REPRODUCTIVE HEALTH SURVEY GEORGIA, 2010

Summary Report

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Preface

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

The efforts to improve the health of women, infants and children are at the core of the health care reforms in Georgia. For these efforts to be successful, public health professionals have to identify the needs of women and children, to design and implement appropriate interventions, and to monitor and evaluate those interventions. The Ministry of Labor, Health and Social Affairs (MoLHSA) is directly responsible for implementing several reproductive health reforms, including: compliancy with international standards and treaties in the health sector; provision of basic packages of medical care for mothers and child death reviews to help design the most appropriate evidenced-based preventive measures. The surveys provide the MoLHSA with a much needed ability to track progress in program outcomes, formulate targeted interventions, monitor the national development programs, and report on progress toward the Millennium Development Goals (MDGs).

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

Andria Urushadze Georgian Minister of Labor, Health and Social Affairs

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he 2010 Georgian Reproductive Health Survey (GERHS10) was conducted by the Georgian Center for Disease Control (NCDC) in collaboration with the Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA). The Division of Reproductive Health of the United States Centers for Disease Control and Prevention (CDC/DRH) provided technical assistance on the survey design, questionnaire development, training, data processing and report writing. Paata Imnadze (NCDC) and Florina Serbanescu (CDC/DRH) served as the principal investigators. The NCDC and CDC/DRH wish to express their appreciation to those involved in the implementation of the 2010 Georgian Reproductive Health Survey and the preparation of this report.

Particular thanks go to the Ministry of Health for its chairmanship of the steering committee and its interface with the National Reproductive Health Council. Special thanks are extended to Andria Urushadze, Minister and Michael Dolidze, Deputy Minister. Our special thanks go to the NCDC technical staff for their input of field staff and data quality teams and for the joint efforts that ensured the effective implementation of the survey. We would like to acknowledge the following NCDC individuals: Natalia Avaliani, Director General, George Kandelaki, Deputy Director, Maia Butsashvili, Deputy Director and Lela Sturua, Head of Noncommunicable Diseases Division. The operational activities were led by Paata Imnadze, Head of Science Board and Survey Director, Neli Chakvetadze, Survey Manager, Marina Shakhnazarova, Chief Specialist and Director of Field Activities, Khatuna Zakhashvili, Head of Communicable Diseases Division and Field Work Coordinator, and Konstantin Kazanjian, Data Entry supervisor. Their dedication and collaboration with the CDC team in all three surveys was exceptional.

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

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

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Executive Summary

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

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

A major purpose of the RHS project in Georgia was to produce national and sub-national estimates of factors related to pregnancy and fertility, such as sexual activity and contraceptive use; use of abortion and other medical services; maternal and infant health, and women's health. The first RHS was conducted in Georgia in 1999; a new cycle was implemented in 2005, followed by the most recent cycle, implemented in

2010. As was the case with the first two rounds, the Georgian Ministry of Labor, Health and Social Affairs (MoLHSA) conducted the survey in collaboration with the Georgian National Center for Disease Control (NCDC). CDC provided technical assistance with the survey design, sampling, questionnaire development, training, data processing and analysis to all rounds of the RHS in Georgia through funding from the USAID. Local costs were primarily covered by UNFPA and UNICEF.

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

Several findings of the GERHS10 are highlighted below:

GERHS10 Overview

- Set within the context of overall social and economic development in Georgia, the aim of the GERHS10 was to obtain national and regional estimates of basic demographic and reproductive health indicators and compare them with previous RHS results.
- In response to the need of decentralized coordination of health activities, the survey employed a sample design that produce estimates for 11 regions of the country and enables key stakeholders to assess reproductive health indicators at the subnational level.
- The survey employed a stratified multistage sampling design, similar with the design used in the 1999 and 2005 cycles.

Characteristics of Households and Respondents

- While the majority of households had tap water in their residence or yard (76%) there is a great disparity between urban and rural households (96% vs. 55%). Overall, 98% of urban and 88% of rural households in Georgia use improved sources of drinking water (tap water and water from protected wells).
- Overall, 96% of urban households and 71% of rural households using improved sanitation facilities.
- The distribution of the Georgian population across the wealth quintiles varied greatly by residence; almost three in four (74%) of urban households were classified in the two highest

wealth quintiles while only 3% of rural households were in these wealth groups.

- The majority of respondents were of Georgian ethnicity (87%), followed by Azeri (5%) Armenian (5%) and other ethnicities (3%). Respondents belonging to minority ethnic groups were more likely to live in rural areas than in urban areas.
- Eighty two percent of women were Georgian Orthodox and 11% were Muslim.
- Educational attainment is wide-spread in Georgia with 77% of women reporting at least completion of secondary education. Thirty-nine percent of women had gone on to complete university or postgraduate education. Tbilisi residents reported much higher educational attainment than in other regions: 60% of respondents have undergone university training while only 13% did not complete secondary education.
- Most women (79%) reported not working outside of the house, a situation that was even more pronounced in rural areas (87%) where job availability is very low.

Marriage and Fertility

- Nearly 60% of women in the sample were married or in consensual unions, 7% were divorced or separated, and 34% had never been married.
- Using data from all Georgia reproductive health surveys, period fertility rates can be compared across three 3 year periods. The

TFR calculated from GERHS10 of 2.0 children per woman (95%CI=1.9-2.1 births per woman) for the period 2007-2010 is the highest survey-based TFR ever reported for Georgia. The most recent period fertility rate is 25% higher than the TFR of 1.6 births per woman (95%CI=1.4-1.7 births per woman) observed during 2002-2005.

- Traditionally, Georgian women initiate and complete childbearing at an early age, as reflected in very high age-specific fertility rates for young women. The highest fertility levels were among 20- to 24 year old and 25- to 29 year old women, accounting for 36% and 29%, respectively, of the TFR. Fertility among adolescent women (39 births per 1,000 women aged 15–19 years) contributed to only 10% of the TFR. Fertility among women aged 30–34 years was the third-highest ASFR, contributing 15% of the TFR.
- Compared to the previous survey, agespecific fertility rates increased in all but one age group, the group of adolescent women, suggesting a gradual transition to fertility postponement in Georgia.
- Generally, peak fertility occurred at ages 25– 29 among women with the highest educational attainment, whereas peak fertility among women with lower educational levels occurred at ages 20–24.
- Fertility rates of ethnic minorities, particularly among the Azeri minority (2.4 children per woman) were higher than those of the Georgians, the major ethnic group (2.0

children per woman), due to much higher ASFRs among Azeri women aged 15–24.

Pregnancy Intention Status

- Most women who have been pregnant in the past 5 years reported the last pregnancy as planned and only 36% said they had an unplanned pregnancy—11% mistimed and 26% unwanted. This compares with a level of 51% of women reporting their last pregnancy as unplanned in 2005 and 59% in this category in 1999. Mistimed pregnancies represented a larger share of unplanned pregnancies in 2010 than in previous surveys, suggesting that more women than in the past want to postpone rather than end childbearing.
- Almost all but a small percentage of women whose last pregnancy ended in induced abortion reported that their conceptions were unplanned (96%).
- Thirty-five percent of women currently married or in consensual union wanted more children, compared to 25% in 1999 (a 40% increase). This trend was consistent regardless of the number of living children. Particularly notable was the relatively high proportion of women with two or more children (21%) who said in 2010 they want more children, compared to only 12% in 1999.
- The desire to have children was very high among young women (89% among 15-19 year-olds and 73% among 20-24 year-olds),

dropped to 47% among 25- to 29 year olds and declined further among women aged 30 or older.

- Between 1999 and 2010, there are notable changes in the timing of having a (another) child by the current age. Among the youngest women, the proportion who wanted a child within two years had declined by 29% (from 61% to 44%) but much higher proportions of women aged 30 or older wanted to have a (another) child within the next two years.
- Among fecund married women who had had two or more children, the majority (68%) were ready to terminate childbearing. This pattern is similar to the one documented in the 1999 and 2005 surveys, but fewer women with two or more children in 2010 said they do not want to have a (another) child.

Induced Abortion

The survey data allow for calculation of the total abortion rate (TIAR), which describes the number of abortions a woman would have had in her lifetime under the current age specific abortion rates (ASIARs). Previous RHS surveys showed a steep increase in the TIAR after 1990, with a peak of 3.7 abortions per woman in 1997–1999. The abortion rate declined gradually to a level of 3.1 abortions per woman (95%CI= 2.9–3.4 abortions per woman) in 2002–2005. Between 2005 and

2010, the abortion rate dropped significantly to 1.6 abortions per woman (95%CI= 1.5–1.8 abortions per woman), a 48% decline.

- The estimated TIAR for the period 2007–2010 according to official sources was 0.9 abortions per woman (44% lower than the rate documented in the survey but an improvement from over 80% underreporting documented in 1999 and 2005).
- More than one-half of Georgian women obtaining abortions in 2007–2010 were of ages 25–29 years (102 abortions per 1,000 women) and 30–34 years (83 abortions per 1,000 women). The third highest age specific abortion rate, contributing to 25% of the TIAR, occurred among women aged 35–39 years. The ASIARs were significantly higher than ASFRs only among women aged 30 or older, suggesting that most Georgian women continue to achieve their desired family size before age 30 after which, in the event of having unplanned pregnancies they are more likely to end them in induced abortions.
- The survey-based estimate of the abortion-to-live-birth ratio changed from to 2.1 induced abortions for each live birth (2.1:1) in 1999, to 1.5:1 in 2005 to 0.8:1 in GERHS10. Thus, birth experience surpassed abortion experience for the first time since survey-based reports were collected. This was mainly achieved by a combination of increases in fertility and declines of abortion in the age-groups 20-24, 25-29, and 30-34 which contribute the most to both total fertility and total abortion rates.

- Reports of higher abortion rates among rural women, less educated women, and women of Azeri descent suggest that access to services is unequal and that Georgia's family planning program needs to expand its reach to disadvantaged subgroups.
- Main reasons given for choosing abortion included: desire to stop childbearing (51%), socioeconomic circumstances that prevent the family to support another child (20%) and desire to space the next birth (18%).
- Of all abortions reported by survey respondents in the past 5 years, 71% were mini-abortions; this contrasts with 40% and 56% of all abortions, respectively, which were reported as mini-abortions in 1999 and 2005.
- Most induced abortions occurring in 2005 or later were performed in gynecological wards (56%); 42% were performed in ambulatory clinics, such as women's consultation clinics (WCCs); and 2% were performed outside medical facilities.; the average abortion payment did not vary by type of medical facility. At the time of the survey, mean charges for an abortion procedure were about US\$29.00, which represents an increase of 65% compared to the average cost in 2005.
- The receipt of family planning services around the time of having an abortion remains quite limited. One in three (33%) respondents with a history of abortion in 2005-2010 reported receiving contraceptive counseling before or/and after the abortion; only 6.6% of women (20% of women who received counseling) received a contraceptive

method to prevent future unintended pregnancies; and an additional 7.4% of women received a prescription for contraceptive supplies (22% of all women counseled).

• Receipt of contraceptive information in 2010 was more than twice the level documented in the 1999 survey (33% vs. 15%); more importantly, receipt of a contraceptive method or prescription for a method had almost tripled, from 5% to 14%.

Maternal and Child Health Services

- Use of prenatal care was almost universal: 98% of pregnant women received at least one prenatal examination. Initiation of prenatal care in the first trimester was more common in urban areas than in rural areas (93% vs. 86%) and was most widespread in Tbilisi (94%).
- Ninety percent of women received at least 4 prenatal care visits and this was more common among women in urban areas (95%) than in rural areas (86%).
- One in two women received most of their prenatal care from women's consultation clinics (49%) and 44% received their care from raional or regional maternity hospitals. Only 7% of the women received care from primary care clinics or family medicine centers.
- In both 1999 and 2005, about one in twelve births (8%) was delivered at home, the majority without skilled attendance; in 2010

only 2% of births were delivered at home. Home births were slightly higher among Azeri women (5%), but in clear decline compared to the level of 40% home deliveries among this ethnic group in 2005.

- Eighty four percent of newborns received a well-baby checkup but only 23% of women reported receiving postpartum care in 2010. Use of postpartum care was also low in 2005 (23%), indicating that this service is still vastly underutilized in Georgia.
- Virtually all (97%) babies born alive in 2005–2010 were registered, according to the mother; however, registered births ranged from a low of 92% in the region of Kakheti to a high of 99% in the region of Samtskhe-Javakheti. Home births were least likely to be registered (67%).

Breastfeeding

- The majority (87%) of infants born within the five years leading up to the 2010 survey had been breastfed, virtually unchanged compared to 1999 and 2005. Georgian women reported lower rates of breastfeeding than women of other ethnicities.
- Since the 1999 survey, the proportion of babies who were breastfed within the first hour after birth increased by 4 times (from 5% in 1999 to 10% in 2005 and 20% in 2010), while the proportion of those who received breast milk 1–23 hours after birth doubled, from 28% to 55%.

On average, the duration of any breastfeeding was 12.1 months, 2 months longer from the 10.1 months recorded in the The duration of full 2005 survey. breastfeeding (either exclusive breastfeeding or predominantly breastfeeding) was 4.1 months, longer than the 3.7 months documented in the 1999 and 2005 surveys. Perhaps the most important gain was in the duration of exclusive breastfeeding (only breast milk), which doubled from the level documented in the 1999 survey (from 1.5 to 3 months).

Perinatal & Childhood Mortality

- Of all births that occurred during the five years prior to the survey, 8 per 1,000 were stillbirths. The stillbirth rate was highest among women who did not receive any prenatal care (50 stillbirths per 1,000), women who suffered complications during their pregnancies (34 stillbirths per 1,000), women who had prolonged labor (30 stillbirths per 1,000) and women who delivered after age 35 (11 stillbirths per 1,000).
- The infant mortality rate, the rate at which babies less than one year of age die, has continued to steadily decline, from 41.6 per 1,000 live births in 1995–1999 to 21.1 per 1,000 live births in 2000–2004 and to 14.1 per 1,000 live births in 2005-2009. More specifically, the neonatal mortality rate went down from 25.4 per 1,000 live births in

1990–1999 to 16.8 per 1,000 live births in 2000–2004 and even lower to 9.5 per 1,000 live births in 2005-2009.

- The reduction of mortality among children under five by two-thirds between 1990 and 2015 is centrally formulated in the Millennium Development Goal 4 (MDG 4). The child-under-5 mortality rate dropped from 45.3 per 1,000 in 1995–1999 to 25 per 1,000 2000–2004 and 16.4 per 1,000 births in 2005-2009—a nearly 64% decline. Thus, according to the survey estimates, Georgia has almost achieved MDG4 by 2010.
- Child survival in Georgia improved substantially over the past 15 years, mainly through significant reductions in neonatal and post-neonatal mortality. Given that neonatal deaths continues to account for most of infant mortality and 58% of child under-5 deaths in Georgia, further reductions in child mortality will depend on continuing the improvements in survival during the neonatal period.

Contraception Awareness

- Virtually all respondents (96%) had heard of at least one modern method—particularly the condom (94%), IUD (87%), and oral contraceptives (81%). However, only 39% of women had heard of tubal ligation and few (4%) had heard of vasectomy.
- For each contraceptive method, there is a considerable gap between awareness of the

method and knowledge of how that procedure or product is used.

 Most women do not have correct knowledge about how effective the modern methods of contraception are; while 30% of women correctly stated that IUDs are very effective in preventing pregnancy, only 16% believed that contraceptive sterilization is very effective. The majority of women incorrectly thought that pills were not very effective.

Contraceptive Use

- 32% of all women aged 15–44 years were currently using a contraceptive method including 21% who were using supplied methods (condoms, IUDs, oral contraceptives, tubal ligation, and spermicides).
- More than half (53%) of married women were currently using contraception, including 35% using modern methods. The use of modern contraceptive methods almost doubled, from 20% in 1999 to 35% in 2010. For the first time, the prevalence of modern methods exceeded the prevalence of traditional methods. result. As а contraceptive prevalence rate (CPR) for married women increased from 41% in 1999 to 45% in 2005 and 53% in 2010.
- Among married women currently using contraception, 26% were using the condoms (14% out of 53%), followed by 25% using IUD (13% out of 53%), 21% using

withdrawal (11% out of 53%), 13% using periodic abstinence (7% out of 53%), and 7% using oral contraceptives (4% out of 53%). Between 1999 and 2010, condom use among couples increased 2.5 times (from 6% to 14%) and IUD use increased from 10% to 13%, becoming the first and second most used methods, respectively. Withdrawal and the rhythm method, the leading methods in 1999, became third and 4th most commonly used methods in 2010. Pill use, still very low, had increased from 2% in 1999 to 4% in 2010.

Health facilities including primarily health care clinics/centers, women's consultation clinics and city or rational hospitals with gynecology wards were the main source of modern contraceptive methods, supplying 50% of users. Commercial sales, specifically through pharmacies, were the second largest source of contraceptive supplies (45%). Nearly 5% of users obtain their method from "other" sources, such as their partners, friends and relatives, and open market.

Potential Demand for Contraception

Almost two-thirds of married women have a potential demand for contraception, including 12% whose demand has yet to be satisfied (i.e. have a unmet need for any contraceptive methods). The unmet need for contraception among married women in 2010 is half the level documented in 1999 (12% vs. 24%), mostly as a result of increased use of modern methods.

- Despite increased use of modern contraceptives, 35% of married women continued to be at risk of unplanned pregnancy because they do not use effective contraceptive methods.
- Most (77%) married women who were not using contraceptives were currently pregnant (27%), desired pregnancy (20%), were infertile for medical (non contraceptive) reasons or menopausal (19%), or they were not currently sexually active (12%).

Contraceptive Counseling

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

health care services.

- Most respondents were advised by a gynecologist or reproductologist to use their current or most recent modern method (56%). Women who did not receive medical advice started using their last method at the partner's suggestion (23%), at their own counsel (9%), at the suggestion of friend (5%), or at the suggestion of a relative (4%), bypassing any potential family planning counseling. In only 1% of cases was the choice of the method made at the suggestion of a pharmacist.
- During provider-client interaction, 64% of women received general information about other contraceptive methods in 2010, compared to only 32% in 1999; 59% were counseled about the effectiveness of the chosen method in 2010 compared to only 31% in 1999; 82% reported that the provider had explained possible side effects of the method chosen, compared to 70% in 1999.

Women's Health

• The majority of respondents (79%) reported having a usual place where they obtain most of their health care. Women who reported they had a usual place of care, obtained most of the care in hospitals (38%) and ambulatory clinics (i.e. policlinics and women's consultation clinics) (26%). Only a minority obtained usual care in primary health care (PHC) facilities (14%).

- More than one in every three women (37%) reported visiting a health care facility in the last year; one half (51%) were seen for acute care, 41% were seen for preventive care, including family planning services, and 20% visited health care facilities for care of a chronic condition.
- One quarter (25%) of respondents indicated they had to delay getting medical care in the last 12 months (preventive, acute, or chronic care). The overwhelming majority of these women (82%) reported that the cost of health care services was the most important deterrent.
- Only 22% of women had any health insurance at the time of the interview. Given the unequal geographical distribution of the population under poverty level, insured women in rural areas were much more likely to have government-supported health insurance than urban women and less likely to have private insurance.
- The prevalence of routine gynecological visits remains low in Georgia, as indicated by only 24% of women with sexual experience who had accessed this preventative service Since screening for cervical and breast cancer are generally provided or prescribed during the routine gynecologic visits, a low prevalence of routine gynecologic exams inevitably has an impact on early detection and treatment of the gynecologic cancers. It also has a substantial negative effect on family planning counseling and dissemination of other health messages.

- Overall, 42% of sexually experienced women had ever performed BSE, which was higher than in 2005 (29%), but still indicates significant room for improvement. In terms of BSE frequency, 17% of sexually experienced women reported doing one every month, 12% every 2–5 months, 12% every 6– 12 months or less, and 58% never.
- BSE is not adequate on its own; consequently, women were also asked about the utilization of CBE and mammography. Less than one in five (18%) of sexually experienced women had ever had a CBE- a physical examination of the breast done by a health professional to detect abnormalities.
- Only 10% of women aged 40-44 have ever had a mammography; the two most important reasons women gave for not having a mammogram were lack of a recommendation from their health provider and lack of awareness.
- The prevalence of cervical cancer screening was also low; only 12% of sexually experienced women reported ever having had a Pap smear test; however, this represents a 3-fold increase from the 4% reported in both 2005 and 1999.
- For the first time, GERHS10 explored the level of awareness and use of the HPV vaccine in Georgia. Only a quarter (25%) of sexually experienced women had ever heard of HPV, 21% had heard of the vaccine, and once told about the vaccine's effectiveness in preventing cervical cancer, 29% expressed an interest in receiving the vaccine.

- Almost all women surveyed (95%) were aware of tuberculosis (TB); two-thirds (67%) correctly indicated that it is transmitted through the air when coughing. A substantial proportion of women had been exposed to TB either from a family member who has had TB (9%) or from frequent contact with someone who has had TB (12%).
- Only three-quarters (75%) of women were aware that TB can be completely cured. When asked the most appropriate treatment for TB-infected people, the vast majority (82%) said they should be hospitalized, 14% said they should be hospitalized initially and then treated at home, and 2% said they should be treated entirely at home.
- Across all age groups, reports of ever, current and past smoking were low with only 8% of women having ever smoked, 6% being current smokers and 2% past smokers. These figures were constantly higher in urban areas and lower in rural areas. For example, 9% of urban women reported being current smokers (13% of Tbilisi women), compared to only 2% of women in rural areas.
- Although the majority of women surveyed did not smoke, one in two reported high levels of current (in the past 30 days) secondhand smoke, both at home and at work. The level of SHS in the home was high for everyone, reported by 52% of women aged 15–44 and 50% of non-smokers. Among women working indoors, 44% were exposed to SHS, including 40% of non-smokers.

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

Young Adult Behaviors

- Nearly a third of young women (aged 15-24 years) in Georgia reported sexual experience (32%); of those, the overwhelming majority (31%) reported sexual initiation after marriage.
- One of the most noticeable differences in age at first intercourse is across education levels; over half of women who had secondary education or less had engaged in sexual activity prior to age 22, whereas only 39% of young women with university or technicum education had done so.
- Among young women who had their first sexual intercourse before age of 18, more than half had partners who were 5 or more years older.
- Contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status. The primary reasons given for not using a contraceptive method at first intercourse were wanting to get pregnant (67%) and not thinking about using a method (24%).

Domestic Violence

- Despite new legal regulations and increased efforts to raise awareness on domestic violence, women's reports of violence by an intimate partner remain very low. Few women in Georgia reported experience of physical and sexual abuse, both during the last 12 months (2%) and during lifetime (7%). These rates remained relatively unchanged since 1999. Moreover, the patterns of formal reports of abuse to the authorities did not change significantly.
- Physical abuse by an intimate partner affected all women, regardless of socioeconomic and educational background, and was the highest (23%) among previously married women. Higher prevalence of recent physical violence was reported by young women aged 15 to 19 years compared to older women.
- Domestic violence has consequences for children too. On average, 8% of all respondents reported having heard or seen abuse between their parents, and 8% reported that they had experienced parental physical abuse. Witnessing or experiencing domestic abuse as a child increases the likelihood of becoming a victim of intimate partner violence as an adult; among women who had experienced parental abuse, the prevalence of recent psychological abuse was three times as high and prevalence of physical abuse twice as high as those who had not experienced parental abuse.
- Living in households with low gender equity was associated with a higher risk of any type of domestic violence.

- Among women who had ever experienced physical abuse, about one in three (29%) had not disclosed their experience to anyone. Those who disclosed the abuse had primarily discussed it with a family member or friend; only 5% reported the abuse to the police; 3% sought medical help; and 2% sought legal counsel.
- Overall, almost 20% of ever-married women agreed with at least one specified circumstance in which they consider wifebeating justifiable. This percentage was greater among women who reported lifetime physical or sexual abuse compared to those who had never been abused, suggesting that lack of empowerment may leave women more vulnerable to physical or sexual intimate partner violence.

