent's current marital status, women categorized as previously married had significantly higher prevalence of past verbal and physical abuse, compared with currently married women (see also Figure 19.3.2). Whereas 49% and 43%, respectively, of previously married women reported past verbal and physical abuse by a partner, only 28% and 18% of women currently married reported having been verbally or physically abused. Similarly, previously married women reported, on average, twice as much sexual abuse as currently married women did. Although the survey did not ask whether IPV contributed to a woman's decision to separate from her partner, the data suggest that women who were divorced and separated may have been exposed to more domestic abuse, contributing to their decision to split up with an abusive partner.

As shown in the right panel of Table 19.3.1, 14% of all women interviewed reported having been

295

Figure 19.3.3
Recent IPV by Witnessing or Experiencing Parental Physical Abuse As A Child—Ever Married Women 15-44

Witnessed As a Child
- Yes: Physical Abuse 16, Verbal Abuse 28
- No: Physical Abuse 5, Verbal Abuse 10

Experienced As a Child
- Yes: Physical Abuse 13, Verbal Abuse 24
- No: Physical Abuse 5, Verbal Abuse 10

Legend:
- ■ Physical Abuse
- ☐ Verbal Abuse

X-axis: 0, 10, 20, 30, 40

verbally abused by a partner or ex-partner during the past 12 months. Current physical and sexual abuse was reported by 8% and 5% of women, respectively. Some characteristics of the women who experienced higher levels of recent abuse were similar to those of women who reported lifetime abuse. The only substantive difference was among young women, who reported twice as much verbal and physical abuse as women aged 35 or older. Currently married women experience higher levels of current abuse than previously married women presumably because episodes of abuse may have contributed to the latter group's marital dissolution and because previously married women were less exposed to IPV at the time of the survey.

As mentioned previously, history of witnessing or experiencing abuse as a child is a well-known predictor of adult violence. The reports from Azerbaijan are consistent with other studies in the literature. Among women who reported having witnessed abuse in the home as a child, prevalence of having been verbally and physically abused during the past 12 months was 3 times as high as the prevalence among those who had not witnessed abuse in their childhood home (Figure 19.3.3). Similarly, those who had experienced parental abuse had prevalence of current IPV more than twice that of those who had not experienced parental abuse.

TABLE 19.3.2
Percentage of Respondents Who Reported Lifetime Physical Abuse and Recent Abuse
by Severity of Abuse by Selected Characteristics
Ever Married Women Aged 15–44
Reproductive Health Survey: Azerbaijan, 2001

| | Lifetime Abuse | | | | | Abuse During the Last Year | | | | | |
| | Moderate | | Severe | | | Moderate | | Severe | | | |
Characteristic	Pushed Shoved	Slapped	Hit with Fist	Was Beaten Up	Threatened With A Weapon	Slapped	Pushed, Shoved	Hit with Fist	Was Beaten Up	Threatened With a Weapon	No. of Cases
Total	**15.4**	**13.9**	**7.7**	**3.9**	**1.5**	**5.4**	**5.5**	**2.4**	**1.3**	**0.4**	**5,533**
Residence											
Urban	14.6	13.4	7.4	4.3	1.7	5.1	4.7	2.4	1.3	0.3	2,816
Rural	16.4	14.5	8.1	3.5	1.3	5.9	6.5	2.5	1.3	0.4	2,717
Region											
Baku	10.8	11.9	5.0	3.8	2.3	5.8	4.1	2.2	1.5	0.4	1,136
North & North East	18.3	16.5	10.3	3.9	2.1	5.3	5.8	3.4	1.5	0.8	674
West	17.9	16.4	7.6	4.0	0.6	7.0	7.7	2.8	1.2	0.0	568
South West	16.0	13.7	7.2	2.5	0.5	5.7	6.8	2.8	1.0	0.2	1,648
South	15.9	13.7	7.9	4.9	0.9	5.8	5.6	1.5	1.1	0.0	640
Central	14.5	10.7	8.1	3.9	1.2	3.0	4.1	1.5	1.3	0.5	867
Age Group											
15–24	16.8	14.7	9.1	4.9	1.9	8.2	10.2	4.8	2.8	1.1	828
25–34	16.5	14.5	7.6	4.1	1.1	6.2	6.4	2.1	1.4	0.2	2,345
35–44	13.9	13.1	7.3	3.4	1.6	3.8	3.0	1.8	0.7	0.3	2,360
Marital Status											
Currently Married/in Union	13.4	11.8	5.8	2.5	0.7	5.4	5.6	2.3	1.2	0.3	5,146
Previously Married	37.0	37.5	29.0	19.6	10.6	5.4	4.7	3.5	2.8	1.7	387
No. of Living Children											
None	18.6	15.7	11.7	6.4	2.0	4.6	5.9	2.3	1.0	0.1	520
One	14.6	14.3	7.2	5.9	3.2	6.6	5.8	2.2	2.2	1.3	784
Two	15.0	13.9	7.4	3.2	0.9	5.8	6.0	2.8	1.5	0.3	2,094
Three or More	15.2	13.2	7.1	3.1	1.2	4.8	4.8	2.2	0.9	0.2	2,135
Education Level											
Sec. Incomplete or less	22.8	17.4	12.5	7.0	2.9	7.8	9.7	4.6	3.0	1.1	1,057
Secondary Complete	14.4	13.8	6.9	3.2	1.2	5.2	4.6	1.9	0.9	0.2	2,843
Post-secondary	12.1	11.8	5.9	3.1	1.0	4.3	4.2	1.9	0.9	0.2	1,633
Socio-economic Status											
Low	18.8	16.2	9.6	4.2	1.3	6.3	7.1	3.0	1.6	0.5	2,956
Medium	12.7	12.4	6.4	4.1	1.8	4.7	4.2	1.7	1.2	0.3	1,996
High	10.2	9.7	4.5	2.4	1.2	4.5	3.3	2.3	0.8	0.1	581

The acts of violence most often mentioned were slaps, pushing, shoving and thrown objects, all defined as moderate acts of violence (Table 19.3.2). Between 11% and 23% of women reported such acts at some point during their life. Lifetime severe physical violence was reported by less than 8% of women (almost 8% were kicked or hit with the fists or objects, 4% suffered severe beating, and almost 2% were threatened with a knife or other weapon). Severity of abuse was more prominent among previously married women and women with low education level, who reported higher rates of any type of abuse. Similarly, the most common acts of current physical abuse (i.e., abuse during the past year) were slaps, pushing, and shoving (5%-6%); severe acts were reported by less than 2% of currently physically abused women.

19.4 Discussions of Physical Abuse With Others

Women are generally reluctant to disclose their history of current abuse (Table 19.4). Only 1 in 3 women who were abused during the past 12 months had talked to a family member about it, and less than 1 in 7 had talked to a friend. More important, abused women almost never reported the abuse to health care providers or law enforcement authorities. Only 1% reported the episodes of IPV to the police or talked to a medical care provider, and less than 1 % sought legal counsel for recent domestic abuse. These findings are particularly disturbing because about 1 in 5 women reporting recent abuse had also reported injuries resulting from the abuse, but only 1% of those who had injuries sought medical help. Health care providers in Azerbaijan should be made aware of the prevalence of IPV and the reluctance of victims to seek treatment, and they should initiate inquiries about IPV during routine health visits. Such screening could effectively reduce the frequency and severity of IPV and could provide early interventions for victims.

Few differences were found in recent abuse by respondent characteristics. Older women were more likely to talk to the police or other legal authority and to seek medical advice, whereas young adults were more likely to report abuse to a family member. The least educated women were the most likely to talk to a family member and the least likely to report IPV to the police. Compared with non-IDP/R women, IDP/R women were less likely to seek help from a family member but more likely to report abuse to the police.

The most common reason that a battered woman did not report IPV to the law enforcement agencies or health providers was that it would "bring the family a bad reputation" (48%). Other reasons mentioned were that IPV is "normal" (19%), that it would be too embarrassing to report domestic abuse (13%), and that it "would not do any good" because no charges would be brought (11 %). Only 3% of respondents did not report abuse because they feared a divorce; 2% cited fear of more beating (data not shown).

TABLE 19.4
Percentage of Women Who Were Physically Abused by an Intimate Partner During the Past Year
Who Discussed the Abuse With Family, Friends, Health Providers, Police, or Lawyers
by Selected Characteristics
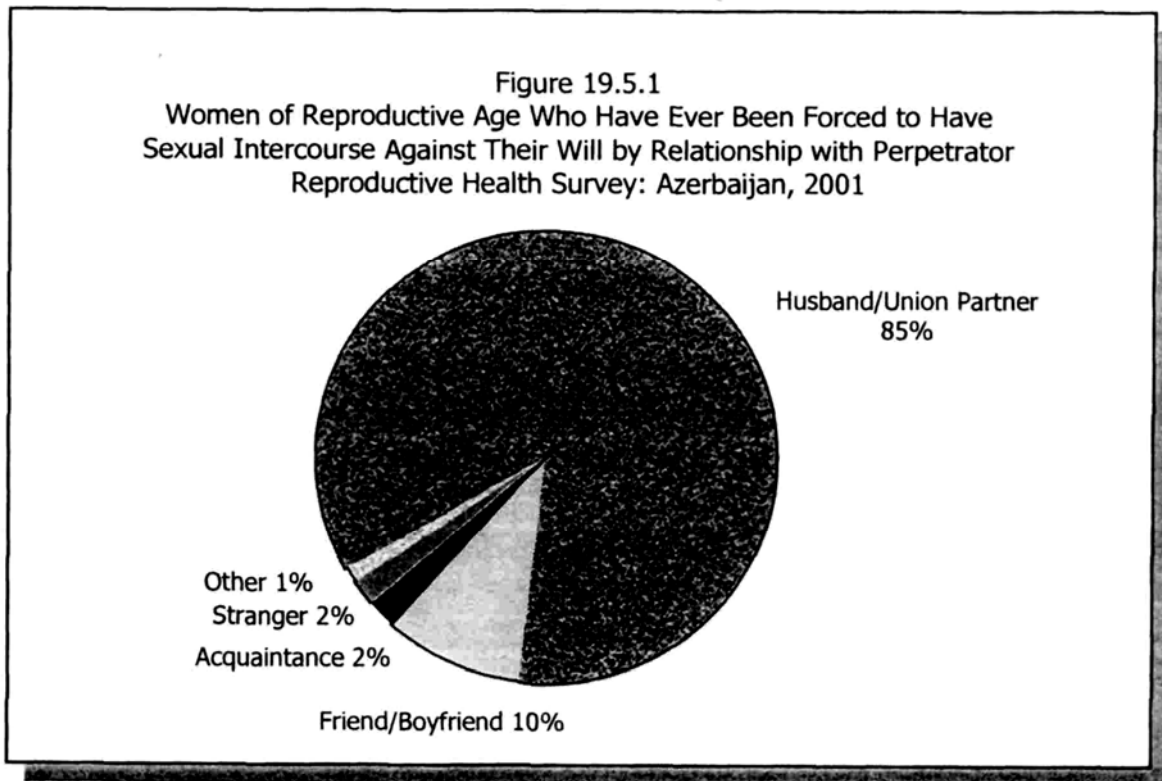**Reproductive Health Survey: Azerbaijan, 2001**

Characteristic	Family	Friends	Police	Health Provider	Lawyer	No. of Cases
Total	**34.1**	**14.6**	**1.3**	**1.1**	**0.3**	**658**
Residence						
Urban	34.5	12.9	2.5	0.7	0.5	298
Rural	33.7	16.4	0.1	1.5	0.1	360
Age Group						
15–24	38.6	16.2	1.2	0.1	0.0	144
25–34	35.0	12.1	0.8	1.6	0.5	314
35–44	29.2	16.9	2.3	1.1	0.1	200
Marital Status						
Currently Married/In Union	31.9	13.2	0.5	1.1	0.2	639
Previously Married	*	*	*	*	*	19
No. of Living Children						
None	44.0	17.6	0.0	0.0	0.0	55
One	46.6	15.1	2.0	1.8	0.0	92
Two	30.6	14.2	1.6	1.2	0.3	271
Three or More	30.0	14.0	1.0	0.9	0.5	240
Education Level						
Secondary Incomplete	48.0	17.6	0.1	0.1	0.6	156
Secondary Complete	28.1	12.7	2.0	1.4	0.1	356
Technicum	30.0	14.8	1.5	1.7	0.3	146
Socio-economic Status						
Low	35.3	15.4	0.6	0.9	0.2	400
Medium	32.2	13.3	2.9	0.8	0.5	211
High	33.7	13.7	0.0	3.1	0.0	47
IDP/Refugee Status						
IDP/R	18.4	4.8	4.8	1.1	0.5	131
Non-IDP/CA	28.7	13.2	0.5	3.6	0.2	282
Non-IDP/NCA	38.6	16.8	0.9	0.4	0.2	245

* Less than 25 cases.

19.5 Prevalence of Forced Sexual Intercourse

It is difficult to know the frequency of forced sexual intercourse, especially in countries with strong traditional values like Azerbaijan, where shame and fear of social stigma would be important deterrents to reporting sexual abuse to the police. Another reason, particularly when the perpetrator is an intimate partner, is the poor treatment received by victims from law enforcement agencies and the failure of the criminal justice system to punish aggressors. Marital rape is not considered a criminal offense in many countries of Eastern Europe and the former Soviet Union, including Azerbaijan (International Helsinky Federation [IHF], 2000).

Thus, population-based surveys inquiring about physical violence, including rape, are regarded as an alternate methodology for obtaining information about the prevalence of these events with the understanding that findings may provide only a minimum estimate due to underreporting. The most common legal description of rape includes vaginal, anal, or oral penetration against a victim's will. To estimate the prevalence of forced sexual intercourse, women were asked if they had "ever been forced by a man to have sexual intercourse against [their] will." Respondents who answered affirmatively were considered to have been forced to have intercourse against their will and were asked to specify their relationship to the perpetrator(s) and the age at which the first forced intercourse occurred.

Figure 19.5.1
Women of Reproductive Age Who Have Ever Been Forced to Have
Sexual Intercourse Against Their Will by Relationship with Perpetrator
Reproductive Health Survey: Azerbaijan, 2001

Husband/Union Partner 85%

Other 1%
Stranger 2%
Acquaintance 2%

Friend/Boyfriend 10%

TABLE 19.5

Percentage of Women Who Have Ever Been Forced to Have Sexual Intercourse Against Their Will
and Their Relationship with the Perpetrator at the Time of the Forced Intercourse
by Selected Characteristics
Reproductive Health Survey: Azerbaijan, 2001

Characteristic	Women With History of Forced Intercourse %	N	Relationship with the Perpetrator Among Raped Victims (Percent Distribution) Husband, Ex-Husband	Friend Boyfriend	Acquaintance	Stranger	Other	Total	No. of Cases
Total	6.1	7,668	85.2	10.0	2.0	1.5	1.3	100.0	546
Residence									
Urban	6.1	3,832	82.2	11.4	2.0	2.1	2.4	100.0	248
Rural	6.1	3,836	88.8	8.3	2.1	0.8	0.1	100.0	298
Age Group									
15–24	2.8	2,414	83.2	12.9	1.0	1.6	1.2	100.0	84
25–34	8.0	2,689	83.0	8.8	4.2	3.0	0.9	100.0	242
35–44	8.4	2,565	88.1	9.8	0.4	0.0	1.7	100.0	220
Marital Status									
Currently Married/In Union	8.4	5,146	87.0	10.9	0.9	0.7	0.5	100.0	473
Previously Married	19.1	387	87.6	0.0	7.9	2.3	2.2	100.0	67
Never Married	0.4	2,135	*	*	*	*	*	100.0	6
No. of Living Children									
0	2.0	2,655	66.5	15.6	6.5	6.3	5.0	100.0	58
1	7.9	784	83.1	6.5	5.9	4.6	0.0	100.0	68
2	10.2	2,094	91.3	6.9	0.5	0.0	1.4	100.0	224
3+	8.5	2,135	86.9	12.5	0.5	0.0	0.1	100.0	196
Woman's Education Level									
Secondary Incomplete	7.2	1,697	86.0	11.1	0.6	0.2	2.0	100.0	142
Secondary Complete	5.9	3,868	86.5	9.5	1.9	1.7	0.4	100.0	285
Post-secondary	5.3	2,103	81.5	9.5	4.0	2.7	2.3	100.0	119
Socioeconomic Status									
Low	6.5	4,068	91.6	7.8	0.4	0.2	0.1	100.0	318
Medium	6.1	2,770	76.0	12.9	4.8	3.5	2.8	100.0	184
High	4.3	830	87.9	9.9	0.0	0.0	2.1	100.0	44
IDP/Refugee Status									
IDP/R	7.6	1,272	92.5	5.3	1.6	0.3	0.3	100.0	104
Non-IDP/CA	6.6	3,047	90.6	8.7	0.0	0.7	0.0	100.0	227
Non-IDP/NCA	5.7	3,349	82.4	11.1	2.7	1.9	1.9	100.0	215

* Less than 25 cases.

Figure 19.5.2
Women of Reproductive Age Who Have Ever Been Forced to Have Sexual Intercourse Against Their Will by Age at First Forced Intercourse Reproductive Health Survey: Azerbaijan, 2001

30+ Years 22%
25-29 Years 22%
Do not Answer 12%
20-24 Years 23%
15-19 Years 21%
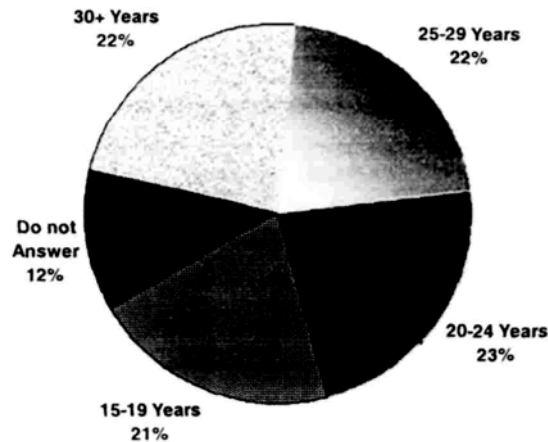
Six percent of women of childbearing age reported they were subjected to forced sexual intercourse some time in their life (Table 19.5). As was shown earlier in this chapter, among ever-married women, the prevalence of lifetime sexual abuse is 1.5 times higher (10%) than among all women.

The prevalence of forced sexual intercourse was significantly higher among previously married women (19%) and among women with at least one child than among childless women (who are also the least likely to have ever been married and to be exposed to any intimate partner abuse). The majority of women aged 15-44 had been raped by someone they knew (Table 19.5 and Figure 19.5.1). Only 2% of women who had ever been raped reported having been raped by a stranger. Overwhelmingly, women who were forced to have sexual intercourse against their will reported that the perpetrator was a husband or ex-husband; 1 in 10 women had been raped by a friend or boyfriend, and 2% were raped by a date or acquaintance.

Because marital rape accounted for 85% of forced sexual intercourse, the median age at first forced intercourse is older than the median age at first marriage (25 years vs. 22.3 years) (Figure 19.5.2). Only 1 in 5 women reported being raped before age 20, and virtually none before age 15. Most of those who were not abused before age 20 were abused before age 30 (45%). Almost 1 in 4 women (23%) reported first forced sex at age 30 or older. Almost 12% did not remember or refused to answer at what age they had been raped.

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Glossary

Abortion-to-Live-Birth Ratio: the number of induced abortions divided by the number of live births among women aged 15-44 years during a specified period of time.

Age-Specific Fertility Rate (ASFR): the number of births among women of a specific age group per 1,000 women aged 15-44 years during a specified period of time; traditionally given for 5-year age groups.

Age-Specific Induced Abortion Rate (ASIAR): the number of induced abortions among women of a specific age group per 1,000 women aged 15-44 years during a specified period of time; traditionally given for 5-year age groups.

AIDS: Acquired Immune Deficiency Syndrome- a disease caused by infection with HIV (human immunodeficiency virus), which disrupts the immune system and leads to death from opportunistic infections.

Anemia: a condition characterized by a decrease in the concentration of hemoglobin in the blood. Anemia results from conditions that decrease the number or size of red cells, such as excessive bleeding, a dietary deficiency (most often iron deficiency), destruction of red cells (e.g., transfusion reaction), or abnormally formed hemoglobin.

Anthropometry: height and weight measurements used to estimate the nutritional status of women and children.

AZRHS01: Azerbaijan Reproductive Health Survey, 2001.

Below Replacement Fertility: total fertility rate or average number of children per woman below that needed to maintain the current size of a population.

Body Mass Index (BMI): measure used to classify surveyed women as underweight, overweight, or obese; derived from the weight in kilograms, divided by the square of the height in meters. A BMI value of less than 18.5 indicates underweight, 24.0-29.9 indicates overweight, and 30.0 and greater indicates obesity.

Caucasus Region: Armenia, Azerbaijan, and Georgia.

Central Asian Republics: (for this report) Kazakhstan, Kyrgyz Republic, Turkmenistan, and Uzbekistan.

Child Mortality Rate: the probability that a child who is born during a specified time period will die after reaching 1 year of age and before 5 years of age; expressed as a rate per 1,000 children aged 1-4 years of age. For this report, the child mortality gives the probability of dying between the first and the fifth birthday based on direct estimates using information from the pregnancy histories.

Childbearing Age: age range during which most women are assumed to be capable of bearing children and contributing significantly to the total fertility rate and the contraceptive prevalence rate; Reproductive Health Surveys consider childbearing age to be 15-44 years of age and Demographic and Health Surveys consider childbearing age to be 15-49 years of age. Also known as reproductive age.

Contraceptive Effectiveness: the reduction in pregnancy rate resulting from the use of a contraceptive method relative to the pregnancy rate expected by chance if not using contraception. Contraceptive failure is the inverse of contraceptive effectiveness.

Contraceptive Prevalence Rate (CPR): percentage of women who are currently legally married or living with a man in a consensual, unregistered union who are using some method of pregnancy prevention (modern or traditional).

Crowding: characteristic of a household indicating that more than one household member lives in each room (not including the kitchen and the bathroom). A household is classified as having crowded conditions if the total number of persons living in the household divided by total number of rooms in the house is greater than one.

Dermatovenerology Clinic: in former Soviet countries, clinic that specializes in diagnosis, reporting, and treatment of sexually transmitted infections.

DHS: Demographic and Health Survey project managed and provided technical assistance by ORC/Macro International.

Eastern Europe: (for this report) Czech Republic, Moldova, Romania, Russia, and Ukraine.

Fecund: physically capable of becoming pregnant. A woman is classified as fecund if she or her husband/partner does not have impaired fertility (see definition of infecundity); a couple using female or male contraceptive sterilization is classified as fecund, because of the potential reversibility of these procedures.

General Fertility Rate: the number of live births among women of all ages per 1,000 women aged 15-44 years during a specified period of time.

General Induced Abortion Rate: the number of induced abortion among women of all ages per 1,000 women aged 15-44 years during a specified period of time.

Gross Domestic Product (GDP): the total value of goods and services produced exclusively within a nation's domestic economy. Normally computed over 1-year periods.

Hemoglobin: is an oxygen-carrying protein inside red blood cells (gives these cells the red color) whose function is to distribute oxygen to tissues and cells. A low hemoglobin level usually means a person has anemia.

HIV: Human Immunodeficiency Virus; virus that causes AIDS; spread by sexual contact with an infected person or by the use of needles or blood and blood products contaminated with the virus.

Household: a household consists of one person or more who share a dwelling and the household expenses.

Induced Abortion: purposeful termination of an intrauterine pregnancy with the intention of avoiding a live birth. Abortion "on request" has been available within the first 12 weeks of gestation in all former Soviet Union countries since November 1955. In these countries, abortion during the first 28 weeks of gestation may be legally performed on medical and social grounds.

Infant Mortality Rate (IMR): the number of infants who die between birth and the first birthday per 1,000 live births during a specified time period (conventional definition). In this report, the IMR gives the probability of dying between birth and the first birthday based on direct estimates using information from the pregnancy histories.

Infecund: physically incapable of becoming pregnant. A woman is classified as infecund if she reported that she or her husband had a sterilizing operation other than for contraceptive purposes (e.g., hysterectomy), it is impossible for her or her husband/ partner to have a baby for any other medical reasons, or she and her husband/partner have not used contraception and have not had a pregnancy for 2 years or longer.

Internally Displaced Persons or Refugees (IDP/Rs): include Azeri nationals who fled Nagorno-Karabakh and surrounding occupied territories (internally displaced persons) or Armenia (refugees) because of war. Other Azeri nationals were classified as non-IDP/Rs and were further divided into non-IDP/Rs living in conflict-affected areas (CA) (rayons where 20% or more of population is IDP/Rs) and non-IDP/Rs living in areas not affected or less affected by the war (NCA) (rayons with less than 20% of population being IDP/Rs).

Low Birth Weight Rate (LBWR): number of live births with a birth weight less than 2,500 grams per 100 live births during a specified period of time.

Marital Status: classifies women according to their formal (legal) marital status at the time of the interview into several categories—legally married, cohabiting or living in a consensual (unregistered) marital union, widowed, divorced, separated, or never married. The term "currently married" (used interchangeably with "women in union") refers to women in formal and consensual marital unions, excepting for the Tables 3.2.1 and 4.3, where women in "consensual unions" are presented separately. The term "previously married" encompasses two categories: women who have been in formal (legal) marital unions and are currently widowed, divorced, or separated and women who have been in consensual (unregistered) marital unions and are currently widowed or separated. The term "never married" refers to women who have never been in an either formal or consensual marital relationship.

Maternal Mortality Ratio (MMR): number of women who die of any cause related to or aggravated by pregnancy or its management per 100,000 live births during a specified period of time.

Method Mix: percent distribution of methods used by contracepting women, which adds up to 100 percent.

Mini-Abortion: purposeful termination of an intrauterine pregnancy (requires pregnancy confirmation) performed in the earliest stages of gestation (up to 6 weeks of gestation) by the means of electrical vacuum aspiration, usually without cervical dilatation or anesthesia.

Modern Methods of Contraception: pregnancy prevention by supplied or surgical means including condoms, diaphragms, cervical caps, spermicides, intrauterine devices (IUDs), oral contraceptives, emergency contraception, injectables, patches, implants, and male and female sterilization; more effective than traditional methods of contraception (e.g., periodic abstinence or withdrawal) in preventing pregnancy.

Neonatal Mortality Rate (NNMR): the number of infants who die during the neonatal period (from birth to, but not including, 28 days) per 1,000 live births during a specified time period. In this report, the NNMR represents the probability of dying during the neonatal period based on direct estimates using information from the pregnancy histories.

Oblast: geographic administrative district in former Soviet Republics.

Post-Neonatal Mortality Rate (PNNMR): the number of infants who die during the post-neonatal period (from 28 days to, but not including, 1 year of age) per 1,000 live births during a specified time period. In this report, the PNNMR represents the difference between the infant and neonatal mortality rates.

Rayon: geographic administrative district in former Soviet Republics, smaller than an oblast or a city.

RHS: Reproductive Health Survey of women aged 15-44 years, and sometimes also men aged 15-49 years, performed with technical assistance from CDC.

Replacement Level Fertility: the average number of children women must have in order to maintain the current size of a population.

Reproductive Age: see childbearing age.

Semashko Model: centralized, top-down, state-run method of planning and supplying health care in former Communist countries of Eastern Europe and the Soviet Union.

SES: socioeconomic status of the household that is estimated based on the presence or absence of household amenities and goods. Equal values were assigned for possession of 10 selected amenities or goods to create a socioeconomic score with values from 0 (no amenities or goods) to 10 (all 10 items). The score was further divided into terciles to create three levels for the SES as following: households with 0-3 items were classified as having low SES, households with 4-6 items were classified as having middle SES, and household with scores of 7 or higher were classified as having high SES.

STI: sexually transmitted infection; infection spread by sexual contact.

Stillbirth rate: the number of babies born after 28 weeks of gestation who show no signs of life after separation from the mother per 1,000 births (live births and stillbirths) during a specified period of time.

Stunting: having height-for-age more than 2 standard deviations below the median of the reference population; below normal height-for-age resulting from prolonged inadequate food intake or from recurrent episodes of illness.

Sub-Fecund: having a diminished capacity of becoming pregnant.

Technicum: type of technical education that trains mid-level specialists for either 2 years after completing secondary education (total of 10-11 years of school) or for 4-5 years after competing basic general education (total of 8-9 years of school). Technicum diploma may count toward university credits. The technicum system of education was developed in the Soviet Union and is still in existence in the former Soviet Republics.

Total Fertility Rate (TFR): the average number of children that a woman would have over the course of her life if she experienced the current level of age-specific fertility rates (ASFRs); the sum of the ASFRs.

Total Induced Abortion Rate (TIAR): similar to total fertility rate, the average number of abortions that a woman would have over the course of her life if she experienced the current level of age-specific abortion rates (ASARs); the sum of the ASARs.

Traditional Methods of Contraception: pregnancy prevention by means such as periodic abstinence or withdrawal; traditional methods are often considered natural but are generally less effective than modern methods.

Under-5 Mortality Rate: the number of children who die before their fifth birthday per 1,000 live births during a specified time period. In this report, the under-5 mortality rate gives the probability of dying between birth and the fifth birthday based on direct estimates using information from the pregnancy histories.

Unintended Pregnancy: a pregnancy is classified as unintended if the woman stated that "just before she got pregnant with that pregnancy" she did not want to have a(another) baby "then or at any time in the future" *(unwanted* pregnancy) or if she wanted to get pregnant at a later time *(mistimed* pregnancy).

Unmet Need for Contraception: in the RHS, the percentage of women, who are currently sexually active, fecund, not wanting to become pregnant, and not currently using any method of contraception; in the DHS the same as the RHS plus women who are currently pregnant or postpartum and whose pregnancies were unwanted or mistimed at the time of conception and who did not use any method of pregnancy prevention at the time of conception.

Unwanted Pregnancy: a pregnancy is classified as unwanted if the woman stated that "just before she got pregnant with that pregnancy" she did not want to have a(another) baby "then or at any time in the future."

Wasting: having weight-for-age more than 2 standard deviations below the median of the reference population; below normal weight-for-age reflecting a recent period of inadequate food intake or a recent episode of illness.

Women in Union: women who are currently legally married or living with a man in a consensual, unregistered union (see also marital status).

ANNEX A

SAMPLING ERROR ESTIMATES

The estimates for a sample survey are affected by two types of errors: non-sampling error and sampling error. Non-sampling error is the result of mistakes made in carrying out data collection and data processing, including the failure to locate and interview the right household, errors in the way questions are asked or understood, and data entry errors. Although intensive quality-control efforts were made during the implementation of the AZRHS01 to minimize this type of error, non-sampling errors are impossible to avoid altogether and difficult to evaluate statistically. Sampling error is a measure of the variability between an estimate and the true value of the population parameter intended to be estimated, which can be attributed to the fact that a sample rather than a complete enumeration was used to produce it. In other words, sampling error is the difference between the expected value for any variable measured in a survey and the value estimated by the survey. This sample is only one of the many probability samples that could have been selected from the female population aged 15-44 using the same sample design and projected sample size. Each of these samples would have yielded slightly different results from the actual sample selected.

Because the statistics presented here are based on a sample, they may differ by chance variations from the statistics that would result if all women 15-44 years of age in Azerbaijan would have been interviewed. Sampling error is usually measured in terms of the variance and standard error (square root of the variance) for a particular statistic (mean, proportion, or ratio). The standard error (SE) can be used to calculate confidence intervals (CI) of the estimates within which we can say with a given level of certainty that the true value of population parameter lies. For example, for any given statistic calculated from the survey sample, there is a 95 percent probability that the true value of that statistic will lie within a range of plus or minus two SE of the survey estimate. The chances are about 68 out of 100 (about two out of three) that a sample estimate would fall within one standard error of a statistic based on a complete count of the population.

The estimated sampling errors for 95% confidence intervals (1.96 x SE) for selected proportions and sample sizes are shown in Table A.1.   The estimates in Table A.1 can be used to estimate

95% confidence intervals for the estimated proportions shown for each sample size. The sampling error estimates include an average design effect of 1.6, needed because the AZRHS01 did not employ a simple random sample but included clusters of elements in the second stage of the sample selection.

TABLE A.1
Sampling Error Estimates (Expressed in Percentage Points) for 95% Confidence Intervals
for Selected Estimated Proportions and Sample Sizes
on Which the Proportions Are Based Assuming a Design Effect of 1.6

Sample Size	Estimated Proportions (Pi)					
	0.05/0.95	0.10/0.90	0.20/0.80	0.30/0.70	0.40/0.60	0.50/0.50
25	0.108	0.149	0.198	0.227	0.243	0.248
50	0.076	0.105	0.140	0.161	0.172	0.175
100	0.054	0.074	0.099	0.114	0.121	0.124
200	0.038	0.053	0.070	0.080	0.086	0.088
400	0.027	0.037	0.050	0.057	0.061	0.062
800	0.019	0.026	0.035	0.040	0.043	0.044
1000	0.017	0.024	0.031	0.036	0.038	0.039
1500	0.014	0.019	0.026	0.029	0.031	0.032
2000	0.012	0.017	0.022	0.025	0.027	0.028
3000	0.011	0.014	0.020	0.021	0.022	0.023
4000	0.008	0.012	0.016	0.018	0.019	0.020
5000	0.008	0.011	0.014	0.016	0.017	0.018

The selection of clusters is generally characterized by some homogeneity that tends to increase the variance of the sample. Thus, the variance in the sample for the AZRHS01 is greater than a simple random sample would be due to the effect of clustering. The design effect represents the ratio of the two variance estimates: the variance of the complex design using clusters, divided by the variance of a simple random sample using the same sample size (Kish L, 1967). For more details regarding design effects for specific reproductive health variables, the reader is referred to the Le and Verma report, which studied demographic and health surveys in 48 countries (Le TN and Verma JK, 1997). The pattern of variation of design effects is shown to be consistent across countries and variables. Variation among surveys is high but less so among variables. Urban - rural and regional differentials in design effects are small, which can be attributed to the fact that

similar sample designs and cluster sizes were used across domains within each country. At the country level, the overall design effect, averaged over all variables and countries, is about 1.5 (we used 1.6 in Table A. 1 to be slightly more conservative).

To obtain the 95% CI for proportions or sample sizes not shown in the table, one may interpolate. For example, for a sample size of 200 and a point estimate of 25% (midway between 0.20/0.80 and 0.30/0.70), the 95% CI would be plus or minus 7.5 percentage points; for a sample size of 300 (midway between 200 and 400) and an estimate of 20%, the 95% CI would be plus or minus 6.0 percentage points.

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

The relative standard error of a statistic (also called "coefficient of variation") is the ratio of the standard error (SE) for that statistic to the value of the statistic. It is usually expressed as a percent of the estimate. Estimates with a relative standard error of 30% or more are generally viewed as unreliable by themselves, but they may be combined with other estimates to make comparisons of greater precision. For example, an estimate of 20% based on a sample size of only 50 observations yields a SE of 7% (one half the 95% confidence interval shown in Table A.1). The relative standard error would be 35% (the ratio of the SE of 7% to the estimate of 20%), too large for the estimate to be reliable.

ANNEX B

INSTITUTIONAL PARTICIPATION

ADRA Azerbaijan	Shafag Rahimova, MD, PhD, DSc, Survey Director
	Farid Agamaliyev, MD, Survey Manager
	Linda Fardy Hayes, Survey Consultant
	Tamilla Rashidova, Survey Data Entry Supervisor
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	Wagner Kuhn, Country Director
	Conrad Vine, Health Coordinator
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2001 AZERBAIJAN REPRODUCTIVE HEALTH SURVEY
HOUSEHOLD QUESTIONNAIRE

STRATA ——— **ID NUMBER** ——— ——— ——— ——— ———

PSU ——— ——— ———

RESIDENCE (URBAN/RURAL) ———

RAION ———————————— ——— ——— ———

STATISTICS CODE ——— ——— ——— ——— ———

SECTOR ——— ——— ———

ENROLLMENT AREA ——— ———   INSTRUCTOR AREA _____   COUNTING AREA _____

LOCALITY _____

STREET ADDRESS _____

BUILDING/HOUSE NUMBER ——— ——— ——— ———

APARTMENT NUMBER ——— ——— ———

VISIT RECORD

Visit number	1	2	3	4
Date of visit	DAY MONTH —— —— —— ——	DAY MONTH —— —— —— ——	DAY MONTH —— —— —— ——	DAY MONTH —— —— —— ——
Result*	—— ——	—— ——	—— ——	—— ——
Interviewer	—— ——	—— ——	—— ——	—— ——
Supervisor	—— ——	—— ——	—— ——	—— ——

* RESULT CODES

1. **COMPLETED INTERVIEW**
2. **NO ELIGIBLE WOMAN (AGE 15-44) LIVES IN THE HOUSEHOLD**
3. **NOBODY HOME**
4. **SELECTED RESPONDENT NOT HOME**
5. **HOUSEHOLD REFUSAL**
6. **SELECTED RESPONDENT REFUSAL**
7. **UNOCCUPIED HOUSE**
8. **RESPONDENT INCOMPETENT**
9. **OTHER** _____
10. **INCOMPLETE INTERVIEW**

1.   How many families live in this household?   ___ families

(NOTE: A HOUSEHOLD CONSISTS OF ONE PERSON OR MORE; IF THERE ARE TWO OR MORE PERSONS--WITH OR WITHOUT FAMILY RELATIONS - WHO SHARE THE DWELLING AND THE HOUSEHOLD EXPENSES, HEY CONSTITUTE ONE HOUSEHOLD WITH ONE OR MORE FAMILIES; IF THE PERSONS DO NOT SHARE THE DWELLING AND HOUSEHOLD EXPENSES, REGARDLESS OF BEING RELATED, THEY CONSTITUTE TWO OR MORE HOUSEHOLDS)

2.   How many people normally live in this flat/house?   ___ ___ people

2A.   Are any of the persons living in this household either internally displaced or refugees?

   1. YES

   2. NO ------>**GO TO Q3**

2B.   How many persons living in this dwelling are internally dispaced or refugees?

      ___ ___ person(s)

3.   How many females between the ages of 15 and 44 live in this flat/house?   ___ women aged 15-44

IF NO ELIGIBLE WOMAN (AGE 15-44) LIVES IN THE HOUSEHOLD FINISH THE INTERVIEW (CODE-2)
IF THE HOUSEHOLD CONTAINS AT LEAST ONE ELIGIBLE WOMAN, CONTINUE

4.   For each of these women could you give me the following information **(STARTING WITH THE OLDEST WOMAN TO THE YOUNGEST) :**

No.	First Name	Age	Marital Status	Education Level	IDP/Refugee Status* Yes	No
1	_____	__ __	___	___	1	2
2	_____	__ __	___	___	1	2
3	_____	__ __	___	___	1	2
4	_____	__ __	___	___	1	2
5	_____	__ __	___	___	1	2
6	_____	__ __	___	___	1	2

Marital Status
1 Married
2 Unregistered Marriage
3 Separated
4 Divorced
5 Widowed
6 Never Married
9 UNKNOWN

Education:
0. No formal education
1. Primary education (1-4 yrs)
2. Basic Secondary (5-9 yrs.)
3. Complete Secondary (10-11 yrs of school)
4. Basic secondary + vocational education
5. Complete secondary + technical education
6. Incomplete postsecondary
7. Complete postsecondary (Diploma)
8. Postgraduate Education
9. UNKNOWN

IDP/Refugee Status*
DO NOT ASK IF Q2B=0

GO TO THE RANDOMIZATION TABLE

SELECTION OF INDIVIDUAL RESPONDENT USING RANDOMIZATION TABLE:

NUMBER OF ELIGIBLE WOMEN LIVING IN THE HOUSEHOLD (SEE # IN Q 3)	LAST DIGIT OF QUESTIONNAIRE NUMBER									
	0	1	2	3	4	5	6	7	8	9
1	1	1	1	1	1	1	1	1	1	1
2	1	2	1	2	1	2	1	2	1	2
3	3	1	2	3	1	2	3	1	2	3
4	3	4	1	2	3.	4	1	2	3	4
5	1	2	3	4	5	1	2	3	4	5
6	6	1	2	3	4	5	6	1	2	3

IF ONLY ONE WOMAN AGED 15-44 LIVES IN THIS HOUSEHOLD, WRITE "1" IN Q5

5.   **RANK ORDER OF THE SELECTED RESPONDENT: _____**

IF YOU DO NOT SPEAK WITH THE SELECTED RESPONDENT OR IF SHE IS NOT AVAILABLE FOR AN INTERVIEW AT THAT TIME, WRITE DOWN HER FIRST NAME AND SCHEDULE ANOTHER VISIT (DATE AND TIME)

FIRST NAME_____

DATE OF THE NEXT VISIT: _____   TIME: _____

2001 AZERBAIJAN REPRODUCTIVE HEALTH SURVEY
INDIVIDUAL QUESTIONNAIRE

Hello. I am_____ from ADRA. We are doing a national survey about the health of women and children in Azerbaijan. The purpose of the survey is to collect information that will help us to plan health services for women and children.

I would like to ask you about your health and where you obtain health services. All of the information you give us will be confidential. The interview is completely voluntary and if we should come to any question that you don't want to answer, just let me know and we'll go on to the next question. The interview will take about 35-40 minutes. I would like to start now, is that OK?

SIGNATURE OF THE INTERVIEWER_____　　　　　　**DAY ___ ___MONTH ___ ___**

MARK IF THE WOMAN AGREES TO BE INTERVIEWED　　　**1. YES——> CONTINUE**
_____ **2. NO ....>END OF INTERVIEW_____**

TIME STARTED: ___ ___ : ___ ___　　　　　**ID NUMBER　 ___ ___ ___ ___ _-_____**

I. BACKGROUND CHARACTERISTICS

100.　　In what month and year were you born?

　　　　　　　MONTH ___ ___　　　　　　　　　　　　　　99 DON'T KNOW
　　　　　　　YEAR 19 ___ ___

101.　　How old are you (at last birthday)?　 ___ ___　YEARS OLD　　　　99 DON'T KNOW

MAKE SURE THAT AGE AND DATE OF BIRTH CORRESPOND

102.　　What is the highest level of education you completed, not counting the current grade you are in?

000. NEVER ATTENDED (NO FORMAL EDUCATION)
　1. GENERAL SCHOOL/HIGH SCHOOL　　　　　　1 2 3 4 5 6 7 8 9 10 11　　99
　2. PROFESSIONAL (VOCATIONAL) SCHOOL　　　1 2 3　　　　　　　　　99
　3. TECHNICAL SCHOOL (POSTSECONDARY)　　　1 2 3　　　　　　　　　99
　4. UNIVERSITY/FACULTY　　　　　　　　　　1 2 3 4 5+　　　　　　99
　5. POST UNIVERSITY/POSTGRADUATE STUDIES　1 2 3 4 5+　　　　　　99
999. DON'T REMEMBER; DON'T KNOW

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

1 YES —> **GO TO Q105**
2 YES, BUT ON MATERNITY/PREGNANCY LEAVE—> **GO TO Q105**
3 NO

104. What is the <u>main</u> reason that you are not working at this time?

   1. ATTENDING SCHOOL
   2. I NTERNAL DISPLACEMENT
   3. LOOKING FOR WORK
   4. LAID OFF
   5. DOES NOT NEED/WANT/LIKE TO WORK
   6. MEDICAL LEAVE
   7. MATERNITY LEAVE
   8. INABILITY TO FIND/AFFORD CHILD CARE
   9. HOMEMAKER
   10. PERMANENT DISABILITY
   11. HUSBAND DOES NOT ALLOW HER TO WORK
   12. PARENTS DO NOT ALLOW HER TO WORK
   20. OTHER (SPECIFY)_____

105. I would like to ask you some questions about where you have lived. For most of the time <u>until you were 12 years old</u>, did you live in a city, in a town, or in a village?

   1. CITY
   2. TOWN
   3. VILLAGE

106. In what month and year did you start to live continuously at this current place of residence?

   ___ ___ MONTH   ___ ___ ___ ___ YEAR   00. ALWAYS, SINCE BIRTH
                                                   11. DON'T REMEMBER
                                                   l2

| IFQ106 YEAR=1987 OR LESS, GO TO Q116; OTHERWISE (1988 OR LATER) CONTINUE |

107. Before 1988, did you live in either Armenia or Nagorno-Karabakh and surrounding occupied regions?

   1. YES- Armenia
   2. YES- Nagorno Karabakh or surrounding occupied regions ------------->**GO TO Q109**
   3. NO--> **GO TO Q116**

108. What province in Armenia did you live in?

   1. ARARAT   8. SISYAN
   2. IDJEVAN   9. SPITAK
   3. KIROVAKAN   10. STEPANOVAN
   4. LENINAKAN   11. VEDI
   5. MASIS   12. YEREVAN
   6. MEGRI   20. OTHER
   7. NOVEMBERYAN   88. DK/NR

| **GO TO Q110** |

109. What occupied region of Azerbaijan did you live in?

   1. AGDAM   7. KODJAVEND   13. GERANBOY
   2. AGHDERE   8. KOJALI   14. TER-TER
   3. FIZULI   9. LACHIN
   4. GUBADLI   10. SHUSHA
   5. JEBRAI   11. ZANGILAN
   6. KELBAJAR   12. KHANKENDI

110. What was the most important reason of your moving?

   1. RELOCATION DUE TO POLITICAL UNREST/WAR
   2. GOT MARRIED ------------------------> **GO TO Q116**
   3. TO ATTEND SCHOOL --------------> **GO TO Q116**
   4 JOB RELATED------------------------ > **GO TO Q116**
   7 OTHER----------------------------------> **GO TO Q116**

111. During the past 12 months, did you or your family receive any humanitarian aid such as food supplies, household goods, clothing or shelter?

    1. YES
    2. NO—> **GO TO Q113**
    8 DK—> **GO TO Q113**

112. From whom did you receive humanitarian aid **(CIRCLE ALL MENTIONED)?**

	MENTIONED	NOT MENTIONED
1. STATE ORGANIZATION	1	2
2. INTERNATIONAL RELIEF ORGANIZATION	1	2
3. LOCAL NGO	1	2
4. OTHER _____	1	2

113. Do you have an IDP card?

    1. YES
    2. NO

114. Are you willing to return to your former place of residence?

    1. YES —>**GO TO Q116**
    2. NO
    8. DK—>**GO TO Q116**

115. Why not **(CIRCLE ALL MENTIONED)?**

	MENTIONED	NOT MENTIONED
1. HAVE ALREADY SETTLED AT THE PRESENT PLACE	1	2
2. NO SOURCE OF INCOME IF SHE RETURNS	1	2
3. HOUSE SHE LEFT BEHIND IS RUINED/DESTROYED	1	2
4. NO MEANS FOR RETURN	1	2
5. MOST OF THE RELATIVES WERE RELOCATED ELSEWHERE	1	2
6. WILL NOT FEEL SAFE/GENERAL SENSE OF THREAT	1	2
7. CHILDREN WILL NOT BE ABLE TO GO TO SCHOOL	1	2
8. LACK OF ADEQUATE HEALTH CARE	1	2
9. PAINFUL EXPERIENCE OF THE PAST	1	2
20. OTHER _____	1	2

116. Are you <u>currently</u> married, not married but living with someone, separated, divorced, widowed, or have you never been married ?