Key Indicators

	Georgia	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe- Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta- Mtianeti	Racha- Svaneti
Fertility														
Total fertility rate (births per woman)	2.0	1.9	2.1	2.1	1.9	1.9	1.9	2.1	2.2	1.7	1.9	2.0	2.3	2.3
General fertility rate (births per 1,000 women 15-44)	72	67	78	79	70	99	71	80	78	61	65	74	82	78
Adolescent birth rate (women 15–19) (births per 1,000)	39	25	57	77	21	ŝ	64	55	19	45	23	53	39	65
Induced Abortion														
Total induced abortion rate (abortions per woman)	1.6	1.2	2.1	1.9	-	2.2	2.4	1.6	1.2	21	2 1	1.6	2.0	. .
General abortion rate (abortions per 1,000 women 15-44)	56	41	74	65	39	74	82	51	40	76	73	56	68	40
Adolescent abortion rate (women 15–19) (abortions per 1,000)	10	9	14	30	6	7	÷	e	0	12	9	9	œ	13
Abortions in the 5 years preceding the survey for which the woman had:						1								
Received abortion counseling	33.1	35.6	31.3	25.8	36.3	40.0	25.6	13.8	33.0	29.2	30.0	45.7	31.8	29.9
Received a contraceptive method or prescription postabortion	14.0	15.3	13.0	12.1	13.8	14.2	13.6	7.2	12.5	6.8	6.9	25.7	5.7	17.7
Perinatal and Childhood Mortality														
Stillbirth rate (per 1,000 births)	7.8	10.3	5.2	11.8	10.7	5.4	7.8	8.1	0.0	6.3	4.8	5.1	21.8	10.2
Infant mortality rate (per 1,000 live births)	23.8	21.8	25.7	27.0	16.9	28.2	28.1	21.8	26.6	21.3	34.1	19.7	38.0	6.8
neonatal	17.5	16.3	18.6	16.0	14.7	21.2	16.5	13.6	19.8	14.2	31.0	12.4	34.8	3.4
postnatal	6.3	5.6	7.0	10.9	2.1	7.0	11.6	8.3	6.8	7.1	з.1	7.2	3.2	3.3
Child mortality rate (per 1,000 live births)	2.2	0.5	3.9	5.9	0.0	7.5	2.4	3.1	3.7	0.0	0.0	1.9	0.0	0.0
Under-5 mortality rate (per 1,000 live births)	26.0	22.4	29.4	32.8	16.9	35.5	30.4	24.9	30.3	21.3	34.1	21.6	38.0	6.8
Family Planning														
Heard of any method (all women ages 15–44)	96.6	98.4	94.6	95.7	98.9	97.0	90.6	95.0	95.4	99.2	98.3	96.8	97.5	96.3
Know how to use at least one method (all women ages 15-44)	79.9	83.4	75.9	79.3	83.8	80.9	74.1	73.6	84.4	79.8	77.1	78	79.5	76.4
Never used a method (all women ages 15-44)	53.5	53.3	53.7	52.4	51.9	50.3	55.3	53.1	55.8	54.8	54.5	54.5	53.6	58.3
Currently using a method (married women ages 15-44)	53.4	56.9	50.0	50.6	60.9	61.3	48.9	55.6	44.4	53.5	57.0	49.0	44.7	52.3
Unmet need for any contraceptive method (married women ages 15-44)	7.7	6.1	9.5	9.5	5.3	5.7	9.7	5.0	10.5	10.2	7.4	8.5	10.8	8.2
Unmet need for modern contraception (married women ages 15-44)	18.5	14.2	23.2	18.2	12.7	21.1	24.6	24.7	25.0	25.0	15.1	17.4	19.4	21.8
Maternal and Child Health														
Births in the 5 years preceding the survey for which the mother had:														
Received prenatal care from a health professional	97.6	99.1	96.1	88.6	99.2	100.0	94.9	99.1	98.6	99.4	98.1	99.8	97.4	98.4
4+ prenatal care visits	90.2	94.6	85.7	83.6	95.5	97.9	79.5	80.5	91.3	88.7	85.2	95.9	86.9	78.1
Initiated prenatal care during the 1st trimester	89.8	93.1	86.4	79.6	93.6	91.4	86.4	89.8	93.2	86.2	91.9	90.0	84.3	87.2
Delivered in a health facility	98.3	99.4	97.2	91.8	99.9	99.9	98.5	100	97.5	100	97.2	98.7	99.5	97.0
Delivered with the assistance of a health professional	97.4	0.66	95.7	92.2	99.2	98.4	95	98.4	95.6	100	97.6	66	96.1	97.4
Delivered by C-section	23.9	26.0	21.7	19.5	22.8	19.5	16.4	8.9	28.5	23.3	33.0	32.5	21.5	25.3
Pregnancy complications	15.7	15.0	16.3	12.7	13.6	22.2	14.2	14.2	17.2	4.4	11.7	20.8	23.8	7.3
Received postpartum care	23.0	28.6	17.9	18.8	27.6	15.7	24	20.3	21.5	15.7	15.8	25.3	32.8	16.8
Infants in the 5 years preceding the survey who:														
Heceived well-baby visits	84.1	89.5	78.7	79.6	91.9	87.0	74.7	72.6	81.7	86.2	82.5	85.7	83.5	72.4
Were ever breastfed	87.4 2.2	87.1 2.1	87.7 2.2	90.6	88.3 1 .3	85.9 0 -	88.3 0 0	90.3 0.2	83.7	82.5	82.5	88.8	86.2 0.2	85.7 2.2
Mean duration of exclusive breastfeeding (in months)	5.6 Z.	2.5	9.Z	۲. ۲.	7.7 Z	3./	2	2.8	ю. Г	2.2	9 7	L'X	3.8	9 Z
Women's Health														
Has Health Insurance	22.1	21.4	23.0	20.1	23.3	24.9	14.1	19.1	25.4	26.6	21.2	21.1	33.7	42.1
Use of healthcare in the last 12 months	36.6	38.7	34.3	39.2	40.7	34.9	32.7	30.9	25.9	33.0	35.0	43.0	29.7	38.9
Women who perceived cost as a barrier to healthcare	82.0	75.5	87.7	84.3	67.6	94.7	85.3	89.0	89.0	87.1	87.5	84.9	82.3	79.1
Women who had ever had a pap smear	12.2	15.2	9.0	10.9	20.3	8.9	9.6	6.0	11.7	14.7	2.5	11.3	8.0	8.9
Current Smokers	5.5	8.9	1.7	3.6	13.3	1.4	2.1	1.1	4.3	0.6	1.8	2.6	3.2	0.9
Current Drinkers	16.6	18.5	14.5	21.8	23.2	15.8	8.9	7.6	7.3	10.4	19.2	16.8	16.5	16.9
Ever had Pelvic Inflammatory Disease	29.4	29.6	29.3	32.4	30.0	33.4	27.1	27.2	23.1	17.7	31.3	32.0	31.8	36.4
Ever diagnosed with high blood pressure	5.5	5.1	6.1	8.5	5.4	7.1	3.6	2.8	5.9	5.2	5.5	5.4	7.2	6.4

* Numbers are percentages unless otherwise indicated.

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Chapter **1**

Introduction

1.1 Background

eorgia's progress toward social and economic development after 1990 has been uneven. Due to a significant decline in socioeconomic conditions in the 1990s

and the secessionist conflicts in Abkhazia and South Ossetia the health status of the population deteriorated seriously. The status of women's health in Georgia is strongly influenced by cultural, historical, and socioeconomic factors. The previous Communist regime, notorious for its lack of support for family planning and other preventive services, had a particularly profound impact on women and their reproductive health. The Soviet-style health system, which placed emphasis on curative rather than preventive services, allocated funding according to the number of hospital beds, relied on too many hospital-based, specialized hospitals and physicians, and did not maintain adequate primary health care services. With the end of the centralized Soviet administration and the postcommunist economic decline, the costly hospitalbased curative system became impossible to maintain. Most hospitals lacked minimal equipment, drugs, and supplies, and could not afford maintenance costs.

In response to the collapse of the publiclysupported hospital-based health system, Georgia initiated an extensive health sector reform in mid-1990s. The process was designed to address all aspects of the health-care sector and to place emphasis on quality of care, improved access, efficiency, and rehabilitation of the primary health care system. Decentralization has been a major of the reform component process. The governmental institutions supporting this process are the Ministry of Labor, Health and Social Affairs (MoLHSA), the key health decision-maker, the State United Social Insurance Fund and the Ministry of Finance, the key financial players in the health care system. At the local level, much of the health decision-making and responsibility for health financing are under the authority of 12 regional health departments.

In 2007, the Government of Georgia has launched a comprehensive health care reform aimed at privatization of the system. Reforms of the primary health care system have been supported by various international donors. The privatization of hospitals was regulated in the Hospital Development Master Plan (MoLHSA, Decree #11, January 26, 2007), which called for complete replacement of existing hospital infrastructure by full transferring of ownership to the private sector. Primary health care services are also in various stages of privatization. The entire privatization process is planned to be completed by the end of 2012 (Chaturidze et al., 2009).

Despite the progress made during the last decade, the legacy of the past is compounded by the present lack of resources, placing Georgia far behind other European countries in family planning (FP) and reproductive health (RH) services. Although the country's gross domestic product (GDP) improved in recent years, healthcare expenditures comprise a decreasing portion of public expenditures, resulting in the underfunding of medical facilities, including family planning and reproductive health services (Georgian European Policy and Legal Advice Centre, 2008). The Government finances programs such as TB, HIV/AIDS, immunization, mother and child health and provides insurance coverage for the population under the poverty line for a limited package of services.

Currently, Georgia does not have a national family planning program and neither state nor private health insurance packages include family planning provisions. Even the poorest population of the country (800,000 persons, according governmental estimates) does not benefit from subsidies for FP services, although most other care is covered by the government via private insurance contributions. All family planning activities are maintained with donor support, primarily from the United States Agency for International Development (USAID) and United Nations Population Fund (UNFPA).

Due to the state's financial limitations, USAID, UNFPA and other bilateral and multilateral donors have worked with the Georgian government and local non-governmental organizations to increase access to reproductive health and family planning services. Since the early 1990s, most of the efforts have focused on designing client centered family planning and reproductive health policies and programs, training physicians and other medical professionals, organizing public information campaigns, and developing a nationwide system for delivery of contraceptive supplies. UNFPA has been the major provider of family planning commodities through several contraceptive-supply projects.

USAID funded several reproductive health initiatives, including the recently concluded Healthy Women in Georgia (HWG) project. The project was implemented and managed by John Snow Research and Training Institute, Inc (JSI) over a period of six years (2003-2009) and expanded from one region to most of the country. While adding funding and geographic coverage, the project expanded its technical scope that primarily focused on evidence-based, womenfriendly, and client-focused family planning and reproductive health services. New technical areas included working with internally-displaced persons and people in breakaway regions, including a rapid assessment of the impact of war on women who were forced to flee the conflict areas. More emphasis was placed on maternity and newborn care by introducing effective perinatal care in 16 maternities, providing on-the-job training, and supporting parents schools. Family planning services were expanded to several hundreds of service delivery points, free distributed, contraceptive supplies were contraceptive logistics management was promoted, and hundreds of primary care doctors, pediatricians, and nurses were trained in family planning counseling and services (after securing a "waiver" from MoLHSA to allow non-OB/Gyn to provide such services). The program also supported breast and cervical cancer screening, quality of care trough supportive supervision in reproductive health, dissemination of health promotion messages, social marketing and operational research, and the introduction of family life education courses in 155 schools. In 2008-2009, MoLHSA in collaboration with CDC and HWG conducted the first mortality study among women of reproductive age (RAMOS) with USAID support (Serbanescu et al., 2009).

Two additional RH programs funded by USAID and implemented by JSI have followed and expanded the approach used by HWG: SURVIVE, conducted in 2009-2010, and "Sustaining Family Planning and Maternal and Child Health Services in Georgia" (SUSTAIN), which is currently in progress. SURVIVE supported early detection of breast cancer and cervical cancer prevention through training for health providers; it also promoted health education of the public on issues related to breast and cervical cancer through the use of IEC materials and mass media. SUSTAIN introduced of FP/RH modules and practicum into medical and nursing school curricula, continued training for primary health care and family doctors, pediatricians, and OB/Gyns, supported for social marketing of contraceptive supplies, and expanded behavioral change communication in RH through public awareness and IEC campaigns.

UNFPA Office in Georgia was established in 1999, though UNFPA assistance began in 1993. The 2006–2010 country programme (CP) includes the largest portfolio of reproductive health (RH) activities. Building on the results achieved during previous years, UNFPA supports three main areas: developing/updating RH policies and standards in line with internationally recognized documents, increasing access of the population, including youth, to comprehensive client-oriented RH services at various levels of the healthcare system, and increasing awareness of reproductive health information. With UNFPA advocacy and support and in collaboration with other donors, the National RH Council (NRHC) has been established at the MoLHSA. UNFPA actively participates in the formulation of national RH strategies policies and and supports the development and dissemination of postgraduate

training curricula and guidelines and protocols for RH clinical practice—there have been 10 nationwide roll-outs of these guidelines. One UNFPA approach to increase access has been the support for 5 RH mobile teams, which offer high quality services to vulnerable population, such as internally displaced population and rural residents. Since August 2008, over 6,500 IDP women in post conflict areas have been assisted by these mobile teams.

The partnership of UNFPA Georgia, MoLHSA and Municipality of Tbilisi for reproductive tract cancer prevention and early diagnoses was initiated in 2006 and stood behind the opening of the Georgian National Screening Center in Tbilisi. From 2008 to 2010, more than 44,000 women benefited from breast cancer screening (clinical examination or mammography) and a similar number benefited from cervical cancer screening services. In 2009 the center was awarded a "Pearl of Wisdom" award at the European Parliament Cervical Cancer Prevention Summit. The center also promoted the formation of the Black Sea Countries Coalition on Breast and Cervical Cancer Prevention, with support from UNFPA and the First Lady of Georgia. Reproductive health of youths has been one of the major focus areas of UNFPA support; activities include the introduction of youth-focused reproductive health services through training of health professionals and assistance with in-service integration of youth- friendly services at the primary health care level.

Through USAID and UNFPA contributions, Georgia has increased women's access to modern contraceptives and other reproductive health services. However, many challenges remain, particularly in reaching the most vulnerable women and improving the quality of services. To help policymakers and program managers assess and respond to current needs, nationwide surveys on reproductive health were conducted in Georgia in 1999, 2005 and 2010. Funding for all three surveys was primarily provided by two major international donors: USAID, which supported technical assistance from the US Centers for Disease Control and Prevention Division of Reproductive Health (CDC/DRH) for survey design, implementation, data processing, analyses and dissemination, and UNFPA, which covered all costs related to field work, translation, and dissemination seminars. Local funding for the 2010 survey was also contributed by the United Nations Children Fund (UNICEF). For all three surveys, CDC/DRH provided technical assistance to the National Centers for Disease Control and Health Statistics (NCDC) and MoLHSA, the implementing agencies and key stakeholders.

The 1999 Georgia Reproductive Health Survey (GERHS) was the first national representative household survey ever conducted in Georgia and documented low levels of contraceptive use and high levels of abortion. Based on its findings, USAID expanded its funding for reproductive health activities in Georgia, including the funding for the HWG project, and UNFPA developed three main programming strategies: improving the quality of RH services; increasing the access of population to RH services; and population information, education, and communication (IEC) campaigns on sexual reproductive health and rights. The second round of GERHS was carried out during the first part of 2005. Its aim was to assess the impact of new programs and activities and provide planning data for upcoming women's

reproductive health projects and information, education, and communication campaigns. Similarly, the 2010 GERHS continues to provide accountability for RH efforts and allow for the study of trends of main RH indicators. The surveys included nationally representative samples of women aged 15-44 and were similar in scope, design and content. The 1999 survey included a supplemental sample of internally displaced women living in nonresidential housing, which was not replicated in the later rounds. All surveys used multistage probability samples; the selection of primary sampling units in 2005 and 2010 was based on the 2002 Census and allowed for independent regional estimates for the most important reproductive health indicators; the sampling design in 1999, based on the sampling frame of MICS 1999, did not allow independent estimates for all regions.

The availability of high-quality RHS data provided the opportunity to document levels of contraceptive use and induced abortion in Georgia with more accuracy than was previously possible. Survey estimates of contraceptive prevalence are more accurate than estimates based on service statistics, which count only women attending facilities that provide family planning services. Survey-based estimates of the number of abortions in Georgia are several times higher the official values, indicating problems with the government system for collecting routine abortion data.

1.2 Objectives

Periodic household-based probability surveys are the best and most timely way to collect data on a wide assortment of health topics that are essential to determining the health needs of Georgian families and the types of services they should receive. Set within the context of overall social and economic development in Georgia, the aim of the GERHS10 was to obtain national and regional estimates of basic demographic and reproductive health indicators, in order to set targets for improvement, allocate resources, and monitor performance of family planning and maternal and child health programs. The GERHS10, which was conducted between October 2010 and February 2011, was similar in design and content to the 1999 and 2005 Reproductive Health Surveys as well as with surveys conducted in other Eastern European and Central Asian countries. A sample of 6,292 women aged 15-44 years was interviewed during GERSH10.

The GERHS10 was specifically designed to meet the following objectives:

- to assess the current situation in Georgia concerning fertility, abortion, contraception and various other reproductive health issues;
- to enable policy makers, program managers, and researchers to evaluate and improve existing programs and to develop new strategies;
- to document the socio-economic characteristics of households in Georgia and their patterns of access to and utilization of health care services;
- to measure changes in fertility and contraceptive prevalence rates and study factors that affect these changes, such as geographic and socio-demographic factors,

breast-feeding patterns, use of induced abortion, and availability of family planning;

- to provide data needed to estimate global development indicators related to education, maternal and child survival, gender equality, and reduction of HIV and other disease transmission;
- to obtain data on knowledge, attitudes, and behavior of young adults 15–24 years of age and assess their exposure to sex education and health promotion programs;
- to identify and focus further reproductive health studies toward high risk groups.

By making available appropriate country- and region-specific data on reproductive health and related health services and enhancing the ability of national organizations to collect, analyze, and disseminate such information, the survey has fostered collaboration between the Georgian government, international donors, and other partners. Survey data can be used to appropriate funds, develop or revise existing policies, modify existing programs, increase visibility of a program or issue, build capacity to conduct monitoring and evaluation, and guide secondary research and special studies. By continuing the process of monitoring RH and maternal and child health programs in Georgia within the context of health sector reforms and poverty reduction strategies, the survey will also help to identify linkages among health needs, health services, and health sector reforms. International bilateral and multilateral donors (e.g., USAID, UN agencies, European Union) and various government partners, particularly MoLHSA, the Ministry of Economic Development, and Ministry of Finance, can use these data for developing new health strategies and health sector reforms and for monitoring and evaluating progress toward achieving the Millennium Development Goals.

Chapter **Z**

Methodology

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

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

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

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

2.1 Sampling Design

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

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

The number of households included in the sample was calculated to yield approximately 6,000 interviews with women aged 15-44. As in the 2005 RHS, the survey employed a stratified multistage sampling design that used the 2002 Georgia census as the sampling frame (State Department for Statistics, 2003). To better monitor the health issues situation at a subnational level and assist key stakeholders in assessing decentralization efforts, the sample was designed to produce estimates for 11 regions of the country. Census sectors were grouped into 11 strata, corresponding to Georgia's administrative regions; three small regions, Racha-Lechkhumi, Kvemo Svaneti, and Zemo Svaneti were included in one stratum, identified as the Racha-Svaneti stratum.

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

The overall sample consisted of 310 PSUs, and the target number of completed interviews was an

average of 20 completed interviews per PSU. The minimum acceptable number of interviews per stratum was set at 400, so that the minimum number of PSUs per stratum was set at 20.

With these criteria, 20 PSUs were allocated to each stratum, which accounted for 220 of the available PSUs. The remaining 80 PSUs were distributed in the largest regions in order to obtain a distribution of PSUs approximately proportional to the distribution of households in the 2002 census. An additional 10 PSUs were added to the smallest stratum, Racha-Svaneti, to compensate for the considerable sparseness of women of reproductive age in this stratum.

Table 2.1 also compares the distribution of households in the sample with the distribution of households in the 2002 Census by the 11 strata. The sampling fraction ranges from 1 in 13 households in the Racha-Svaneti

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



stratum (the least populated stratum) to 1 in 136 in Adjara.

As shown in Table 2.1, if the ratio of households in the census to households in the sample is above 87.8, the region has been under-sampled, whereas if the ratio is less than 87.8, the region has been over-sampled.

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

2.2 Questionnaire Content

Similar to the 1999 and 2005 RHS, GERHS10 used two questionnaires to collect information from the households and from eligible respondents: the household questionnaire and the women's questionnaire. Both questionnaires were available in Georgian and Russian languages. The household questionnaire was supplemented with a detailed household composition, questions about the education attainment of the household members and school readiness and attendance among children and youth, socio-economic characteristics of the household, and questions about the availability and type of social assistance received by the household members. These questions were adapted to country needs based on the RHS model household questionnaire and the fourth round of the Multiple Indicator Cluster developed Surveys (MICS) by UNICEF (UNICEF, 2010).

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

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

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

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

2.3 Data Collection

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

The field unit for GERHS10 consisted of two coordinators who divided the fieldwork assignments among the eight teams of interviewers and supervisors. The field work coordinators and supervisors prepared interviewer assignments and were responsible for monitoring the progress of each observations. interviewer, performing field conducting in-person verifications of the interviewers' work, and conducting refusal conversion efforts. Field supervisors were also responsible for analyzing each interviewer's weekly production and quality of work, reviewing errors, and serving as the point of contact for the data entry supervisors.

2.4 Response Rates

Of the 13,363 households selected in the household sample, 6,356 included at least one eligible woman (aged 15–44 years). Of these identified respondents, 6,292 women were successfully interviewed, yielding a response rate of 99%. Virtually all respondents who were selected to participate and who could be reached agreed to be interviewed and were very cooperative. The refusal rates for the household questionnaire and the women's questionnaire were very low (0.2%). Response rates did not vary significantly by geographical location (Table 2.4).

2.5 Quality Control Measures

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

The training team selected 48 interviewers and supervisors after one week classroom training and another week in the field; the training was very competitive and allowed for selection of the most highly qualified staff from an original pool of 75 trainees. Supervisors were trained to review and edit the questionnaires immediately after each interview; thus, if they noticed errors or omissions the interviewers or the respondents had made, the interviewers could make immediate corrections during short follow-up visits. These edits reduced the item non-response rate for most questions to less than 2%. Supervisors and field work coordinators spot-checked the quality of each interviewer's work often and carefully. This process of verifying fieldwork was a critical component of the overall quality control system.

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

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

2.6 Sampling Weights

The purpose of the RHS is to produce statistical estimates that are nationally representative. National estimates are produced by devising a "sampling weight" for each respondent that adjusts for her probability of selection in the sample. The weights for the RHS were calculated as follows: First, a household weight was calculated to reflect probabilities of selection of households within different strata of the sample. Second, a woman weight was calculated to reflect different probabilities of selection depending on the number of eligible women in each household. In cases where households included more than one eligible female respondent, the woman weight is not the same as the household weight. Because the overall response rate (99%) was so high, the weights have not been adjusted for nonresponse for households or women. After the weighted survey population distribution was broken down by five-year age-groups and by residence and was with the Census estimates. compared poststratification weights were not deemed to be necessary (see Section 2.7). Finally, the weights have been normalized, so that the total of the weights is equal to the number of observations with a completed interview.

Except for Table 2.4, all tables in this report present weighted results, but the unweighted number of cases, used for variance estimation, is shown in each table. Generally, tables where percent distributions are shown should add up to 100%, but due to rounding they may add up to either 99.9% or 100.1%.