    1 MARRIED--> **GO TO Q120**
    2 NOT MARRIED BUT LIVING WITH A PARTNER —> **GO TO Q120**
    3 SEPARATED   \ -------------------------------- ----------->**GO TO Q120**
    4 DIVORCED   /
    5 WIDOWED   /
    6 NEVER MARRIED

117. Have you ever lived with a boyfriend or partner ? **(LIVING TOGETHER MEANS HAVING A SEXUAL RELATIONSHIP WHILE SHARING THE SAME USUAL ADDRESS.)**

    1 . YES—>**GO TO Q120**
    2. NO

118. If you could choose exactly the number of children to have in your whole life, how many would that be?

    ___ ____ CHILDREN   22. AS MANY AS GOD GIVES
                             33. AS MANY AS HUSBAND WOULD WANT
                             88. NOT SURE/DON'T REMEMBER

GO TO Q135

120.   How many **times** have you been married or lived with a man as husband and wife?

__ TIMES   9. REFUSAL-------- >**GO TO Q127**

TIMES	121. In what month and year did you begin living with your... (first, second, third, or fourth) husband/partner?	122. How old was your I, II, III, IV husband/ partner when you started to live together?	123. What was the highest grade in school that your 1,11,111,1V husband/ partner completed when you got married/started to live together ?	124. What is your current union relationship with your I, II, III, IV, husband/ partner, are you still in the relationship or how did the relationship end?	125. In what month and year did your union with your I,II,III,IV. .husband/partner end?	126 IF:
I	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRLMARY/B.SEC (1-9) 2. SECONDARY (10-11) 3. VOCATIONAL 4. TECHNICAL SCH 5. UNIVERSITY 8. UNKNOWN	1 Married—>**Q126** 2 Living with partner->**Q126** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**Q120=1->Q127 ELSE CONTINUE**
II	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRLMARY/B.SEC (1-9) 2. SECONDARY (10-11) 3. VOCATIONAL 4. TECHNICAL SCH 5. UNIVERSITY 8. UNKNOWN	1 Married—>**Q126** 2 Living with partner->**Q126** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**0120=2->Q127 ELSE CONTINUE**
III	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRLMARY/B.SEC (1-9) 2. SECONDARY (10-11) 3. VOCATIONAL 4. TECHNICAL SCH 5. UNIVERSITY 8. UNKNOWN	1 Married—>**Q126** 2 Living with partner->**Q126** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**Q120=3->Q 127 ELSE CONTINUE**
IV	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	__ __ AGE 88 DK	0.NEVER ATTENDED 1. PRLMARY/B.SEC (1-9) 2. SECONDARY (10-11) 3. VOCATIONAL 4. TECHNICAL SCH 5. UNIVERSITY 8. UNKNOWN	1 Married—>**Q126** 2 Living with partner->**Q126** 3 Separated 4 Divorced 5 Widowed	MTH __ __ YR __ __ __ __ 88. DON'T KNOW/REF	**GO to Q127**

127.   When you first got married/living together as husband and wife did you wish to have any children?

1 YES
2 NO----------->**GO TO Q130**
8 NOT SURE —>**GO TO Q130**

128.   How many children did you wish to have when you first got married?

__ __ CHILDREN   22. AS MANY AS GOD GIVES
                            33. AS MANY AS HUSBAND WANTS
                            88. NOT SURE/DON'T REMEMBER

130.   How many children did your husband wish to have when you first got married?

__ __ CHILDREN   22. AS MANY AS GOD GIVES
                            33. AS MANY AS RESPONDENT WANTS
                            88. NOT SURE/DON'T REMEMBER

BOX 1

> **IF CURRENTLY SEPARATED DIVORCED OR WIDOWED (Q124_LAST=3,4,5) GO TO Q135**

132. Is your husband currently employed (either in Azerbaijan or abroad)?

1. YES
2. NO --------->**GO TO Q135**
8. DK/REF

133. Is he away for work in another country?

1. YES
2. NO --------- >**GO TO Q135**
8. DK/REF-—> **GO TO Q135**

134. Since when has he been working abroad?

A. ___ ___ MONTH   B. ___ ___ ___ ___ YEAR   22. SEASONAL WORKER
                                                            88. DK/DR

135. More or less how many hours a day do you listen to the radio?

HOURS A DAY ___ ___   00 NEVER-. --->**GO TO Q139**
                             55. DOES NOT HAVE ACCESS TO RADIO .... >**GO TO Q139**
                             77. NOT EVERY DAY
                             88. DON'T KNOW

136. What stations do you most often listen to? **(PROBE FOR MORE THAN ONE STATION, DO NOT READ LIST)**

	MENTIONED	**NOT MENTIONED**
FIRST STATE RADIO CHANNEL	1	2
ARAZ	1	2
ANS	1	2
106 FM	1	2
104 FM	1	2
101 FM	1	2
EUROPE PLUS	1	2
RADIO LIBERTY	1	2
VOICE OF AMERICA	1	2
BBC	1	2
OTHER _____	1	2

137. What types of programs do you most often listen to? **(PROBE FOR MORE THAN ONE PROGRAM, DO NOT READ LIST)**

	MENTIONED	**NOT MENTIONED**
NEWS	1	2
SPORTS	1	2
MUSIC	1	2
PLAYS/DRAMAS	1	2
CHURCH/RELIGIOUS PROGRAMS	1	2
WOMEN'S PROGRAMS	1	2
HEALTH PROGRAMS	1	2
POLITICAL EVENTS	1	2
BUSINESS PROGRAMS	1	2

138. What times do you most often listen to the radio? **(PROBE FOR MORE THAN ONE TIME, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
6-8 AM	1	2
8-10 AM	1	2
10AM-NOON	1	2
NOON-2PM	1	2
2-4 PM	1	2
4-6 PM	1	2
6-8 PM	1	2
8-10 PM	1	2
AFTER 10 PM	1	2
NO REGULAR TIMES	1	2

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

HOURS A DAY ___ ___

00 NEVER-->**GO TO Q144**
55. DOES NOT HAVE ACCESS TO TV................... >GO **TO Q144**
66. WHEN THE HOUSEHOLD HAS ELECTRICITY
77. NOT EVERY DAY
88. DON'T KNOW

140. What channels do you most often watch? **(PROBE FOR MORE THAN ONE CHANNEL, DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
AZTV 1 (CHANNEL 1)	1	2
AZTV 2 (CHANNEL 2)	1	2
SPACE	1	2
ABA	1	2
ANS	1	2
LOCAL CHANNELS (e.g. NACHICIVAN ?)	1	2
RUSSIAN CHANNELS (PTP, OPT, NTV, ORT, RTR)	1	2
TURKISH CHANNELS (TRT, STV, TGRT)	1	2
OTHER FOREIGN CHANNELS (e.g. CNN, BBC, EURONEWS, STAR)	1	2
OTHER _____	1	2

141. What types of programs do you most often watch? **(PROBE FOR MORE THAN ONE PROGRAM , DO NOT READ LIST)**

	MENTIONED	NOT MENTIONED
NEWS	1	2
COMERC1ALS	1	2
ENTERTAINMENT PROGRAMS	I	2
SERIALS/MOVIES	1	2
SPORTS	1	2
MUSIC PROGRAMS, VIDEO CLIPS	1	2
PLAYS/DRAMAS	1	2
CHILDREN'S PROGRAMS	1	2
CHURCH/RELIGIOUS PROGRAMS	1	2
WOMEN'S PROGRAMS	1	2
HEALTH PROGRAMS	1	2
POLITICAL EVENTS	1	2
BUSINESS PROGRAMS	1	2

142.   What times do you most often watch television? **(CIRCLE ALL MENTIONED, DO NOT READ LIST)**

	MENTIONED	**NOT MENTIONED**
6-8 AM	1	2
8-10 AM	1	2
10AM-NOON	1	2
NOON-2PM	1	2
2-4 PM	1	2
4-6 PM	1	2
6-8 PM	1	2
8-10 PM	1	2
AFTER 10 PM	1	2
NO REGULAR TIMES	1	2

144.   How often do you read a newspaper?

1   DAILY/NEARLY EVERY DAY
2   ABOUT 3-4 TIMES PER WEEK
3   ONCE OR TWICE PER WEEK
4   LESS THAN ONCE PER WEEK
5   NEVER/ALMOST NEVER------------------ **>GO TO MODULE II**

145.   Which newspaper(s) do you read most often? **(CIRCLE ALL MENTIONED, DO NOT READ LIST)**

	MENTIONED	**NOT MENTIONED**
1. AZERBAIJAN	1	2
2. ARODYL	1	2
3. AZADLIG	1	2
4. AYNA	1	2
5. BAKINSKI REBOSHI	1	2
6. BIRJE	1	2
7. KHALG GAZETI	1	2
8. MUKHALIFAT	1	2
9. MUSAVAT	1	2
10. PANORAMA	1	2
11. RESPUBLICA	1	2
12. ZERKALO	1	2
13. 525	1	2
14. 7 GYUN	1	2
15. FOREIGN NEWSPAPER (TURKISH, RUSSIAN, ENGL).	1	2
20. OTHER _____	1	2

II. SEX EDUCATION

The next set of questions are about sex education.

201.   Do you think schools should teach courses about human reproduction, contraception, and prevention of sexually transmitted diseases?

    1. YES
    2. NO -> **GO TO 203**
    8. DK
    9. NR -> **GO TO 203**

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

    A. Human Reproduction? **___ ___**   77. SHOULD NOT BE TAUGHT IN SCHOOL.

    B. Contraception?   **___ ___**   88. DK

    C. STD's   **___ ___**   99. NR

    <div style="text-align:center">

GO TO BOX 2-I

    </div>

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

	AGREE	**DISAGREE**	**DK**	**NR**
A. Sex education will give adolescents the Idea to begin sex earlier 1		2	8	9
B. Sex education should be taught only in the house 1		2	8	9
C. Sex education goes against my religious beliefs................................. 1		2	8	9
D. Teachers do not have enough training to teach such courses..............1		2	8	9

BOX 2-I

IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO SECTION III

204.   Before you were 18 years old, did a parent ever talked to you about......(**READ A-F**)

	YES	**NO**	**DK/DR**	**REF**
A. Menstrual Cycle? 1		2	8	9
B. How Pregnancy Occurs? 1		2	8	9
C. Not Having Sexual Intercourse Before Marriage?.............................1		2	8	9
D. Methods of Contraception? 1		2	8	9
E. HIV/AIDS? 1		2	8	9
F. Other Sexually Transmitted Diseases?...1		2	8	9

READ EACH QUESTION 205-207 FROM THE TABLE FOR EACH TOPIC OF SEX EDUCATION:

TOPIC	205. Before you were 18 years old, have you ever been taught at school about.? (READ A-G)	206. How old were you when you first were taught at school about...?	207. Who taught you at school about...?
A. Menstrual Cycle	1 YES -> GO TO Q206 2 NO --> GO TO Q205B 8 DK -> GO TO Q205B 9 NR -> GO TO Q205B	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
B. Female Reproductive System	1 YES --> GO TO Q206 2 NO --> GO TO Q205C 8 DR --> GO TO Q205C 9 NR -> GOTO Q205C	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
C. Male Reproductive System	1 YES --> GO TO Q206 2 NO--- > GO TO Q205D 8 DR --> GO TO Q205D 9NR -> GO TO Q205D	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
D. How Pregnancy Occurs	1 YES --> GO TO Q206 2 NO -> GO TO Q205E 8 DR --> GO TO Q205E 9 NR -> GO TO Q205E	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
E. Contraceptive Methods	1 YES --> GO TO Q206 2 NO---- ->GO TO Q205F 8DR---- > GO TO Q205F 9NR----> GO TO Q205F	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
F. HIV/AIDS	1 YES -> GO TO Q206 2 NO -> GO TO Q205G 8 DR --> GO TO Q205G 9NR-----> GO TO Q205G	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER
G. Other Sexually Transmitted Diseases	1 YES --> GO TO Q206 2 NO----> GO TO Q208 8DR-----> GO TO Q208 9NR ----> GO TO Q208	___ ___	1 TEACHER 2 DOCTOR/NURSE 3 VOLUNTEER 7 OTHER_____ 8 DON'T REMEMBER

208.   In your opinion, who or what was <u>the most important</u> source of information you have had about topics related to sexual matters?

1. MOTHER
2. FATHER
3. RELATIVE
4. BOYFRIEND
5. FRIENDS
6. CO-WORKER
7. COLLEAGUES, PEER
8. PARTNER/HUSBAND
9. DOCTOR

10. NURSE, MIDWIFE
11. TEACHER
12. PHARMACIST
13. BOOKS
14. NEWSPAPERS, MAGAZINES, BROCHURES, FLYERS
15. RADIO
16. TV
20. OTHER (SPECIFY): _____
88. DON'T REMEMBER

III. FERTILITY/PREGNANCY

300.   Are you currently pregnant?

    1 YES
    2 NO—>**GO TO Q305**
    3 NOT SURE—>**GO TO Q305**

301.   How many months pregnant are you now? _____ MONTHS

302.   Just before you get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?

    1. WANTED TO GET PREGNANT THEN
    2. WANTED TO GET PREGNANT LATER
    3. DID NOT WANT THE PREGNANCY THEN OR ANY TIME IN THE FUTURE
    8. NOT SURE

303.   Is this your first pregnancy?

    1 YES
    2 NO ---------->**GO TO Q307**
    3 NOT SURE

304.   Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

    1 YES ---->**GO TO PREGNANCY HISTORY, PAGE 11**

    2 NO ----->**GO TO MODULE IV, PAGE 23**

305.   Have you ever been pregnant?

    1 YES --------->**GO TO Q307**
    2 NO
    3 NOT SURE
    4 NEVER HAD SEX ->**GO TO MODULE IV, PAGE 23**

306.   Have you ever had a stillbirth, ectopic pregnancy, miscarriage, or an induced abortion?

    1 YES----->**GO TO PREGNANCY HISTORY, PAGE 11**

    2. NO----->**GO TO MODULE IV, PAGE 23**

307.   Have you ever had any live-born children?

    1. YES

    2. NO------->**GO TO PREGNANCY HISTORY, PAGE 11**

308.   How many living children do you have, including those who do not live with you?

    ___ ___ CHILDREN

309.   Have you ever had a child born alive who later died or died in the first hours or days after birth?

    1. YES

    2. NO --> **GO TO PREGNANCY HISTORY, PAGE 11**

310.   How many children died? ___ ___ CHILDREN

311.   So altogether you had a total of ___ ___ **(Q308+Q310)** live births?

    I. YES
    2 NO------->**CHECK Q308 AND Q310 AND MAKE CHANGES IF NECESSARY**

PREGNANCY HISTORY

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

#	312 How did that pregnancy end?	313 When did that pregnancy end? (month & year)	314 How many weeks or months had you been pregnant when that pregnancy ended?	315 Was the baby a boy or a girl?	316 Is the child still alive?	317 How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS)	318 **IF Q313B < 1996 —>GO TO NEXT PREGNANCY** Just before YOU get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?
1	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1.__ __ DAYS OR 2.__ __ MTHS OR 3.__ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
2	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1.__ __ DAYS OR 2.__ __ MTHS OR 3.__ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
3	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1.__ __ DAYS OR 2.__ __ MTHS OR 3.__ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
4	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1.__ __ DAYS OR 2.__ __ MTHS OR 3.__ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

#	312	313	314	315	316	317	318
	How did that pregnancy end?	When did that pregnancy end? (month & year)	How many weeks or months had you been pregnant when that pregnancy ended?	Was the baby a boy or a girl?	Is the child still alive?	How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS)	**IF Q313B < 1996 —>GO TO NEXT PREGNANCY** Just before YOU get pregnant, did you want to get pregnant then, did you want to get pregnant later, or did you not want to get pregnant then or any time in the future?
5	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
6	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
7	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
8	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
9	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B__ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

#	312	313	314	315	316	317	318
							IF Q313B<1996 —>GO TO NEXT PREGNANCY
10	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B_ _ _ _ _ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
11	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B_ _ _ _ _ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
12	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B_ _ _ _ _ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
13	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B_ _ _ _ _ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE
14	1.LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4.ST1LLB1RTH (SINGLE) 5.MULTIPLE STILLBIRTH 6.M1SCARRIAGE 7 INDUCED ABORTION 8. MINIABORTION 9 ECTOPIC PREGNANCY	A__ __MTH B_ _ _ _ _ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO Q318**	1. BOY 2. GIRL 3. BOTH	1. YES->**Q318** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR	1. WANTED TO GET PREG. THEN 2. WANTED TO GET PREG. LATER 3. DID NOT WANT PREGNANCY THEN OR ANY TIME IN THE FUTURE 8. NOT SURE

Q16

#	312	313	314	315	316	317
	How did that pregnancy end?	When did that pregnancy end? (month & year)	How many weeks or months had you been pregnant when that pregnancy ended?	Was the baby a boy or a girl?	Is the child still alive?	How old was the child when he died? (RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS)
15	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..BOY 2. GIRL 3. BOTH	1 YES >**GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
16	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..BOY 2. GIRL 3. BOTH	1 YES >**GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
17	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..BOY 2. GIRL 3. BOTH	1 YES >**GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
18	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..BOY 2. GIRL 3. BOTH	1 YES >**GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
19	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..BOY 2. GIRL 3. BOTH	1 YES >**GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR

#	312	313	314	315	316	317
20	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..B O Y 2. GIRL 3. BOTH	1 YES > **GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
21	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..B O Y 2. GIRL 3. BOTH	1 YES > **GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
22	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..B O Y 2. GIRL 3. BOTH	1 YES > **GO TO THE NEXT PG.** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR
23	1..LIVE BIRTH (SINGLE) 2.MULTIPLE LIVE BIRTH 3.MULTIPLE (LB WITH SB) 4 STILLBIRTH (SINGLE) 5.MULT1PLE STILLBIRTH 6.M1SCARR1AGE 7.INDUCED ABORTION 8. MINIABORTION 9.ECTOPIC PREGNANCY	A __ __ MTH B __ __ __ __ YR 98. DK/NR	1 __ __ WEEKS OR 2 __ __ MONTHS 888. DK 998. NR **IF Q312>3 GO TO NEXT LINE**	1..B O Y 2. GIRL 3. BOTH	1 YES > **GO TO BOX 3-1** 2. NO	1. __ __ DAYS OR 2. __ __ MTHS OR 3. __ __ YRS. 888. DK 998. NR

BOX 3-1

> **THE FOLLOWING QUESTIONS ARE ONLY FOR PREGNANCIES ENDED BETWEEN 1996-2001 IF RESPONDENT HAD AT LEAST A LIVE BIRTH, STILLBIRTH, INDUCED ABORTION OR MINIABORTION (Q312=1-5,7, 8) ENDED BETWEEN 1996-2001 THEN <u>CONTINUE WITH Q319</u> ON THE NEXT PAGE;**

> **IF SHE HAD ONLY MISCARRIAGE(S) OR ECTOPIC PREGNANCY(IES) (Q312=6.9). <u>GO TO MODULE IV, PAGE 23 AFTER COMPLETING Q319 and Q338</u>**

> **IF SHE DID NOT HAVE ANY PREGNANCY ENDED IN 1996-2001 (CHECK Q313B), <u>GO TO MODULE IV. PAGE 23 AFTER COMPLETING Q319 and Q338</u>.**

319. HOW MANY INDUCED ABORTIONS AND/OR MINIABORTIONS DID THE RESPONDENT HAVE BETWEEN JANUARY 1996 AND THE PRESENT (SEE PAGE 11)

1. INDUCED ABORTIONS ___ ___
2. MINIABORTIONS ___ ___ (IF NO INDUCED ABORTION OR MINIABORTION, GO TO Q338)

319A. COPY LINE #. FROM PG. TABLE PAGE 11	LAST ABORTION ___ ___	NEXT TO LAST AB. ___ ___	SECOND TO LAST AB. ___ ___	THIRD TO LAST AB. ___ ___
319B. ABORTION TYPE (SEE Q312)	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**	**1. INDUCED ABORTION** **2. MINIABORTION**
320. What was the principal reason that you decided to have this (mini)abortion?	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER _____	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER _____	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER _____	1. PREGNANCY WAS LIFE OR HEALTH THREATENING 2. RISK OF BIRTH DEFECTS 3. SOCIOECONOMIC REASONS 4. RESPONDENT DID NOT WANT (ANYMORE) CHILDREN 5. SPACING NEXT PREGNANCY 6. PARTNER DID NOT WANT (ANY) CHILDREN 7. DID NOT HAVE A PARTNER 8. OTHER _____
320A. What was the attitude of the child's father toward you having that abortion?	1. FAVORED 2. OPPOSED 3- NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER.	1. FAVORED 2. OPPOSED 3- NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER.	1. FAVORED 2. OPPOSED 3- NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER.	1. FAVORED 2. OPPOSED 3- NEUTRAL 4. DID NOT KNOW ABOUT IT 8. DO NOT REMEMBER.
321. When you got pregnant with this baby. were you using any method of contraception?	1. YES 2. NO ---------------->**GO TO Q323** 8. DK/NR ------------->**GO TO Q323**	1. YES 2. NO----------------->**GO TO Q323** 8. DK/NR ------------- **GO TO Q323**	1. YES 2. NO----------------->**GO TO Q323** 8. DK/NR------------->**GO TO Q323**	1. YES 2. NO----------------->**GO TO Q323** 8. DK/NR------------- >**GO TO Q323**
322. What method of contraception was that?	1. PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3.CONDOM 12. WITHDRAWAL 4.CONDOM+SP 13. CAL+WDR 5.CONDM+TRD 20. OTHER 6.SPERMICIDE 88. DR	1. PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3.CONDOM 12. WITHDRAWAL 4.CONDOM+SP 13. CAL+WDR 5.CONDM+TRD 20. OTHER 6.SPERMICIDE 88. DR	1. PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3.CONDOM 12. WITHDRAWAL 4.CONDOM+SP 13. CAL+WDR 5.CONDM+TRD 20. OTHER 6.SPERMICIDE 88. DR	1. PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3.CONDOM 12. WITHDRAWAL 4.CONDOM+SP 13. CAL+WDR 5.CONDM+TRD 20. OTHER 6.SPERMICIDE 88. DR
323. Before this (mini) abortion, have you been lab tested for any infection?	1. YES 2 NO -------- >**GO TO Q325** 8. DK/ DR---------->**GO TO Q325**	1. YES 2 NO--------->**GO TO Q325** 8. DK/ DR---------->**GO TO Q325**	1. YES 2 NO--------->**GO TO Q325** 8. DK/ DR---------->**GO TO Q325**	1. YES 2 NO--------->**GO TO Q325** 8. DK/ DR---------->**GO TO Q325**
324. Did you have a blood exam, vaginal bacteriologic exam or both?	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/DR	1. BLOOD EXAM 2. VAGINAL SWAB 3. BOTH 8. DON'T KNOW/DR
325. Where was that abortion performed?	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER _____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER _____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER _____	1. HOSPITAL/ MATERNITY 2. WOMEN'S CONSULATION 3. PRIVATE CLINIC/OFFICE 4. AT HOME 5. AT HOME AND HOSP. 7. OTHER _____
326. Who performed that abortion?	I. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5 SELF-INDUCED 8. DON'T KNOW/ DR	I. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5 SELF-INDUCED 8. DON'T KNOW/ DR	I. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5 SELF-INDUCED 8. DON'T KNOW/ DR	I. OB/GYN 2. OTHER PHYSICIAN 3. NURSE/MIDWIFE 4. LAY PERSON 5 SELF-INDUCED 8. DON'T KNOW/ DR
327. What method was used?	1. D&C 2. VACUUM ASPIRATION 3. RU 486/PROSTAGLANDINES 4. OXITOCIN 5. CATHETER 7. OTHER _____ 8. DON'T KNOW/DR	1. D&C 2. VACUUM ASPIRATION 3. RU 486/PROSTAGLANDINES 4. OXITOCIN 5. CATHETER 7. OTHER _____ 8. DON'T KNOW/DR	1. D&C 2. VACUUM ASPIRATION 3. RU 486/PROSTAGLANDINES 4. OXITOCIN 5. CATHETER 7. OTHER _____ 8. DON'T KNOW/DR	1. D&C 2. VACUUM ASPIRATION 3. RU 486/PROSTAGLANDINES 4. OXITOCIN 5. CATHETER 7. OTHER _____ 8. DON'T KNOW/DR

CONTINUE ON NEXT PAGE

	LAST ABORTION	NEXT TO LAST AB.	SECOND TO LAST AB.	THIRD TO LAST AB.
328. How much did you pay for that abortion, including gifts or money given to the doctor?	—— —— —— THOUSANDS MANAT 0 0 0 0 NO CHARGE 7 7 7 7 ONLY GIFTS 8 8 8 8 DK	—— —— —— THOUSANDS MANAT 0 0 0 0 NO CHARGE 7 7 7 7 ONLY GIFTS 8 8 8 8 DK	—— —— —— THOUSANDS MANAT 0 0 0 0 NO CHARGE 7 7 7 7 ONLY GIFTS 8 8 8 8 DK	—— —— —— THOUSANDS MANAT 0 0 0 0 NO CHARGE 7 7 7 7 ONLY GIFTS 8 8 8 8 DK
329 Did you have any local or intravenous anesthesia for that abortion? By local anesthesia we mean an injection in the uterus opening.	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR	1. LOCAL (UTERINE CERVIX) 2. INTRAVENOUS 3. NEITHER LOCAL NOR IV 8. DK/DR
330. Did you take any antibiotics after that abortion?	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER	1. YES 2. NO 8. NOT REMEMBER
331. Within 30 days after that abortion did you have any health problems as a result of that abortion?	1. YES 2 NO ------->**GO TO Q333**	1. YES 2 NO ------->**GO TO Q333**	1. YES 2 NO-------->**GO TO Q333**	1. YES 2 NO-------->**GO TO Q333**
332. Did you have one of the following problems: **(READ 1-7)**	**YES NO** 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever>38°C 1 2 4. Purulent Discharge 1 2 5. Belly Pain 1 2 7. Other _____ 1 2	**YES NO** 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever>38°C 1 2 4. Purulent Discharge 1 2 5. Belly Pain 1 2 7. Other _____ 1 2	**YES NO** 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever>38°C 1 2 4. Purulent Discharge 1 2 5. Belly Pain 1 2 7. Other _____ 1 2	**YES NO** 1. Perforation 1 2 2. Severe Bleeding 1 2 3. Fever>38°C 1 2 4. Purulent Discharge 1 2 5. Belly Pain 1 2 7. Other _____ 1 2
3.33. How many nights did you spend in the hospital after that abortion (+re-admissions during the first month) ?	—— —— NIGHTS 88 DK	—— —— NIGHTS 88 DK	—— —— NIGHTS 88 DK	—— —— NIGHTS 88 DK
334. Did you have any related health problems more than 6 months later as a result of that abortion?	1. YES 2. NO ----->**Q336** 3. NOT YET 6 MTH.—>**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------>**Q336** 3. NOT YET 6 MTH.—>**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------>**Q336** 3. NOT YET 6 MTH.—>**Q336** 8. DON'T REMEMBER->**Q336**	1. YES 2. NO------>**Q336** 3. NOT YET 6 MTH.—>**Q336** 8. DON'T REMEMBER->**Q336**
335. What was the most important health problem?	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____	1. BELLY PAIN 2. STERILITY 3. INFECTION 4. LACK OF MENSES 5. IRREGULAR BLEEDING 6. MORE PAINFUL PERIODS 7. OTHER_____
336. Either before or after the most recent abortion, did a doctor talk to you about contraception?	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO------->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO------->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO------->**GO TO Q337A** 8. DON'T REMEMBER	1. YES, BEFORE ABORTION 2. YES, AFTER ABORTION 3. YES, BEFORE & AFTER 4. NO------->**GO TO Q337A** 8. DON'T REMEMBER
337. After that abortion, did you receive a method of contraception or prescription for a method?	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER	1. RECEIVED A METHOD 2. RECEIVED PRESCRIPTION 3. NO METHOD OR RX. 8. DON'T REMEMBER
337A. After that abortion, did a doctor or nurse refer you to a Family Planning cabinet?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER

338. HOW MANY BIRTHS HAS THE RESPONDENT HAD BETWEEN JANUARY 1996 AND PRESENT (SEE PG. 11-15)

1. LIVE BIRTHS   __ __
2. STILLBIRTHS   __ __ (IF NO LIVE BIRTH OR STILLBIRTH GO TO MODULE IV PAGE 23)

339. COPY LINE #. FROM PREGNANCY TABLE PAGE 11	LAST BIRTH __ __	NEXT TO LAST BIRTH __ __	SECOND TO LAST BIRTH __ __
340. During the <u>6 mths before</u> you found out you were pregnant, how many cigarettes did you smoke a day, on average?	0. NONE —->**GO TO Q.342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER—>**GO TO Q342**	0. NONE —->**GO TO Q.342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER—>**GO TO Q342**	0. NONE —->**GO TO Q.342** 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + (MORE THAN ½ PACK) 8. DON'T REMEMBER—>**GO TO Q342**
341. On the average, how many cigarettes did you smoke per day after you found out that you were pregnant?	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER	0. NONE 1. 1-4 (JUST A FEW) 2. 5-10 CIGARETTES (OR ½ PACK) 3. 11 + + (MORE THAN ½ PACK) 8. DON'T REMEMBER
342. How many times per week did you drink alcoholic beverages during that pregnancy?	1. 4 TIMES OR MORE/ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER	1. 4 TIMES OR MORE/ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER	1. 4 TIMES OR MORE/ALMOST DAILY 2. 1-3 TIMES 3. LESS THAN ONCE PER WEEK 4. NEVER
343. When you got pregnant with this baby, were you using any method of contraception?	I. YES 2. NO ----------------------->**GO TO Q345** 3. DON'T REMEMBER->**GO TO Q345**	I. YES 2. NO ----------------------->**GO TO Q345** 3. DON'T REMEMBER->**GO TO Q345**	I. YES 2. NO ----------------------->**GO TO Q345** 3. DON'T REMEMBER->**GO TO Q345**
344. What method of contraception was that?	1.PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR	1.PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR	1.PILL 9. INJECTABLES 2. IUD 11. CALENDAR 3. CONDOM 12. WITHDRAWAL 4. CONDOM+SP 13. CAL+WDR 5. CONDM+TRAD 20. OTHER_____ 6. SPERMICIDES 88. DR
345. How many weeks or months pregnant were you when you learned that you were pregnant that time?	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR
346. During that pregnancy, did you have any prenatal care visits?	1. YES 2 NO—>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**	1. YES 2 NO—>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**	1. YES 2 NO—>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**
347. How many weeks or months pregnant were you at the time of your first prenatal care visit?	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR

348 How many prenatal visits did you have during that pregnancy?	__ __ VISITS 88. DK
	                98. REF
		__ __ VISITS 88. DK
		                98. REF
			__ __ VISITS 88. DK
			                98. REF

349. Where did you go for <u>most</u> of the prenatal care visits?	1. RURAL AMBULATORY (FAP, DAK) 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER _____	1. RURAL AMBULATORY (FAP, DAK) 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER _____	1. RURAL AMBULATORY (FAP, DAK) 2. VILLAGE HOSPITAL 3. WOMEN'S CONSULTATION CLINIC 4. RAIONAL MATERNITY/HOSPITAL 5. PRIVATE OFFICE/CLINIC/HOSP 6. HOME 7. OTHER _____
350. Whom did you see for most of these visits?	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER	1. GENERAL PRACTITIONER 2. OB/GYN 3. NURSE/MIDWIFE 4. FELTCHER
351. During those visits, did you receive any information about: **(READ A-H):**	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2	YES NO A. Nutrition 1 2 B. Smoking during Pregnancy 1 2 C. Drinking Alcohol during Pg. 1 2 D. Breastfeeding 1 2 E. Delivery 1 2 F. Contraception 1 2 G. Warning Signs of Pg Complic 1 2 H. Postnatal Care 1 2

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
352. During this pregnancy, were any of the following done at least once: A. Were you weighed? B. Was your height measured? C. Did you give a urine sample? D. Did you give a blood sample?	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2	YES NO A. WEIGHT 1 2 B. HEIGHT 1 2 C. URINE SAMPLE 1 2 D. BLOOD SAMPLE 1 2
353. During those visits, did you have your blood pressure measured?	1. YES 2. NO------>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**	1. YES 2. NO------>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**	1. YES 2. NO------>**GO TO Q355** 8. DON'T REMEMBER->**GO TO Q355**
354. During those visits, were you ever told that you have high blood pressure?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER
355. Did you have an ultrasound (US) exam during that pregnancy?	1. YES 2. NO ----->**GO TO Q357** 8. DON'T REMEMBER->**GO TO Q357**	1. YES 2. NO----- >**GO TO Q357** 8. DON'T REMEMBER->**GO TO Q357**	1. YES 2. NO ----->**GO TO Q357** 8. DON'T REMEMBER->**GO TO Q357**
356. How many weeks or months pregnant were you at the time of your first US?	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR
357. During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus (convulsions after birth)?	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER	1. YES 2. NO 8. DON'T REMEMBER
358. During this pregnancy, have you taken any iron supplements (iron tablets, injection or iron syrup)?	1. YES 2 NO .... --------- >**GO TO Q360** 8. DON'T REMEMBER ->**GO TO Q360**	1. YES 2 NO .... --------->**GO TO Q360** 8. DON'T REMEMBER ->**GO TO Q360**	1. YES 2 NO .... --------- >**GO TO Q360** 8. DON'T REMEMBER ->**GO TO Q360**
358A. In what week or month of pregnancy did you start taking iron supplements?	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR	1. __ __ WEEKS OR 2. __ __ MONTHS 888 DK/DR
359. How often did you take iron supplements[9]	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR	1. EVERY DAY 2. SEVERAL TIMES PER WEEK 3. ONCE A WEEK 4. LESS THAN ONCE A WEEK 8. DK/DR
360. During that pregnancy, did you have any complications that required medical attention?	1. YES 2 NO------->**GO TO Q364** 8. DON'T REMEMBER->**GO TO Q364**	1. YES 2 NO------->**GO TO Q364** 8. DON'T REMEMBER->**GO TO Q364**	1. YES 2 NO------->**GO TO Q364** 8. DON'T REMEMBER->**GO TO Q364**
361. What complications did you have? Did you have: **(READ EACH CONDITION A-K)**	YES NO A. A Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 1. Risk of Preterm Delivery 1 2 I. Rh Isoimmunization 1 2 K. Other _____ 1 2	YES NO A. A Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 1. Risk of Preterm Delivery 1 2 I. Rh Isoimmunization 1 2 K. Other _____ 1 2	YES NO A. A Weak Cervix 1 2 B. Bleeding During First 6 Mths of Pregnancy 1 2 C. Bleeding at 6 Mths or More of Pregnancy 1 2 D. High BP Related to Preg. 1 2 E. Diabetes Related to Preg. 1 2 F. Water Retention or Edema 1 2 G. Anemia Related to Preg. 1 2 H. Urinary Tract Infection 1 2 1. Risk of Preterm Delivery 1 2 I. Rh Isoimmunization 1 2 K. Other _____ 1 2
362. Not Including the delivery, how many times were you hospitalized for pregnancy complications?	00 NEVER HOSP. __ __ TIMES 88 DK/DR **IF "00" GO TO Q364**	00 NEVER HOSP. __ __ TIMES 88 DK/DR **IF "00" GO TO Q364**	00 NEVER HOSP. __ __ TIMES 88 DK/DR **IF "00" GO TO Q364**
363. Altogether, how many total nights were you in the hospital for these complications?	__ __ NIGHTS 85. 85+NIGHTS 88. DK/DR	__ __ NIGHTS 85. 85+NIGHTS 88. DK/DR	__ __ NIGHTS 85. 85+NIGHTS 88. DK/DR
364. Where did you give birth to this baby?	1. DISTRICT MATERNITY HOSPITAL 2. PRIVATE CLINIC/HOSPITAL 3. VILLAGE HOSPITAL 4. DAC/FAP 5. HOME——>**Q370** 6. ON THE WAY TO HOSP.----> **Q366**	1. DISTRICT MATERNITY HOSPITAL 2. PRIVATE CLINIC/HOSPITAL 3. VILLAGE HOSPITAL 4. DAC/FAP 5. HOME——>**Q370** 6. ON THE WAY TO HOSP.----> **Q366**	1. DISTRICT MATERNITY HOSPITAL 2. PRIVATE CLINIC/HOSPITAL 3. VILLAGE HOSPITAL 4. DAC/FAP 5. HOME——>**Q370** 6. ON THE WAY TO HOSP.----> **Q366**
365. How many hours before delivery were you admitted to the place where you gave birth?	__ __ HOURS 85. 85+HOURS 88. DK/DR	__ __ HOURS 85. 85+HOURS 88. DK/DR	__ __ HOURS 85. 85+HOURS 88. DK/DR

	LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
366. How many nights were you in that place after delivery?	___ ___ NIGHTS 85. 85+NIGHTS 88 DK/DR	___ ___ NIGHTS 85. 85+NIGHTS 88 DK/DR	___ ___ NIGHTS 85. 85+NIGHTS 88 DK/DR
367. Where was your husband at the time of delivery, was he: (READ 1-4)	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home, or 4. Travelling/away for Work? 8. DK/DR	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home, or 4. Travelling/away for Work? 8. DK/DR	1. In the Delivery Room, 2. At the Hospital/clinic, 3. At Home, or 4. Travelling/away for Work? 8. DK/DR
368. Was that baby born by vaginal delivery, forceps, or C-section?	1. VAGINAL DELIVERY->**GO TO Q370** 2. FORCEPS->**GO TO Q370** 3. VACUUM EXTRACTION—>**Q370** 4. CESAREAN SECTION	1. VAGINAL DELIVERY->**GO TO Q370** 2. FORCEPS->**GO TO Q370** 3. VACUUM EXTRACTION—>**Q370** 4. CESAREAN SECTION	1. VAGINAL DELIVERY->**GO TO Q370** 2. FORCEPS->**GO TO Q370** 3. VACUUM EXTRACTION—>**Q370** 4. CESAREAN SECTION
369. Do you know what was <u>the most important reason</u> that you had to deliver by cesarean section ?	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR/FAILED INDUCTION 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C-SECTION 7. ON REQUEST 88. DON'T KNOW 20. OTHER_____	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR/FAILED INDUCTION 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C-SECTION 7. ON REQUEST 88. DON'T KNOW 20. OTHER_____	1. BABY TOO BIG (CPD) 2. MALPRESENTATION 3. BABY STARTED TO SUFFER 4. PROLONGED LABOR/FAILED INDUCTION 5. OBSTETRIC HEMORRHAGE 6. PREVIOUS C-SECTION 7. ON REQUEST 88. DON'T KNOW 20. OTHER_____
370. How long had you been in labor with that pregnancy (regular contractions 5' apart)	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR	___ ___ HOURS 00. C-SECTION BEFORE LABOR 88. DK/DR
371. Who attended the delivery of that child?	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER 5. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER 5. UNATTENDED	1. PHYSICIAN 2. NURSE/MIDWIFE 3. TRADITIONAL BIRTH ATTENDANT 4. OTHER 5. UNATTENDED
372. How much did the baby weigh at birth?	___ ___ ___ ___ GRAMS->**GO TO Q374** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS->**GO TO Q374** 8888 DON'T KNOW	___ ___ ___ ___ GRAMS->**GO TO Q374** 8888 DON'T KNOW
373. Do you know if the baby weighed less than 2500 g or was considered too small?	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR	1. YES, WAS LESS THAN 2500g 2. NO, WAS MORE THAN 2500g 8. DK/DR
374. During the first 6 weeks after birth, did you have any of the following complications: **(READ A-I)**	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 3. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 3. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2	YES NO A. Severe Bleeding 1 2 B. Bad-smelling Vaginal Discharge 1 2 C. Infection of Surgical Wound 1 2 D. Faint/coma 1 2 E. High Fever (39-40c) 1 2 F. Painful Urination 1 2 3. Painful Uterus (pelvic pain) 1 2 H. Breast Infection 1 2 I. Other_____ 1 2
375. After leaving the hospital **(DO NOT READ IF HOME DELIVERY)** did you have any postdelivery check-ups?	1. YES 2. NO - ->**GO TO Q378** 8. DO NOT REMEMBER -->**GO TO Q378**	1. YES 2. NO - ->**GO TO Q378** 8. DO NOT REMEMBER -->**GO TO Q378**	1. YES 2. NO - ->**GO TO Q378** 8. DO NOT REMEMBER -->**GO TO Q378**
376. How many days or weeks after the delivery did the first check take place?	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000 SAME DAY 888 DK/DR	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000 SAME DAY 888 DK/DR	1. ___ ___ DAYS OR 2. ___ ___ WEEKS 000 SAME DAY 888 DK/DR
377. During those visit(s) did you receive information about: **(READ A-F)**	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2	YES NO A. Breastfeeding 1 2 B. Breast Care 1 2 C. Child Care 1 2 D. Immunization 1 2 E. Nutrition 1 2 F. Contraception 1 2
378. For how many months after birth did YOU not have a period?	___ ___ MONTHS 88. DK/DR **77.** NOT YET	___ ___ MONTHS 88. DK/DR **77.** NOT YET	___ ___ MONTHS 88. DK/DR **77.** NOT YET
379. How many months after birth did you resume sexual relations?	___ ___ MONTHS 88. DK/DR **77.** NOT YET	___ ___ MONTHS 88. DK/DR **77.** NOT YET	___ ___ MONTHS 88. DK/DR **77.** NOT YET

	LAST BIRTH IF STILLBIRTH -> NEXT BIRTH	NEXT TO LAST BIRTH IF STILLBIRTH—>NEXT BIRTH	SECOND TO LAST BIRTH IF STILLBIRTH—> MODULE IV
380. After leaving (he hospital **(DO NOT READ IF HOME DELIVERY)** did a health professional check on the baby's health?	1. YES 2. NO —>**GO TO Q382** 3. NO. BABY DIED—-->**GO TO Q382** 8. DO NOT REMEMBER -->**GO TO Q382**	1. YES 2. NO —->**GO TO Q382** 3. NO. BABY DIED—-->**GO TO Q382** 8. DO NOT REMEMBER -->**GO TO Q382**	1. YES 2. NO —->**GO TO Q382** 3. NO. BABY DIED—-->**GO TO Q382** 8. DO NOT REMEMBER -->**GO TO Q382**
381. How many days or weeks after delivery did the first health check take place?	1. __ __ DAYS OR 2. __ __ WEEKS 000 SAME DAY 888 DK/DR	1. __ __ DAYS OR 2. __ __ WEEKS 000 SAME DAY 888 DK/DR	1. __ __ DAYS OR 2. __ __ WEEKS 000 SAME DAY 888 DK/DR
381A. Was the health check because the baby was sick or was a routine health exam?	1. HEALTH EXAM FOR SICKNESS 2. ROUTINE HEALTH EXAM 8. DO NOT REMEMBER	1. HEALTH EXAM FOR SICKNESS 2. ROUTINE HEALTH EXAM 8. DO NOT REMEMBER	1. HEALTH EXAM FOR SICKNESS 2. ROUTINE HEALTH EXAM 8. DO NOT REMEMBER
382. How many days or weeks after the delivery did you register the baby at the city/village council?	l. __ __ DAYS OR 2. __ __ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	l. __ __ DAYS OR 2. __ __ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER	l. __ __ DAYS OR 2. __ __ WEEKS 000. NOT REGISTERED YET 777. BABY DIED AND NOT REGISTERED 888. DO NOT REMEMBER
383. Did you breastfeed?	1**.** YES 2. NO ------ >**GOTOQ387** 3. NO, INFANT DIED—>**NEXT BIRTH**	1**.** YES 2. NO ------>**GOTOQ387** 3. NO, INFANT DIED—>**NEXT BIRTH**	1**.** YES 2. NO-------->**GOTOQ387** 3. NO, INFANT DIED—>**NEXT BIRTH**

384. How long after birth did you start breastfeeding?	1. __ __ HOURS 777. LESS THAN 1HR
	                    OR
	2. __ __ DAYS 888. DON'T REMEMB.
		1. __ __ HOURS 777. LESS THAN 1HR
		                    OR
		2. __ __ DAYS 888. DON'T
			1. __ __ HOURS 777. LESS THAN 1HR
			                    OR
			2. __ __ DAYS 888. DON'T

385. Are you still breastfeeding?	1. YES.......>**GO TO Q387** 2. NO 3. NO, INFANT DIED—>**NEXT BIRTH**		
386. How old was the baby when you stopped breastfeeding?	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
387. How old was the baby when you gave him/her water or other liquids?	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
388. How old was the baby when you started feeding with formula or other milk?	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS	1. __ __ DAYS OR 777. NOT YET 2. __ __ WEEKS OR 888. DK/DR 3. __ __ MTHS
389. How old was the baby when you started feeding with solid or semi-solid food?	1. __ __ DAYS OR 777. NOT YET 2. __ __ MTHS 888. DK/DR **IF STILL BREASTFEEDING; Q391**	1. __ __ DAYS OR 777. NOT YET 2. __ __ MTHS 888. DK/DR **IF STILL BREASTFEEDING; Q391**	1. __ __ DAYS OR 777. NOT YET 2. __ __ MTHS 888. DK/DR **IF STILL BREASTFEEDING; Q391**
390. Why did you **Stop** breastfeeding of this baby? **FOR WOMEN WHO DID NOT BREASTFEED (Q383=2) ASK:** Why did you not breastfeed this baby?	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED 8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED 8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR	1. MOTHER WEAK/ILL 2. CHILD WEAK/ILL 3. CHILD DIED 4. NIPPLE/BREAST PROBLEMS 5. NOT ENOUGH MILK 6. MOTHER WORKING 7. CHILD REFUSED 8. BECAME PREGNANT 9. WEANING AGE/AGE TO STOP 10. PREFERRED BOTTLE-FEEDING 20. OTHER_____ 88. DK/DR
391. Do you have a card where the child vaccinations are written down? IF YES: May I see it please?	1. YES, SEEN -----**GO TO Q393** 2. YES, NOT SEEN 3. NO CARD ----- **GO TO Q395**	1. YES, SEEN----- **GO TO Q393** 2. YES, NOT SEEN 3. NO CARD -----**GO TO Q395**	1. YES, SEEN----- **GO TO Q393** 2. YES, NOT SEEN 3. NO CARD------**GO TO Q395**
392. Did you ever have a vaccination card for this child?	1. YES--------------->**GO TO Q395** 2. NO--------------->**GO TO Q395**	1. YES--------------->**GO TO Q395** 2. NO--------------->**GO TO Q395**	1. YES--------------->**GO TO Q395** 2. NO--------------->**GO TO Q395**

	LAST BIRTH			NEXT TO LAST BIRTH			SECOND TO LAST BIRTH		
	Vaccine	Month	Year	Vaccine	Month	Year	Vaccine	Month	Year
393. COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD: **RECORD:** **"00" IF NOT RECEIVED** **"88" FOR UNKNOWN MONTH AND/OR YEAR**	**A. BCG**			**A. BCG**			**A. BCG**		
	B. Polio 0			**B. Polio 0**			**B. Polio 0**		
	C. Polio 1			**C. Polio 1**			**C. Polio 1**		
	D. Polio 2			**D. Polio 2**			**D. Polio 2**		
	E. Polio 3			**E. Polio 3**			**E. Polio 3**		
	F. Polio 4			**F. Polio 4**			**F. Polio 4**		
	G. DPT 1			**G. DPT 1**			**G. DPT 1**		
	H. DPT 2			**H. DPT 2**			**II. DPT 2**		
	I. DPT 3			**I. DPT 3**			**I. DPT 3**		
	J. DPT 4			**J. DPT 4**			**J. DPT 4**		
	K. Measles			**K. Measles**			**K. Measles**		

394. Has the baby received any vaccinations that are not recorded on this card, including those received in a national immunization day campaign?

LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
1. **YES-—> GO BACK TO 393 AND ADD THIS INFORMATION** 2. NO 8. DO NOT REMEMBER	1. **YES-—> GO BACK TO 393 AND ADD THIS INFORMATION** 2. NO 8. DO NOT REMEMBER	1. **YES—> GO BACK TO 393 AND ADD THIS INFORMATION** 2. NO 8. DO NOT REMEMBER
GO TO MODULE IV	**GO TO MODULE IV**	**GO TO MODULE IV**

395. Did the baby ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?

LAST BIRTH	NEXT TO LAST BIRTH	SECOND TO LAST BIRTH
1. YES 2. NO-------> **GO TO MODULE IV** 8. DON'T REMEMBER--> **MODULE IV**	1. YES 2. NO .... > **GO TO MODULE IV** 8. DON'T REMEMBER-> **MODULE IV**	1. YES 2. NO .... > **GO TO MODULE IV** 8. DON'T REMEMBER-> **MODULE IV**

396. Please tell me if the baby received any of the following vaccinations:

A. BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?

B. Polio vaccine, that is, drops in the mouth **(IF YES ASK HOW MANY TIMES WAS THE POLIO VACCINE RECEIVED?**

C. DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops **(IF YES ASK HOW MANY TIMES WAS THE DPT VACCINE RECEIVED)?**

D. An injection to prevent measles?

	LAST BIRTH				NEXT TO LAST BIRTH				SECOND TO LAST BIRTH		
		YES	NO	DK		YES	NO	DK		YES	NO	DK
A.	BCG	1	2	8	A. BCG	1	2	8	A. BCG	1	2	8
B.	Polio	1	2	8	B. Polio	1	2	8	B. Polio	1	2	8
	TIMES _____				TIMES _____				TIMES _____			
C.	DTP	1	2	8	C. DTP	1	2	8	C. DTP	1	2	8
	TIMES _____				TIMES _____				TIMES _____			
D.	Measles	1	2	8	D. Measles	1	2	8	D. Measles	1	2	8

MODULE IV: FAMILY PLANNING KNOWLEDGE/ SEXUAL EXPERIENCE

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

METHOD	400. Have you ever heard of it?	401. Do you know how to use it?	402. Have you ever used it?	403. Do you know where to get it?	404. How did you hear about it? (SEE CODES BELOW)
A. The Pill (Oral Contraceptives)	1 Yes->Q401 2 No—>B	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
B. IUD *(Spirali)*	1 Yes->Q401 2 No—>C	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
C. Condoms *(Prezervativ)*	1 Yes->Q401 2 No—>D	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
D. Foam/Jelly/ Cream/ Foamy Tablets	1 Yes->Q401 2 No—>E	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
E. Tubal Ligation	1 Yes->Q40t 2 No—>F	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
F. Vasectomy (Male Sterilization)	1 Yes->Q401 2 No—>G	1 Yes~>Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
G. Injectables (e.g. Depo-Provera)	1 Yes->Q401 2 No—>H	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes\ 2 No / Q404	__ __
H. Emergency Hormonal Contraception ("Morning After Pill"; Postinor)	1 Yes->Q401 2 No—>I	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q403	1 Yes \ 2 No / Q404	__ __
I. Rhythm/Calendar Method	1 Yes->Q401 2 No—>J	1 Yes->Q402 2 No->Q402	1 Yes\ 2 No / Q404		__ __
J. Withdrawal (Coitus Interruptus)	1 Yes->Q401 2 No—>K	1 Yes->Q402 2 No—>Q402	1 Yes\ 2 No /Q404		__ __
K. Other contraceptive methods **(SPECIFY):** _____	1 Yes->Q401 2 No—>Q405	1 Yes->Q402 2 No—>Q402	1 Yes\ 2 No / Q404		__ __

CODES FOR Q404 (DO NOT READ)

1. MOTHER
2. FATHER
3. RELATIVE
4. BOYFRIEND
5. FRIENDS
6. CO-WORKER
7. COLLEAGUES, PEER
8. PARTNER/HUSBAND
9. DOCTOR

10. NURSE, MIDWIFE, FELDCHER
11. COMMUNITY HEALTH WORKER
12. TEACHER
13. PHARMACIST
14. BOOKS
15. NEWSPAPERS, MAGAZINES, BROCHURE, FLYERS
16. RADIO
17. TV
20. OTHER (SPECIFY):_____
88. DON'T REMEMBER

405.   Looking at this CARD, please tell me which do you think is the <u>most effective</u> contraceptive method?
        (SHOW CARD A)

      1. The Pill
      2. IUD
      3. Condom
      6. Foams/jelly/creams/Foamy Tablets
      7. Tubal Ligation
      8. Emergency Hormonal Contraception ("Morning After Pill")
      9. Injectables (Depo-Provera)
    10. Vasectomy (Male Sterilization)
    11. Rhythm Method
    12. Withdrawal
    77. NONE OF THEM
    88. DON'T KNOW/NOT SURE

406.   How would you rate each of the following methods with regard to effectiveness at preventing
        pregnancy? Would you say that _____is very effective, effective, somewhat effective, not
        very effective or not at all effective? (INTERVIEWER: ASK THE QUESTION FOR EACH OF THE
        METHODS LISTED BELOW, UNLESS RESPONDENT HAS SAID IN Q400 THAT SHE NEVER HEARD
        OF THAT SPECIFIC METHOD; MARK "9" FOR THOSE CASES WITHOUT ASKING)

	Very Effective	**Effective**	**Somewhat Effective**	**Not Very Effect.**	**Not Effect.**	**DO NOT KNOW**	**NEVER HEARD**
1. THE PILL	1	2	3	4	5	8	9
2. IUD	1	2	3	4	5	8	9
3. CONDOM	1	2	3	4	5	8	9
7. TUBAL LIGATION	1	2	3	4	5	8	9
11. CALENDAR	1	2	3	4	5	8	9
12. WITHDRAWAL	1	2	3	4	5	8	9

   BOX 4-I

        IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO Q420 PAGE 26
---

408.   How old were you when you had your first menstruation ___ ___ AGE   00. NOT YET
                                                     88. DON'T REMEMBER
                                                     99. REFUSE TO ANSWER

409.   Did you know what menstruation was at that time?

    1. YES
    2. NO
    8. NOT SURE

410. Now I have some questions about your first sexual intercourse. When did you have sexual intercourse for the first time - in what month and year was that? **(PROBE: Can you tell me what year that was?)**

A. __ __ MONTH   B. __ __ YEAR   00. NEVER HAD INTERCOURSE—>**GO TO**
                                            88. DON'T REMEMBER   **Q601, PG 40**
                                            99. REFUSE TO ANSWER

411. How old were you at that time?   __ __ YEARS   88. DON'T REMEMBER

412. At the time you first had sexual intercourse, what was your relationship to that man?

1. HUSBAND, CONSENSUAL PARTNER   7. JUST MET
2. FIANCEE   8. RELATIVE
3. BOYFRIEND   9. RAPE...............>**GO TO Q421**
4. FRIEND   10..INCEST...............>**GO TO Q421**
5. LOVER   20. OTHER(SPECIFY)_____
6. ACQUAINTANCE   88. DO NOT REMEMBER/REF

413. How old was your first partner?   __ __ YEARS   88. DK/DR

414. How long were you and your first partner dating when you first had sexual relations?

1. __ __ DAYS   OR   2. __ __ WEEKS   OR   3. __ __ MONTHS OR   4. __ __ YEARS

000=FIRST TIME WE MET
888=DONT REMEMBER
999=NO RESPONSE
777=OTHER _____

415. Before you had sex for the first time, did you and your partner ever talk about using contraception?

1. YES
2. NO
8. DON'T REMEMBER

416. At the time you had first sexual intercourse, did you or your partner use any contraceptive method?

1 YES
2 NO —>**GO TO Q419**
8. DK/DO NOT REMEMBER —>**GO TO Q421**
9 REF —>**GO TO Q421**

417. Which contraceptive method did you or your partner use at the first intercourse?

1 THE PILL
2 IUD
3 CONDOM
6 FOAM/JELLY/CREAM/VAGINAL FILMS
8 EMERGENCY HORMONAL CONTRACEPTION
9 INJECTABLES
10 OTHER MODERN METHODS _____
11 CALENDAR METHOD
12 WITHDRAWAL
19 DOUCHE
20 OTHER: _____
88 DON'T KNOW/DON'T REMEMBER

Q28

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

1. You
2. Your partner
3. Both you and your partner
8. DON'T REMEMBER

GO TO Q421

419.   What was the main reason for not using a contraceptive method at that time?

1. SEX WAS NOT EXPECTED
2. THOUGHT IT WAS A SAFE TIME OF THE MONTH
3. DID NOT KNOW WHERE TO GET A METHOD//DIFFICULT TO GET/NOT AVAILABLE
4. RESPONDENT WAS AGAINST IT
5. PARTNER WAS AGAINST IT
6. DID NOT KNOW ABOUT CONTRACEPTION
7. WANTED TO GET PREGNANT
8. THOUGHT THAT CONTRACEPTIVE METHODS ARE HARMFUL
9. DID NOT THINK ABOUT USING A METHOD/NEGLIGENCE
10.   RESPONDENT AFRAID OF PARTNERS REACTION
11. TOO DRUNK (PARTNER OR RESPONDENT)
12. RESPONDENT WAS TOO EMBARRASSED TO USE A METHOD
20. OTHER (SPECIFY) **_____**
88. DON'T REMEMBER/DON'T KNOW

GO TO Q421

420.   I low old were you at the time of your first sexual intercourse?

__ __ YEARS   00. NEVER HAD INTERCOURSE—->**GO TO Q601 PAGE 40**
                                   88. DK/DR

421.   During the past 30 days (past month) have you had sexual intercourse?

1. YES
2. NO —>**GO TO Q423**
9. REF —>**GO TO Q423**

422.   How many times have you had sexual intercourse during the past 30 days **(READ 1-5)?**

1. Every day
2. 3-5 times per week,
3. 1-2 times per week,
4. 2-3 times per month, or
5. Only once
9. REF

GO TO Q424

Q29

423. During the past 3 months, have you had sexual intercourse?

1. YES
2. NO—>**GO TO Q425**
9. REF — >**GO TO Q425**

424. During the past 3 months, with how many different men have you had intercourse? Please count every sexual partner, even those you had sex with only once.

___ ___ PARTNERS

88. DK
99. NR

425. When was the last time you had sexual intercourse?

A. ___ ___ MONTH   B. ___ ___ ___ ___ YEAR   88. DK/DR
                                                            99. REFUSE TO ANSWER

426. At the time of your last intercourse, what was your relationship with that man?

1. HUSBAND, CONSENSUAL PARTNER   7. JUST MET
2. FIANCEE   8. RELATIVE
3. BOYFRIEND   9. RAPE ....>**GO TO Q429**
4. FRIEND   10..INCEST .... >**GO TO Q429**
5. LOVER   20. OTHER(SPECIFY)_____
6. ACQUAINTANCE   88. DO NOT REMEMBER/REF

427. At the time you had your last sexual intercourse, did you or your partner use any contraceptive method?

1. YES
2. NO .... **>GO TO Q429**
9. DK/REF —>**GO TO Q429**

428. Which contraceptive method did you or your partner use at the last intercourse?

1. THE PILL
2. IUD
3. CONDOM
4. CONDOM+SPERMICIDE
5. CONDOM +WITHDRAWAL/CALENDAR
6. FOAM/JELLY/CREAMS/C-FILMS
7. FEMALE STERILIZATION
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES(DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS _____
88. NOT SURE

429. Counting all the men you had sexual intercourse with, even only once, how many partners have you had sexual intercourse with <u>in your life</u>?

____ ___ PARTNERS

85. 85+PARTNERS
88. DK
99. NR

V. CURRENT AND PAST CONTRACEPTIVE USE

501.   **RECORD WHETHER RESPONDENT REPORTED HAVING USED ANY METHOD (ANY Q402=l AT PG.23)**

    1 NEVER USED (NO Q402=l)

    2 EVER USED (ANY Q402=l)--->GO TO Q503

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

    1 NEVER USED—>**GO TO Q515, PAGE 30**
    2 EVER USED—>**CORRECT Q402 THEN CONTINUE**

503.   Are you (or your partner) **currently** using (in the last 30 days) any method or doing anything to prevent pregnancy?

    1 YES
    2 NO **->GO TO Q515 PAGE 30**

504.   What method are you currently using?
    1. THE PILL
    2. IUD
    3. CONDOM ----------------------->**GO TO Q506**
    4. CONDOM +SPERMICIDE—>**GO TO Q506**
    5. CONDOM +WITHDRAWAL/CALENDAR->**GO TO Q506**
    6. FOAM/JELLY/CREAMS/C-FILMS
    7. FEMALE STERILIZATION
    8. EMERGENCY HORMONAL CONTRACEPTION
    9. INJECTABLES(DEPO PROVERA)
    10. OTHER MODERN METHODS _____
    11. CALENDAR
    12. WITHDRAWAL
    13. WITHDRAWAL AND CALENDAR
    20. OTHER TRADITIONAL METHODS_____
    88. NOT SURE

505.   In the last 30 days, did you and your partner ever use a condom in addition to the method you are using?

    1. YES
    2. NO

> **IF Q504=4,2,7,9,10, OR 11 GO TO Q507**

506.   In the last 30 days how often did you/your partner use this method **(READ 1-4)** ?

    1. Always, at each sexual intercourse,
    2. almost always,
    3. Sometimes,
    4. Only once
    9. REF

507.   What was the most important reason for choosing this method?

    1. DOCTOR RECOMMENDED
    2. AFFORDABLE COST
    3. VERY EFFECTIVE
    4. VERY SAFE (FEW SIDE EFFECTS)
    5. SAW ADS (TV, RADIO, PRESS, BROCHURES)
    6. EASY TO USE
    7. PARTNER PREFERS IT
    8. KNOWS SOMEBODY WHO USES IT
    9. CURIOSITY/WANTED TO TRY IT
    10. ALLOWS SPONTANEITY DURING INTERCOURSE
    20. OTHER _____
    88. DO NOT KNOW/ DO NOT REMEMBER
    BOX 5-1

> **IF Q504 = 1-10, OR 88 GO TO Q510; IF SHE USES NATURAL METHODS (Q504=11-20), CONTINUE**

508. Please tell me whether each of the following reasons was very important, somewhat important, or not important at all in your decision to use _____ (CODE FROM Q504 FOR TRADITIONAL METHOD) instead of a modern method:

	Very Important	Somewhat Important	Not Important	Not Sure
A. Difficult to get a modern method	1	2	3	8
B. Cost of these modern methods	1	2	3	8
C. Little knowledge of modern methods	1	2	3	8
D. Fear of or experience with side effects	1	2	3	8
E. Husband/Partner choice	1	2	3	8
F. Religious beliefs	1	2	3	8
G. Doctor's recommendation	1	2	3	8
H. Another person's advice	1	2	3	8

509. How effective at preventing pregnancy do you think _____ (CODE FROM Q504 FOR TRADITIONAL METHOD) is compared to modern methods, like the pill or the IUD? (READ 1-3)

1 Current method more effective
2 About equally effective
3 Current method less effective
8 DON'T KNOW/NOT SURE

510. Do you have any problems or concerns with using your current method?

1 YES
2 NO—>GO TO Q512

511. What is the most important problem?

1. SIDE EFFECTS
2. HEALTH CONCERNS
3. ACCESS/AVAILABILITY
4. COST
5. SOMETIMES FORGET TO USE
6. SOMETIMES DIFFICULT/INCONVENIENT TO USE
7. HUSBAND/PARTNER DISAPPROVES
8. LESS EFFECTIVE METHOD/GOT PREGNANT WHILE USING IT
9. DEEPLY UNSATISFIED WITH THE METHOD
0. OTHER _____

512. Would you prefer to use a different method of family planning from the one you are currently using?

1 YES

2 NO—>GO TO BOX 5-11

513. What method would you prefer to use (OTHER THAN THE METHOD SPECIFIED IN Q504) ?

1. THE PILL
2. IUD
3. CONDOM
4. CONDOM+SPERMICIDE
5. CONDOM +WITHDRAWAL/CALENDAR-
6. FOAM/JELLY/CREAMS/C-FILMS
7. FEMALE STERILIZATION
8. EMERGENCY HORMONAL CONTRACEPTION
9. INJECTABLES(DEPO PROVERA)
10. OTHER MODERN METHODS_____
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL AND CALENDAR
20. OTHER TRADITIONAL METHODS_____
88. DO NOT KNOW/NOT SURE

514.   What is the most important reason that you do not use that method?

    1. DOCTOR WILL NOT PRESCRIBE IT
    2. COST
    3. NOT AVAILABLE/UNRELIABLE SUPPLIES/DIFFICULT TO OBTAIN
    4. TOO FAR AWAY
    5. DO NOT KNOW HOW/WHERE TO OBTAIN IT
    6. HUSBAND/PARTNER OBJECTS TO IT
    7. RELIGIOUS REASONS
    8. FEAR OF SIDE EFFECTS
    9. HAS NOT YET MADE UP HER MIND
  10. DIFFICULT TO USE
  11. FEAR OF SURGICAL PROCEDURE (IUD, TL, NORPLANT)
  20. OTHER
  88. DON'T KNOW

BOX 5-11

> **GO TO Q 521 PAGE 31**

515.   What is the main reason that you or your partner are not currently using a contraceptive method?

    1. DOES NOT CURRENTLY HAVE A PARTNER/ NOT SEXUALLY ACTIVE IN THE LAST MONTH
    2. TRYING TO GET PREGNANT
    3. POSTPARTUM/ BREASTFEEDING
    4. CURRENTLY PREGNANT
    5. HYSTERECTOMY/MENOPAUSE--->**GO TO Q523**
    6. DOCTOR SAID SHE OR HER PARTNER CANNOT HAVE CHILDREN------------------------->**GO TO Q523**
    7. SHE/COUPLE TRIED TO GET PREGNANT FOR AT LEAST 2 YEARS AND DIDN'T SUCCEED —> **Q523**
    8. FEAR OF SIDE EFFECTS
    9. LOVEMAKING WOULD BE INTERRUPTED
  10. RESPONDENT DID NOT THINK ABOUT USING CONTRACEPTION
  11. COST, CANNOT AFFORD BIRTH CONTROL
  12. BIRTH CONTROL IS THE PARTNER'S RESPONSIBILITY
  13. BIRTH CONTROL IS NOT (VERY) EFFECTIVE
  14. RESPONDENT DOES NOT WANT TO USE A METHOD
  15. PARTNER OBJECTS TO USING METHOD
  16. OBJECTS DUE TO RELIGIOUS REASONS
  17. DOES NOT KNOW WHERE TO GET METHOD
  18. RESPONDENT DOES NOT KNOW HOW TO USE BIRTH CONTROL METHODS
  19. RESPONDENT DOES NOT THINK THAT SHE CAN GET PREGNANT
  20. RESPONDENT HAS NO TIME TO GO TO A FP CLINIC
  21. RESPONDENT USES DOUCHING
  77. OTHER (SPECIFY) _____
  88. DK/REF

516.   Do you think that you will use a contraceptive method during the next 12 months (ADD:OTHER THAN
       DOUCHING IF Q515=21)?