2.7 Comparison with Official Statistics

The weighted percentage distribution of women selected in the 2010 survey sample by 5-year age groups differs only slightly from the 2009 midyear official estimates, based on the official census projections (Table 2.7).

For the overall distribution by age, the differences were not statistically significant after confidence intervals are taken into account. Unfortunately, the urban/rural distribution of the sample cannot be compared with current official estimates because the official statistics do not project population figures separately for the urban and rural areas. Compared to 2002, both the total and the urban/rural distribution of the sample include fewer women aged 35-39 and 39-However, age composition had changed 44. significantly since 2002 and comparisons need to be made with projected population figures. The official age projections for 2009 for the percentages of women in these age groups is similar with the figures documented by GERHS10 and there was no great variation in age distribution among these women when stratified by urban or rural residence. These findings suggest that the sample distribution of women aged 35-39 and 39-44 by residence would be close to the official projections, if such projections were available.



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

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

*Source: SDS, 2002 Census Population

[†] Includes the regions of Racha-Lekhumi, Kv emo Sv aneti, and Zemo Sv aneti as one stratum.

HH = households; PSU = primary sampling unit

|--|

Table 2.4

			Residence							Region					
Households Visits	Total	Tbilisi	Other Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe- Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta- Mtianeti	Racha- Svaneti
Identified elegible woman	47.6	52.7	49.5	44.9	47.4	52.7	47.0	52.0	57.5	65.6	40.8	45.5	48.1	47.7	28.7
No eligible women	49.0	43.7	48.0	51.4	49.5	43.7	50.2	44.8	40.1	30.9	59.0	53.8	48.9	49.5	62.2
Resident(s) not at home	0.1	0.5	0.0	0.1	0.2	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Household refusal	0.2	0.9	0.1	0.1	0.0	0.9	0.0	0.4	0.2	0.0	0.0	0.0	0.0	0.1	0.1
Unoccupied house	3.0	1.9	2.4	3.6	2.8	1.9	2.9	2.8	2.0	3.4	0.2	0.7	3.0	2.4	9.0
Other	0.1	0.3	0.1	0.0	0.0	0.3	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Households Visited	13,363	2,734	3,152	7,477	1,056	2,734	841	1,053	842	643	1,005	1,057	1,684	845	1,603
Elegible Women															
Completed interviews	99.0	98.9	99.4	98.9	99.4	98.9	99.2	9.66	99.4	99.3	97.8	99.2	99.4	97.5	98.7
Selected respondents not at home	0.1	0.3	0.1	0.1	0.0	0.3	0.0	0.0	0.0	0.0	0.7	0.0	0.0	0.0	0.0
Selected respondent refused	0.2	0.3	0.1	0.1	0.6	0.3	0.0	0.0	0.0	0.0	0.2	0.2	0.0	0.2	0.0
Selected respondent is not competent	0.7	0.4	0.5	0.9	0.0	0.4	0.8	0.4	0.6	0.7	1.2	0.6	0.6	2.2	1.3
Incomplete Interview	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Florible Women Handler	0.050	077	011	190 C		010	L C C	07.0	101	000		Ş	ç	υσγ	100
No. of Elegible women identified	005,0	1,442	Acc,1	3,300	Inc	1,442	CAS	240	1 97	774	410	10	810	403	460
No. of Completed interviews	6,292	1,426	1,549	3,317	498	1,426	392	546	481	419	401	477	805	393	454

Chapter 2: Methodology

Table 2.7Women with Complete Interviews Compared with Official Estimates by Residence,
by Age Group Percentage Distribution — Reproductive Health Survey: Georgia, 2010

Age Group		GERHS1	0 (±95% (Confidenc	e Interva	I)	2009 Official Estimates (mid-year) [*]	2002 O	fficial Est	imates ⁺
	Т	otal	U	rban	R	ural	Total	Total	Urban	Rural
15–19 20–24 25–29 30–34 35–39 40–44	17.9 18.9 16.6 16.3 15.8 14.4	 (1.3) (1.4) (1.3) (1.3) (1.3) (1.4) 	17.4 19.7 16.3 16.7 15.6 14.3	(1.3) (1.4) (1.3) (1.3) (1.3) (1.3)	18.6 18.0 17.0 15.9 16.1 14.5	(1.3) (1.3) (1.3) (1.3) (1.3) (1.4)	17.2 18.1 17.0 16.1 15.8 15.8	17.6 16.4 15.8 15.5 17.0 17.7	16.7 16.2 15.9 15.6 17.4 18.3	18.8 16.7 15.8 15.3 16.6 16.8
Total	100.0		100.0		100.0		100.0	100.0	100.0	100.0

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

+ SDS, 2003. Population of Georgia in 2002.

Chapter 3

Characteristics of the Sample

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

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

Thus, the wealth index measures the standard of living of a household relative to other households, indicating that respondents living in households with a higher wealth quintile have a better socioeconomic status (SES) than those in the lower wealth quintile.

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

3.1 Housing Characteristics

In order to assess the socioeconomic conditions of the respondents, the GERHS10 included questions on a number of dwelling characteristics (e.g. availability of electricity, source of drinking water, type of sanitation facilities, fuel used for cooking and heating, main roof material of the dwelling) that may affect the health status of household members (Table 3.1.1). Further, the availability of selected amenities and goods in the household (e.g. T.V., phone, refrigerator, working automobile, satellite dish, computer, VCR/DVD, etc.) were also assessed (Table 3.1.2).

Overall, virtually in all households (96%) the electricity is available 24 hours per day, ranging from 91% in Mtskheta-Mtianeti to 99% in Samtskhe-Javakheti. This is a great improvement over the situation documented in the 2005 RHS (37%) and the 1999 RHS (9%) (Serbanescu et al., 2001, 2007).

As shown in Table 3.1.1, the source of drinking water for 76% of the households is a tap found either in the residence or in the yard. An additional 15% of the households obtain their drinking water from a private well, while 6% obtain their water from a public tap. As expected, piped water in the household or in the yard is more common in urban areas (96%) than in rural areas (55%), and is almost universally available in the Tbilisi and Adjara regions (Figure 3.1.1). Private well water is the primary source of drinking water in Guria and Samegrelo regions, while public taps are an important source of drinking water in the Kakheti and Kvemo-Kartli regions. Overall, 98% of urban and 88% of rural households in Georgia use improved sources of drinking water (water from unprotected wells or unprotected springs being considered as unsafe).

In general, 48% of the households have a flush toilet, while 50% have a pit latrine. The probability of dwellings of having flush toilets is highest in the Tbilisi region (95%) and lowest in Kakheti and Racha Svaneti regions (7%) (Figure 3.1.2). Overall, 96% of urban households and 71% of rural households were using improved sanitation facilities.





The principal source of energy used in Georgia households for cooking is natural gas (45%), followed by wood (40%). The vast majority of rural households use wood for cooking (70%), while 74% of urban households use natural gas. The use of natural gas is highest in the Tbilisi region (90%) and lowest in the Racha-Svaneti region (2%).

More than half of the households are heated centrally with wood stoves (67%), followed by individual room-based heating with electric, gas, kerosene, or other space heaters (29%). Only 1.4% of Georgian households use central heating.

The principal materials used for roofing are corrugated iron (36%), sheet metal (33%) and tile or concrete (27%). Corrugated iron and sheet metal are the main roofing materials in all regions, excepting Tbilisi where most dwellings have tile or concrete roofing (62%). The availability of basic services in the household is generally higher in urban than in rural areas (Figure 3.1.3). The only dwelling characteristic that is more favorable for rural households is the number of rooms per person. Rural dwellings have more rooms per person and are less crowded than urban households.

As shown in Table 3.1.2 and Figure 3.1.4, almost every household has a television (97%), with little difference between urban and rural households. The likelihood of possessing other household goods is higher in urban than in rural areas, sometimes by a considerable margin.





Nearly 80% of households have a refrigerator; the urban/rural differential is almost 20 percentage points in favor of the urban households. About one in two households (56%) has a land-line telephone and three out of four (75%) have at least one cell phone. Interestingly, the urban/rural gap is very large for having a land-line telephone (73% vs. 38%), but narrows significantly for ownership of cellular phones. While the percentage of urban households with cell phones is 82%, a substantial proportion of rural households (67%) also have cell phones The proportion of households with at least one cell phone ranges from a low 57% in Racha-Svaneti to a high 86% in Tbilisi (Figure 3.1.5).

Overall, 25% of households have a functioning automobile and the ownership rates are highest in Tbilisi (31%). One in five households has a satellite dish and a similar proportion has a computer (with virtually all computers having internet access). Only 7% of households own a vacation home (villa).

Figure 3.1.6 shows changes in selected basic services in the households. While the availability of flush toilets remained basically unchanged, the availability of electricity 24 hours per day increased more than 10 times, from 9% in 1999 to 96% in 2010. More households have now land-line phone service (56% vs. 36%) and 10 times more households have central heating.

Changes in the availability of household goods are shown in Figure 3.1.7. The only substantial increase was in ownership of cell phones, from less than 10% in 1999 to almost 75% in 2010. In contrast, during the interval between the surveys, the percentage









of households with a villa declined significantly and ownership of a refrigerator or a functioning automobile decreased slightly.

Table 3.1.3 presents the proportion of households with selected characteristics (i.e. availability of amenities and goods) within each of the five wealth quintile. As expected, the proportion of households with each specific characteristic increases as wealth quintile increases, with the exception of having uncrowded living conditions. If only one in four households in the lowest two wealth quintiles has crowded living conditions, this proportion increase to one in two households with the wealth quintile.

Table 3.1.4 shows the distribution of the Georgian population across the wealth quintiles, according to urban-rural residence and region.

The distribution indicates the degree to which wealth is distributed in geographic areas. Almost three in four (74%) of urban households were classified in the two highest wealth quintiles while only 3% of rural households were in these wealth groups. Looking at regional variation, Tbilisi has the largest proportion of households in the highest two wealth quintiles (91%) while Racha-Svaneti, Guria and Samegrelo have the largest proportion of households in the lowest two wealth quintiles (85%, 75%, and 70%, respectively) (Figure 3.1.8).



3.2 Characteristics of the Respondents

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

Nearly 60% of the respondents were legally married or living in a consensual union; the vast majority were legally married (58%). The percentage of respondents who were married or living in a consensual union was higher in rural area (63%) than in Tbilisi (52%) or other urban areas (57%).

Slightly more than one-third of the respondents had never been married or had never lived with a partner. In Tbilisi the proportion of women who have never been married is the highest (40%). Seven percent of the respondents stated that they had been previously married and were now either divorced or separated.

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



Georgian women are well-educated, as evidenced by the fact that only 23% have less than a complete secondary education. In general, respondents living in Tbilisi and other urban areas were better educated than those living in rural areas (Figure 3.2.2). For example, as shown in Table 3.2.1, respondents living in Tbilisi were almost three times more likely than rural respondents to have received university training. The regions with the least educated populations are Kvemo Kartli, Samtskhe-Javakheti, Kakheti, and Guria: only 37%–42% of respondents have 12 or more years of education (Figure 3.2.3).

Focusing on the likelihood of having less than a secondary complete education, the regions with the highest proportions of women in this category are Kvemo Kartli (37%), followed by Kakheti (31%), Racha-Svaneti (31%) and Guria and Shida Kartli (29%) (Figure 3.2.4). Not surprisingly, respondents living in these regions are the least likely to receive university training and, to a certain degree, technical training. With regards to higher education, the Tbilisi region stands out: 60% of respondents have undergone university training while only 13% did not complete secondary education.

No other region in the country is within 20 percentage points of achieving the same educational attainment rates as Tbilisi. This disparity is likely due to better access to higher education among women living in Tbilisi.

Slightly more than one-third of the respondents lived in households within the two lowest wealth quintiles, while 21% lived in middle-quintile





households, and 44% lived in households within the two highest wealth quintiles. The percentage living in the lowest two quintiles was highest for rural respondents (66%) and lowest for Tbilisi respondents (1%). In contrast, only 5% of rural respondents were classified as living in highquintiles households, while virtually all respondents living in Tbilisi households were classified as living in the highest two wealth quintiles.

Only 21% of the respondents reported working outside of the home at least 20 hours per week. Rural women were less likely to work outside of the home (13%) than women residing in Tbilisi and urban areas (31% and 26%). The vast majority of the respondents reported themselves to be Georgian (87%), while 5% each reported to be of Azeri and Armenian descent. Respondents belonging to minority ethnic groups were more likely to live in rural areas than in urban areas (19% vs. 8%).

The dominant religion among the survey respondents is Georgian Orthodox (82%). Most remaining respondents declared that they were Muslim (11%) and 5% belonged to other Orthodox denomination. As shown in the table, the majority of Muslims live in rural areas, where they constitute 18% of the population.

Table 3.2.2 provides additional details on the marital status and educational attainment of the respondents by age groups. The vast majority of women aged 15–19 years have never been married or lived with a partner (Figure 3.2.5). Among women 20–24 years of age, one in two (49%) is married or living in a consensual union;



by the time women reach 25–29 years of age, 71% are married. The proportion of married respondents continues to increase with age, and by the time women reach 40–44 years of age, 90% have been married. The proportion of women who have previously been married increases from 0.4 % among women aged 15–19 years to 13% among women aged 40–44 years.

Table 3.2.2 also presents the percentage distribution of respondents by the highest level of education attained and age group. Overall, less than one in four Georgian women did not complete a secondary education while 39% have a university or other postgraduate education. With the exception of women aged 15–19 years, who presumably are still in school, younger women are more likely than older women to have a university education. Women aged 40-44 years are the most likely to report technical training as their highest education level.

Table 3.1.1

Availability of Basic Services in the Household by Residence and Region (Percentage Distribution) Reproductive Health Survey: Georgia, 2010

		Resid	lence						Regio	n				
Characteristic	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe– Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta– Mtianeti	Racha– Svaneti
Electricity 24 hours														
Yes	96.4	96.6	96.2	98.3	97.1	97.7	91.9	99.3	91.8	97.9	97.4	97.6	90.9	98.1
No	3.6	3.4	3.8	1.7	2.9	2.3	8.1	0.7	8.2	2.1	2.6	2.4	9.1	1.9
Source of Drinking Water														
Piped water (piped into dwelling)	53.3	86.8	17.4	19.4	96.8	30.7	44.8	55.8	63.0	16.7	19.8	49.1	38.2	15.9
Piped water (into compound, yard or plot)	22.7	9.2	37.2	42.3	2.7	33.7	23.9	34.8	20.8	23.8	25.7	26.0	36.3	68.5
Piped water/public tap/standpipe	5.8	0.8	11.2	19.6	0.3	11.6	13.7	7.2	2.9	5.7	2.0	2.1	8.0	7.1
Tube well, borehole	1.2	0.3	2.2	1.6	0.1	1.2	0.5	0.0	1.1	3.0	3.2	1.5	3.3	1.3
Protected well	8.4	1.1	16.2	11.0	0.0	5.8	2.8	0.4	1.1	46.2	19.8	16.0	6.8	1.0
Unprotected well	5.3	1.5	9.2	1.6	0.0	12.2	5.0	0.0	0.2	4.2	29.2	3.2	1.0	1.2
Protected srping	2.0	0.2	4.1	2.6	0.0	2.4	5.0	1.1	7.9	0.3	0.2	1.5	4.8	1.4
Unprotected spring	0.8	0.0	1.7	1.1	0.0	1.5	3.3	0.7	0.8	0.2	0.0	0.6	0.7	3.6
Other	0.4	0.0	0.8	0.8	0.0	0.9	0.9	0.0	2.3	0.0	0.0	0.1	0.9	0.1
Toilet Facilities														
Flush toilet piped to sewer system/septic tank	45.8	82.9	6.0	7.3	95.3	19.8	38.2	24.8	54.1	14.2	13.8	41.7	25.8	7.0
Flush toilet piped to somewhere else	2.2	1.3	3.2	6.8	1.1	0.7	2.7	1.9	5.3	0.7	0.5	1.4	5.4	1.4
Ventilated improved pit latrine	1.9	0.9	2.9	2.7	0.5	1.6	2.6	2.8	1.3	1.0	4.9	1.3	1.7	3.6
Pit latrine with slab	34.5	11.1	59.6	64.5	2.0	54.8	42.3	26.6	12.7	69.3	67.8	36.6	33.9	58.2
Pit latrine without slab	14.0	3.4	25.3	18.4	1.0	20.9	13.9	38.7	11.4	14.7	13.0	18.7	32.9	29.6
Hanging latrine	1.4	0.0	2.9	0.3	0.0	0.0	0.1	4.5	15.1	0.2	0.0	0.2	0.2	0.1
No facility/Bush/Field	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.5	0.0	0.0	0.0	0.0	0.1	0.1
Other	0.2	0.4	0.0	0.0	0.1	2.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0
Energy Used for Cooking														
Electricity	3.7	6.3	1.1	0.4	7.5	1.5	2.9	0.6	6.0	1.2	3.3	2.2	3.8	0.2
Natural gas	44.8	73.7	13.8	26.2	89.8	29.3	51.8	9.9	26.9	8.1	3.7	43.8	33.0	1.5
Coal/Wood	39.8	11.5	/0.1	57.6	1.1	55.7	36.1	64.7	39.3	81.3	/5.5	40.7	54.8	96.2
Other	11.6	8.5	15.0	15.8	1.6	13.6	9.2	24.8	27.9	9.5	17.4	13.3	8.4	2.1
Heating System Used in the Household	4.4	0.0	0.4	0.4	4.4	0.5	0.0	0.4	4.0	0.4	0.4	0.4	0.0	0.4
Central neating	1.4	2.0	0.1	0.1	4.1	0.5	0.3	0.4	1.0	1.1	0.1	0.4	0.0 0.5	0.1
Own boller	0.0	1.4	0.2	0.2	1./	0.0	04.0	0.2	1.0	1.2	0.1	0.2	0.0	0.1
Stove besting	20.9 66 5	47.0	9.0	02.0	07.1 20.7	23.9 74.7	24.0 71 E	0.1	CI.3	0./ 00 E	23.2 75.5	21.0 7E 0	00.2	7.0 02.1
No beating	2 1	40.0	09.0	95.0	JZ.1 19	/4./ 0.5	71.0 2.2	93.1	10	09.0	10.5	10.0	00.J 1 2	92.1
Other	0.3	0.2	0.0	0.1	4.2 0.1	0.0	0.3	0.2	1.5	0.0	0.0	0.4	0.4	0.2
Main Roof Material	0.0	0.2	0.0	0.1	0.1	0.0	0.0	0.0	1.0	0.0	0.0	0.4	0.4	0.0
Tile or concrete	26.5	45.3	6.5	31	61.8	8.8	17 2	47	187	71	13.5	22.2	25.3	34
Corrugated iron	36.0	19.6	53.6	42.7	6.8	47.1	48.7	58.9	517	69.7	49.2	38.5	34.0	23.1
Sheet metal	33.2	28.3	38.3	52.8	23.7	42.8	27.4	35.4	27.5	22.5	33.7	36.1	36.1	68.9
Asphalt shingles	2.4	4.5	0.1	0.1	5.2	0.1	5.3	0.0	0.6	0.3	0.9	1.6	1.2	1.0
Natural maternials	1.3	1.6	1.1	0.7	2.0	0.9	0.6	0.6	0.6	0.2	2.6	1.0	2.2	2.5
Other	0.5	0.7	0.4	0.6	0.5	0.2	0.9	0.4	0.8	0.2	0.1	0.7	1.2	1.1
Total No. of Cases	100.0 12,904	100.0 5,708	100.0 7,196	100.0 1,024	100.0 2,636	100.0 817	100.0 1,020	100.0 822	100.0 621	100.0 1,003	100.0 1,050	100.0 1,633	100.0 821	100.0 1,457

(Percentage Distribution)	
Availability of Various Household Amenities and Goods in the Household	
Table 3.1.2	

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		Resid	tence						Region					
Characteristic	Total	Urban	Rural	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe- Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta- Mtianeti	Racha- Svaneti
Т.V.	96.6	97.9	95.1	0.79	97.9	96.1	94.5	96.2	96.3	97.5	95.9	67.7	91.6	90.7
Cellular phone	74.5	81.9	66.5	73.8	85.7	65.4	70.3	79.2	73.3	62.4	64.2	74.0	71.7	57.4
Refrigerator	78.8	89.1	67.9	76.8	92.3	72.7	73.4	73.1	81.0	58.9	72.2	7.77	69.5	57.2
Household phone	56.0	72.5	38.3	44.3	81.9	42.7	47.7	47.2	39.0	49.0	36.7	62.0	34.1	35.9
Working automobile	25.2	28.1	22.0	28.1	30.7	17.4	24.2	31.3	21.4	16.2	21.0	25.0	22.4	12.5
Computer	21.0	35.2	5.8	8.2	47.0	7.8	15.0	13.0	19.5	4.5	7.5	15.6	10.6	3.1
Internet	19.7	34.0	4.4	7.1	46.0	7.1	13.4	10.5	19.2	3.9	6.2	13.6	7.9	2.1
VCR/DVD	18.6	26.0	10.6	12.1	31.0	7.8	18.3	30.4	19.2	6.4	9.2	14.6	13.8	5.2
Satellite dish	21.3	13.9	29.2	29.0	8.3	15.8	33.2	65.0	39.3	12.7	18.1	13.2	30.3	37.7
Vacation home (villa)	6.9	12.2	1.2	0.8	17.5	1.6	3.5	1.8	8.7	1.8	1.7	4.4	2.1	1.1
Air conditioner	3.8	6.9	0.5	0.3	9.4	0.6	2.0	0.5	7.7	0.3	0.9	2.3	1.5	0.0
No. of Cases	12.904	5.708	7.196	1.024	2.636	817	1.020	822	621	1.003	1.050	1.633	821	1.457

Table 3.1.3

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

Characteristic	Total	Resid	lence		V	Vealth Quintil	e	
Characteristic	Total	Urban	Rural	Lowest	Second	Middle	Fourth	Highest
Electricity 24 hours	96.4	96.6	96.2	94.6	96.4	97.0	96.0	97.9
Piped water	76.0	96.0	54.6	45.3	57.3	79.1	98.6	99.9
Flush toilet	48.0	84.2	9.3	0.0	2.4	40.6	97.8	100.0
Cooking with electricity or natural gas	48.6	80.0	14.9	0.2	11.8	46.7	87.7	96.9
Central or individual room healting	31.1	51.5	9.3	0.2	8.0	18.8	47.9	81.1
Uncrowded living conditions*	66.5	57.8	75.8	76.1	76.3	73.0	61.4	45.4
T.V.	96.6	97.9	95.1	89.3	98.0	97.8	98.0	99.8
Cellular phone	74.5	81.9	66.5	43.4	74.0	79.2	78.1	97.7
Refrigerator	78.8	89.1	67.9	41.7	78.2	85.2	90.4	98.9
Household phone	56.0	72.5	38.3	15.9	41.3	59.0	70.3	93.7
Working automobile	25.2	28.1	22.0	3.2	25.3	28.9	20.9	47.3
Computer	21.0	35.2	5.8	0.0	1.1	11.7	18.8	73.7
Internet	19.7	34.0	4.4	0.0	0.6	8.8	17.6	71.7
VCR/DVD	18.6	26.0	10.6	0.6	9.3	17.6	19.5	45.8
Satellite dish	21.3	13.9	29.2	17.6	29.0	30.7	13.0	16.1
Vacation home (villa)	6.9	12.2	1.2	0.2	1.0	1.8	4.2	27.3
Air conditioner	3.8	6.9	0.5	0.0	0.1	0.4	1.6	17.2
No. of Cases	12,904	5,708	7,196	3,312	2,815	2,603	2,121	2,053

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

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

Table 3.1.4Percentage Distribution of Households by Wealth Quintiles by Residence and Region
Reproductive Health Survey: Georgia, 2010

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

Characteristic	Total		Residence	
Characteristic	TOTAL	Tbilisi	Other Urban	Rural
Age Group				
15–19	17.9	17.2	17.7	18.6
20–24	18.9	20.3	18.9	18.0
25–29	16.6	16.3	16.3	17.0
30-34	16.3	17.2	16.2	15.9
35–39	15.8	14.9	16.3	16.1
40-44	14.4	14 1	14.5	14.5
Marital Status			11.0	11.0
l egally married	57.9	50.2	57.2	62.8
Consensual union	12	1 4	13	12
Previously married	6.5	87	7.2	4.8
Never married	34.4	39.8	34.2	31.2
Number of Living Children	01.1	00.0	01.2	01.2
0	41 3	46.8	41.6	37 9
1	41.0 19.0	21.8	20.7	16.5
2	29.5	21.0	20.7	31.8
3	20.0	5 1	6.5	11.0
1 or more	1.0	1.1	1.5	2.6
Education	1.5	1.1	1.5	2.0
Secondary incomplete or less	22.6	12.6	17.8	31.2
Secondary complete	22.0	17.5	21.7	30.6
	24.7 13.2	10.0	21.7	1/ 6
Lipiyorsity/Postaraduato	13.2 30.4	10.0 60.0	14.1	14.0
Wealth Quintile	55.4	00.0	40.5	25.0
	14.6	0.5	3.5	28.0
Second	14.0	0.5	7.6	20.9
Middlo	21.5	0.5	26.0	28.0
Fourth	18.5	4.0 27.0	20.0	20.5
Highest	25.0	66.7	07.0	4.0
Employment	20.0	00.7	21.5	0.5
Working	21.3	30.9	25.7	13 3
Notworking	78.7	69 1	74.3	86.7
Ethnicity	10.1	00.1	14.0	00.7
Georgian	988 0	01 3	02.5	81.2
Azeri	5.2	0.0	2.5	01.2
Armenian	5.2	0.5 4 2	2.5	7.0
Other	2.8	3.6	2.0	2.5
Religion	2.0	0.0	۲.4	2.0
Georgian Orthodox	82.4	92.1	80.2	73.0
Other Orthodox	۵۲.۲ ۵ Q	4.8	3 3	6.0
Muslim	4.9 10 5	4.0	6.2	18.4
Other	16	1.0	0.2	2.0
No Religion	0.5	0.4	0.5	0.6
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	1,426	1,549	3,317

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

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



Fertility and Pregnancy Experience

imilar to previous RHS surveys, the GERHS10 collected information on current, past, and cumulative fertility and identified factors that influence fertility behaviors. Information on childbearing patterns was collected in several ways. First, each woman age 15-44 was asked a series of questions on the number of sons and daughters living with her, the number living elsewhere, and the number who may have died. Next, each woman was asked to give a detailed history of all pregnancy outcomes, which consisted of information about all births, abortions, and fetal losses, month and year of each pregnancy outcome, pregnancy duration, and survival status of each birth. For dead children, the age at death was recorded. Women were also asked to recall the pregnancy intention at the time of getting pregnant for each pregnancy they might have had during the last five years. Finally, information was collected on whether the woman was pregnant at the time of the survey.