    1. YES ------- > **GO TO Q518**
    2. NO
    8. NOT SURE

517.   Do you think that you will use a contraceptive method any time in the future?

    1. YES
    2. NO-----------------> **GO TO Q521**
    8. NOT SURE--------> **GO TO Q521**

518.   What method would you want to use most?

    1. THE PILL
    2. IUD
    3. CONDOM
    4. CONDOM+SPERMICIDE
    5. CONDOM +WITHDRAWAL/CALENDAR-
    6. FOAM/JELLY/CREAMS/C-FILMS
    7. FEMALE STERILIZATION
    8. EMERGENCY HORMONAL CONTRACEPTION
    9. INJECTABLES(DEPO PROVERA)
  10. OTHER MODERN METHODS _____ .
  11. CALENDAR-->**GO TO Q521**
  12. WITHDRAWAL-->**GO TO Q521**
  13. WITHDRAWAL + CALENDAR----------------->**GO TO Q521**
  20. OTHER _____ ------->**GO TO Q521**
  88. NOT SURE-------------------------------- Q33-------------->**GO TO Q521**

519.   On average, how much are you willing to pay for contraception, per month?

        ___ ___ THOUSAND MANAT   85. 85 THOUSAND OR MORE
                                                         99. NOT SURE/DON'T KNOW

520.   Where would you want to get your contraceptive method?

        1. RURAL AMBULATORY (FAP, DAC)   9. PHARMACY
        2. VILLAGE HOSPITAL   10. OPEN MARKET, BAZAAR
        3. POLICLINIC   11. STORE/KIOSK
        4. WOMEN'S CONSULTATION CLINIC   12. PARTNER/HUSBAND
        5. GOV HOSPITAL-GYN WARD   13. FRIEND
        6. GOV HOSPITAL-MATERNITY WARD   14. RELATIVE
        7. PRIVATE CLINIC OR OFFICE   20. OTHER (SPECIFY): _____
        8. NGO   88. DON'T KNOW

521.   During the last year, how often did you talk about contraception with your husband/ partner?

        1. NEVER----------------------------->**GO TO Q523**
        2. ONE OR TWO TIMES
        3. THREE TIMES OR MORE
        4. RESPONDENT HAD NO PARTNER DURING THE LAST YEAR ---------- >**GO TO Q523**

522.   Generally, does your husband/ partner agree or disagree with the use of contraceptive methods?

        1. AGREES
        2. DISAGREES
        3. NEITHER AGREES NOR DISAGREES
        8. NOT SURE/DON'T KNOW

523.   Some people use condoms for reasons other than birth control, for instance because they are concerned about
        getting diseases that can result from sexual intercourse. Have you ever used condoms for: **(READ 1-4)**

        1. Birth Control Only-------------------------------------->**GO TO BOX 5-III**
        2. Disease Prevention Only-------------------------------->**GO TO BOX 5-III**
        3   Both, or-->**GO TO BOX 5-III**
        4. You Never Used a Condom?
        5. USED CONDOM OUT OF CURIOSITY
        8. NOT SURE/ DO NOT REMEMBER

524.   Why have you and your partner(s) never used condoms?

        1. PREVENTING PREGNANCY IS WOMAN'S RESPONSIBILITY
        2. PARTNER(S) OBJECTED TO USE CONDOMS
        3. HAVE ONLY ONE PARTNER
        4. THEY ARE ONLY FOR USE WITH PROSTITUTES
        5. THEY ARE ONLY FOR EXTRAMARITAL RELATIONS
        6. CONDOMS DIMINISH PLEASURE/SPONTANEITY
        7. CONDOMS ARE LESS EFFECTIVE IN PREVENTING PREGNANCY
        8. CONDOMS ARE TOO DIFFICULT TO USE
        9. LOVEMAKING WOULD BE INTERRUPTED
        10. CONDOM USE IS TOO MESSY
        11. COST
        12. SHE HAS NEVER THOUGHT ABOUT IT
        13. IT IS EMBARRASSING TO BUY CONDOMS
        14. PREFERS OTHER CONTRACEPTIVE METHODS
        20. OTHER _____
        88. DON'T KNOW

**COMPLETE FIRST COLUMN 1 AND 4 (SEE ALSO PREGNANCY HISTORY PG.11 AND MARITAL
HISTORY PAGE 4). ASK THE MONTH-BY-MONTH CONTRACEPTIVE HISTORY STARTING WITH
THE CURRENT MONTH AND GOING BACK TO JANUARY 1996.**

➔**IF RESPONDENT HAS USED ANY CONTRACEPTIVE METHOD SINCE JANUARY 1996,
FILL IN ALL FOUR COLUMNS OF THE CALENDAR**
➔**IF NO METHOD HAS BEEN USED SINCE JANUARY 1996, WRITE "0" AT THE BEGINNING
AND THE END OF THE 2ND COLUMN <u>THEN GO TO 0554. PAGE 36</u>**

525.   CONTRACEPTIVE METHODS USED/PREGNANCY OUTCOMES/AND MARITAL STATUS CALENDAR

COLUMN 1

PREGNANCY

OUTCOME

1. PREGNANT THAT MONTH
2. LIVE BIRTH
4. STILLBIRTH
6. MISCARRIAGE
7. INDUCED ABORTION
8. MINIABORTION
9. ECTOPIC PREGNANCY

COLUMN 2

METHOD USED
0. NO METHOD
1. PILL
2. IUD
3. CONDOM
4. CONDOM+SPERMICIDES
5. CONDOM+CAL/WITHRAWAL
6. SPERMICIDES
7. TUBAL LIGATION
8. EMERGENCY HORM. CONTRACEPTIO
9. DEPO-PROVERA
10. OTHER MODERN MET.
11. CALENDAR
12. WITHDRAWAL
13. WITHDRAWAL +CALENDAR
20. OTHER TRADITIONAL MET.
88. DO NOT REMEMBER

COLUMN 3

REASON STOPPED USING A METHOD
1. GOT PREGNANT WHILE USING
2. WANTED TO GET PREGNANT
3. HUSBAND OBJECTED
4. SIDE EFFECTS
5. HEALTH CONCERNS
6. STOPPED TO "REST THE BODY"
7. PHYSICIAN DECISION
8. SUPPLY/AVAILABILITY
9. DIFFICULT/INCONVENIENT TO USE
10. MARRIAGE/RELATIONSHIP ENDED
11. WANTED TO TRY OTHER METHOD
12. SPORADIC SFXIIAI. ACTIVITY
13. SHE NEGLECTED TO USE
20. OTHER _____

COLUMN 4 (MARITAL STATUS)

0. NOT MARRIED/NOT IN UNION
1. MARRIED/IN UNION

DATE	1	2	3	4		DATE	1	2	3	4
1996						**1999**				
1 Jan						1 Jan				
2 Feb						2 Feb				
3 Mar						3 Mar				
4 Apr						4 Apr				
5 May						5 May				
6 Jun						6 Jun				
7 Jul						7 Jul				
8 Aug						8 Aug				
9 Sep						9 Sep				
10 Oct						10 Oct				
11 Nov						11 Nov				
12 Dec						12 Dec				
1997						**2000**				
1 Jan						1 Jan				
2 Feb						2 Feb				
3 Mar						3 Mar				
4 Apr						4 Apr				
5 May						5 May				
6 Jun						6 Jun				
7 Jul						7 Jul				
8 Aug						8 Aug				
9 Sep						9 Sep				
10 Oct						10 Oct				
11 Nov						11 Nov				
12 Dec						12 Dec				
1998						**2001**				
1 Jan						1 Jan				
2 Feb						2 Feb				
3 Mar						3 Mar				
4 Apr						4 Apr				
5 May						5 May				
6 Jun						6 Jun				
7 Jul						7 Jul				
8 Aug						8 Aug				
9 Sep						9 Sep				
10 Oct						10 Oct				
11 Nov						11 Nov				
12 Dec						12 Dec				

IF SHE DID NOT USE A METHOD IN JANUARY 1996 (COLUMN 2_JAN 1996=0) GO TO Q527

526.   You said that in January of 1996 you were using _____ **(WRITE CODE # FOR THE MET. USED IN COLUMN 2_JAN 1996)**. When did you start using that method?

    A. MONTH ___ ___   B. YEAR 19 ___ ___   22. DK/REF

527. **LAST CONTRACEPTIVE METHOD USED (COPY THE METHOD FROM THE CONTRACEPTIVE CALENDAR):**

1. **THE PILL**
2. **IUD**
3. **CONDOM**
4. **CONDOM +SPERMICIDES**
5. **CONDOM +WITHDRAWAL/CALENDAR**
6. **FOAM/JELLY/CREAMS**
7. **FEMALE STERILIZATION**
8. **EMERGENCY HORMONAL CONTRACEPTION**

9. **DEPO-PROVERA**
10. **OTHER MODERN METHOD** _____
11. **CALENDAR** .... >GOTOQ536
12. **WITHDRAWAL** .... >GO TO Q536
13. **WITHDRAWAL+CALENDAR** ------- >GO TO Q536
20. **OTHER TRADITIONAL MET.** ....>GO TO Q536
88. **DO NOT REMEMBER** ....>GO TO Q536

528. The next following questions concern **the last contraceptive <u>method</u>** you have used. Where did you get that method?

1. RURAL AMBULATORY (FAP, DAC)
2. VILLAGE HOSPITAL
3. POLICLINIC
4. WOMEN'S CONSULTATION CLINIC
5. GOV HOSPITAL-GYN WARD
6. GOV HOSPITAL-MATERNITY WARD
7. PRIVATE CLINIC OR OFFICE
8. NGO

9. PHARMACY
10. OPEN MARKET, BAZAAR
11. STORE/ KIOSK
12. PARTNER/HUSBAND
13. FRIEND
14. RELATIVE
20. OTHER (SPECIFY): _____
88. DON'T KNOW

529 Do (Did) you pay for this method?

1. YES
2. NO .... **>GO TO Q531**
3. PARTNER GETS THE METHOD—->**GO TO Q531**

530. How much did you pay?   ___ ___   THOUSAND MANAT   85. 85 THOUSAND OR MORE
                                                                   88. NOT SURE/DON'T KNOW

531. At the time you started using the last contraceptive method, who advised you about how to use that method?

1. OB/GYN
2. GENERAL PRACTITIONER
3. NURSE/MIDWIFE/FELDCHER
4. PHARMACIST----->**GO TO Q536**
5. MOTHER ----------- >**GO TO Q536**

6. OTHER RELATIVE------------>**GO TO Q536**
7. FRIEND------------------------>**GO TO Q536**
8. PARTNER----------------------->**GO TO Q536**
9. NOBODY----------------------->**GO TO Q536**
20. OTHER _____—->**GO TO Q536**

532. When you received the information concerning use of the method, did the health provider tell you about other contraceptive methods?

1. YES
2. NO--------->**GO TO Q534**

533. Did the health provider explain <u>how effective</u> your method is compared to other contraceptive methods?

1. YES
2. NO

534. Did the health provider explain the possible side effects of your method?

1. YES
2. NO

536. **OBSERVE THE CALENDAR AND RECORD IF RESPONDENT HAS USED PILLS OR IUD AT ANY TIME DURING THE PAST FIVE YEARS:**

    1. ONLY PILLS
    2. PILL AND IUD
    3. ONLY IUD---------------->GO TO Q545
    4. NEITHER PILL NOR IUD (OTHER MODERN OR TRAD. METHODS)—>GO TO BOX 5-IV, PG. 36

537. **OBSERVE THE CALENDAR AND VERIFY IN WHAT MONTH AND YEAR RESPONDENT STARTED TO TAKE PILLS MOST RECENTLY (PAST OR CURRENT USERS).** You said you <u>most recent</u> started taking pills in: ....

    ___ ___ MONTH   ___ ___ YEAR   88. DO NOT REMEMBER

538. What brand of pills did you use <u>most recently</u>? **(SHOW CARD B; ASK TO SEE PACKAGE, IF SHE IS CURRENTLY USING PILLS)**

1. <u>ANTEOVIN</u>	9. MICROGYNON	17. R1GEVIDON
2. BISECURIN	10. MINISISTON	18. <u>TRINORDIOL</u>
3. CILEST	11. MINULET	19. <u>TRINOVUM</u>
4. DIANE-35	12. NELOVA	20. <u>TRISISTON</u>
5. FEMODEN	13. NON-OVLON	21. <u>TRIQUILAR</u>
6. LO-FEMENAL	14. OVIDON	22. <u>TRI-REGOL</u>
7. MARVELON	15 OVRETTE	77. OTHER _____
8. MERC1LON	16. POSTINOR	88. DO NOT KNOW

539. When you started taking pills, how long did your physician tell you that you could take them? **(Q539 REFERS TO THE LAST INTERVAL OF USE, INCLUDING CURRENT USE)**

    ___ ___ MONTHS   00. NEVER TALKED TO A DOCTOR ABOUT IT
                             44. THREE OR MORE YEARS (36 MONTHS OR MORE)
                             55. AS LONG AS RESPONDENT WANTED/INDEFINITELY
                             66. DID NOT SAY HOW LONG
                             77. OTHER (SPECIFY) _____
                             88. DON'T REMEMBER

540. At any time during the last usage of pills have you had any health problems or side effects that you think are related to using pills?

    1. YES
    2. NO—>**GO TO Q543**

541. What kind of problem or side effect have you had? **(IF MORE THAN ONE PROBLEM, CIRCLE MORE THAN ONE ANSWER)**

	<u>YES</u>	<u>NO</u>
A. HEADACHES OR DIZZINESS 1		2
B. BLURRED VISION, SEEING FLASHING LIGHTS 1		2
C. WEIGHT GAIN 1		2
D. NAUSEA 1		2
E. BREAST TENDERNESS 1		2
F. BLEEDING/SPOTTING BETWEEN MENSTRUAL PERIODS 1		2
G. MOOD CHANGES (LESS INTEREST IN SEX, DEPRESSION)................... .1		2
H. OTHER (SPECIFY) _____ ___ 1		2

542.   Was this problem serious enough that you went to a doctor or clinic about it?

   1.   YES
   2.   NO

IF RESPONDENT HAS USED ONLY PILLS (Q536=l) THEN GO TO BOX 5-IV PAGE 36; ELSE CONTINUE

---

545.   **OBSERVE THE CALENDAR AND VERIFY IN WHAT MONTH AND YEAR RESPONDENT STARTED TO USE THE <u>LAST (OR CURRENT) IUD</u>.**   You said you had an IUD inserted in ----

   ___ ___ MONTH   ___ ___ YEAR   88. DO NOT REMEMBER

546.   Now, I want you to think back at <u>the time when you had inserted</u> your (last) IUD. Was that IUD inserted immediately after an abortion?

   1. YES
   2. NO

547.   After the IUD was inserted, when did the physician tell you to come back for a routine check-up?

   ___ ___ WEEKS   00 DID NOT SAY TO COME BACK FOR CHECK-UP

                          33 AFTER THE FIRST PERIOD
                          44 SAID TO COME BACK ANYTIME SHE WANTS
                          55 SAID TO COME BACK ONLY WHEN SHE HAS SPECIFIC PROBLEMS
                          77 OTHER (SPECIFY) _____
                          88 DON'T REMEMBER

548.   When the IUD was inserted, did the physician tell you how to check that the IUD is in place?

   1. YES
   2. NO
   8. DON'T REMEMBER

550.   Did the physician tell you how long could the IUD be left in place?

   1. YES
   2. NO
   8. DON'T REMEMBER

551.   Thinking back at the <u>first year</u> after you had this IUD inserted, did you have any health problems or side effects that you think are related to your IUD?

   1 YES
   2 NO—>**GO TO BOX 5-IV ON NEXT PAGE**

Q38

552.   What kind of problem or side effect did you have? **(CODE MORE THAN ONE IF NECESSARY)**

	YES	NO
A. ABDOMINAL CRAMPING	1	2
B. HEAVY BLEEDING DURING MENSTRUAL PERIODS	1	2
C. SPOTTING/BLEEDING BETWEEN PERIODS	1	2
D. INFECTION/DISCHARGE/PID	1	2
E. PARTNER'S COMPLAINS ABOUT THE STRINGS	1	2
F. EXPULSION	1	2
G. OTHER (SPECIFY) _____	1	2

553.   Did you see a doctor for this(ese) problem(s)?

1.   YES
2.   NO

> **BOX 5 IV**
> **IF ANY CONTRACEPTIVE METHOD WAS USED IN THE LAST MONTH (LAST CELL IN**
> **COLUMN 2 >"0") THEN GO TO Q556;   ELSE CONTINUE**

554.   Do you think you are physically able to get pregnant <u>at the present time</u>?

1   YES—>**GO TO Q556**
2.   NO
3.   NOT SURE
4   CURRENTLY PREGNANT—>**GO TO Q556**

555.   What is the main reason why you think you cannot get pregnant?

1. RESPONDENT DOES NOT HAVE A PARTNER/ IS NOT SEXUALLY ACTIVE
2. CURRENTLY BREAST-FEEDING /POSTPARTUM
3. PELVIC INFLAMMATORY DISEASE (PID)
4. ENDOCRINE DYSFUNCTION
5. HYSTERECTOMY (SURGICAL REMOVAL OF UTERUS)----------------------------------->**GO TO Q561 PAGE 37**
6. PREMENOPAUSE/ MENOPAUSE--->**GO TO Q561 PAGE 37**
7. OVARIAN CYSTS/ OVARIAN DYSFUNCTION-->**GO TO Q560A PG. 37**
8. RESPONDENT HAD BOTH TUBES REMOVED OR OBSTRUCTED------------------ ----->**GO TO Q560A PG. 37**
9. HAS TRIED TO GET PREGNANT IN THE PAST 2 YEARS AND DID NOT SUCCEED->**GO TO Q560A PG 37**
10. PARTNER CANNOT HAVE CHILDREN--->**GO TO Q560A PG. 37**
11. PARTNER IS INFERTILE ------------------------------------ --------------------------------->**GO TO Q560A PG. 37**
12. CURRENTLY USES A METHOD **(GO BACK TO Q504 AND CORRECT IT)**
20. OTHER (SPECIFY) _____
88. DO NOT KNOW
99. REFUSE TO ANSWER

556.   Looking to the future, do you <u>yourself</u> intend to have (a/another) baby at some time **(IF CURRENTLY
PREGNANT ADD** ".. .after this pregnancy"?)

1. WANTS A BABY
2. DOES NOT WANT A BABY — >**GO TO Q559**
3. RESPONDENT WANTS A BABY BUT PARTNER DISAGREES
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS —> **GO TO Q559**
8. DK —->**GO TO Q559**

558.   When do you, <u>yourself</u>, actually want to get pregnant (again)…**(READ 1-4)**

1. Right away, **(DO NOT READ IF THE WOMAN IS ALREADY PREGNANT)**
2. Within the next 12 months,
3. Within 1-2 years,
4. or after 2 years?
6. AFTER SHE MARRIES
7. WHEN GOD WANTS
8. DK

559.   **(IF Q556 =1,3, OR 8 BEGIN WITH:** "After having all the children you want,...")
Do you think you would be interested in having an operation to prevent you from having any more children?

1 YES------------>**GO TO Q561**
2 NO
3 ALREADY STERILIZED-------------->**GO TO Q561**
8. NOT SURE

560.   What is the most important reason you wouldn't be interested in such a procedure?

1. HEALTH RISKS/FEAR OF SIDE EFFECTS
2. FEAR OF OPERATION
3. DOESN'T KNOW ENOUGH ABOUT/NEVER HEARD OF STERILIZATION
4. MIGHT WANT ANOTHER CHILD
5. COST
6. DOES NOT HAVE A PARTNER/NOT SEXUALLY ACTIVE
7. AGE TOO YOUNG OR TOO OLD (APPROACHING MENOPAUSE)
8. HAVEN'T THOUGHT ABOUT IT
9. NOT CULTURALLY ACCEPTABLE
10. RELIGIOUS REASONS
11. PREFERS (OR USES) OTHER CONTRACEPTIVE METHODS
12. CANNOT GET PREGNANT (INFERTILITY, MEDICAL REASONS)
20. OTHER_____
88. DON'T KNOW

> **GO TO Q561**

560A. Looking to the future, do you yourself intend to seek any medical help to have a(nother) baby ?

1. YES
2. NO
3. RESPONDENT WANTS A BABY BUT PARTNER DISAGREES
4. RESPONDENT DOES NOT WANT A BABY BUT PARTNER WANTS
8. DK

561.   The next questions are about any infertility services you may have ever received. This includes any medical help to become pregnant that you or your husband(s)/partner(s) may have received. Have you or your husband(s)/partner(s) ever been to a doctor or other medical care provider to talk about ways to help you become pregnant?

1. YES
2. NO.............>**GO TO Q575**
8. DK/NR --------->**GO TO Q575**

562. Think about all of the medical help you or your partners have <u>ever</u> received to help you become pregnant. Please tell me which of the following services have you or your partner had to help you become pregnant.

Have you or your partner(s) received <u>medical advice (</u>HOW TO TIME INTERCOURSE DURINGMONTHLY CYCLE. QUIT SMOKING, DRINKING, ETC)?

1. YES
2. NO

563. Have you or your partner(s) received <u>Infertility testing (</u>**FEMALE TESTING** INCLUDE: BASAL BODY TEMPERATURE CHARTING, POST-COITAL TEST, PELVIC ECHOGRAPHY, HISTROSALPINGOGRAM, LAPAROSCOPY, BLOOD HORMONE LEVELS, ENDOMETRIAL BIOPSY; **MALE TESTING** INCLUDE: SPERM ANALYSIS. BLOOD HORMONE LEVELS)

1. YES
2. NO .... >**GO TO Q565**
8. DK/NR......>**GO TO Q565**

564. Who was it that had <u>infertility testing,</u> was it (READ ALL):

1. You,
2. Him,
3. Both of you?

565. Have you received any <u>Drugs to improve your ovulation</u> (e.g. CLOMIFEN, PERGONAL, PARLODEL)?

1. YES
2. NO

566. Have you received any <u>Surgery to correct blocked tubes?</u>

1. YES
2. NO

568. Have you received any <u>other types of medical help</u> (e.g. TRATMENT FOR ENDOMETRIOSIS, OVARIAN CYSTS, UTERINE FIBROIDS, SURGERY FOR ADESIONS, MALE SURGERY FOR VARICOCELE, ARTIFICIAL INSEMINATION, ETC)?

1. YES
2. NO

569. Thinking back to your or your partner's first visit when you sought medical help for becoming pregnant, in what month and year was that visit **(IF PARTNER 1ST VISIT PRECEEDED HERS, RECORD THAT DATE)**

A. ___ ___ MONTH   B. ___ ___ ___ ___ YEAR   88. DK/NOT REMEMBER

570. When you first went for medical help in **(MONTH/YEAR)**, how many <u>months or years</u> had you (and your husband/partner) been trying to become pregnant?

1. ___ ___ MONTHS   OR   2. ___ ___ YEARS   888. DK/DR

571. When you and your husband or partner went for medical help to become pregnant were you ever told that you
or he had any of the following infertility problems: **(READ A-E AND CODE ALL THAT APPLY.)**

	YES	**NO**
A. Problems with ovulation (includes hormonal dysfunction)?	1	2
B. Blocked tubes?	1	2
C. Endometriosis (a disease in which tissue from the inside of uterus fixes to other places)?.....................	1	2
D Semen or sperm problems (low count, poor motility, varicocele) ?	1	2
E. Any other infertility problems? **(SPECIFY)**_____	1	2

572. During the past 12 months, were you (and your (husband/partner)) pursuing medical help to become regnant?

1. YES
2. NO...........>**GO TO Q574**

573. During the past 12 months, how many visits have you or your husband/partner made to a doctor to help you to get pregnant?

___ ___ VISITS   88. DK/DR

574. In what month and year was your (<u>most recent/last</u>) visit for help to become pregnant?

.A. ___ ___ MONTH   B. ___ ___ ___ ___ YEAR   88. DK/NOT REMEMBER

575. Have you <u>ever</u> been treated for an infection in your fallopian tubes, womb, or ovaries, also called a pelvic infection, pelvic inflammatory disease, or P.I.D.? (IF DON'T KNOW, PROBE: This is a female <u>infection</u> that sometimes causes abdominal pain or lower stomach cramps.) **<u>NOTE:</u>** INFECTIONS OF THE VAGINA ALONE, ENDOMETRIOSIS,   PELVIC TUMORS, AND CYSTS **DO NOT COUNT** AS PELVIC INFECTIONS

1. YES
2. NO-------->**GO TO MODULE VI**
8. DK/NR-—>**GO TO MODULE VI**

576. Were you having any symptoms, such as pain, discharge, or bleeding, that caused you to go for treatment?

1. YES
2. NO

577. Please try to remember when you first received treatment for a pelvic infection or P.I.D. In what month and year was that?

A. ___ ___ MONTH   B. ___ ___ YEAR   88. DK/NOT REMEMBER

578. In what month and year did you last receive treatment for a pelvic infection or P.I.D.?

A. ___ ___ MONTH   B. ___ ___ YEAR   88. DK/NOT REMEMBER

579. Altogether, how many different times have you been <u>hospitalized</u> one night or longer for a pelvic infection?

1. NEVER----------->**GO TO MODULE VI**
2. ONCE
3. 2-3 TIMES
4. 4 TIMES OR MORE
8. DO NOT REMEMBER

580. Overall, how many nights did you spend in the hospital for a pelvic infection or P.I.D.?

NIGHTS: ___ ___   88. DK/NOT REMEMBER

VI. WOMEN'S HEALTH

Now 1 would like to ask you some questions about your health.