This information represents an important addition to vital statistics routinely compiled at the local and state level, because it allows for analysis of fertility and abortion differentials by background characteristics and health behaviors. It also allows for more accurate national and regional estimates of pregnancy events, particularly related to pregnancies ending in abortion, which are seriously underestimated in the health management information system (Serbanescu et al., 2001).

4.1 Fertility Levels and Trends

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

According to the official statistics, fertility levels have been declining steadily over the last three decades in the former Soviet Union countries with most prominent declines observed between 1985 and 1995; however fertility levels, trends and the pace of decline differed between the Central Asia republics and the European part of the former Soviet Union (WHO, 2011a). The decline in TFR started sooner in Central Asia and the pace of decline was faster resulting in the present convergence of fertility rates (Figure 4.1.1). In the mid-1980s, the disparity between regions with the highest (Central Asia) and the lowest fertility (European Soviet Union) was over 3 births per woman. By the mid-1990s, this difference had decreased to 2 births per woman.



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

The information obtained from the birth histories collected in surveys is another source of computing total fertility rates. Similar to analyses performed in the 1999 and 2005 surveys, the pregnancy histories were used to calculate two of the most widely used measures of current fertility—the total fertility rate and its component age specific fertility rates. These measures are based on information from each woman's pregnancy history regarding the month and year of each live birth and the maternal age at the time of delivery.

The total fertility rate (TFR) for a period is computed by accumulating the age-specific fertility rates (ASFRs) in each 5-year age group and multiplying the sum by five (the number of years in each group). The TFR for a period is thus defined as the average number of live births a woman would have during her reproductive lifetime (ages 15–44 years) if she experienced the currently observed ASFRs for that period. ASFRs are expressed as the number of births to women in a given age group per 1,000 women in that age group. In this survey, as in the previous rounds, the ASFR for any five-year age group was calculated by dividing the number of births to women in that age group, during the period 1 to 36 months preceding the survey, by the number of woman-years lived by women in that age group during the same period. Age-specific fertility rates are very useful in understanding the age pattern of fertility.

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

As in previous comparisons, the survey-based total fertility rate for the most recent 3 years was higher than the corresponding TFR based on vital registration figures. In the previous Georgian survey rounds, the underestimation of births in the vital registration has been attributed mainly to two factors: 1) undercounting of births in the numerator, mainly due to delays in birth registration and 2) denominator inflation due to the use of inaccurate population projections (Serbanescu et al., 2001; Aleshina and Redmond, 2005). As shown later in this report, early registration (within the first 2 weeks after birth) was almost universal among children born in the last 5 years in Georgia, so under- registration of births is unlikely to explain differences in the TFR. The persistence of inflated denominators is still an issue, since the census projections are done without adjustment for out-migration and overestimate women of childbearing age. This may result in underestimation of the fertility rates and other official population-based statistics.

The ASFRs and corresponding TFR for the period 2007–2010 are shown in Table 4.1 and Figure 4.1.3. Traditionally, Georgian women initiate and complete childbearing at an early age, as reflected in very high age-specific fertility rates for young women. The highest fertility levels were among 20to 24-year-old and 25- to 29-year-old women, accounting for 36% and 29%, respectively, of the TFR. Fertility among adolescent women (39 births per 1,000 women aged 15-19 years) contributed to only 10% of the TFR. Fertility among women aged 30-34 years was the third-highest ASFR, contributing 15% of the TFR. Women aged 35-39 and 40-44 had minimal contributions to total fertility; their ASFRs accounted for only 8% and 3%, respectively, of overall fertility. Thus, 26% of the period TFR was contributed by births to women aged 30 or older.

Using data from all Georgia reproductive health surveys, period fertility rates can be compared across three 3-year periods (Table 4.1.1 and Figure 4.1.4).







In the most recent survey, there is an increase of 25% in the 3-year (2007-2010) total fertility rate, compared to the rate during 2002-2005. Compared to the period 1996-1999, the TFR increased by 18%. Age-specific fertility rates increased in all but one age group, the group of women, suggesting adolescent a gradual transition to fertility postponement in Georgia. Among the youngest age group, the fertility dropped from 65 births per 1,000 between 1996-1999, to 47 births per 1,000 in 2002-2005 and to 39 births per 1,000 during the most recent 3-year period (2007-2010). As a result, the ASFRs for 15- to 19-year-old women declined by 40% between 1996-1999 and 2007-2010. At the same time, the ASFRs of women aged 20-24 and 25-29 increased by 26% and 25%, respectively. As a result, their contribution to the period total fertility rate increased from 59% to 65% between 1996-1999 and 2007-2010. There was also a notable change in fertility among older women: ASFRs of women aged 30-34, 35-39, and 40-44 increased by 29%, 43%, and 57%, respectively. As a result, their contribution to the period total fertility rate increased from 22% to 26%.

Table 4.1.2 shows the number of children ever born among all women and women currently married who were interviewed in the GERHS10 (calculated as the percentage distribution of women by the number of live births and stratified by the current age of each woman at the time of the interview). Information on cumulative past fertility reflects the accumulation of births over a woman's entire childbearing years and is useful in looking at how average family size varies across age groups. These data, however, have a limited relationship to current fertility levels. Overall, 41% of all women aged 15–44 years were childless at the time of the interview, 18% reported giving birth to only one child, 29% gave birth to two children and 13% gave birth to three or more children. Although only 5% of women aged 15–19 years reported giving birth, 69% of women aged 25–29 had given birth. About one in ten women remained childless among women aged 40–44.

Among currently married women, 26% have had only one live-born child, 45% have had two children, and 19% have had three or more children. One in ten currently married women age 15-44 has never had a child. Almost one in two of the few adolescent women (15- to 19-yearolds) who were married have already had her first child; 79% of married women aged 20-24 years have already given birth and 92% of women aged 25-29 years have had their first child. Five percent of married women aged 35-44 remained childless—suggesting fertility impairment, because voluntary childlessness is rare in Georgia and most couples tend to have at least one child.

4.2 Fertility Differentials

In examining fertility trends, it is useful to compare its levels among various subgroups of women. Fertility levels vary by social, cultural, and economic factors, which influence decision making regarding the number of children a woman or couple decides to have (indirect determinants of fertility).

Fertility among women living in urban areas, including Tbilisi, was on average almost 10%

lower than among rural-dwelling women in the 3-year period preceding the interview (Table 4.2). Most of the difference between rural and urban fertility rates was due to higher ASFRs among rural residents aged 15-19, 20-24 and 25-29 years. Fertility rates at age 35 and older were higher in urban than in rural areas. By region, fertility rates were the lowest in Guria (1.7 children per woman); fertility was the highest in Mtskheta-Mtianeti and Racha-Svaneti (2.3)children per woman), followed by Adjara (2.2. children per woman) and Samtskhe-Javakheti and Kakheti (2.1 children per woman) (Figure 4.2.1). The highest adolescent ASFR was reported by residents of Kakheti, Kvemo-Kartli, and Racha-Svaneti (Figure 4.2.2), probably because the average age of first marriage and first birth is lower in these regions than in the rest of the country. Fertility differences according to education were more pronounced among younger women. Generally, peak fertility occurred at ages 25-29 among women with the highest educational attainment, whereas peak fertility among women with lower educational levels occurred at ages 20-24. Fertility rates of the Azeri minority (2.4 children per woman) were higher than those of the Georgians, the major ethnic group (2.0 children per woman), due to much higher ASFRs among Azeri women aged 15-24 (Figure 4.2.3).







4.3 Planning Status of the Last Pregnancy

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

consequences, in turn, have a broad societal impact such as the burden placed on the family, the increase in governmental health expenditures and the financial assistance for women living in poverty.

Conventional measures of unintended pregnancy are designed to reflect a woman's intentions before she became pregnant (Henshaw, 1998). Thus, for each pregnancy ended since January 2005, all respondents were asked about the planning status of their pregnancies at the time of conception. Each pregnancy was classified as either planned (i.e., wanted at the time it occurred), mistimed (i.e., occurred earlier than desired), unwanted (i.e., occurred when no children, or no more children, were desired), or unsure. Mistimed and unwanted pregnancies together constitute unintended or "unplanned" pregnancies (Westoff, 1976) (Figure 4.3.1).



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

In GERHS10, almost two thirds (63%) of women who have been pregnant in the past 5 years reported the last pregnancy as planned; 11% reported their last pregnancies as mistimed and 26% as unwanted, resulting in 36% of unplanned pregnancies at the last pregnancy experience (Table 4.3). This compares with a level of 51% of women reporting their last pregnancy as unplanned in 2005 and 59% in this category in 1999 (Figure 4.3.2). As in previous surveys, the majority of unplanned pregnancies were unwanted, but more mistimed pregnancies were reported in 2010 than in any previous survey. In the GERHS10. 11% of women reported their pregnancies as mistimed, accounting for 31% of unplanned pregnancies. Fewer women reported their unplanned pregnancies as mistimed in 2005 (23%), and in 1999 (17%), indicating an increased need among Georgian couples for spacing births through adequate contraceptive methods.



The majority of women whose last pregnancies resulted in live births said those births were intended (94%). Conversely, all but a small percentage of women whose last pregnancy ended in induced abortion reported that their conceptions were unplanned (96%). A relatively high proportion (19%) of women whose last pregnancy ended in miscarriage or stillbirth reported that it was an unwanted conception. This is almost 10 times the proportion of women with live births who reported an unwanted pregnancy, suggesting that either unintendedness had a negative influence on pregnancy development and outcome or some of these outcomes may have been in fact induced abortions, misreported as other fetal losses. The high rate of unintended conception among pregnancy ended in miscarriage or stillbirth was similar to that observed in the 1999 and 2005 (Serbanescu et al., 2001, 2007).

Both the proportion of pregnancies that were unplanned and the ratio between unwanted and mistimed conceptions varied with age and the number of living children. The proportion of planned pregnancies surpassed those unplanned in all age groups except the women aged 40-44 years. Among 15- to 19-year-olds, only 16% of pregnancies were unintended; the majority of their unintended pregnancies was mistimed rather than unwanted (the unwanted-to- mistimed ratio for these women was about 1:2). Among women aged 20 years or older, more pregnancies were unintended, and the unwanted-to-mistimed ratio ranged from almost 1.5:1 among 20- to 24-year-olds to 2:1 among 25- to 29-year-olds, almost 4:1 among 30- to 34-year-olds, and almost 15:1 among those aged 35 years or older (Figure 4.3.3).



Thus, mistimed pregnancies were rapidly replaced by unwanted pregnancies with an increase in maternal age, primarily because the desire for birth-spacing is replaced by the desire to terminate childbearing. As a result, virtually all unintended pregnancies were unwanted at older ages. Similarly, women who had never had a live birth and women with only one child (presumably younger women) were less likely to report that their last pregnancies were unwanted than were women with two or more live births (Figure 4.3.4).

Rates of unintended pregnancy and particularly unwanted pregnancy were higher among women with the lowest education level and those with the lowest wealth quintile. These rates were slightly higher among women with an Azeri or Armenian background than among Georgian women.

4.4 Future Fertility Preferences

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

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



The data presented in Table 4.4.1 and Figure 4.4.1 demonstrate that more than one in three women currently married or in consensual union wanted more children; an additional 6% were unsure if they wanted to have more. Nine percent of women reported that either they or their partners were infecund. Those women were not asked about their future fertility preferences.

Future fertility preferences are strongly influenced by the number of living children. For example, 70% of married women with no children wanted to have a child and almost all of them (66%/69.6%=95%)wanted to have a child within two years. Among women with one living child, 71% wanted to have another child in the future, including 37% who would like to have a child within the next two years. This percentage decreased rapidly to 21% among women with two children, and 8% among women with three or more children. Conversely, the intention to have no more children increased rapidly with increasing number of living children (Figure 4.4.2). Among women who had had three or more children, the majority (81%) were ready to terminate childbearing. Conversely, among those with no living children, only 1% said they did not want children.

The changes in fertility preferences across the three RHS in Georgia are very relevant in interpreting the recent transition to higher fertility rates documented in GERHS10. As shown in Figure 4.4.3, the proportion of women who stated they wanted to have more children increased from 25% in 1999 to 35% in 2010, a 40% increase. This trend was consistent regardless of the number of living children.





Particularly notable is the relatively high proportion of women with two or more children (21%) who said in 2010 they want more children, compared to only 12% in 1999.

The study of fertility patterns in Georgia has demonstrated a high concentration of childbearing at relatively young ages. Not surprisingly, the desire to have children was very high among young Georgian women (89% among 15–19 year-olds and 73% among 20–24 year-olds), dropped to 47% among 25- to 29-year-olds and declined further among women aged 30 or older (bottom panel of Table 4.4.1). Among women aged 29 or younger who desired additional children, one in two wanted to wait at least 2 years. Women aged 30 or older who wanted more children were more likely to want the child within the next two years and by age 40 almost all women wanted to have a (another) child within the next two years.

Between 1999 and 2010, there are notable changes in the timing of having a (another) child by the current age. Among the youngest women, the proportion who wanted a child within two years had declined by 29% (from 61% to 44%) but much higher proportions of women aged 30 or older wanted to have a (another) child within the next two years. These findings are consistent with the observed decline in adolescent age specific fertility rates and increased fertility of women aged 30 years or older and may predict future increases of childbearing among older women.

Table 4.4.2 shows the proportion of married women who can get pregnant (i.e., fecund women) but want no more children. This is a more accurate analysis



of women who want no more children and may be at risk of unintended pregnancy. Further, by excluding the infecund women, this analysis allows a better examination of trends (between 1999 and 2010 there was a 40% reduction in this group, from 14% to 9%). The inverse relationship between wanting no more children and parity is more pronounced. Overall, 54% of Georgian women who could conceive reported that they did not want to have more children, but this proportion increased from 18% among those with one living child to 87% among women with three or more children (Table 4.7.2 and Figure 4.4.5). Among women with one child, the desire to have no more children was higher for urban women as for rural women (21% vs. 15%) and increased directly with the education level.

At any parity, the intention to terminate childbearing was directly correlated with age. This pattern is similar to the one documented in the 1999 and 2005 surveys, but fewer women with two or more children in 2010 said they do not want to have a (another) child.

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


In conclusion, the decline in fertility observed in Georgia in 1990s and early 2000s was likely precipitated by the economic and social impact of the post-Communist transition. The recent fertility recovery documented by GERHS10 coincided with the recent economic growth and political stability in the country. Currently, the adolescent fertility rate has declined but women of childbearing age have an increased desire for additional children and a lesser likelihood to experience unintended pregnancies than their counterparts 5 years ago. Consequently, an increasing number of women have the number of children they want when they want them and fewer state they want no more children. As such, it is essential for the family planning efforts in Georgia to provide contraception advice that adequately takes into account the fertility preferences of the individuals and their plans for onset, spacing and completion of childbearing.

Table 4.1.1Three-Year, Age-Specific Fertility Rates and Total Fertility Rates
for Three Time Periods Among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 1999, 2005 and 2010

	Age-Specific Fertility Rate (per 1,000 Women)*					
	2007–2010 GERHS10 [†]	2002–2005 GERHS05 [‡]	1996–1999 GERHS99 [¶]			
	20	47	65			
15–19	59	47	05			
20–24	142	109	113			
25–29	115	85	92			
30–34	62	47	48			
35–39	30	18	21			
40–44	(11)	(7)	(7)			
Total Fertility Rate (Per Woman)	2.0	1.6	1.7			
General Fertility Rate (per 1, 000 Women)	72	55	66			

* Age at birth

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

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

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

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

Table 4.1.2	Number of Children Born Alive by Current Age of Respondents
	Among All Women and Among Married Women Aged 15–44 Years
	Reproductive Health Survey: Georgia, 2010

	All Women								
Number of Children Born Alive	Total			Age G	roup				
	TOTAL	15–19	20–24	25–29	30–34	35–39	40–44		
0	<i>A</i> 11	94.8	59.3	31.2	10 1	15.2	15 3		
1	18.4	4.6	27.3	27.5	18.0	16.8	15.4		
2	28.5	0.5	12.0	33.5	45.7	44.8	42.0		
3	9.3	0.1	1.3	7.3	13.4	16.9	20.6		
4 or more	2.7	0.0	0.0	0.5	3.8	6.2	6.7		
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0		
No. of Cases	6,292	861	1,099	1,191	1,168	1,051	922		
	Married Women								
Number of Children Born Alive	Total	Age Group							
	TOLAI	15–19	20–24	25–29	30–34	35–39	40–44		
	_								
0	9.7	55.5	20.6	8.0	5.7	5.0	4.7		
1	26.0	39.6	52.5	35.5	18.0	15.5	12.4		
2	45.4	4.2	24.1	46.0	55.7	52.5	49.5		
3	14.8	0.7	2.6	9.8	16.3	19.6	25.5		
4 of more	4.1	0.0	0.1	0.7	4.3	1.5	7.9		
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0		
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0		
Total No. of Cases	100.0 4,098	100.0 124	100.0 610	100.0 863	100.0 948	100.0 836	100.0 717		

Table 4.2Three-Year* Age-Specific Fertility Rates and Total Fertility Rates
by Selected Characteristics Among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

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

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

Table 4.3

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

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

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

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

Table 4.4.1Fertility Preferences by Number of Living Children and Age GroupAmong Married Women Aged 15–44 YearsReproductive Health Survey: Georgia, 2010

Proforance for Children	Total	Number of Living Children*						
	TOtal	()	1	2	3 or 1	more	
Want more Children	<u>35.3</u>	<u>69</u>	<u>.6</u>	<u>70.8</u> <u>20.5</u>		<u>7.9</u>		
Want pregnancy right away	9.5	54	.7	14.2	3.6	1	.9	
Want a child within a year	4.0	8	.1	7.0	2.3	2	.3	
Want a child 1-2 years	7.3	3	.2	16.1	5.1	1	.0	
Want a child 2 or more years	14.5	3	.6	33.5	9.5	2	.7	
Undecided	6.3	0	.4	3.9	9.0	4	.7	
Want no (no more) children	49.7	0	.8	16.6	63.7	80	.8	
Subfecund, infecund couple	8.7	29	.2	8.7	6.7	6	.7	
Total	100.0	100.0		100.0	00.0 100.0 100.0		.0	
No. of Cases	4,098	28	31	1,110	2,053	654		
Broforonco for Children	Total			Age Group				
Preference for children	Total	15–19	20–24	25–29	30–34	35–39	40–44	
					-			
Want more Children	<u>35.3</u>	<u>88.9</u>	<u>72.8</u>	47.0	<u>31.1</u>	17.4	<u>7.2</u>	
Want pregnancy right away	9.5	29.9	14.1	11.5	9.0	7.1	3.2	
Want a child within a year	4.0	3.6	6.4	3.3	4.5	3.9	2.2	
Want a child 1-2 years	7.3	11.2	17.5	8.3	7.1	3.8	1.1	
Want a child 2 or more years	14.5	44.2	34.8	23.9	10.5	2.6	0.7	
Undecided	6.3	3.7	8.1	9.0	8.3	4.9	1.8	
Want no (no more) children	49.7	7.4	17.6	38.7	53.2	66.4	72.6	
Subfecund, infecund couple	8.7	0.0	1.5	5.3	7.4	11.4	18.5	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
No. of Cases	4,098	124	610	863	948	836	717	

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

Table 4.4.2Percentage of Fecund Married Women Aged 15-44 Years Reporting They Want
No More Children, by Number of Living Children and Selected Characteristics
Reproductive Health Survey: Georgia, 2010

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

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

Chapter 5

Induced Abortion

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

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

After consistency checks were performed, the data collected on pregnancy histories were used to calculate age-specific and total abortion rates, in a manner similar to age-specific and total fertility rates. It should be noted that surveybased abortion statistics are often a better source of information about abortion in many countries in Eastern Europe (see below). The use of selfreports allows direct estimates of abortion levels among all subgroups of women (including those who seek care outside the formal health system); provides geographic, demographic and socioeconomic characteristics of women who have had abortions (thus identifying subgroups with high unmet need for family planning); simplifies analysis because both the numerator and denominator of interest are readily measurable; and allows abortion to be examined in context with other sexual and reproductive health data. Survey data also have the added benefit of placing abortion research within a broader context of social and reproductive health behaviors, such as fertility and union dynamics, demand for contraceptive methods and unmet need for family planning.

5.1 Abortion Levels and Trends

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

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

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

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

Accurate estimates of abortion incidence are difficult to obtain in any country. The accuracy of abortion statistics depends on the presence and quality of health information infrastructure, the



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

The RHS surveys in Eastern Europe provide a quick and affordable way to obtain more complete data on abortion than those provided by the routine health information systems. Despite a certain degree of sampling error and some inherent limitations (omissions, misclassification of abortions that are obtained outside the legal system, and poor recall of events that occurred long before the survey date), survey-based measurements in Eastern Europe generally allow for a better estimate of abortion rates and ratios than the official statistics. Figure 5.1.2 compares abortion statistics from the surveys and from government sources in terms of the general abortion rate (GAR), a summary measure that indicates the annual number of abortions per 1,000 women of reproductive age. With the exception of Moldova, where there is good agreement between the abortion levels from both data sources, in all other countries the survey estimates exceed government rates by at least 20%. In the Caucasus, the survey estimates are several times higher than official rates-which suggests the presence of a breakdown in the government system for collecting abortion statistics. Overall, it appears that government statistics underestimate abortion levels in most of the surveyed countries.