601. In the past 12 months, have you visited any health facility for care for yourself, including obtaining preventive services, such as family planning counselling or health check-ups?

    1. YES
    2. NO------------------------>**GO TO Q604**
    8. DK/DO NOT REMEMBER--------->**GO TO Q604**

602. Where did you receive these services **(CIRCLE ALL MENTIONED AND PROBE "Any Other Place")?**

	MENTIONED	**NOT MENTIONED**
A. GOVT. HEALTH CLINIC OR HOSPITAL	1	2
B. PRIVATE HEALTH CLINIC OR HOSPITAL	1	2
C. INTERNATIONAL RELIEF ORGANIZATION	1	2
D. LOCAL NGO	1	2
E. MOBILE HEALTH UNIT	1	2
F. OTHER_____	1	2

603. During your visit in the past 12 months at the health facility, did a doctor or medical provider talk to you about family planning methods?

    1. YES
    2. NO
    8. DK

604. Many different factors can prevent women from getting medical advice or treatment for themselves. When you want to get medical advice or treatment, is each of the following a big problem or not **(READ A -G)?**

	BIG PROBLEM	**NOT A BIG PROBLEM**
A. Knowing where to go 1		2
B. Getting permission to go 1		2
C. Getting money needed for treatment..............................1		2
D. The distance to the health facility 1		2
E. Having to take transport 1		2
F. Not wanting to go alone 1		2
G. Concern that there may not be a female health provider 1		2

605. Have you <u>ever had</u> a routine gynecologic exam **(PHYSICAL EXAMINATION OF EXTERNAL AND INTERNAL GENITAL AREA FOR DIAGNOSTIC OTHER THAN PREGNANCY) ?**

    1. YES —->**GO TO Q607**
    2. NO
    8. NR

606. What is the most important reason that you have never had a routine gynecologic exam?

    1. DOES NOT NEED TO GO TO GYNECOLOGIC EXAM
    2. SHE IS HEALTHY AND HAS NOT GYNECOLOGIC PROBLEMS
    3. THERE IS NOT TIME TO GO FOR EXAM
    4. SHE FORGETS ABOUT IT
    5. SHE DOES NOT LIKE GYNECOLOGIC EXAM
    6. IT IS DIFFICULT TO GET APPOINTMENT
    7. DOES NOT LIKE PLACE/FACILITY
    8. DOES NOT LIKE THE STAFF
    9. WAITING TIME IS TOO LONG
    10. DOCTOR DID NOT RECOMMEND
    11. SHE IS EMBARRASSED TO HAVE GYNECOLOGIC EXAM
    12. NEVER THOUGHT ABOUT IT
    13. DOES NOT KNOW WHERE TO GO FOR SUCH AN EXAM
    14. CANNOT AFFORD THE COST
    15. NEVER HAD SEXUAL INTERCOURSE (VIRGIN)
    20. OTHER _____
    88. DK/NOT RESPONSE

GO TO Q611

607.   When was your last <u>routine</u> gynecologic exam (not pregnancy related) ? **(READ 1-4)**

   1. During the past 12 months
   2. 1-2 years ago (12-23 MTH)
   3. 2-3 years ago (24-35 MTH)
   4. 3 or more years ago
   8. DK/DR

608.   Have you ever had a cervical smear (a test that takes a sample of cells from the cervix, or opening to the uterus to detect cancer), also called Papanicolau test?

   1 YES —->**GO TO Q610**
   2. NO
   8. DK
   9. REF

609.   What is the main reason you have never had a Pap smear?

   1. NEVER HEARD OF IT
   2. DOCTOR HAS NOT RECOMMENDED IT
   3. SHE IS HEALTHY AND HAS NO GYNECOLOGIC PROBLEMS
   4. SHE DOES NOT FEEL TEST IS NECESSARY
   5. DOES NOT HAVE TIME TO GO FOR A TEST/ SHE FORGETS ABOUT IT
   6. NEVER THOUGHT OF IT
   7. SHE IS AFRAID OF THE RESULTS
   8. SHE IS AFRAID IT COULD BE PAINFUL
   9. TOO EMBARRASSED TO GET THE TEST OR A PELVIC EXAM.
   10. SHE HAD NO PARTNER/ NOT SEXUALLY ACTIVE
   20. OTHER (SPECIFY): **_____**
   88. DON'T KNOW
   99. REFUSE TO ANSWER

   GO TO Q611

610.   When did you have your last Pap smear? Was it**...(READ 1-4)**

   1. within the last year, (0 TO 11 MONTHS AGO)
   2. 1 to 2 years ago, (12 TO 23 MONTHS AGO)
   3. 2-3 years ago, (24 to 35 MONTHS AGO)
   4. more than 3 years ago? (36+MONTHS AGO)
   8. DON'T KNOW

611.   Have you heard about breast self-examinations?

   1 YES
   2 NO------------------>**GO TO Q614**

612.   Do you ever do breast self-examinations?

   1 YES
   2 NO-------------------->**GO TO Q614**

613.   How often do you do it, on average?

   1. ONCE A MONTH/AFTER EACH MENSTRUATION
   2. EVERY 2-5 MONTHS
   3. EVERY 6-11 MONTHS
   4. ONCE PER YEAR OR LESS

614.   Have you ever tried cigarette smoking, even one or two puffs?

    1. YES
    2. NO—> **GO TO 621**

615.   How old were you when you smoked a cigarette for the first time?

    ___ ___ YEARS   88. DK
                            99.NR

616.   Have you smoked at least 100 cigarettes in your entire life? **(PROBE:** 100 cigarettes is about 5 packs)

    1. YES
    2. NO—> **GO TO 621**
    8. DK—> **GO TO 621**
    9. REF—>**GO TO 621**

617.   How old were you when you first started smoking fairly regularly?

    ___ ___ YEARS   00. NEVER SMOKED REGULARLY

                            99. DO NOT REMEMBER

618.   During the last 30 days, did you smoke cigarettes: **(READ 1-4)**

    1. Every Day
    2. Almost Every Day
    3. Some Days
    4. Not at All in the last 30 days-->**GO TO Q620**
    9. REF ---------- >**GO TO Q620**

619.   During the last 30 days, on the days you smoked, how many cigarettes did you smoke per day?

    1. 1 CIGARETTE PER DAY
    2. 2-5 CIGARETTES PER DAY
    3. 6-10 CIGARETTES PER DAY
    4. 11-19 CIGARETTES PER DAY
    5. 20 OR MORE CIGARETTES PER DAY

                      | **GO TO Q621** |

620.   In what month and year did you last smoke cigarettes at all? **(PROBE FOR SEASON IF MONTH IS UNKNOWN)**

    A. ___ ___ MONTH   B. ___ ___ ___ ___ YEAR   88. DK
                                                               99. REF

621.   Now, I will ask you about some medical conditions that you may have had. Has a doctor or other medical care provider ever told you that you had Diabetes or "high sugar"?

    1. YES
    2. NO—>**GO TO Q623**
    8. NOT SURE------>**GO TO Q623**
    9. REFUSAL-------->**GO TO Q623**

622.   Were you ever told you had diabetes when you were <u>not pregnant</u>?

    1. YES
    2. NO
    3. NEVER BEEN PREGNANT

623.   Has a doctor or other medical care provider ever told you that you had Anemia, or "thin blood"?

1. YES
2. NO — -->**GO TO Q625**
8. NOT SURE —-->**GO TO Q625**
9. REFUSAL------->**GO TO Q625**

624.   Were you ever told you had anemia or "thin blood" when you were <u>not pregnant</u>?

1. YES
2. NO
3. NEVER BEEN PREGNANT

625.   Has a doctor or other medical care provider ever told you that you had Hypertension or High Blood Pressure?

1. YES
2. NO---------------->**GO TO Q627**
8. NOT SURE —-->**GO TO Q627**
9. REFUSAL------->**GO TO Q627**

626.   Were you ever told you had Hypertension or High Blood Pressure when you were <u>not pregnant</u>?

1. YES
2. NO
3. NEVER BEEN PREGNANT

627.   Has a doctor ever told you that you have...**(READ A-D)**

	YES	NO	DK	REF
A. Urinary infection?..1		2	8	9
B. Malaria?..1		2	8	9
C. Toxoplasmosis? 1		2	8	9
D. Hepatitis B?..1		2	8	9

628.   In the past 12 months have you had any vaginal discharge that was not menstrual?

1. YES
2. NO ....>**GO TO Q632**
8. NOT SURE........>**GO TO Q632**
9   REFUSAL ------- >**GO TO Q632**

629.   Along with the discharge, did you have any:

	YES	NO	NOT SURE
A. Itching..	1	2	8
B. Painful urination	1	2	8
C. Painful intercourse..	1	2	8
D. Lower abdominal pain	1	2	8

630.   Did you have any treatment for this(ese) condition(s)?

1. YES
2. NO—>**GO TO Q632**
8. NOT SURE —> **GO TO Q632**

631.   Who treated you?

1. OB/GYN   6. PHARMACIST
2. TERAPEUT/GP   7. PARTNER
3. VENEROLOGIST   8. FRIEND/RELATIVE
4. FP DOCTOR   9. SELF-TREATMENT
5. NURSE/MIDWIFE/FELDCHER   20. OTHER: _____
                                   99. REFUSE TO ANSWER

632.   In the past 12 months have you had any sores, warts, or ulcers in the genital area?

1. YES
2. NO--------------->**GO TO MODULE VII**
8. NOT SURE –—>**GO TO MODULE VII**
9 REFUSAL------->**GO TO MODULE VII**

633.   Did you have any treatment for this(ese) condition(s)?

1 YES
2 NO —>**GO TO MODULE VII**
8 NOT SURE -->**GO TO MODULE VII**

634.   Who treated you?

1. OB/GYN   6. PHARMACIST
2. TERAPEUT/GP   7. PARTNER
3. VENEROLOGIST   8. FRIEND/RELATIVE
4. FP DOCTOR   9. SELF-TREATMENT
5. NURSE/MIDWIFE/FELDCHER   20. OTHER: _____
                                   99. REFUSE TO ANSWER

VII REPRODUCTIVE HEALTH KNOWLEDGE/ATTITUDES

700.   What do you think is the ideal number of children for a young family in Azerbaijan?

0. 0 CHILDREN	6. 3-4 CHILDREN
1. 1 CHILD	7. 4 CHILDREN
2. 1-2 CHILDREN	8. 5 OR MORE
3. 2 CHILDREN	9. AS MANY AS GOD GIVES
4. 2-3 CHILDREN	77. AS MANY AS POSSIBLE
5. 3 CHILDREN	88. DON'T KNOW

701.   During a woman's menstrual cycle, are there certain days when she is more likely to become pregnant if she has sexual relations?

1. YES
2. NO------------------>**GO TO 702**
8. DO NOT KNOW->**GO TO 702**

701A.   When is it most likely for a woman to become pregnant, just before her period begins, during her period, right after her period has ended, or halfway between two periods?

1   Just before her period starts
2   During her period
3   Right after period ends
4   Halfway between her periods
8   DON'T KNOW

702.   Do you think that breastfeeding increases, decreases or has no effect on a woman's chance to get pregnant?

1. INCREASES THE CHANCE
2. DECREASES THE CHANCE
3. HAS NO EFFECT
8. DO NOT KNOW

703.   Do you think that a woman <u>always</u> has the right to decide about her pregnancy, including whether or not to have an abortion?

1.   YES—>**GO TO Q705**
2.   NO

704.   Under which of the following conditions is it all right for a woman to have an abortion (**READ A-F**)?

	YES	**NO**	**DEPENDS**	**DK**
A. Her life is endangered by the pregnancy	1	2	3	8
B. The fetus has a physical deformity	1	2	3	8
C. The pregnancy has resulted from rape	1	2	3	8
D. Her health is endangered by the pregnancy	1	2	3	8
E. She is unmarried	1	2	3	8
F. The couple cannot afford to have a(nother) child	1	2	3	8

705.   If a woman had an unwanted pregnancy what should she do? (**READ 1-3**):

1.   Have the baby and keep it
2.   Have the baby and give it up for adoption
3.   Have an abortion
8.   DON'T KNOW

706. I would like to know if you are in agreement with the following statements **(READ A-I):**

	AGREE	DISAGREE	DK
A. A woman can become pregnant the first time she has sexual intercourse............. 1		2	8
B. All people should get married 1		2	8
C. A woman should be a virgin when she marries... 1		2	8
D. The main job for a woman is to take care of the home and cook for her family . 1		2	8
E. A married woman needs her husband's permission to work outside the home ... 1		2	8
F. If a woman works, she should give her money to her husband.............................. I		2	8
G. If a woman works, her husband should help her with the household chores I		2	8
H. The men in the family should have the final say in all family matters 1		2	8
I. Child care is a woman job 1		2	8

707. Who do you think should decide how many children a couple should have **(READ 1-5)?**

1. The woman,
2. The man,
3. Both
4. Mother in law, or
5. God?
8 DON'T KNOW

708. How would you rank each of the following birth control methods **(SHOW CARD C)** with regard to their risk of developing health problems; please tell me if the risk is low, medium, or high:

	Low Risk	Medium Risk	High Risk	DK
1. Pill 1		2	3	8
2. IUD 1		2	3	8
3. Condom.. 1		2	3	8
4. Tubal Ligation 1		2	3	8
7. Abortion on Request.. 1		2	3	8

BOX 7-1

IF Q400_A=2 ON PAGE 23 (NEVER HEARD OF PILLS), GO TO BOX 7-II BELOW

710. Please tell me if you agree or disagree with the following statements about birth control pills **(READ A-J):**

	AGREE	DISAGREE	DK
A. Pills are easy to use 1		2	8
B. Pills are easy to get... 1		2	8
C. Pills are too expensive.. 1		2	8
D. It is stressful to remember to take the pill every day............ 1		2	8
E. Pills protect against some gynecologic cancers.................... 1		2	8
F. Pills may make you gain weight.. 1		2	8
G. Pills make women's periods more regular 1		2	8
H. Pills decrease blood loss during menstruation 1		2	8
I. Pills decrease menstrual cramps and pain 1		2	8
J. Pills are bad for blood circulation 1		2	8

BOX 7-II

IF Q400_B=2 ON PAGE 23 (NEVER HEARD ABOUT IUD), GO TO Q712

711.   Please tell me if you agree or disagree with the following statements about IUDs **(READ A-G):**

	AGREE	DISAGREE	DK
A. IUD is easy to use	1	2	8
B. IUD increases the risk of pelvic inflammatory disease	1	2	8
C. IUD is a relatively inexpensive contraceptive method..	1	2	8
D. IUD may cause spotting between periods	1	2	8
E. IUD may increase the blood loss during menses..	1	2	8
F. IUD increases menstrual pains..	1	2	8
G. IUD decreases the risk of ectopic pregnancy	1	2	8

712.   Do you want to have more information about contraceptive methods?

1. YES
2. NO-----------------> **GO TO Q714**
8. DON'T KNOW—> **GOTO Q714**

713.   Who do you think would be the best source of information about contraceptive methods?

1. MOTHER
2. OTHER RELATIVE
3. BOYFRIEND
4. HUSBAND, PARTNER
5. SOMEBODY WHO USES CONTRACEPTION
6. CO-WORKER
7. FRIEND, COLLEAGUE, PEER
8. GYNECOLOGIST
9. GENERAL PRACTITIONER
10. NURSE, MIDWIFE
11. TEACHER
12. PHARMACIST
13. BOOKS
14 NEWSPAPERS, MAGAZINES, BROCHURES
15. RADIO----------------------->**GO TO Q715**
16. TV----------------------------->**GO TO Q715**
20. OTHER (SPECIFY): _____
88. DON'T REMEMBER

714.   Do you think that information about contraception should be broadcast on radio or television?

1. YES
2. NO
8. DO NOT KNOW

715.   Some people use condoms to keep from getting sexual transmitted diseases. How effective do you think a properly used condom is for this purpose? **(READ 1-4)**

1. Very Effective
2. Somewhat effective
3. Not very effective
4. Not at all effective
8. DON'T KNOW

BOX 7-IV

IF RESPONDENT IS 15-24 YEARS OF AGE CONTINUE; IF SHE IS 25-44 YEARS GO TO SECTION VIII

718.   Have you ever talked to a partner about him using a condom?

1. YES
2. NO
3. NEVER HAD A SEXUAL PARTNER—> **GO TO Q721**
8. DON'T REMEMBER
9. REFUSE

719.   Have you ever asked a partner to use a condom?

1. YES
2. NO --> **GO TO Q721**
8. DON'T REMEMBER ------> **GO TO Q721**
9. REFUSE------ ->**GO TO Q721**

720.   Has any of the following **ever** happened because you asked a partner to wear a condom ....**(READ A-F)**
(ANY OF THESE INCIDENTS COULD HAVE HAPPENED MORE THAN ONCE, WITH THE SAME PARTNER OR DIFFERENT PARTNERS)

	YES	NO	DK	REF
A. Did a partner refuse to wear a condom? .... '...................1		2	8	9
B. Did a partner refuse to have sexual intercourse with you? 1		2	8	9
C. Did a partner threaten to break up with you?......................................1		2	8	9
D. Did a partner yell at you or threaten to hurt you? 1		2	8	9
E. Did a partner make you have sex any way without a condom? 1		2	8	9
F. Did a partner physically hurt you?..1		2	8	9

721.   If your partner/husband would want to use a condom when having sex with you, would you feel:
(READ A-G)

	AGREE	DISAGREE	DK	REF
A. Insulted? 1		2	8	9
B. Angry?...1		2	8	9
C. Safe from getting pregnant? 1		2	8	9
D. Safe from getting HIV? 1		2	8	9
E. Like you had done something wrong?.....................................1		2	8	9
F. Safe from getting STD?...1		2	8	9
G. Suspicious that he may sleep around? 1		2	8	9

722.   Please indicate whether you agree or disagree with the following statements about condoms **(READ A-H):**

	AGREE	DISAGREE	DK	REF
A. Using condoms with a new partner is a smart idea............................ 1		2	8	9
B. Using condoms is not necessary if you know your partner 1		2	8	9
C. Women should ask their partners to use condoms 1		2	8	9
D. It is easy to discuss using a condom with a prospective partner........ 1		2	8	9
E. Condoms diminish sexual enjoyment.. 1		2	8	9
F. Same condoms can be used more than once....................................... 1		2	8	9
G. People who use condoms sleep around a lot 1		2	8	9
H. It is embarrassing to ask for condoms in FP clinics or pharmacies.. 1		2	8	9

VIII. SOCIOECONOMIC CHARACTERISTICS

800. Please tell me whether this household or any member of it has the following items: **(READ A-I):**

		YES	NO
A.	Flush Toilet	1	2
B.	Heating System	1	2
C.	Refrigerator	1	2
D.	TV	1	2
E.	Working Automobile	1	2
F.	VCR	1	2
G.	Household phone	1	2
H.	Cellular phone	1	2
I.	Vacation home (villa)	1	2

801. Does your family have access to a garden where you grow your own vegetables?

1. YES
2. NO

802. During the past week, how many times did you eat meat?   ___ ___ TIMES

803. During the past week, did you skip any meals because of insufficient food?

1. YES

2. NO

804. Which of the following describes your living arrangements.   Do you live: **(READ 1-11)**

1. In your privately owned flat or house
2. In rented space (room, flat or house)
3. With your immediate family (NO RENT)
4. With or other relatives (NO RENT)
5. With friends (NO RENT)
6. Public building (SCHOOL, FACTORY, FARM, ETC)

7. Shelter built by NGO (Finnish Camps?)
8. Railroad wagons
9. Mudhouse
10. Dugouts
11. Tents
20. OTHER _____

805. How many rooms are occupied by you and your family (not including bathrooms and kitchen):   ___ ___ ROOMS

806. How many hours per day do you have electricity?   ___ ___ HOURS

807. What is your ethnic background?

1. .AZERI
2. RUSSIAN
3. GEORGIAN
4. ARMENIAN
5. LESG1
6. KURDISH
7. TALISH

8. AVAR
9. TAT
10. PERSIAN/FARS
11. MESKHETIAN TURK
20. MIXED ETHNICITY (SPECIFY)_____
77. OTHER (SPECIFY): _____
99. REFUSED/NOT STATED

808. What language does your family speak at home most of the time?

1. AZERI
2. RUSSIAN
3. GEORGIAN
4. ARMENIAN
5. LESGI

6. KURDISH
7. TALISH
8. TURKISH
9. TAT
0. OTHER (SPECIFY): _____

809. What is your religion?

1 MUSLIM
2 ORTHODOX
3. CATHOLIC
4. KHRISHNAIT
5. BAHAI

6. PROTESTANT (BAPTIST, LUTHERAN, PENTECOSTAL, ETC)
7. ADVENTIST
20. OTHER (SPECIFY): _____
77. NO RELIGION------->**GO TO Q900**
99. UNDECLARED—~>**GO TO Q900**

810. About how often do you usually attend religious services? **(READ 1-5)**

1. At least once a week
2. At least once a month, but less than once a week
3. Less than once a month
4. Only on holidays, or
5. Never

IX-A. AIDS/STDs

The next set of questions are about sexually transmitted infections Including HIV/ AIDS. For each of the following conditions please tell me if:

CONDITION	900. Have you ever heard of it?	901. Have you ever been tested for...?	902. Have you ever been told that you have...?	903. Did you take any treatment for...?	904. Who treated you for ...? (SEE CODES BELOW)
A. Syphilis	1. YES 2. NO—>**B**	1. YES 2. NO—>**B** 8. DK—>**B**	1. YES 2 NO—>**B** 8. DK/DR-->**B**	1. YES 2. NO—>**B** 8. DK/DR->**B**	———
B. Gonorrhea	1. YES 2. NO—>**C**	1. YES 2. NO—>**C** 8. DK—>**C**	1. YES 2. NO—>**C** 8. DK/DR-->**C**	1. YES 2. NO—>**C** 8. DK/DR~>**C**	———
C. Chlamydia	1. YES 2. NO—>**D**	1. YES 2. NO—>**D** 8. DK—>**D**	1. YES 2. NO—>**D** 8. DK/DR-->**D**	1. YES 2. NO—>**D** 8. DK/DR->**D**	———
D. Yeast Infection	1. YES 2. NO—>**E**	1. YES 2. NO—>**E** 8. DK—>**E**	1. YES 2. NO—>**E** 8. DK/DR->**E**	1. YES 2. NO—>**E** 8. DK/DR->**E**	———
E. Genital Herpes	1. YES 2. NO—>**F**	1. YES 2. NO—>**F** 8. DK—>**F**	1. YES 2. NO—>**F** 8. DK/DR->**F**	1. YES 2. NO—>**F** 8. DK/DR->**F**	———
F. Genital Warts	1. YES 2. NO—>**G**	1. YES 2. NO—>**G** 8. DK—>**G**	1. YES 2. NO—>**G** 8. DK/DR-->**G**	1. YES 2. NO—>**G** 8. DK/DR->**G**	———
G. Trichomoniasis	1. YES 2. NO—>**H**	1. YES 2. NO—>**H** 8. DK~->**H**	1. YES 2. NO—>**H** 8. DK/DR-->**H**	1. YES 2. NO—>**H** 8. DK/DR->**H**	———
H. Bacterial Vaginosis	1. YES 2. NO—>**I**	1. YES 2. NO—>**I** 8. DK—>**I**	1. YES 2. NO—>**I** 8. DK/DR-->**I**	1. YES 2. NO—>**I** 8. DK/DR->**I**	———
I. HIV/AIDS	1. YES 2. NO->**Q905**	1. YES->**Q905** 2 NO->**Q905** 8. DK->**Q905**			

CODES FOR Q904:

1. OB/GYN	6. PHARMACIST
2. TERAPEUT/GP	7. PARTNER
3. VENEROLOGIST	8. FRIEND/RELATIVE
4. FP DOCTOR	9. SELF-TREATMENT
5. NURSE/MIDWIFE/FELDCHER	20. OTHER: _____
	99. REFUSE TO ANSWER

905.   If a woman has a sexually transmitted disease, what symptoms might she have?
        (RECORD ALL MENTIONED, DO NOT READ LIST)

	YES	NO
A. ABDOMINAL PAIN	1	2
B. VAGINAL DISCHARGE	1	2
C. FOUL SMELLING DISCHARGE	1	2
D. BURNING PAIN ON URINATION	1	2
E. REDNESS/INFLAMMATION IN GENITAL AREA	1	2
F. SWELLING IN GENITAL AREA	1	2
G. GENITAL SORES/ULCERS OR WARTS	1	2
H. GENITAL ITCHING	1	2
I. WEIGHT LOSS	1	2
J. HARD TO GET PREGNANT/HAVE A CHILD	1	2

906. Do you know a place where you could get an HIV/AIDS test?

    1. YES
    2. NO

907. In general, what has been your most important source of information about STDs including AIDS?
(Where or from whom have you learned the most about STDs?)