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

As shown in Figure 5.1.3, the abortion trends in Georgia are very different based the official

statistics when compared to the survey reports and do not inform health policies about the real demand for contraceptive methods and unmet need for family planning. Reported vital statistics data indicate a steep decline in the total abortion rate since the break up of the former Soviet Union (from 1.8 abortions per woman in 1989, to 0.6 abortion per woman in 1997-1999, to 0.4 abortion per woman in 2002-2004) and a recent increase to almost one abortion per woman for the period 2008–2010. This trend, however, is not paralleled in the RHS data. Previous RHS surveys showed a steep increase in the TIAR after 1990, with a peak of 3.7 abortions per woman in 1997-1999. The abortion rate declined gradually to a level of 3.1 abortions per woman (95%CI= 2.9-3.4 abortions per woman) in 2002–2005. Between 2005 and 2010, the abortion rate dropped significantly to 1.6 abortions per woman (95%CI= 1.5-1.8 abortions per woman), a 48% decline (Table 5.1. and Figure 5.1.4).

The abortion decline documented in the surveys is consistent with the increase in fertility levels, fertility desires and use of modern contraceptive methods (Figure 5.1.5). However, to verify that potential changes in women's willingness to disclose abortion experiences did not affect significantly the downward abortion trend, a validation of survey-based abortion levels was performed.







Without the existence of reliable national data, there are few options for estimating the level of completeness of abortion reporting in populationbased surveys. Consistency of reporting on abortion may be examined by comparing abortion rates for the same cohorts of women in the same period of time from successive surveys. The 5year, age-specific abortion rates of women aged 15–39 in the period 6–8 years before the most recent cycle of the survey (GERHS10) was found to be within confidence intervals of the corresponding abortion rates for the same calendar period (2002–2005) using data from the GERHS05 (Figure 5.1.6).

Table 5.1 also presents age specific abortion rates for women aged 15–44 years for three time periods. To avoid age truncation, the most recent 3-year period before each survey is shown. As such, the ASIARs per 1,000 women aged in 5year age groups represent the proportion of women in each specific age group who terminated pregnancy by induced abortion within the 3-year period preceding each survey. The rates were calculated by using the month and year of each abortion and the age of the woman at the time of the pregnancy's termination.

The GERHS data were also used to calculate the general abortion rate (the number of abortions per 1,000 women aged 15–44) in the 3 years preceding each survey. The general abortion rate dropped from 125 abortions per 1,000 women aged 15–44 years in 1996–1999 to 104 per 1,000 in 2002–2005 and 56 per 1,000 in 2007–2010.

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



The survey-based estimate of the abortion-tolive-birth ratio changed from to 2.1 induced abortions for each live birth (2.1:1) in GERHS99, to 1.5:1 in GERHS05 to 0.8:1 in GERHS10. Thus, birth experience surpassed abortion experience for the first time since survey-based reports were collected. This was mainly achieved by a combination of increases in fertility and declines of abortion in the age-groups 20–24, 25– 29, and 30–34 which contribute the most to both total fertility and total abortion rates (Figure 5.1.7).

Unlike fertility, which is most concentrated at ages 20 - 24years, abortions are most concentrated at ages 25-29 years (102 induced abortions per 1,000 women) and 30-34 years (83 per 1,000), the two age groups that account for more than half (56%) of the TIAR. The third highest age specific abortion rate, contributing to 25% of the TIAR, occurred among women aged 35-39 years. The ASIARs were significantly higher than ASFRs only among women aged 30 or older, suggesting that most Georgian women continue to achieve their desired family size before age 30 after which, in the event of having unplanned pregnancies they are more likely to end them in induced abortions (Figure 5.1.7).

The same age-specific distribution pattern (a concentration of abortions among 25–29-, 30–34and 35–39-year-olds) was documented in previous surveys (Table 5.1 and Figure 5.1.8). The greatest drop in abortion rates, however, was observed among women aged 15–24 years (a 65%





decline), who are now almost three times more likely to have births than abortions. However, while sizable, these decreases in abortion rates among younger women had a lesser impact on the overall decline, since their contribution to the total abortion rate was relatively low (20% in 2007–2010, 22% in 2002–2005 and 26% in 1996– 1999).

The declines that contributed the most to bringing down the total abortion rate in 2007– 2010 were among 25–29 year olds (47%) and 30– 39-year olds (53%). Women aged 40–44 years also reported steep declines but their contribution to the overall abortion rate in all periods was consistently low.

5.2 Induced Abortion Differentials

Table 5.2 shows total and age-specific abortion rates among all women by the women's background characteristics. Women in rural areas continue to have much higher age-specific and total abortion rates than urban women (Figure 5.2.1). Abortion rates were higher among rural women than urban women at all ages, but the highest difference (almost 2.4 times higher) was observed among women aged 25–29 years, the group that accounts for the largest contribution to the TIAR.

Total abortion rates were highest among residents of Kvemo Kartli (2.4 abortions per woman), and





among residents of Shida Kartli, Samegrelo, Guria, Mtskheta-Mtianeti, and Kakheti (1.9–2.2 abortions per woman) (Figure 5.2.2). The lowest TIARs were documented in Tbilisi, Racha-Svaneti, and Adjara (1.1–1.2 abortions per woman). The TIAR was highest for women with less than complete secondary education; on average, these women underwent 1.7 abortions more than women with a university education (2.7 abortions vs. 1.0 abortion per woman).

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

5.3 Abortion Services

As part of the former USSR, Georgia was subject to liberal abortion legislation issued by the Soviet Supreme Council in November 1955. The law remained in force for many years, essentially unchanged except for several minor additions and modifications. Briefly, these changes allowed for abortion by electric vacuum aspiration; permitted



abortions in the first 7 weeks of pregnancy (miniabortions) to be performed in ambulatory clinics; authorized abortion on medical and social grounds up to 28 weeks of gestation; and legalized "commercial" abortions in private clinics and for-fee sections of state hospitals (USSR MOH, Order No. 234 of March 1982, order No. 757 of June 1987 and Order No.1342 of December 1987).

These provisions constituted the foundation for legal abortion in Georgia until 1997, when the new healthcare law included detailed provisions concerning abortion and contraception practices (Government of Georgia, 1997). Under the current law, abortion is permitted without restrictions as to reason during the first 12 weeks and for social or medical reasons beyond 12 weeks (IPPF, 2007). A written consent of the woman and pre-abortion counseling are necessary before the abortion. Parental consent is required for adolescent girls under 16 years of age. Induced abortion can be performed only by gynecologists, using either vacuum aspiration or sharp curettage; abortion procedures are permitted only in medical facilities that have been state-certified for performing abortion. Abortion patients are typically released the same day of the procedure if they do not have postabortion complications. Outpatient medical facilities (e.g., women's consultation clinics and private clinics) can perform induced abortion only by vacuum aspiration.

The cost of abortion procedures is not covered by health insurance, but is relatively low. Unofficial payments or payments for 'extra' services, such as anaesthesia, can increase the cost by a considerable amount. The standard abortion module in RHS includes information on respondents' last four abortions performed during a period of 5 years prior to the survey. For each abortion, questions are asked about the reason for abortion; the place where the procedure was performed; abortion registration and payments; use of local or general anesthesia and antibiotic prescriptions; number of nights, if any, spent in the hospital after the procedure; the experience of any early or late complications after the abortion; and the type of counseling received before or/and after abortion. Data are collected starting with the most recent procedure, in an attempt to minimize recall biases.

Of all abortions reported by survey respondents in the past 5 years, the majority (71%) were miniabortions (Table 5.3.1 and Figure 5.3.1). The high proportion of mini-abortions contrasts with the level documented in 1999 and 2005, when only 40% and 56% of all abortions, respectively, were reported as mini-abortions. Mini-abortions were more prevalent among respondents residing in Tbilisi, Shida-Kartli and Adjara (over 80% of all abortions) (Figure 5.3.2). Urban residents (81%) were more likely to have had miniabortions than rural residents (63%). The proportion of abortions classified as miniabortions decreased somewhat with woman's age and increased directly with education and SES.

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

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

About 1 out of 4 abortions (26%) were reportedly due to contraceptive method failure, most of them (76%) due to failure while using a traditional method (either withdrawal or periodic abstinence) (Table 5.3.3). There was little variation in reporting contraceptive method failure leading to an abortion, except for lower rates among residents of Samegrelo and Shida







Kartli, and among women of other ethnic groups than the main ethnicities in Georgia. However, failure of traditional methods was more likely to be reported by women in rural areas, older women, women with the lowest wealth quintile, and women of Azeri or Armenian ethnic background.

In Georgia, almost all abortions are performed for a fee (which may vary from one facility to another). Reported average abortion payments were lower among rural women than urban women and increased directly with the SES of the household (Table 5.3.4).

At the time of the survey, mean charges for an abortion procedure were almost 48 Georgian Lari or GEL (about US\$29.00), which represents an increase of 65% compared to the average cost in 2005 (data not shown). On average, the cost of an induced abortion was 10 GEL more than of a mini-abortion;

similarly, abortions performed at 10 or more weeks of pregnancy were more costly than abortions performed in the first 9 weeks of pregnancy (64.8 GEL vs. 45.8 GEL). The average abortion payment did not vary by type of medical facility. The amount paid for an abortion ranged from no payment to over 100 GEL. Only 2.3% of abortions were performed at no charge; 29% of abortion payments were 34 GEL or less, 23% were between 35–49 GEL, and 45% were 50 GEL or more, including 6% that were more than 100 GEL.

Most of the abortions in the five years preceding the surveys were obtained because a woman wanted no more children (51%) or because the family socioeconomic circumstances could not support another child (20%) (Figure 5.3.4). Nearly 1 in 5 abortions (18%) were obtained because the woman wanted to space childbearing, 8% were



obtained for health-related reasons (either maternal or fetal) and 2% for partner-related reasons (e.g., the partner objected to the pregnancy). It is worth noting that 1.4% of women stated they obtained abortions because of the sex of the fetus, which was known prior to the decision to terminate the pregnancy (data not shown). Compared to 2005, women in 2010 were less likely to have abortions for limiting fertility and more likely to have them for health reasons and partner-related reasons.

Women who decide to end their pregnancies in abortion and do not adopt an effective contraceptive method afterwards are likely to be at high risk for another unintended pregnancy during the immediate post-abortion period. Family planning counseling around the time of the abortion procedure is mandated as part of the Georgian healthcare law. Similar to previous surveys, GERHS10 asked all respondents who had an abortion in the last five years if they 1) received any family planning advice either before or after the abortion procedure; 2) received any contraceptive method or a prescription for any method; and 3) were referred to a family planning facility following the procedure (Table 5.3.5).

The Ministry of Labor, Health and Social Affairs introduced in 2000 a decree regarding family planning counseling after abortions performed in WCC (MoLHSA, Decree number 136, 2000) In paragraph 11, the decree states that every woman who has terminated a pregnancy through vacuum aspiration should be given information on modern methods of contraception (attending physician required to obtain the patient's signature to certify counseling was provided) and a method should be selected after counseling. Training on family planning counseling and service provision is currently included in the post-graduate and licensing programs for Ob/Gyns and reproductiologists. Despite legal regulations along with significant amounts of resources and technical efforts invested in FP counseling by the donors, the receipt of family planning services around the time of having an abortion remains quite limited. One in three (33%) respondents with a history of at least one abortion on request in the last five years reported receiving contraceptive counseling before or/and after the abortion; most of them had counseling after the abortion procedure or both before and after. Contraceptive counseling was the highest in Imereti (46%) and the lowest in Samtskhe-Javakheti (14%). It increased slightly with education and wealth quintile and was higher among Georgian women than among women of other ethnic backgrounds. Unfortunately, receipt of contraception counseling did not vary significantly by the abortion order (Figure 5.3.5). Although the highest exposure to counseling was reported by women with four or five abortions, , women with six or more repeat abortions had the same likelihood of receiving contraceptive information, supplies, or a prescription for supplies as did women with only one abortion in the last 5 years.

Only 6.6% of all women with a history of abortion in the past five years (20% of women who received counseling) received a contraceptive method to prevent future unintended pregnancies. An additional 7.4% of women received a prescription for contraceptive supplies (22% of all women counseled). Both receipt of contraceptive supplies and receipt of prescription were low across all subgroups, excepting among women in Imereti (16% and 10%, respectively). Receipt of contraceptive information in 2010 was more than twice the level documented in the 1999 survey (33% vs. 15%); more importantly, receipt of a contraceptive method or prescription for a method had almost tripled, from 5% to 14% (Figure 5.3.6).

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





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

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

* Age at induced abortion

† Abortions occurring between October 2007 and September 2010.

‡ Abortions occurring between March 2002 and February 2005.

 \P Abortions occurring between December 1996 and November 1999.

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

Table 5.2Three-Year Period Age-Specific Abortion Rates and Total Abortion Ratesby Selected Characteristics among All Women Aged 15–44 YearsReproductive Health Survey: Georgia, 2010

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

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

	Type of Pregnancy Termination (Percentage Distribution)							
Characteristic	Induced abortion	Miniabortion	Total	No. of Cases				
Total	29.3	70.7	100.0	2,054				
Residence (urban/rural)								
Urban	19.3	80.7	100.0	768				
Rural	36.6	63.4	100.0	1.286				
Region				.,				
Kakheti	43.4	56.6	100.0	185				
Tbilisi	18.7	81.3	100.0	333				
Shida Kartli	17.1	82.9	100.0	183				
Kvemo Kartli	31.4	68.6	100.0	253				
Samtskhe-Javakheti	50.8	49.2	100.0	160				
Adiara	19.6	80.4	100.0	90				
Guria	47.4	52.6	100.0	163				
Samegrelo	40.5	59.5	100.0	169				
Imereti	27.0	73.0	100.0	265				
Mtskheta-Mtianeti	22.2	77.8	100.0	152				
Racha-Svaneti	45.8	54.2	100.0	101				
Age Group								
15–24	28.6	71.4	100.0	501				
25–34	27.9	72.1	100.0	1.196				
35–44	34.3	65.7	100.0	357				
Order of Abortion								
First	28.8	71.2	100.0	576				
Second	26.5	73.5	100.0	417				
Thrid	27.2	72.8	100.0	291				
Fourth	31.8	68.2	100.0	185				
Fifth	32.3	67.7	100.0	135				
Sixth or higher	31.8	68.2	100.0	450				
Education								
Secondary complete or less	34.6	65.4	100.0	1,124				
Technicum	33.1	66.9	100.0	286				
University/Postgraduate	18.7	81.3	100.0	644				
Wealth quintile								
Lowest	46.8	53.2	100.0	419				
Second	31.8	68.2	100.0	504				
Middle	29.1	70.9	100.0	506				
Fourth	13.8	86.2	100.0	282				
Highest	22.6	77.4	100.0	343				
Ethnicity								
Georgian	27.4	72.6	100.0	1,661				
Azeri	37.2	62.8	100.0	181				
Armenian	38.1	61.9	100.0	141				
Other	34.0	66.0	100.0	71				

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

	Place of Pregnancy Termination (Percentage Distribution)								
Characteristic	Hospital/ Maternity		Outside a		No. of				
	Ward	Ambulatory Clinics	Medical Facility	Total	Cases				
Total	55.8	42.2	1.9	100.0	2,054				
Residence	20.6	50.0	1.0	100.0	769				
Urban	30.0 69.4	59.6	1.0	100.0	1 000				
Rural	00.4	29.6	2.0	100.0	1,200				
Residence	20.4	60.6	1.0	100.0	222				
	29.4	09.0 50.7	1.0	100.0	333 435				
Other Urban	40.9	30.7 20.6	2.4	100.0	1 286				
Rural	00.4	29.0	2.0	100.0	1,200				
Region	71.2	<u> </u>	5.6	100.0	185				
	71.2 29.4	23.2	5.0 1.0	100.0	333				
	29.4	09.0	1.0	100.0	193				
Shida Karti	59.0 60.1	40.5	0.0	100.0	103				
Kvemo Kartli	00.1	37.5	2.4	100.0	203				
Samtskhe-Javakheti	12.4	27.1	0.0	100.0	160				
Adjara	47.3	46.4	0.3	100.0	90				
Guria	/5.5	21.9	2.6	100.0	163				
Samegrelo	51.6	47.9	0.5	100.0	169				
Imereti	69.3	30.0	0.7	100.0	265				
Mtskheta-Mtianeti	54.0	44.9	1.1	100.0	152				
Racha-Svaneti	88.8	10.3	0.9	100.0	101				
Age Group (at Abortion)									
15–24	62.2	36.9	0.9	100.0	501				
25–34	53.4	44.2	2.4	100.0	1,196				
35–44	55.3	43.1	1.6	100.0	357				
Order of Abortion									
First	58.1	40.5	1.4	100.0	576				
Second	52.4	46.3	1.3	100.0	417				
Thrid	51.9	45.6	2.4	100.0	291				
Fourth	53.1	44.7	2.3	100.0	185				
Fifth	61.2	37.2	1.5	100.0	135				
Sixth or higher	58.1	39.3	2.7	100.0	450				
Education									
Secondary complete or less	60.4	37.1	2.5	100.0	1,124				
Technicum	58.4	40.6	1.0	100.0	286				
University/Postgraduate	47.0	51.8	1.2	100.0	644				
Wealth quintile									
Lowest	76.0	22.7	1.3	100.0	419				
Second	68.4	29.6	2.0	100.0	504				
Middle	55.0	41.0	4.0	100.0	506				
Fourth	43.3	55.7	1.1	100.0	282				
Highest	34.3	65.2	0.5	100.0	343				
Fthnicity					-				
Georgian	54.0	44.0	2.0	100.0	1,661				
Azeri	77.4	20.5	2.1	100.0	181				
Armenian	59.0	39.5	1.4	100.0	141				
Other	33.4	66.7	0.0	100.0	71				
Tupe of Abortion	50.1	00.1	0.0						
Induced abortion	65.9	30.5	3.5	100.0	645				
Minishortion	55.5	00.0	0.0	400.0	4 400				
	51.7	47.1	1.2	100.0	1,409				

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

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

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

	Mean Payment [⁺]	Cost of Abortion (in GEL)*								
Characteristic		None	< 30	30–34	35–49	50–99	100 or more	Does not Remember	Total	No. of Cases
Total	48.2	2.3	12.6	16.0	22.6	39.4	5.9	1.3	100.0	2,054
Residence										
Tbilisi	61.5	3.1	4.1	7.4	18.9	49.1	15.3	2.0	100.0	333
Other Urban	46.0	1.9	12.2	18.2	23.3	39.3	4.4	0.7	100.0	435
Rural	44.5	2.2	15.7	18.1	23.6	36.0	3.2	1.3	100.0	1,286
Age group (at Abortion)										
15–24	50.8	1.6	9.7	14.1	23.7	43.5	6.3	1.1	100.0	501
25–34	46.2	2.7	15.1	15.5	22.1	38.5	4.8	1.3	100.0	1,196
35–44	51.2	1.9	8.7	19.6	22.9	37.0	8.5	1.4	100.0	357
Order of Abortion										
1	53.2	3.1	8.3	12.3	19.0	46.5	9.1	1.7	100.0	576
2	50.6	1.1	11.2	14.5	24.4	40.5	6.7	1.6	100.0	417
3	49.5	1.9	13.9	14.8	21.1	41.8	5.5	1.1	100.0	291
4	45.6	2.0	12.5	19.5	26.8	34.1	4.4	0.7	100.0	185
5	43.6	2.3	15.4	17.1	26.4	37.2	1.6	0.0	100.0	135
6 or more	41.8	2.7	17.3	20.6	23.6	31.2	3.3	1.4	100.0	450
Education Level										
Secondary incomplete or less	47.1	2.2	11.2	22.6	22.6	33.8	6.4	1.3	100.0	456
Secondary complete	45.6	1.9	14.7	15.1	24.4	38.5	3.9	1.5	100.0	668
Technicum/University	50.7	2.6	11.9	13.1	21.4	42.9	7.0	1.2	100.0	930
Wealth quintile										
Lowest	40.6	2.5	20.7	20.8	22.8	30.7	2.4	0.2	100.0	419
Second	42.6	2.0	12.2	21.0	22.7	39.8	1.0	1.3	100.0	504
Middle	49.2	2.0	16.1	14.5	23.9	35.1	5.9	2.5	100.0	506
Fourth	49.5	2.9	6.0	11.0	27.0	47.0	5.0	1.0	100.0	282
Highest	59.3	2.3	6.8	11.3	17.6	45.8	15.0	1.2	100.0	343
Ethnicity										
Georgian	48.5	2.2	12.0	16.0	22.9	40.6	5.5	0.9	100.0	1,661
Azeri	40.2	3.6	22.1	21.8	14.5	32.7	2.5	2.8	100.0	181
Armenian	49.0	3.7	9.0	9.9	23.9	47.2	4.9	1.5	100.0	141
Other	62.3	0.0	4.8	9.7	35.5	23.2	21.5	5.2	100.0	71
Type of Abortion										
Induced Abortion	54.8	3.3	12.4	15.3	16.7	39.5	11.4	1.4	100.0	645
Miniabortion	45.5	1.9	12.7	16.2	25.0	39.3	3.6	1.3	100.0	1,409
Abortion Facility										
Hospital/ maternity	48.2	1.4	14.2	17.6	22.0	36.8	6.8	1.2	100.0	1,207
Ambulatory clinics	49.2	1.2	10.4	14.1	24.1	43.9	4.8	1.5	100.0	810
Outside a medical facility	26.6	53.3	14.0	10.1	7.5	13.1	2.0	0.0	100.0	37
Gestational Age										
<10 weeks	45.8	2.4	13.4	16.3	23.4	39.3	4.0	1.2	100.0	1,763
10 weeks of more	64.8	1.4	7.1	13.4	17.5	39.9	18.5	2.2	100.0	291

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

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

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

Characteristic	Contra	ception Coun	seling	Distribution Prescription	No. of		
	Any Counseling	Before Abortion	After Abortion	Method Distributed	Prescription Offered	Referral Offered	Cases
Total	33.1	9.9	13.2	6.6	7.4	2.7	2,054
Residence (urban/rural)							
Urban	35.6	10.5	13.6	6.1	9.2	3.3	768
Rural	31.3	9.4	12.8	6.9	6.1	2.3	1,286
Region	05.0	4.5	10.0	7.0	4.5	4.5	405
Kakheti Thiliai	25.8	4.5	10.6	/.b	4.5	1.5	185
i billsi Shida Kartli	30.3	9.7	11.0	4.1	9.7	1.5	333 183
Siliua Karti	40.0	13.2	19.0	4.4	9.0	1.0	103
Samtskho lavakhoti	23.0 13.8	7.0	5.0	4.4	9.Z 2.8	2.4	200
Adiara	33.0	17.0	9.8	5.4	2.0 7 1	5.4	90
Guria	29.2	8.9	9.9	5.4	16	4 2	163
Samegrelo	30.0	4.2	15.8	5.3	1.6	4.7	169
Imereti	45.7	15.0	15.7	15.7	10.0	4.7	265
Mtskheta-Mtianeti	31.8	10.8	8.5	2.3	3.4	0.0	152
Racha-Svaneti	29.9	2.8	13.1	5.6	12.1	3.7	101
Age Group (at Abortion)							
15–24	33.7	11.3	13.5	7.9	8.1	3.4	501
25–34	34.0	8.8	13.9	6.2	8.2	2.3	1,196
35–44	29.7	11.3	10.4	6.1	4.2	3.0	357
Education							
Secondary complete or less	32.3	9.3	13.6	6.3	7.2	2.1	1,124
Technicum	27.1	7.7	8.1	3.7	7.5	0.9	286
University/Postgraduate	36.8	11.7	14.5	8.2	7.7	4.3	644
Wealth quintile	05.0					4.0	440
Lowest	25.2	9.9	8.9	4.9	5.0	1.8	419
Second	35.5	9.4	14.7	11.1	6.3 7 5	4.1	504
	32.0	0.4 10.2	10.5	5.1 5.6	7.5	1.1	506
Fourt	35.6	10.3	12.5	5.0 5.4	0.1 10.3	0.2 1.0	202
Fthnicity	55.0	11.7	12.0	5.4	10.5	1.0	545
Georgian	34.9	10 5	13.4	7.6	69	3.2	1 661
Azeri	28.4	77	13.7	3.7	9.7	0.0	181
Armenian	26.3	9.0	13.7	1.9	8.9	1.9	141
Other	21.2	4.2	7.2	1.1	8.6	1.1	71
Order of Abortion							
First	30.5	10.5	12.1	7.4	7.0	3.7	576
Second	34.4	12.4	12.7	7.5	9.6	2.9	417
Thrid	30.6	9.0	11.9	5.6	5.2	1.2	291
Fourth-fifth	38.2	11.4	14.7	8.8	7.7	3.1	320
Sixth or higher	33.2	6.4	14.6	4.1	7.3	1.9	450

Chapter 6

Contraceptive Knowledge and Use

ontraceptive use is an important and direct determinant of the variation in fertility and abortion rates. In Georgia, the availability of high quality contraceptive methods has been limited until recently. Currently, Georgia does not have a stand-alone national family planning program, and neither state nor private health insurance packages include family planning provisions. However, family planning goals and objectives are included in the national reproductive health strategy and specific targets are set to increase the use of modern contraceptive methods and reduced the unmet need for family planning (MoLHSA, 2007). All family planning activities are maintained through donor support, primarily from the United Nations Population Fund (UNFPA) and United States Agency for International Development (USAID). Since 1996-1999, both agencies have invested heavily in building capacity, providing free contraceptive supplies in government clinics, integrating contraceptive services into primary care, training family planning providers, providing services to remote areas, minorities and internally displaced families, and funding information, education and communication efforts. Supplied contraceptive methods are available: at no cost, at subsidized prices via social marketing programs, and at market prices in pharmacies and the commercial for-profit sector. Most health facilities with family planning services-hospitals, polyclinics

and primary health centers—provide oral contraceptives, condoms, and spermicides free of charge; free contraceptives are also distributed by mobile clinics. For a fee, tubal ligations and intrauterine device (IUD) insertions can be obtained in facilities that have trained obstetricians/gynecologists on staff.

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

6.1 Contraceptive Awareness and Knowledge of Use

Limited knowledge about modern methods of contraception among women of reproductive age is an important barrier to utilization of family planning services. To address this gap, GERHS10 included questions on general awareness of specific contraceptive methods, knowledge of source(s) of supplied methods, perceived reliability (knowledge of the contraceptive efficacy), and knowledge of how these methods are used.

At first glance, women of reproductive age in Georgia appeared to be well informed about contraception.



Virtually all of them (97%) had heard of at least one modern method, though fewer were aware of at least one traditional method (64%) (Table 6.1.1). Levels of awareness of any method were lowest in the Kvemo Kartli region and highest in Tbilisi and Imereti. On average, women recognized 3.4 modern methods-ranging from 3.8 modern methods known by married women and 2.7 modern methods known by women who have never been married. As expected, awareness increased directly with the age of the respondent; young adults knew, on average 2.6 modern methods while women aged 35 or older knew of almost 4 modern methods (Table 6.1.2). Awareness of modern contraception also increased with the level of education, from knowing on average 2.4 methods among women with less than complete secondary education to 4 methods among women with the highest education attainment (Table 6.1.3). Condoms (94%), IUDs (87%), and oral contraceptives (81%) were the most know methods known regardless of marital status, age or education.

Lower awareness of tubal ligation and vasectomy and hormonal methods was common in all subgroups. Only 39% of women had heard of tubal ligation and fewer (4%) had heard of vasectomy. This low level of awareness is common among all former Soviet-bloc countries (Figure 6.1.1), which often limited the access to tubal ligation for contraceptive purposes. In most countries of Eastern Europe, including Georgia, tubal ligation is either specifically permitted by law or is not specifically prohibited (and is, therefore, implicitly allowed). However, most countries have set certain conditions or limitations to obtain surgical contraception (e.g. or/and parity requirements, medical age

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

Access to tubal ligation in Georgia is regulated by the Georgian Law on Health Care (Government of Georgia, 1997). Article 145 of the law stipulates that tubal ligation can be carried out only in certified medical facilities by certified physicians after written consent of the patient was obtained and after a mandatory waiting period of one month from the time of initial discussion of the issue with the patient. Although the legal statute of tubal ligation is permissive, few women have enough knowledge about the method to make a decision if they want to use it or not. Limited awareness about the use of tubal ligation as a method of family planning seems to be the most important deterrent for its use in Georgia. Among women interviewed in GERHS10 who wanted no more children, almost two-thirds stated their limited knowledge about the procedure—lack of awareness about the procedure, not knowing where it can be obtained, fear of surgery or complications after surgery-as the most important reason for not being interested in tubal ligation (data not shown).

Lack of awareness and misconceptions about hormonal contraception are another legacy of the former Soviet regime, particularly among older women. Under the Soviet regime, hormonal methods were not actively promoted for family planning purposes and were usually prescribed for medical benefits. Further, potential health risks and side effects sometimes associated with the use of hormonal methods were overstated. As a result, some women of childbearing age in the former Soviet-bloc countries continue to be unaware of oral contraceptives (Figure 6.1.2).

Awareness of contraception does not immediately translate into knowledge of how a contraceptive method should be used. Knowledge about how to use any modern or traditional method was much lower than the very high level of contraceptive awareness in Georgia (76% vs. 96% and 51% vs. 64%, respectively). For the most widely known modern contraceptive methods, there was a serious gap between awareness of the method and knowledge about how the procedure or product should be used (Tables 6.1.2 and 6.1.4 and Figure 6.1.3). Although condom and IUD awareness were almost universal, only two thirds of women stated they knew how to use condoms and only 59% said they knew how the IUD is used. Knowledge about using oral contraceptives was much lower than awareness of it: 81% of women had heard of oral contraceptives, but only 50% had knowledge about how this method could be used.





A considerable gap exists between awareness of other contraceptive methods and knowledge of how the procedures or products are used.

On average, women reported having knowledge about how contraceptives work for about two methods. The difference modern between awareness of and knowledge about use was the greatest among never married women (93% vs. 58%) and young adults (94% vs. 63%); this difference diminished among married women (99% vs. 92%) and among women aged 25-44 (98%-99% vs. 88%-92%). Never married and young adult women, on average, could identify how contraceptives work for 1.5 modern methods; women with marital experience and older women could identify up to 3 modern methods.

The low level of knowledge among never-married

young women, often still in school, highlights the need to include information on contraceptive methods in nationwide, age-appropriate sexual health education programs.

The majority (84%) of women of reproductive age could name a source for methods of contraception (Table 6.1.5 and Figure 6.1.4). On average, women were able to name sources for about two contraceptive methods. Respondents were more likely to know a source for the most commonly used modern methods (see below). For instance, 78% of women knew a source for condoms, 67% knew where to obtain IUDs, and 65% knew a source for pills. However, only 31% knew where tubal ligations were performed, and very few knew where vasectomies were performed or where to obtain injectables, spermicides, or emergency contraception.



Knowledge of a source was the higher among women living in Tbilisi (90%) and among those living in other urban areas (87%) than among rural residents (79%) (Table 6.1.5). Similar to other aspects of contraceptive knowledge, knowing a source for contraceptives increased with age.

The GERHS10 addressed not only awareness of contraceptive methods and their sources, but also understanding of contraceptive effectiveness. Correct information about contraceptive effectiveness can greatly influence couples' decisions about how to prevent unplanned pregnancies. Knowledge about the effectiveness of specific contraceptive methods in a population is

an indicator of the adequacy of contraceptive counseling and of information and education programs. In the GERHS10, a majority of women did not recognize any modern method as very effective (Table 6.1.6 and Figure 6.1.5). While 30% of women correctly stated that IUDs are very effective in preventing pregnancy, only 16% believed that contraceptive sterilization is very effective. The majority of women incorrectly thought that pills were not very effective. In fact, the proportion of women who correctly said that pills were very effective was lower than the proportion who perceived the condoms as very effective (10% vs. 19%), although the documented contraceptive use effectiveness of condoms is far lower than that of oral contraceptives (Hatcher et al., 2004).



Misperceptions among users of traditional methods of contraception constitute a striking example of how lack of knowledge about contraceptive effectiveness could affect informed choice and increase reliance on less effective methods. Overall, 38% and 28% of women, respectively, stated that the rhythm method and withdrawal are very effective or effective. While the proportion of women who have heard of these methods is declining (from 68% to 59% and from 55% to 43%, respectively), believes of high effectiveness of traditional methods constitute in fact the predominant view among women with awareness of these methods.

In examining the level of knowledge about contraceptive effectiveness, it is useful to compare the changes in correct knowledge with the rates from surveys covering earlier periods (Figure 6.1.5). Between 1999 and 2005, the perceived effectiveness of IUDs and oral contraceptives increased (from 31% to 40% and from 9% to 13%, respectively). However, the level of confidence in the effectiveness of IUD and oral contraceptives declined in 2010 to the 1999 level (30% and 10%, Furthermore, the number of respectively). women who had never heard of IUDs doubled between 2005 and 2010 (from 6% vs. 12%). Belief that tubal ligation is very effective declined by 50% between 1999 and 2005 (from 28% to 14%) and remained approximately constant from 2005 to 2010.

6.2 Contraceptive Use

Georgia has a relatively small percentage of women who had ever used contraception, indicating that adoption of contraceptive use, particularly of methods of high efficacy, is quite recent.

Less than one in every two women of reproductive age reported they had ever used contraception and less than two in every five women had ever used a modern method of contraception (Figure 6.2.1). The most commonly used methods ever used were condoms (19%), calendar (rhythm) method (17%), IUDs (16%) and withdrawal (15%) (Figure 6.2.2). Between 1999 and 2010, the percentage of women who reported that their partner had ever used a male condom almost doubled (from 10%, to 13%, to 19%). As a result, condoms became the most ever used method in 2010, seconded by the calendar (rhythm) method, which was reported as the leading method in the 1999 and 2005 surveys. The percentage of women who had ever used IUDs increased slightly (from 14% to 16%). Ever-use of the rhythm method appears to plateau between 1999 and 2010 at 17-18%. The percentage of women whose partner had ever used withdrawal decreased from 17% in 2005 to 15% in 2010, but was still higher than the 1999 level of 12%. Ever use of oral contraceptives increased slightly but not significantly from 6% in 1999 to 8% in 2005 and 10% in 2010. The percentage of those who had ever used spermicide products, injectables, emergency contraception and tubal ligation did not increase or registered a small increase between 2005 and 2010. Only one woman reported that her partner had a vasectomy.

At the time of the survey, 32% of all women aged 15–44 years (or about 317,000 women) were currently using a contraceptive method including 21% (about 207,000 women) who were using supplied methods (condoms, IUDs, oral contraceptives, tubal ligation, and spermicides)
(Table 6.2.1 and Figure 6.2.3). In general, the most commonly used method was the condom, followed by the IUD, withdrawal and the rhythm method (also known as the calendar method). Oral contraceptives were used by 2.4% of women and tubal ligation was used by 1.8%.

Generally, contraceptive use by women in legal and consensual marriages is higher than use by single women because married women represent the majority of sexually active women, have greater frequency of intercourse, and have higher fertility and risk of unplanned pregnancies. In Georgia, virtually all users of contraceptive methods were married. As such, 53% of married women were currently using contraception, including 35% who were using modern methods. In contrast, use among previously married and never married women was almost nonexistent. Only 6% of previously married women were using any method of contraception at the time of the survey and virtually all were using modern methods (4% were using condoms and 2% were using long term or permanent methods, such as IUDs or tubal ligation).

Despite the recent increase in current contraceptive use—from 41% in 1999 to 53% in 2010—Georgia continues to have one of the lowest overall contraceptive prevalence rate (CPR) in Eastern Europe and Eurasia (Figure 6.2.4).







In many Eastern European countries (i.e. Albania, Moldova, Russia, and Ukraine), around twothirds of couples are using contraceptives, compared to Georgia's contraceptive rate of 53%. The CPR in Georgia is comparable with the rates documented in Armenia in 2005 (54% or married women) and Azerbaijan in 2006 (51% of married women), but the prevalence of modern methods is twice as high in Georgia. The use of modern methods in 2010 was comparable with the corresponding rate in Romania in 2004 (34%) but lower than the most recent available rates in Moldova, Ukraine, Russia and Central Asia. The use of traditional methods in Georgia (19%) was higher in 2010 than in the Central Asian countries (ranging from 4% to 9%) and comparable with the rates in Ukraine and Russia.

Table 6.2.2 shows current use of modern and traditional contraception among married women aged 15-44 years in Georgia, according to residence and region. As expected, urban women were more likely than their rural counterparts to be current users of contraceptives. In the urban areas, condoms were the most commonly used method of contraception, surpassing the use in rural areas by 2.5 times.

Any use of contraception varied substantially by region, from a low of 44% in Adjara and Mtskheta-Mtianeti to over 61% in Shida Kartli (Figure 6.2.5). Modern methods usage was higher in Tbilisi and Shida Kartli than in other regions (Table 6.2.2 and Figure 6.2.6). Excepting the regions of Samtskhe-Jahakheti and Adjara, couples in all other regions were more likely to use modern methods over traditional methods.







Figure 6.2.6 Current Use of Modern Contraception, by Region

The most commonly used methods in most regions were condoms and IUDs. Condom use was the highest in Tbilisi (25%) and the lowest in Adjara (5%). The IUD use was the highest in Shida Kartli, Samegrelo and Imereti (15%–16%). Use of oral contraceptives ranged from 1% in Samtskhe-Jahakheti to 9% in Samegrelo. Withdrawal was most commonly used in the Samtskhe-Jahakheti and Adjara regions (27% and 20%, respectively).

As shown in Table 6.2.3 and Figure 6.2.7, the highest rates of marital contraceptive use were among women aged 30–34, women with two children, women with a university-level education, and women of high socioeconomic status. Notably, women in each of these groups were more likely to

be using a modern method of contraception than a traditional method. Childlessness and young adult age (15–24 years) were associated with the lowest contraceptive prevalence and lowest use of modern methods among married women. The use of any method increased substantially with the number of living children, from a low of 6% among childless women to over 60% among women with two or more children. Use of any method of contraception was slightly higher among Georgian women than among women of other ethnic background. The use of modern contraceptive methods was at least 50% higher among Georgians than among Azeri and Armenian women (37% vs. 23% and 20%, respectively).



The percentage of married women aged 15–44 years who were using contraception increased from 41% in 1999 to 45% in 2005 and 53% in 2010 (Figure 6.2.8). The use of modern contraceptive methods increased from 20% to 35% (a 75% increase). For the first time, the prevalence of modern methods exceeded the prevalence of traditional methods in 2010. The adoption of modern methods of contraception in Georgia occurred at a much faster pace than elsewhere (Figure 6.2.9). From 1999 to 2010, use of modern methods in Georgia increased by 75% compared to only 33% in the average of modern contraceptive prevalence for the Eastern European region. At the same time, the world average remained relatively unchanged.

According to the official figures of population distribution by age and sex, the change in modern contraceptive prevalence represents an apparent increase of almost 67,000 women between 1999 and 2010, all of whom started to use supplied methods of contraception. These findings have important implications for contraceptive forecasting and preventions of supply shortfalls, particularly at a time when donated contraceptive supplies are decreasing.

The study of contraceptive method mix showed a slight preference for condoms (14%), IUDs (13%) and withdrawal (11%) (Table 6.2.4 and Figure 6.2.10). Condom prevalence was much higher among urban than rural couples (20% vs. 8%) and directly increased with education (from 7% of women with less than completed education to 21% of those with a university education) and with the socioeconomic status (SES) of the household (from 7% of women living in low-SES households to 20% of women from high-SES households).







The only other modern method commonly used was the IUD; use was as high as 16% in Shida Kartly and 15% in Samegrelo and Imereti. IUD use increased with age, number of living children and SES of the household. Use of withdrawal, the third most prevalent contraceptive method, was associated with rural residence (15%), less than complete secondary education (15%), low SES (15%), having two or more children (14%–15%) and being of Armenian or Azeri descent (26% and 20%, respectively).

Prevalence of hormonal contraception remained low across all subgroups. The highest prevalence was reported by women in Samegrelo and Kakheti regions, probably due to recent regional family planning activities focused on increased used of hormonal methods implemented by donors. There was also an extremely low prevalence (3%) of and lack of interest in tubal ligation, despite the fact that most married and fecund respondents reported that they wanted no more children. The low usage and lack of desire for surgical contraception is likely rooted in the lack of information about the method among family planning clients, providers' attitudes, and limited provider training in modern sterilization mini-laparotomy techniques (i.e. for female sterilization and vasectomy) (Tsertsvadze et al., 2010). Other modern methods (such as injectables, spermicides, and the diaphragm) were seldom used.

Data collected in previous RHS rounds in Georgia demonstrated heavy reliance on traditional methods, especially withdrawal. GERHS10 showed a substantial increase in the use of modern methods while the use of traditional methods had declined. Whereas withdrawal and the rhythm method were the leading methods in 1999, they were the second and third most prevalent methods in 2005 and the third and fourth most prevalent methods in 2010

(Figure 6.2.10). From 1999 to 2010, condom use among couples increased 2.5 times (from 6% to 14%) and IUD use increased from 10% to 13%, becoming the first and second most used methods, respectively. Recent well-publicized upsurges in the prevalence of sexually transmitted infections and risk of HIV transmission may have contributed to the increase in condom use. The increase in IUD use is probably related with its cost-effectiveness and the desire to limit family size after having the intended number of children. Pill use, still very low, did increase from 3% in 2005 to 4% in 2010. Increased usage of condoms, IUDs, and oral contraceptives was solely responsible for the overall increase in contraceptive prevalence between 2005 and 2010. There were no noticeable changes in the use of other modern methods of contraception.

6.3 Source of Contraception

Contraceptive supplies in Georgia are not subsidized by the government or health insurance plans. Even the poorest population of the country (800,000 persons, according to governmental estimates) does not benefit from subsidies for FP services, although most other care is covered by the government via private insurance contributions. Through the concerted efforts of donors, primarily UNFPA and USAID, commodities are made available (either free of charge or for a small fee) in health clinics that provide FP services.

Table 6.3 presents the sources of contraception for currently married users of modern contraceptive methods. The health care facilities were the principal source of modern contraceptives in Georgia (50%). Commercial sales, specifically through pharmacies, were the second largest source of contraceptive supplies (45%). Women's consultation clinic supplied almost 25% of women currently in union with their current method of contraception while hospitals supplied 21% of women. Nearly 5% of users obtained their method from "other" sources, such as their partners, friends and relatives, and the open market.

varied greatly according Sources to the contraceptive method used. As shown in the top panel of the table, the medical sector was virtually the only source for IUDs (99%) and tubal ligation (97%). Pharmacies were the predominant source for methods which require periodic re-supply. Pharmacies were the principal provider of condoms, supplying more than four fifths of women who reported their partners were using condoms. Pharmacies were also the leading source for spermicide (89%), other modern methods (73%), and oral contraceptives (56%) (Figure 6.3).

It should be noted that sources of contraceptive supplies are not completely comparable with the data collected in the previous RHS rounds. In 2007, the Government of Georgia has launched a comprehensive health care reform aimed at privatization of the system.

The privatization of hospitals was regulated in the Hospital Development Master Plan (MoLHSA, Decree #11, January 26, 2007), which called for complete replacement of existing hospital









infrastructure by full transferring of ownership to the private sector. Primary health care services are also in various stages of privatization. The entire privatization process is planned to be completed by the end of 2012 (Chaturidze et al., 2009).

6.4 Reasons for not Using Contraception

As shown in Table 6.4, nearly 77% of married women who were not using contraception at the time of the survey cited reasons related to pregnancy, fertility, or sexual activity.

Most of the married women in Georgia who were not using contraception at the time of the survey were currently pregnant (27%), desired pregnancy (20%), were infertile for medical (non contraceptive) or menopausal (19%) reasons, or had not had intercourse recently (12%) (Figure 6.4).

Additionally, almost 23% of the women gave "other" reasons for not using contraception at the time of the survey. Nearly 8% of women said they were using vaginal douching to avoid pregnancy, while another 6% declared that they just did not think about using a contraceptive method. Only 4% of the women stated that their husbands or partners objected to the use of contraception.

Between 1999 and 2010 the percentage of married women who wanted to get pregnant soon increased by 50%, from 13% to 20%.



Reasons for not using a method differed sharply by age group. Most young adult women were pregnant or seeking to become pregnant (79%), whereas women aged 35–44 years were not able to conceive because of either impaired fecundity (37%) or a lack of recent sexual activity (15%). It is worth mentioning that more than 13% of women aged 35–44 reported desire of pregnancy, which is almost a three-fold increase compared to previous surveys, when only 4% and 5%, respectively, expressed such intentions.

6.5 Potential Demand and Unmet Need for Contraception

The concepts of potential demand and unmet need for contraception have been around since 1960s, when researchers first demonstrated a gap in the developing world between women's preferences their fertility and use of contraception. The total potential demand for contraception is generally defined as the sum of current contraceptive use (met need) and the additional contraceptive use that would be required to eliminate the risk of unwanted or mistimed childbearing (unmet need). Thus, the unmet need for contraception is a very specific estimate that measures the gap between desired fertility and the contraceptive practices adopted to ensure that fertility preferences are met in a population.

Monitoring the "need" for contraception has been increasingly recognized as central to family planning efforts. By providing evidence about women whose contraceptive demand is not satisfied, data on unmet need can demonstrate the work left to be done in assisting women and couples to prevent unintended pregnancies. In addition, such data could help document whether global financial and political support is adequate for rectifying this problem. With the addition in 2006 of a new target of universal access to reproductive health services to help assess progress in meeting the MDGs (Target 5b), UN panels have also recommended the approval of the "unmet need for contraception" as one of its indicator to be monitored globally. A second measure, unmet need for a modern contraceptive method, which excludes less-effective traditional methods such as periodic abstinence and withdrawal, has been recommended as a supplement. These measures are based on data collected through large-scale, nationally representative surveys of women conducted periodically in both developing and developed world.

As such, the RHS studies in Georgia play an essential role in describing the current need and potential future demand for contraceptive services by assessing respondent fecundity and stated reproductive preferences. The surveys have employed the definition of unmet need first proposed by Bongaarts, which includes women currently married or in consensual unions who are currently sexually active (within the past month); are currently exposed to the risk of pregnancy (which excludes women not sexually active, currently pregnant women, and women in postpartum abstinence or amenorrhea); are fecund (neither they nor their partners have any subfecundity conditions); do not want to become pregnant (at the time of the interview); and are

not using any method of pregnancy prevention (Bongaarts, 1991). In addition, the standard formulation of unmet need was extended to all women, to more accurately reflect the number of women with an unfulfilled need for contraception.

By documenting periodically the additional contraceptive use that would be required to eliminate the risk of unintended pregnancies in Georgia, the surveys have helped with shaping up the family planning agenda and its monitoring and evaluation, the introduction of contraceptive logistics management, and the assessment of progress toward universal access to reproductive health services over the past 15 years. Overall, the GERSH10 found that 39% of women had a potential demand for contraception. Among married women, the potential demand for contraception was much higher (65%), including 34% of current users of modern method, 18% of current users of traditional methods, and 12% of non users at risk of unplanned pregnancy (Table 6.5.1 and Figure 6.5.1). About one in every three married women had no need for contraception because they were currently pregnant, trying to become pregnant, infecund, or had not had intercourse recently. In addition to the unmet need for any contraception, the GERSH10 documented the unmet need for modern contraception-an indicator particularly useful in countries where the use of traditional, less effective methods is high.