1. MOTHER	11. FAMILY DOCTOR (TERAPEUT)
2. FATHER	12. NURSE, MIDWIFE, FELDCHER
3. OTHER RELATIVE	13. TEACHER
4. BOYFRIEND	14. PHARMACIST
5. HUSBAND, PARTNER	15. SPECIALITY BOOKS
6. SOMEBODY WHO HAD STDs	16. NEWSPAPERS, MAGAZINES, BROCHURES, FLYERS
7. FRIENDS COLLEAGUES, PEERS	17. RADIO
8. FAMILY PLANNING DOCTOR	18. TV
9. DOCTOR, VENEROLOGIST	20. OTHER (SPECIFY): _____
10. DOCTOR, GYNECOLOGIST	77. NEVER HEARD OF ANY STDs **(Q900_A--Q900_I=2)**
	99. DR/REF.

908. In the past 6 months, have you seen or heard any <u>public announcements or ads</u> on television or radio about:
(READ A-D, PROBE FOR BOTH)

	YES, RADIO	**YES; TV**	**YES, BOTH**	**NO**	**DO NOT REMEMBER**
A. AIDS 1		2	3	4	8
B. OTHER STDs 1		2	3	4	8
C. CONDOMS.. 1		2	3	4	8
D. MODERN CONTRACEPTIVE METHODS 1		2	3	4	8

IF Q900_I=2 (NEVER HEARD OF HIV/AIDS) GO TO Q914; ELSE CONTINUE

---

909. Do you think that a person can be infected with the HIV virus but have no symptoms of disease?

    1. YES
    2. NO
    8. DK

910. Please tell me whether you think that the AIDS virus can be transmitted in the following ways?
(READ A-M)

	YES	**NO**	**DK**
A. Through blood transfusion 1		2	8
B. Using public toilets 1		2	8
C. Through Kissing 1		2	8
D. Through unprotected sexual intercourse between a man and a woman................................ 1		2	8
E. Through unprotected sexual intercourse between men 1		2	8
F. By Shaking hands 1		2	8
G. Using non-sterile syringes or needles.. 1		2	8
H. Through mosquito bites.. 1		2	8
I. Sharing plates, forks, or glasses with someone who has HIV/AIDS 1		2	8
J. From a woman who has the AIDS virus to her baby during pregnancy/delivery…………..1		2	8
K. From a mother to her child through breast milk 1		2	8
L. Getting a manicure, pedicure or haircut.. 1		2	8
M. Having dental or surgical treatment.. 1		2	8

911.   What can a person do to reduce the risk of getting AIDS?

	SPONTANEOUS YES	PROBED YES	NO	DK
A. USE CONDOMS 1		3	4	8
B. ABSTAIN FROM SEX 1		3	4	8
C. HAVE ONLY ONE PARTNER/STAY FAITHFUL TO ONE PARTNER 1		3	4	8
D. LIMIT NUMBER OF SEXUAL PARTNERS...................................... 1		3	4	8
E. AVOID SEX WITH PROSTITUTES... 1		3	4	8
F. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS 1		3	4	8
G. AVOID SEX WITH BISEXUALS.. I		3	4	8
H. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY ... 1		3	4	8
I AVOID INJECTIONS 1		3	4	8
J. AVOID TRANSFUSIONS... 1		3	4	8
K. ASK PARTNER TO HAVE BLOOD TESTED FOR AIDS 1		3	4	8
L. STERILIZE NEEDLES 1		3	4	8
M. AVOID SHARING RAZORS/BLADES OR NEEDLES 1		3	4	8
N. OTHER _____ 1		3	4	8

912.   How much of a risk do you think you personally have of getting HIV/AIDS? Would you say you are at **(READ 1-4):**

  1. Great risk,
  2. Moderate Risk,
  3. Little risk, or
  4. No risk at all----------->**GO TO Q913A**
  8. DON'T KNOW>**GO TO Q913B**

913.   Why do you think you have any risk of getting AIDS?

  1. HAVE RECEIVED MANY BLOOD TRANSFUSIONS/BLOOD PRODUCTS
  2. SHE MAY GET INFECTED WHILE RECEIVING MEDICAL OR DENTAL TREATMENT
  3. MANY SEXUAL PARTNERS/ TRADE SEX FOR MONEY
  4. UNPROTECTED INTERCOURSE WITH CASUAL PARTNER(S)
  5. USED IV DRUGS
  6. DOES NOT TRUST HER PARTNER, HE MAY HAVE INTERCOURSE WITH OTHER WOMEN
  7. SHE MAY GET INFECTED GETTING A MANICURE, PEDICURE, OR HAIRCUT
  8. OTHER _____
  9. DK/REF

GO TO Q913B

913A   Why do you think you have no risk of getting AIDS?

  1. MONOGAMOUS RELATIONSHIP
  2. NOT SEXUALLY ACTIVE
  3. USES CONDOMS
  4. TRUSTS HER PARTNER
  7. OTHER_____
  9. DK/REF

913B   How much of a risk do you think you personally have of getting other STD? Would you say you are at **(READ 1-4):**

  1. Great risk,
  2. Moderate Risk,
  3. Little risk, or
  4. No risk at all
  8. DON'T KNOW

IX-B VIOLENCE

914. Thinking back to your childhood and adolescence, did you ever see or hear your parents or step-parents physically abuse each other?

    1. YES
    2. NO
    3. DID NOT LIVE WITH 2 PARENTS--------->**GO TO Q916**
    8. DR/REF

915. As a child, have you ever being beaten or physically mistreated in any way by anyone in your family?

    1. YES
    2. NO
    8. DR/REF

916. **THE INTERVIEWER SHOULD GO BACK TO PAGE 4 AND RECORD HOW MANY TIMES THE RESPONDENT LIVED WITH A MEN AS HUSBAND AND WIFE (SEE Q120):**

    __ TIMES

> **IF Q916=0 GO TO Q930; IF Q916>0 CONTINUE**

The next set of questions is about violence and physical abuse that may have happened between you and a partner or ex-partner. When we say a partner we mean a husband, ex-husband, as well as any other man you have been living with as husband and wife.

918. Please tell me if any of your partners or ex-partners ever (**READ A-H**):		**919.** When was the last time when (**A-H**) happened to you?	**920.** During the last year, how many times did (**A-H**) happen to you?
A. Insulted you, or swore at you?	1. YES—>**Q919** 2. NO—> **Q918-B** 8. DK—> **Q918-B** 9. REF—> **Q918-B**	1 WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO...........> **Q918_B** 3. 4-5 YEARS AGO— ......> **Q918_B** 4. 5 YEARS AGO OR MORE-->**Q918_B**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
B. Threatened to hurt you or someone you care about?	1. YES—>**Q919** 2. NO—> **Q918-C** 8. DK—> **Q918-C** 9. REF—> **Q918-C**	1. WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO...........> **Q918_C** 3. 4-5 YEARS AGO ....> **Q918_C** 4. 5 YEARS AGO OR MORE->**Q918_C**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
C. Pushed you, shook you, shove you, or threw something at you?	1. YES—>**Q919** 2. NO—> **Q918-D** 8. DK—> **Q918-D** 9. REF—> **Q918-D**	1. WITHIN THE LAST YEAR-->**Q920** 2. 1-3 YEARS AGO ------> **Q918_D** 3. 4-5 YEARS AGO ------> **Q918_D** 4. 5 YEARS AGO OR MORE->**Q918_D**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
D. Slapped you or twisted your arm?	1. YES—>**Q919** 2. NO—> **Q918-E** 8. DK—> **Q918-E** 9. REF—> **Q918-E**	1. WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO ------ > **Q918JE** 3. 4-5 YEARS AGO ------ > **Q918_E** 4. 5 YEARS AGO OR MORE~>**Q918_E**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
E. Hit you with his fist or with something else?	1. YES—>**Q919** 2. NO—> **Q918-F** 8. DK—> **Q918-F** 9. REF—> **Q918-F**	1. WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO...........> **Q918_F** 3. 4-5 YEARS AGO...........> **Q918_F** 4. 5 YEARS AGO OR MORE-->**Q918JF**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
F. Threatened you with a knife or other weapon?	1. YES—>**Q919** 2. NO—> **Q918-G** 8. DK—> **Q918-G** 9. REF—> **Q918-G**	1. WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO-------- > **Q918_G** 3. 4-5 YEARS AGO ------> **Q918_G** 4. 5 YEARS AGO OR MORE->**Q918_G**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
G. Kicked you, choke you or beat you up?	1. YES—>**Q919** 2. NO—> **Q918-H** 8. DK—> **Q918-H** 9. REF—> **Q918-H**	1. WITHIN THE LAST YEAR->**Q920** 2. 1-3 YEARS AGO...........> **Q918_H** 3. 4-5 YEARS AGO ------> **Q918_H** 4. 5 YEARS AGO OR MORE->**Q918_H**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES
H. Physically forced you to have sexual relations even though you did not want to?	1. YES—>**Q919** 2. NO—> **BOX 9-I** 8. DK—>**BOX 9-I** 9. REF—>**BOX 9-I**	1. WITHIN THE LAST YEAR«>**Q920** 2. 1-3 YEARS AGO--------->**BOX9-I** 3. 4-5 YEARS AGO...........>**BOX9-I** 4. 5 YEARS AGO OR MORE->**BOX 9-I**	___ ___ TIMES 66. ALMOST DAILY 77. WEEKLY 88. DON'T REMEMB. 99. REFUSES

  BOX 9-1

> **IF ALL Q918_A---Q918_H >1 (NEVER EXPERIENCED ANY TYPE OR ABUSE) GO TO Q929; ELSE CONTINUE**

921.	You told me before that you lived with a man as husband and wife _____ times **(RECORD THE NUMBER OF TIMES FROM Q916).** During which of these periods has a partner physically abused you as you have just mentioned? **MARK THE INTERVAL(S) NUMBER FROM THE UNION TABLE AT PG.4 (ALLOW FOR MULTIPLE RESPONSES):**

I. ___
II. ___
III. ___
IV. ___

BOX 9-II

> ► **IF ANY OF THE INCIDENTS OF PHYSICAL VIOLENCE TOOK PLACE DURING THE LAST YEAR (ANY Q919J>Q919_H=1), CONTINUE;**
> ► **IF ANY OF THE INCIDENTS OF PHYSICAL VIOLENCE TOOK PLACE MORE THAN ONE YEAR AGO (ANY Q919_C--Q919_H>1) GO TO Q925;**
> ► **IF R. SUFFERED ONLY VERBAL VIOLENCE (Q918_C—Q108 H>1 THFN GO TO Q929**

922.	In the past 12 months, did you have any swelling, bruises, cuts, or other physical injuries as a result of this/these incident(s)?

1. YES
2. NO ------------------------- >**GO TO Q925**
8. DON'T REMEMBER------>**GO TO Q925**

923.	Did you see a doctor, or other medical care provider for medical treatment of these injuries?

1. YES
2. NO-------------------------->**GO TO Q925**
8. DON'T REMEMBER ----->**GO TO Q925**

924.	Did this(these) injury(ies) require hospitalization?

1. YES
2. NO
8. DON'T REMEMBER

925.	Have you ever talked to anyone about any of these incidents?

1. YES
2. NO---------->**GO TO Q927**

926.	Did you talk about this(these) incidents with **(READ A-G)?**

	YES	NO
A. Your Mother	1	2
B. Other Relative	1	2
C. A Friend	1	2
D. A Doctor/Health Care Provider	1	2
E. Police	1	2
F. Legal Adviser	1	2
G. Other (Specify) _____	1	2

> **IF Q926_ D, Q926_ E, AND Q926_F=1 GO TO Q928; ELSE CONTINUE**

927.	What is the main reason you have never sought any legal and medical help?

1. DID NOT KNOW WHERE TO SEEK HELP
2. NO USE/WOULD NOT DO ANY GOOD
3. EMBARRASSED
4. AFRAID OF MORE BEATINGS/BEING PUNISHED
5. AFRAID OF DIVORCE/END OF RELATIONSHIP
6. AFRAID OF LOOSING THE CHILDREN
7. THOUGHT WOULD NOT BE TAKEN SERIOUSLY/NOT BELIEVED/LAUGHED AT
8. VIOLENCE IS NORMAL/NO NEED TO COMPLAIN
9. THOUGHT SHE WOULD BE BLAMED
10. BRING BAD NAME TO FAMILY
20. OTHER _____
88. DK/REF

Q57

928. Could you tell me a little more about what usually happens when your partner is/was violent. Are there any particular situations that make him violent? **(CIRCLE ALL THAT APPLY PROBING "ANY OTHER...")**

NOTE: IF SHE REPORTED MORE THAN ONE PARTNER THIS QUESTION REFERS TO THE LAST PARTNER WHO USED PHYSICAL VIOLENCE

	MENTIONED	NOT MENTIONED
A. WHEN DRUNK	1	2
B. WHEN SHE DOES NOT LOOK AFTER CHILDREN	1	2
C. WHEN THE FAMILY HAS MONEY TROUBLES	1	2
D. WHEN HE HAS DIFFICULTIES AT WORK	1	2
E. WHEN HE IS UNEMPLOYED	1	2
F. FAMILY PROBLEMS/MOTHER-IN-LAW PROBLEMS	1	2
G. JEALOUSY	1	2
H. WHEN SHE IS PREGNANT	1	2
I. WHEN HE CANNOT GET ALCOHOL/DRUGS	1	2
J. WHEN THEY DO NOT HAVE FOOD AT HOME	1	2
K. OTHER _____	1	2

929. Sometimes a husband is annoyed or angered by things which his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations **(READ A—G):**

	YES	NO	DK
A. If she goes out without telling him?	1	2	8
B. If she neglects the children?	1	2	8
C. If she argues with him?	1	2	8
D. If she refuses to have sex with him?	1	2	8
E. If he not happy with her household work?	1	2	8
F. If she asks him whether he has other girlfriends?	1	2	8
G. If he finds out that she has been unfaithful?	1	2	8

930. At any time in your life, have you ever been forced by a man to have sexual intercourse against your will? (For this question, sexual intercourse includes vaginal, anal or oral penetration)

1. YES
2. NO -----------------------> **END OF INTERVIEW, GO TO MODULE X**
8 DON'T REMEMBER—> **END OF INTERVIEW, GO TO MODULE X**

931. <u>How old were you</u> the first time you were forced by a man to have sexual intercourse against your will?

___ ___ AGE   88. DON'T REMEMBER

932. At that time, what was your relationship with the person(s) who forced you to have sexual intercourse?

1. STRANGER
2. ACQUAINTANCE
3. FRIEND
4. DATE
5. BOYFRIEND
6. HUSBAND OR PARTNER
7. EX-HUSBAND OR EX-PARTNER
8. FATHER OR STEP-FATHER
9. OTHER RELATIVE (SPECIFY _____)
77. OTHER (SPECIFY _____)
88. DON'T REMEMBER
99. REF

X. CHILD AND MATERNAL NUTRITION INDICATORS

1000. **INTERVIEWER: SEE PREGNANCY HISTORY PG 11, Q312 ANY CHILD BORN ALIVE SINCE 1996?**

YES------------1

NO------------2 —--> GO TO Q1017

INTERVIEWER: SEE Q312 IN THE PREGNANCY HISTORY AND COPY THE LINE NUMBER OF ALL LIVE-BIRTHS (CODE 1,2,3) THAT OCCUR SINCE JANUARY 1996

	MOST RECENT LIVE-BIRTH	SECOND TO THE LAST LIVE-BIRTH	THIRD	FOURTH
LINE NUMBER (See PREGNANCY TABLE) NAME:	— — — _____	— — — _____	— — — _____	— — — _____
1001. IS THE CHILD LIVING? **(See Q316)**	1. LIVING 2. DEAD-----------> NEXT COLUMN	1. LIVING 2. DEAD-----------> NEXT COLUMN	1. LIVING 2. DEAD-----------> NEXT COLUMN	1. LIVING 2. DEAD-----------> NEXT COLUMN
1002. DOES (NAME) LIVE WITH YOU?	1. YES 2. NO ---------------> NEXT COLUMN	1. YES 2. NO ---------------> NEXT COLUMN	1. YES 2. NO ---------------> NEXT COLUMN	1. YES 2. NO ---------------> NEXT COLUMN
1003. BIRTHDATE **(SEE 313)**	MONTH └─┴─┘ YEAR └─┴─┴─┘	MONTH └─┴─┘ YEAR └─┴─┴─┘	MONTH └─┴─┘ YEAR └─┴─┴─┘	MONTH └─┴─┘ YEAR └─┴─┴─┘
1004. CALCULATE AGE IN MONTHS	1. <3 MONTHS ->NEXT COLUMN 2. 3 - 59 MONTH ___>Q1010 3. >59 MONTHS ---> NEXT COLUMN	1. <3 MONTHS ->NEXT COLUMN 2. 3 - 59 MONTH ___>Q1010 3. >59 MONTHS ---> NEXT COLUMN	1. <3 MONTHS ->NEXT COLUMN 2. 3 - 59 MONTH ___>Q1010 3. >59 MONTHS ---> NEXT COLUMN	1. <3 MONTHS ->NEXT COLUMN 2. 3 - 59 MONTH ___>Q1010 3. >59 MONTHS ---> NEXT COLUMN
1005. ANTHROPOMETRY RESULT	1.CHILD MEASURED 2.CHILD SICK 3.CHILD ABSENT 4.CHILD REFUSED 5.MOTHER REFUSED 8.OTHER _____	1.CHILD MEASURED 2.CHILD SICK 3.CHILD ABSENT 4.CHILD REFUSED 5.MOTHER REFUSED 8.OTHER _____	1.CHILD MEASURED 2.CHILD SICK 3.CHILD ABSENT 4.CHILD REFUSED 5.MOTHER REFUSED 8.OTHER _____	1.CHILD MEASURED 2.CHILD SICK 3.CHILD ABSENT 4.CHILD REFUSED 5.MOTHER REFUSED 8.OTHER _____
1006. HEIGHT (IN CMS.)	└─┴─┴─┘ . └─┘	└─┴─┴─┘ . └─┘	└─┴─┴─┘ . └─┘	└─┴─┴─┘ . └─┘
1007. TYPE OF MEASUREMENT TAKEN FOR THE CHILD:	1.LAYING DOWN 2.TANDING UP	1.LAYING DOWN 2.TANDING UP	1.LAYING DOWN 2.TANDING UP	1.LAYING DOWN 2.TANDING UP
1008. WEIGHT (IN KGS.)	└─┴─┘ . └─┘	└─┴─┘ . └─┘	└─┴─┘ . └─┘	└─┴─┘ . └─┘
1009. DATE OF WEIGHT AND HEIGHT MEASUREMENT	DAY └─┴─┘ MONTH └─┴─┘	DAY └─┴─┘ MONTH └─┴─┘	DAY └─┴─┘ MONTH └─┴─┘	DAY └─┴─┘ MONTH └─┴─┘
1010. SEE Q1003 FOR AGE IN MONTHS	1. < 12 MONTHS 2. ≥ 12 MONTHS **GO TO NEXT COLUMN**	1. < 12 MONTHS 2. ≥ 12 MONTHS **GO TO NEXT COLUMN**	1. < 12 MONTHS 2. ≥ 12 MONTHS **GO TO NEXT COLUMN**	1. < 12 MONTHS 2. ≥ 12 MONTHS **GO TO Q1016**
INTERVIEWI ERS: AFTER COMPLETING THE TABLE ON PAGE 56, GO TO QUESTION 1016				

1011. RESULT OF BLOOD SAMPLING FOR CHILD'S HEMOGLOBIN TEST	1. SAMPLE COLLECTED 2. CHILD SICK 3. CHILD ABSENT 4. CHILD REFUSED 5. MOTHER REFUSED 8. OTHER_____	1. SAMPLE COLLECTED 2. CHILD SICK 3. CHILD ABSENT 4. CHILD REFUSED 5. MOTHER REFUSED 8. OTHER_____	1. SAMPLE COLLECTED 2. CHILD SICK 3. CHILD ABSENT 4. CHILD REFUSED 5. MOTHER REFUSED 8. OTHER_____	1. SAMPLE COLLECTED 2. CHILD SICK 3. CHILD ABSENT 4. CHILD REFUSED 5. MOTHER REFUSED 8. OTHER_____
1012. CHILD'S HEMOGLOBIN LEVEL	└──┴──┘ . └──┘	└──┴──┘ . └──┘	└──┴──┘ . └──┘	└──┴──┘ . └──┘

No.	QUESTIONS AND FILTERS	CATEGORIES AND CODES
1013.	Result of blood sampling for the interviewed woman's hemoglobin test	1. SAMPLE TAKEN 2. INTERVIEWEE SICK 3. INTERVIEWEE ABSENT 4. INTERVIEWEE REFUSED 8. OTHER (Specify) _____
1014.	**INTERVIEWER: RECORD THE HEMOGLOBIN VALUE OF THE WOMAN INTERVIEWED**	WOMAN´S HEMOGLOBIN └──┴──┘ . └──┘
1015.	Record the weight and height of the woman interviewed	WEIGHT (in Kgs) └──┴──┴──┘ . └──┘ HEIGHT (in Cms) └──┴──┴──┘ . └──┘
1016.	**INTERVIEWER: IF ANY ANSWER TO 1004 IS 2, EXPLAIN TO THE WOMAN THAT SOMEONE WILL COME LATER TO WEIGH AND MEASURE BOTH HER AND THE CHILD(REN) AND <u>GO TO Q1017</u>.**	
	NAME OF THE PERSON WHO TOOK THE MEASUREMENTS _____	**CODE:** └──┴──┘

1017. THANK THE WOMAN FOR GIVING HER TIME AND RECORD THE TIME THE INTERVIEW ENDED :	
TIME INTERVIEW ENDED _____ _____ : _____ _____	
THANKS!	