Some subgroups of married women exhibited much higher levels of unmet need for contraception than others (Table 6.5.2).



Regional levels of unmet need for any contraception ranged from a high of 15%–16% in Adjara, Guria and Mtskheta-Mtianeti to 8%–9% in Tbilisi, Samstkhe-Javakheti, and Shida Kartli (Figure 6.5.2).

Based on GERSH10 Georgia's unmet need for modern contraception among married women was 30%, down from 44% in 1999 and 37% in 2005 (a decline of 32% and 18%, respectively) (Figure 6.5.5). The unmet need for modern contraception among all women decreased from 27% to 18%. Practically all this decline resulted from increased use of modern methods among couples, while the unmet need among never married and previously married women remained constant and very low.

In absolute numbers, this decline represents an apparent decrease of approximately 75,000 women aged 15–44 with unmet need for modern contraception between 2005 and 2010 and could account for the observed substantial reduction in unplanned pregnancies and induced abortions.

There is still a gap of 18% of Georgian women (31% of married aged 15 - 44women, respectively), however, who have an unfulfilled desire to plan and space their childbearing and continued to be at risk of unplanned pregnancy. This translates into almost 180,000 couples whose modern contraceptive needs are unmet. In order to reduce this gap, policymakers and programs can target subgroups where unmet need is most concentrated, according to characteristics such as age, income, education, and ethnicity.







Among those countries in Eastern Europe and the Caucasus region where population-based reproductive health or demographic health surveys have been recently conducted, Armenia and Azerbaijan had the highest unmet need for modern contraception (52%–53%), followed by Ukraine (47%), and Georgia (44%) (CDC and ORC Macro, 2003) (Figure 6.5.6).

The most common reasons for unmet need in Georgia are lack of information, fears about contraceptive side effects, and inconvenience of services. Women with unmet need typically have low awareness of effective contraceptive methods, lack knowledge about how methods are used, and are less likely to believe that family planning services are readily accessible to them.

In order to meet their needs, considerably more efforts should be made to increase contraceptive awareness through Information Education and Communication and Behavior Change Communication programs and to expand the availability of a wide array of effective, high quality, affordable contraceptive methods, including long-term and permanent methods.

In conclusion, policy makers and donors need to be aware of the level of family planning commodities needed to satisfy the need of Georgian couples currently using contraception (21% or around 207,000 users); in addition, they need to account for a potential increase in contraceptive demand when users of traditional methods and those not currently using any method adopt modern contraceptive methods. On the basis of the need for modern contraceptives





alone, demand may increase dramatically even if population growth is held constant. Changes in fertility preferences and timing of childbearing may also generate additional users.

Currently, all family planning activities are organized with donor support (chiefly from UNFPA and USAID) and implemented by local governmental institutions and international or local NGOs. Donors support three key functions aimed at assisting family planning services in meeting client needs: 1) availability of a range of effective and acceptable family planning methods in family planning offices; 2) training for family planning health personnel through general training programs; and 3)information dissemination and community-based education and outreach activities.

Satisfying the unmet need for modern contraception in Georgia will require а substantial increase in programmatic and financial support. Currently, the majority of contraceptive services are paid for through donor contributions and consumer payments, while government family planning subsidies remain limited. To better meet the demand for family planning services, the Georgian government needs to scale up the partnership with the donor community to make services affordable and accessible to all couples in need for family planning services. By providing free or low-cost contraceptive supplies, educating women about what methods and services are available, and providing accurate information to counter incorrect beliefs about modern contraceptives, the recent national reproductive health strategy should make practicing contraception more accepted in Georgia its priority, in line with the

MDG goal of universal access to reproductive health services.

6.6 Communication with Family Planning Providers

Family planning counseling and services in Georgia are provided by obstetricians, gynecologists and "reproductologists" (a concept unique to Georgia that includes other physicians who have received extra training related to reproductive issues). The Georgian Law on Medical Activities (Government of Georgia, 2001) regulates that physicians already licensed in closely related specialties can be licensed as "reproductologist" after a short post-graduate course; physicians specialized in other areas must complete the full post-graduate course and residency before being licensed to as "reproductologists." An important component of the newly implemented reproductive health strategy is to train health professionals to provide family planning counseling at all levels of medical care, including primary care. Both UNFPA and USAID supported physician postgraduate training in contraceptive technology. A waiver issued by the MoLHSA for the USAIDfunded project Healthy Women in Georgia (WHG) allowed for the first time primary care doctors, pediatricians, and nurses to be trained in family planning counseling and services supported by the project (JSI, 2009). Through UNFPA and USAID contributions, the number of FP providers in Georgia has increased substantially, particularly in the last 5 years. A recent survey among a sample of reproductologists and general physicians in 4 regions conducted with **UNFPA** support

documented that the majority (77%) of respondents received family planning training, mostly after 2005. About two-thirds of providers were classified as having correct knowledge about FP methods, though fewer answered correctly questions related to the side effects of the IUD and oral contraceptives (Tsertsvadze et al., 2010).

As in previous surveys, the GERHS10 included a series of questions to characterize typical interactions between family planning providers and their clients. Specifically, the survey asked about the extent to which health professionals provided basic family planning information and services to women who had used a modern contraceptive method or had an abortion or a birth during the five years prior to the interview. Data on contraceptive counseling at the time of an induced abortion or a birth are provided in Chapter 5 and 8.

Women who have used at least one modern contraceptive method in the previous 5 years were asked who had advised them to use their most recent modern method. If the advice came from a health care provider (e.g., a physician, nurse or midwife), they were also asked about the content of the family planning counseling. Most respondents were advised by a gynecologist to use their current or most recent modern method (56%) and an additional 1% was advised by a nurse, midwife or general practitioner (Table 6.6 and Figure 6.6.1). Women who did not receive medical advice started using their last method at the partner's suggestion (23%), at their own counsel (9%), at the suggestion of friend (5%), or at the suggestion of a relative (4%), bypassing any potential family planning counseling. Only 1% chose a method at the suggestion of a pharmacist.

The source of advice varied widely by the last modern contraceptive method used. Almost all IUD users and women with tubal ligation had chosen their method at the advice of a health care provider (93% and 90%, respectively), but only 13% of condom users were advised by a physician, nurse, midwife, or pharmacist. Most women who had used condoms did so because their partners suggested it (57%) or because they decided to do so themselves (19%). Among women who used pills, almost four of every five women (78%) were advised by a health care provider to use oral contraceptives; the second most important source of advice was a friend (9%).

Interactions between family planning providers and their clients and the messages conveyed during those interactions can affect continued and correct use of the method and client satisfaction with services. Between 1999 and 2010, the percentage of women who were advised by a health provider to use the most recent modern method did not changed noticeably (Figure 6.6.2).

However, the content of these interactions had improved significantly. During provider-client interaction, 64% of women received general information about other contraceptive methods in 2010, compared to only 32% in 1999; 59% were counseled about the effectiveness of the chosen method in 2010 compared to only 31% in 1999; 82% reported that the provider had explained possible side effects of the method chosen, compared to 70% in 1999; and 78% reported they were told what to do if they experienced side effects (Table 6.6 bottom panel). The content of contraceptive counseling varied among the supplied methods. IUD users were more likely to have received counseling about potential side effects than users of other contraceptive methods.

Tubal ligation users were the least likely to receive any counseling, particularly information about other methods (49%) and contraceptive effectiveness (48%).Women who used hormonal contraception were the most likely to have received medical advice about other methods (73%) and contraceptive effectiveness (67%).

The client-health provider interaction is an important opportunity for reproductive health promotion and counseling on risk behaviors. As such, integration of family planning counseling and services with other RH services is amply recognized by MoLHSA and other concerned government agencies and partner organizations a priority strategy. Integration is the as combination of different kinds of services or operational programs to ensure and maximize RH outcomes, including referrals from one service to another, as well as services provided in the same setting or by the same provider. Improved access to FP counseling and low cost or free contraceptives at the primary health care level and in hard to reach geographical locations (via mobile clinics) has been a priority among the government agencies and donors. In order to meet this priority, more primary care doctors, pediatricians, and nurses need to be trained in techniques for family planning counseling and services.





Percentage of Women Aged 15–44 Years Who Had Heard of Specific Contraceptive Methods, by Region Reproductive Health Survey: Georgia, 2010

Table 6.1.1

Awareness of Contracentive							Region					
Methods	Total	Kakheti	Tbilisi	Shida Kartli	Kvemo Kartli	Samtskhe- Javakheti	Adjara	Guria	Samegrelo	Imereti	Mtskheta- Mtianeti	Racha- Svaneti
Ever Heard of Any Method	96.6	95.7	98.9	97.0	90.6	95.0	95.4	99.2	98.3	96.8	97.5	96.3
Ever Heard of a Modern Method	96.2	95.3	98.9	97.0	88.7	94.4	95.0	98.6	98.3	96.5	97.5	96.1
Condoms	94.5	93.8	98.4	95.7	83.1	92.7	90.8	98.2	97.6	95.9	94.9	95.4
IUD	87.5	85.1	6.06	85.0	81.3	88.2	84.7	90.4	84.7	91.1	88.4	84.2
Oral contraceptives	81.1	79.1	89.5	80.9	74.9	73.9	72.8	79.2	73.8	83.6	84.6	76.7
Tubal ligation	39.3	36.4	44.3	47.1	30.1	24.7	19.2	46.2	41.2	51.0	37.8	36.6
Spermicides	20.7	19.3	28.4	16.8	18.7	9.6	16.3	18.6	12.9	23.1	18.8	13.0
Emergency contraception	5.2	3.2	10.2	2.4	3.6	1.2	3.9	1.6	0.8	4.8	5.7	3.0
Injectables	4.8	2.8	9.3	3.4	3.4	1.7	3.2	4.6	2.5	3.2	4.9	3.6
Vasectomy	4.2	2.8	8.4	1.6	1.7	0.9	2.5	2.6	2.2	4.2	2.3	2.0
Average Number of Modern	3.4	3.2	3.8	3.3	3.0	2.9	2.9	3.4	3.2	3.6	3.4	3.1
Ever Heard of a Traditional Method	63.7	62.2	67.9	63.1	60.4	66.6	59.0	61.2	55.6	67.0	65.6	59.5
Calendar (rhythm) method	58.5	57.4	64.7	60.4	48.1	55.6	51.3	51.6	51.6	64.4	62.4	54.9
Withdrawal	43.2	37.0	42.8	40.6	46.6	50.9	49.4	45.8	32.1	44.6	46.4	40.0
No. of Cases	6,292	498	1,426	392	546	481	419	401	477	805	393	454

Table 6.1.2Percentage of Women Aged 15–44 Years Who Had Heard of Specific
by Marital Status and Age Group
Reproductive Health Survey: Georgia, 2010

	_	I	Marital Status	5		Age Group	
Awareness of Contraceptive Methods	Total	Married	Previously Married	Never Married	15–24	25–34	35–44
Ever Heard of Any Method	96.6	98.6	96.8	93.0	93.8	97.9	98.6
Ever Heard of a Modern Method	96.2	98.1	96.3	93.0	93.7	97.7	97.7
Condoms	94.5	96.1	95.0	91.5	91.6	96.7	95.5
IUD	87.5	95.9	94.7	71.8	73.7	95.2	96.0
Oral contraceptives	81.1	89.7	89.7	64.7	65.8	90.4	89.6
Tubal ligation	39.3	48.6	50.8	21.0	19.1	46.5	55.9
Spermicides	20.7	27.2	29.9	7.8	8.1	26.1	30.2
Emergency contraception	5.2	6.2	9.5	2.6	1.8	6.6	7.7
Injectables	4.8	5.6	7.3	3.0	2.1	5.2	7.8
Vasectomy	4.2	4.5	7.8	2.8	1.3	4.8	7.0
Average Number of Modern Methods	3.4	3.7	3.8	2.7	2.6	3.7	3.9
Ever Heard of a Traditional Method	63.7	83.0	74.9	28.5	34.0	77.4	85.1
Calendar (rhythm) method	58.5	75.3	71.6	27.0	30.3	70.6	79.5
Withdrawal	43.2	62.0	56.7	8.2	15.9	53.8	64.8
No. of Cases	6,292	4,098	389	1,805	1,960	2,359	1,973

Table 6.1.3Percentage of Women Aged 15–44 Years Who Had Heard of Contraceptive
by Education
Reproductive Health Survey: Georgia, 2010

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

Table 6.1.4Percentage of Women Aged 15-44 Years Who Said They Knew HowAre Used by Marital Status and Age GroupReproductive Health Survey: Georgia, 2010

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

Table 6.1.5Percentage of Women Aged 15-44 Years Who Said They Knew Where to
Contraceptive Methods by Age Group and Residence
Reproductive Health Survey: Georgia, 2010

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

Table 6.1.6 Percentage of Women Aged 15–44 Years by Their Opinion about Contraceptive Effectiveness If the Method Is Used Correctly and Consistently Reproductive Health Survey: Georgia, 2010

Orașter cantina Mathad [*]		Cont	traceptive Effecti	veness		Total	No. of Coros
Contraceptive Method	Very Effective	Effective	Not Effective	Does Not Know	Never Heard	TOtal	NO. OF Cases
Tubal ligation	16.3	17.9	0.4	4.6	60.7	100.0	6,292
IUD	29.5	43.1	1.7	13.2	12.5	100.0	6,292
Oral contraceptives	10.1	53.3	2.3	15.5	18.9	100.0	6,292
Condoms	19.2	59.1	1.5	14.7	5.5	100.0	6,292
Calendar (rhythm) method	4.7	33.5	10.0	10.2	41.5	100.0	6,292
Withdrawal	3.4	23.9	8.6	7.2	56.8	100.0	6,292

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

			Marital Status	
Current Use of Contraception	Total	Married	Previously Married	Never Married
Currently Using	32.0	53.4	6.3	0.0
Modern Methods	20.9	34.7	6.1	0.0
Oral Contraceptives	2.4	4.1	0.3	0.0
IUD	7.5	12.5	0.9	0.0
Condoms	8.3	13.6	3.8	0.0
Spermicides	0.9	1.5	0.0	0.0
Tubal Ligation	1.8	2.9	1.1	0.0
Other modern method	0.0	0.1	0.0	0.0
Traditional Methods	11.0	18.5	0.2	0.0
Calendar (rhythm) method	4.4	7.4	0.2	0.0
Withdrawal	6.6	11.1	0.0	0.0
Not Currently Using	68.0	46.6	93.7	100.0
Total	100.0	100.0	100.0	100.0
No. of Cases	6,292	4,098	389	1,805

Table 6.2.1Current Use of Contraception by Marital Status and MethodReproductive Health Survey: Georgia, 2010

raception by Residence and Region	
Current Use of Modern and Traditional Cont	Among Married Women Aged 15–44 Years
Table 6.2.2	

Reproductive Health Survey: Georgia 2010

	Anv			Modern M	ethod			ч	aditional Me	thod		No. of
Characterisitc	Method	Condoms	DU	Oral Contraceptives	Tubal Ligation	Other	Any Modern Method	Withdrawal	Calendar (Rhythm)	Any Traditional Method	Total	Cases
Total	53.4	13.6	12.5	4.1	2.9	1.7	34.8	1.11	7.4	18.5	100.0	4,098
Residence Urban	56.9	19.5	13.3	3.4	3.0	2.4	41.5	7.1	8.1	15.3	100.0	1,806
Rural	50.0	7.9	11.8	4.7	2.8	1.1	28.2	15.0	6.6	21.7	100.0	2,292
Region												
Kakheti	50.6	11.5	14.5	7.5	1.0	3.0	36.2	6.2	7.0	14.5	100.0	348
Tbilisi	60.9	25.4	13.3	2.5	2.0	2.7	46.0	5.9	0.6	14.9	100.0	815
Shida Kartli	61.3	13.2	15.8	1.9	3.2	1.9	36.1	10.6	14.5	25.2	100.0	266
Kvemo Kartli	48.9	9.5	10.1	2.5	2.3	1.1	25.5	15.1	8.3	23.4	100.0	375
Samtskhe-Javakheti	55.6	11.4	7.6	1.3	1.0	0.8	22.1	26.6	6.9	33.5	100.0	331
Adjara	44.4	5.0	9.4	3.6	3.6	0.3	21.8	19.8	2.8	22.6	100.0	292
Guria	53.5	9.4	9.7	6.0	2.8	1.9	29.9	17.0	6.6	23.6	100.0	276
Samegrelo	57.0	12.2	14.8	8.6	6.5	1.2	43.3	9.5	4.2	13.6	100.0	302
lmereti	49.0	9.1	14.8	4.7	4.4	1.5	34.4	8.3	6.3	14.6	100.0	540
Mtskheta-Mtjaneti	44.7	12.0	7.2	7.2	1.8	2.4	30.6	7.5	6.6	14.1	100.0	270
Racha-Svaneti	52.3	13.5	10.5	1.5	2.5	0.3	28.3	14.8	9.2	24.0	100.0	283

Table 6.2.3Current Use of Contraception by Method among All Women Aged 15–44 YearsReproductive Health Survey: Georgia, 2010

	Currer	nt Use of Contrac	eption	Percentage Using a	
Characteristic	Any method	Modern Methods	Traditional Methods	Modern Method among Users	No. of Cases
Total	53.4	34.8	18.5	65.2	4,098
Region					
Kakheti	50.6	36.2	14.5	71.4	348
Tbilisi	60.9	46.0	14.9	75.5	815
Shida Kartli	61.3	36.1	25.2	58.9	266
Kvemo Kartli	48.9	25.5	23.4	52.1	3/5
Samtskhe–Javakheti	55.6	22.1	33.5	39.7	331
Adjara	44.4	21.8	22.6	49.1	292
Guria	53.5	29.9	23.6	55.9	276
Samegreio	57.0	43.3	13.6	76.0	302
Imereti	49.0	34.4	14.6	70.2 69.5	540
Mitskneta-Mitlaneti	44.7	30.6	14.1	08.5 54.1	270
Racha–Svaneti	52.3	28.3	24.0	94.1	203
Age Group	20.4	16.0	4.0	70 5	104
15-19	20.4	10.2	4.Z	79.5 70.7	124
20-24	42.7	3U.Z	12.0	70.7	010
20-29	55.9 61.0	37.9	10.0	70.5	000
35 30	50.8	36.0	21.0	60.2	940
40 44	51.3	30.0	23.0	60.Z	717
Number of Living Children	51.5	51.0	15.4	02.1	717
0	58	47	11	80.4	409
1	47.4	33.0	14.5	69.5	1 106
2	64.0	41.1	22.9	64.3	1,956
- 3	62.0	38.0	24.0	61.3	516
4 or more	60.1	37.8	22.4	62.8	111
Education					
Secondary complete or less	48.9	28.1	20.8	57.4	1,845
Technicum	48.4	32.2	16.2	66.5	673
University/Postgraduate	60.5	43.5	17.0	71.9	1,580
Wealth Quintile					
Lowest	46.7	23.0	23.7	49.2	727
Second	50.4	28.6	21.9	56.6	966
Middle	53.8	35.6	18.3	66.0	952
Fourth	51.0	34.4	16.6	67.4	623
Highest	61.4	47.3	14.1	77.1	830
Ethnicity					
Georgian	54.3	36.5	17.9	67.1	3,521
Azeri	44.9	23.0	21.8	51.3	219
Armenian	50.7	20.4	30.2	40.4	249
Other	48.0	35.9	12.1	74.7	109

Table 6.2.4Current Use of Contraceptive Methods by Selected Characteristics
Among Married Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

	_				Cont	raceptive Method				
Characteristic	Any Method	Condoms	IUD	Withdrawal	Calendar Method	Oral Contraceptives	Tubal Ligation	Spermicides	Other Modern Method	No. of Cases
Total	53.4	13.6	12.5	11.1	7.4	4.1	2.9	1.5	0.1	4,098
Region										
Kakheti	50.6	11.5	14.5	6.2	8.2	7.5	1.0	1.7	0.0	348
Tbilisi	60.9	25.4	13.3	5.9	9.0	2.5	2.0	2.6	0.1	815
Shida Kartli	61.3	13.2	15.8	10.6	14.5	1.9	3.2	1.9	0.0	266
Kvemo Kartli	48.9	9.5	10.1	15.1	8.3	2.5	2.3	1.1	0.0	375
Samtskhe–Javakheti	55.6	11.4	7.6	26.6	6.9	1.3	1.0	0.5	0.3	331
Adjara	44.4	5.0	9.4	19.8	2.8	3.6	3.6	0.3	0.0	292
Guria	53.5	9.4	9.7	17.0	6.6	6.0	2.8	1.6	0.3	276
Samegrelo	57.0	12.2	14.8	9.5	4.2	8.6	6.5	1.2	0.0	302
Imereti	49.0	9.1	14.8	8.3	6.3	4.7	4.4	1.3	0.2	540
Mtskheta-Mtianeti	44.7	12.0	7.2	7.5	6.6	7.2	1.8	2.1	0.3	270
Racha–Svaneti	52.3	13.5	10.5	14.8	9.2	1.5	2.5	0.3	0.0	283
Age Group										
15–19	20.4	6.5	5.3	2.6	1.5	3.7	0.0	0.7	0.0	124
20–24	42.7	13.0	11.1	8.6	4.0	4.3	0.5	1.3	0.0	610
25–29	53.9	16.9	12.7	10.2	5.8	5.3	1.3	1.6	0.1	863
30–34	61.0	15.8	12.9	11.9	9.7	5.2	3.0	2.3	0.1	948
35–39	59.8	12.5	14.5	14.5	9.4	3.8	3.8	1.3	0.1	836
40–44	51.3	10.6	12.1	11.0	8.4	1.7	6.2	1.3	0.1	717
Number of Living Children										
0	5.8	3.5	0.3	0.3	0.8	0.4	0.0	0.5	0.0	409
1	47.4	15.8	11.2	7.6	6.9	4.2	0.3	1.4	0.0	1,106
2	64.0	15.4	15.8	14.0	8.9	4.6	3.4	1.8	0.1	1,956
3	62.0	12.6	12.6	15.4	8.6	5.0	6.3	1.3	0.1	516
4 or more	60.1	3.5	13.5	15.4	7.0	2.8	14.6	3.4	0.0	111
Education										
Secondary complete or less	48.9	7.5	12.1	14.9	5.9	4.9	2.6	1.0	0.0	1,845
Technicum	48.4	12.7	9.6	7.7	8.6	2.8	4.9	1.8	0.4	673
University/Postgraduate	60.5	20.9	14.2	8.3	8.7	3.7	2.5	2.1	0.0	1,580
Wealth Quintile										
Lowest	46.7	5.6	10.5	17.5	6.2	4.4	1.9	0.3	0.1	727
Second	50.4	7.8	13.3	14.1	7.7	4.4	2.4	0.6	0.2	966
Middle	53.8	11.3	12.4	11.5	6.8	5.5	4.4	1.9	0.0	952
Fourth	51.0	14.5	10.7	8.4	8.2	3.7	2.6	2.7	0.2	623
Highest	61.4	25.3	14.5	6.0	8.1	2.6	2.9	2.0	0.0	830
Ethnicity										
Georgian	54.3	14.6	13.1	9.8	8.1	4.0	3.2	1.6	0.1	3,521
Azeri	44.9	0.8	14.0	19.8	2.1	6.5	1.7	0.0	0.0	219
Armenian	50.7	11.4	4.5	25.8	4.4	1.0	1.6	2.0	0.0	249
Other	48.0	15.4	7.7	6.8	5.3	8.0	0.9	3.8	0.0	109

Table 6.3Source of Supply for Selected Modern MethodsAmong Married Women Aged 15–44 YearsCurrently Using ContraceptivesReproductive Health Survey: Georgia, 2010

			Moderr	n Contraceptive I	Method	
Source of Suplied Methods	Any Method	Oral Contraceptives	IUD	Condoms	Spermicides	Tubal Ligation
Public Medical Sector	50.0	37.5	99.0	3.2	9.1	97.0
Women's consultation clinic	24.6	15.9	60.0	1.4	6.9	1.9
City hospital	11.6	5.1	14.5	0.2	2.2	65.9
Raion hospital	9.1	5.7	18.2	0.0	0.0	21.7
Primary health care clinic/center	4.0	10.7	5.2	1.1	0.0	4.8
Referral hospital	0.6	0.0	1.1	0.0	0.0	2.8
Mobile clinic	0.2	0.0	0.0	0.5	0.0	0.0
Pharmacy	44.8	56.3	0.4	86.7	89.4	0.0
Other	5.2	6.2	0.6	10.1	1.4	3.0
Partner/ Husband	3.3	0.0	0.0	8.4	0.0	0.0
Friend	0.4	0.6	0.0	0.6	1.4	0.0
Relative	0.3	1.2	0.2	0.3	0.0	0.0
Open market	0.2	0.0	0.0	0.6	0.0	0.0
Other	1.0	4.4	0.4	0.2	0.0	3.0
Does not know	0.0	0.0	0.0	0.1	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,413	176	498	565	66	103

Table 6.4Most Commonly Cited Reasons for Not Currently Using Contraception
by Age Group among Married Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

Boason	Total		Age Group	
Neason	Total	15–24	25–34	35–44
Currently pregnant	26.7	54.6	28.6	6.5
Desires pregnancy	19.5	24.2	22.7	13.1
Subfecund/menopause/operated	18.7	2.0	11.4	37.1
Not sexually active	11.8	5.5	12.3	15.5
Uses douching	8.3	4.0	7.0	12.3
Does not think about using a method	5.9	4.6	6.7	6.0
Partner objects	4.1	2.1	4.8	4.6
Other	4.1	1.8	5.7	3.8
Does not know	0.9	1.1	0.8	1.0
Total	100.0	100.0	100.0	100.0
No. of Cases	1,888	435	766	687

Table 6.5.1Demand for Family Planning (FP) Services by Marital Status and Age GroupAmong All Women Aged 15–44 YearsReproductive Health Survey: Georgia, 2010

		Marital Status			Age Group		
Demand for Family Planning	Total	Married	Previously Married	Never Married	15–24	25–34	35–44
No Demand	60.8	35.3	88.5	99.7	85.3	49.1	44.1
Never had sexual intercourse	34.2	0.0	0.0	99.7	67.7	19.0	10.2
Not currently sexually active*	8.7	5.6	82.2	0.0	2.7	9.0	15.6
Currently pregnant or post-partum	7.6	12.8	1.3	0.0	10.4	9.4	2.3
Seeking to get pregnant [†]	4.9	8.2	1.1	0.0	4.1	6.8	3.8
Infecund/subfecund [‡]	5.4	8.7	3.9	0.0	0.4	4.9	12.2
Potential Demand	39.1	64.7	11.4	0.2	14.8	51.0	55.8
Current users of a modern method	20.6	34.2	5.8	0.0	8.3	28.9	26.7
Current users of a traditional method	10.8	18.2	0.2	0.0	3.2	13.8	16.8
Unmet need of any contraception							
(Nonusers at risk of unintended	7.7	12.3	5.4	0.2	3.3	8.3	12.3
Unmet Need of Modern	18.5	30.5	5.6	0.2	6.5	22.1	29.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	6,292	4,098	389	1,805	1,960	2,359	1,973

* Within the past month.

† Want to get pregnant right away; includes 115 respondents who answered "when God wants."

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

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

Table 6.5.2Unmet Need for Family Planning (FP) Services by Marital Status and Age Group
Among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

Characteriatia	All V	Vomen	No. of	Married	l Women	No. of
Characteristic	Any Method	Modern Method	Cases	Any Method	Modern Method	Cases
Total	7.7	18.5	6,292	12.3	30.5	4,098
Desidence						
Residence	6.1	11.0	2.075	10.1	24.0	1 906
Dural	0.1	14.Z	2,975	10.1	24.0	1,000
Rural	9.5	Z3.Z	3,317	14.5	30.0	2,292
Keylon	0.5	10.0	400	14.0	07.0	240
	9.5	10.2	498	14.2	27.9	348
	5.3	12.7	1,420	8.9	23.2	815
Snida Kartii	5.7	21.1	392	9.0	34.Z	200
Kvemo Kartli	9.7	24.6	546	14.4	37.6	3/5
Samtskne-Javakneti	5.0	24.7	481	7.6	39.8	331
Adjara	10.5	25.0	419	15.7	38.3	292
Guria	10.2	25.0	401	15.1	38.4	276
Samegrelo	7.4	15.1	477	13.1	26.7	302
Imereti	8.5	17.4	805	13.5	27.8	540
Mtskheta-Mtianeti	10.8	19.4	393	16.2	29.7	270
Racha–Svaneti	8.2	21.8	454	14.2	37.8	283
Age Group						
15–19	1.0	1.4	861	9.0	13.1	124
20–24	5.5	11.3	1,099	10.7	22.6	610
25–29	7.7	18.8	1,191	10.7	26.4	863
30–34	9.0	25.5	1,168	10.7	31.9	948
35–39	11.1	29.6	1,051	13.1	36.3	836
40–44	13.7	28.5	922	16.8	36.2	717
No. of Living Children						
0	0.9	1.0	2,276	4.6	5.8	409
1	8.2	19.9	1,286	8.9	23.0	1,106
2	14.0	34.9	2,069	14.6	36.9	1,956
3	16.0	38.9	539	15.9	39.9	516
4 or more	16.3	36.7	122	15.4	37.8	111
Education						
Secondary incomplete or less	8.4	18.7	1,330	17.6	39.9	726
Secondary complete	9.2	21.9	1,568	13.9	33.4	1,119
Technicum	11.2	22.4	903	14.7	30.5	673
University/Postgraduate	5.2	14.9	2,491	7.8	24.2	1,580
Wealth Quintile						
Lowest	12.4	27.2	1,093	18.6	42.1	727
Second	9.0	22.9	1,385	13.9	35.7	966
Middle	6.4	17.4	1,413	10.4	28.1	952
Fourth	6.9	15.5	1,037	11.3	27.3	623
Highest	5.6	13.2	1,364	9.3	22.9	830
Ethnicity			,			
Georgian	7.0	17.2	5,488	11.4	28.8	3,521
Azeri	16.3	32.1	276	22.5	44.4	219
Armenian	7.5	24.9	364	11.8	41.3	249
Other	12.1	20.1	164	18.0	30.1	109

Table 6.6

Source of Contraceptive Advice and Type of Counseling Received by Residence and Last Method Used Among Women Aged 15–44 Years Who Had Used a Modern Method within the Last 5 Years Reproductive Health Survey: Georgia, 2010

		Resic	dence			ast Method Used	-	
Person Who Advised User of Method	Total	Urban	Rural	Oral Contraceptives	IUD	Condoms	Tubal Ligation	Other Modern
Ob/Gyn	56.3	50.1	64.7	78.2	93.4	12.2	89.7	54.2
Partner	23.3	27.4	17.7	0.0	0.0	56.9	1.8	0.5
Nobody	9.0	11.8	5.1	1.4	1.1	19.3	5.3	4.0
Friend	5.1	5.1	5.2	8.6	1.0	6.4	0.0	23.3
Other relative	3.7	3.2	4.4	5.6	3.4	2.7	1.7	12.0
Pharmacist	1.1	1.2	0.9	2.8	0.0	1.2	0.0	4.3
Mother	0.6	0.6	0.7	1.0	0.7	9.0	0.0	0.0
Nurse/Midwife	0.5	0.2	1.0	1.6	0.4	0.3	0.0	1.2
Other	0.4	0.3	9.0	0.8	0.0	0.4	1.5	0.5
General practitioner	0.1	0.1	0.0	0.0	0.0	0.2	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. of Cases	1,779	938	841	263	598	731	103	84
		Resic	dence			ast Method Used		
Type of Counseling	Total	Urban	Rural	Oral Contraceptives	Ð	Condoms	Tubal Ligation	Other Modern
General information about other methods	64.2	64.1	64.3	72.8	62.7	65.4	49.0	77.7
Information about method s effectiveness	59.1	59.3	58.8	67.4	57.6	57.8	48.0	70.2
Information about possible side effects	82.5	82.8	82.2	78.2	90.8	55.5	73.9	69.5
What to do if side effects occur	78.0	77.0	79.1	79.2	86.0	49.6	63.7	62.5
No. of Cases	988	459	529	206	558	86	91	47

Chapter 7

Sexual and Contraceptive Experience of Young Adults

he 2010 Georgia RHS included a module that was administered to adolescent and young adult women aged 15–24 years to assess their sexual and reproductive behaviors, particularly the risk for unintended pregnancy and sexually transmitted infection. Chapter 7 explores several findings among this population in relation to sexual experience, contraceptive use, and sexual partners—all of which can be particularly valuable in planning program strategies and sex education for young people.

7.1 First Sexual Experience

In 2010, sexual experience was reported by nearly a third (32%) of young women aged 15-24 (Table 7.1.1). Just over a tenth (11%) of the adolescent subgroup of 15-19 year olds, reported sexual experience, compared to 52.2% of 20-24 year olds. The delay in sexual activity until the later young adulthood (20-24 year olds) was similarly demonstrated by previous surveys conducted in 1999 and 2005 (Figure 7.1.1).

Sexual experience was lowest among young women in Tbilisi (28%) and highest among young women in rural areas (35%). While sexual experience increased with educational attainment, likely associated with aging, the exception was young women with university or postgraduate education, of whom 66% were inexperienced. Sexual experience was reported more frequently by Azeri women in Georgia (53%) than women of other ethnic groups (30% of ethnic Georgians, 36% of Armenians, and 45% of all others). Premarital sex at first intercourse was highly uncommon, being reported by less than 5% of women in any age, residential, education, wealth or ethnic category.

life table methodology was used to show А differences in age at first sexual intercourse across residence, education, socioeconomic status, wealth quintile, and ethnicity (Table 7.1.2). Overall, there was a steady increase from less than 1% of young women having initiated sex before age 15 up to 62% of young women who had done so by age 24. One of the most significant differences is seen across educational level (Figure 7.1.2). Over half of young women who had secondary education or less had engaged in sexual activity prior to age 22, whereas only 39% of young women with university or technicum education had done so. The majority of young women, regardless of educational level, had sexual experience by age 24 (66% of women with incomplete secondary education, 74% of women who had completed secondary education, and 53% of women with technicum or university education). Respondents in the lower two wealth quintiles







tended to initiate sex at earlier ages, compared to wealthier young women.

Georgian and Armenian young women more frequently reported having ever had sex (70% and 64%, respectively); however, Azeri women who did have sexual experience tended to have their first intercourse at younger ages than women of other ethnicities. This may be explained by ethnic differences in average age of marriage.

7.2 Partner at First Intercourse

Table 7.2.1describes the respondents' relationship to their partner at first intercourse. As mentioned previously, the majority of young adults reported that their first sexual experience was marital; thus, partners at first sex were predominately husbands (95%), and more than 90% of all regional, educational, wealth, or ethnic groups reported their husband as their first sex partner. Among those who were not married at the time of first intercourse, the majority were engaged to be married to their partner (53%). The husband as first partner was most often reported by those who live in urban areas other than Tbilisi (96%), those who had completed secondary education (96%), and those who were of Georgia (95%) or Armenian ethnicity (94%).

Table 7.2.2 depicts the age difference between respondents and their partners at first sexual intercourse. The majority of young women in Georgia (54%) had partners who were less than five years older. Young women in Tbilisi and in rural areas more often reported having had a partner who was more than ten years older (6.3% and 6.2%, respectively, compared to 4.3% in other urban areas). The disparity between the respondent's and her partner's age appeared to be widest among young women who were less than 18 years old at first intercourse; unlike their counterparts who had delayed sex until later, less than half (49%) had partners who were less than 5 years older (Figure 7.2).

7.3 Contraceptive Use at First Intercourse

Contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status. The primary reasons given for not using a contraceptive method at first intercourse were wanting to get pregnant (67%), not thinking about using a method (24%), and not knowing about contraception (3%) (Table 7.3.1). The primary reason varied significantly by marital status, with 69% of young women who were married at the time saying they wanted to get pregnant while most of their counterparts who were unmarried indicating that they did not think about contraception (51%) or the sexual encounter was unexpected (19%) (Figure 7.3). Unfortunately, a full tenth of young women (10%) who were unmarried at the time of first intercourse did not know about contraception.

7.4 Current Sexual Activity and Contraceptive Use

Current sexual activity is an important indicator for determining exposure to the risk of pregnancy, and it has implications for what method of contraception is most appropriate for individual's reproductive behavior and an intentions. The majority of married young women (63%) reported being sexually active within the last three months, while not pregnant or postpartum, suggesting a high opportunity for pregnancy (Table 7.4.1). A higher proportion of unmarried women had unprotected sex at their most recent sexual experience when compared to their married counterparts (70% versus 64%) (Table 7.4.2). Of those unmarried women who did use contraception, almost all reported using condoms and none reported using a traditional method such as withdrawal or the calendar (rhythm) method. Among married young women, 25% reported modern method use with condom (11%) and IUD (9%) being the most common. Married adolescents (15- to 19-year-olds) reported almost half as much contraceptive use than married 20 to 24 year olds (20% versus 39%). When comparing trends over the last decade, the proportion of young women not using any contraceptive method during their most recent sexual encounter has declined steadily, especially among unmarried women (Figure 7.4).

Thirty-seven percent of sexually experienced young women reported talking to a partner about condom use, a method that offers dual protection





against unintended pregnancy and sexually transmitted infection (Table 7.4.3). Discussion of condom use was considerably higher among residents of Tbilisi (62%), 20 to 24 year olds (40%), young women with university or postgraduate education (33%), and those who relied on condom use at last sexual intercourse (95%). The nearly universal communication with a partner about condoms among those who used this method at last intercourse suggests that talking about condoms may result in increased use.

Table 7.1.1Reported Sexual Experience of Young Women Aged 15–24 Years and
Marital Status at First Sexual Experience, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

	S	exual Experience	e		
Characteristic	No Sexual Experience	Marital	Premarital	Total	No. of Cases
Total	67.7	30.6	1.7	100.0	1,960
Residence					
Tbilisi	72.6	25.0	2.5	100.0	451
Other Urban	66.8	32.0	1.2	100.0	486
Rural	65.1	33.2	1.6	100.0	1,023
Age Group					
15–19	88.5	10.6	0.8	100.0	861
20–24	47.8	49.6	2.6	100.0	1,099
Education					
Secondary incomplete or less	80.4	18.3	1.3	100.0	651
Secondary complete	58.0	40.4	1.6	100.0	604
Technicum	53.3	44.7	2.0	100.0	165
University/Postgraduate	66.3	31.3	2.4	100.0	540
Wealth Quintile					
Lowest	66.2	32.2	1.6	100.0	327
Second	61.2	36.6	2.2	100.0	448
Middle	69.1	29.5	1.3	100.0	433
Fourth	70.7	27.7	1.6	100.0	336
Highest	70.1	28.0	1.9	100.0	416
Ethnicity					
Georgian	69.6	28.9	1.5	100.0	1,688
Azeri	47.0	48.8	4.2	100.0	92
Armenian	64.0	34.0	2.0	100.0	135
Other	54.6	42.4	3.0	100.0	45

Table 7.1.2Age at First Sexual Intercourse and Percentage of Women Aged 15–24 Years
Who Reported Sexual Experience, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Charactoristic	Age at F	First Sexual I	ntercourse (Life Table Es	stimates)	Had Had Never Had		No. of Cases
Gliaracteristic	< 15	< 18	< 20	<22	< 24	Intercourse	Intercourse	NO. 01 Cases
Total	0.8	13.6	28.7	49.2	62.3	32.3	67.7	1,960
Residence								
Urban	0.5	11.3	25.1	45.5	57.7	30.2	69.8	937
Rural	1.2	16.0	32.3	52.0	65.7	34.9	65.1	1,023
Education								
Secondary incomplete or less	1.6	21.3	44.2	60.2	66.2	19.6	80.4	651
Secondary complete	0.5	17.4	37.3	59.0	74.1	42.0	58.0	604
Technicum/university	0.4	5.7	16.7	38.9	53.3	36.5	63.5	705
Wealth Quintile								
Lowest	1.2	15.2	37.0	53.1	69.0	33.8	66.2	327
Second	1.7	18.6	34.3	60.2	69.8	38.8	61.2	448
Middle	0.7	12.0	26.2	45.0	61.0	30.9	69.1	433
Fourth	0.6	13.2	26.3	43.0	53.7	29.3	70.7	336
Highest	0.2	9.8	23.0	43.8	56.6	29.9	70.1	416
Ethnicity								
Georgian	0.5	11.3	26.2	46.9	58.9	30.4	69.6	1,688
Azeri	4.7	35.9	53.7	75.0	85.4	53.0	47.0	92
Armenian	1.3	16.6	31.1	41.6	67.3	36.0	64.0	135
Other	1.6	33.3	43.4	62.7	73.5	45.4	54.6	45
Table 7.2.1Relationship to Partner at First Sexual Intercourse among Sexually Experienced
Young Women Aged 15–24 — Reproductive Health Survey: Georgia, 2010

Characteristic		Relationship	with Partner		Total	No. of Coope
Gildracteristic	Husband	Fiancé	Boyfriend	Other	TOLA	NO. OF Cases
Total	94.6	2.8	2.1	0.4	100.0	772
Pasidonas						
Thilici	01 1	3.0	5.8	0.0	100.0	1/18
Other Urban	96.4	J.Z 1 1	5.0 2.4	0.0	100.0	140
Rural	90.4 95 /	3.6	0.2	0.2	100.0	/31
Age at First Sex	55.4	5.0	0.2	0.0	100.0	401
< 18	93.0	3.8	21	11	100.0	272
18_19	95.8	1.8	2.1	0.2	100.0	233
20-24	95.2	2.8	2.2	0.0	100.0	267
Marital Status at First Sex	00.2	2.0	2.0	0.0	10010	201
Not Married	0.0	52.7	39.1	8.2	100.0	40
Married	100.0	0.0	0.0	0.0	100.0	732
Education						
Secondary incomplete or less	93.5	4.1	1.2	1.3	100.0	167
Secondary complete	96.2	2.0	1.9	0.0	100.0	304
Technicum	95.8	4.2	0.0	0.0	100.0	88
University/Postgraduate	92.9	2.6	3.9	0.6	100.0	213
Wealth Quintile						
Lowest	95.1	1.4	1.6	1.8	100.0	128
Second	94.3	5.1	0.0	0.5	100.0	210
Middle	95.7	2.9	1.2	0.2	100.0	170
Fourth	94.7	1.7	3.6	0.0	100.0	118
Highest	93.6	2.1	4.2	0.0	100.0	146
Ethnicity						
Georgian	95.0	2.4	2.5	0.2	100.0	628
Azeri	92.2	7.8	0.0	0.0	100.0	58
Armenian	94.4	0.0	1.8	3.8	100.0	64
Other	93.4	6.6	0.0	0.0	100.0	22

Table 7.2.2 Age Difference between Partners at First Sexual Intercourse among Sexually Experienced Young Women Aged 15–24 Years Reproductive Health Survey: Georgia, 2010

		Age Dif	ference			
	Partner Younger	Partner Less Than 5 Years Older	Partner 5–10 Years Older	Partner More Than 10 Years Older	Total	No. of Cases *
Total	3.6	53.6	37.0	5.8	100.0	769
Residence						
Tbilisi	4.2	55.8	33.7	6.3	100.0	148
Other Urban	5.1	55.1	35.5	4.3	100.0	191
Rural	2.6	51.8	39.4	6.2	100.0	430
Age at First Sex						
< 18	0.4	48.7	45.3	5.6	100.0	270
18–19	4.1	53.5	37.4	5.0	100.0	233
20–24	6.4	58.5	28.6	6.6	100.0	266
Marital Status at First Sex						
Not Married	2.4	48.4	47.1	2.1	100.0	39
Married	3.7	53.9	36.5	6.0	100.0	730

* Exclude 3 cases that does not know

Table 7.3.1

Most Commonly Cited Reasons for Not Using Contraception at First Sexual Intercourse among Sexually Experienced Young Women Aged 15–24 Years Reproductive Health Survey: Georgia, 2010

	Total	Marital Status at First Se	x amoung Young Adults
	TOLAI	Not Married	Married
Reason			
Wanted to get pregnant	66.6	12.1	69.3
Did not think about using a method/negligence	23.7	50.8	22.4
Sex was not expected	2.9	19.4	2.1
Did not know about contraception	3.1	9.5	2.8
Partner was against it	1.3	0.0	1.3
Do not remember/Do not know	1.1	2.9	1.0
Respondent was against it	0.7	5.4	0.4
Other	0.7	0.0	0.7
Total	100.0	100.0	100.0
No. of Cases	759	34	725

Table 7.4.1 Percentage of Currently Sexually Active Young Women Aged 15–24 Years, by Age and Selected Characteristics — Reproductive Health Survey: Georgia, 2010

	Total	Current M	arital Status	Age	Group
	Total	Married	Not married	15–19	20–24
Currently Sexually Active	19.3	62.6	0.6	5.8	32.3
Within the last month	18.5	61.0	0.2	5.6	30.9
1–3 months ago	0.8	1.6	0.4	0.2	1.4
No Current Sexual Activity	2.1	2.1	2.1	0.7	3.5
Over 3 months ago but within last year	1.0	1.5	0.8	0.2	1.8
One year or longer	1.1	0.6	1.3	0.5	1.7
Currently Pregnant or Postpartum	10.4	34.0	0.2	4.9	15.6
Never Had Intercourse	67.7	0.0	96.8	88.5	47.8
No Response	0.5	1.3	0.1	0.2	0.8
Total No. of Cases	100.0 1,960	100.0 734	100.0 1,226	100.0 861	100.0 1,099

Table 7.4.2

Use of Contraception at Most Recent Sexual Intercourse, by Current Marital Status and Age Group, among Sexually Experienced Young Women Aged 15–24 Years Reproductive Health Survey: Georgia 2010

		Currei	וון Married or in L	Jnion	Not Committee Maniford
	Total	Total	Age G	iroup	Not Currently Married
		IOLAI	15–19	20–24	
Use of Contraception at the Most Recent Sexual Intercourse	35.6	36.0	19.7	39.4	29.8
Modern Methods	25.5	25.2	15.5	27.2	29.8
Oral Contraceptives	3.9	4.2	3.7	4.3	0.0
IUD	8.0	8.5	3.9	9.5	1.0
Condoms	12.2	11.0	7.3	11.8	28.8
Spermicides	1.1	1.2	0.7	1.3	0.0
Tubal ligation	0.3	0.3	0.0	0.4	0.0
	0	F 07	1	1.01	
Iraditional Methods	10.0	10.7	4.2	12.1	0.0
Calendar (rhythm) Method	3.1	3.3	1.5	3.7	0.0
Withdrawal	6.9	7.4	2.6	8.4	0.0
Unknown Methods	0.1	0.1	0.0	0.2	0.0
Did Not Use	64.4	64.0	80.3	60.6	70.2
Total	100.0	100.0	100.0	100.0	100.0
No. of Cases [*]	171	734	124	610	37

* Exclude 1 case Most Recent Sexual Intercourse is Rape

Table 7.4.3Percentage of Sexually Experienced Women Aged 15–24 Years Who Had Ever
Talked to a Partner about Using Condoms, by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

	Ever Talked about Using Condoms	No. of Cases
Total	37.0	772
Residence		
Tbilisi	61.6	148
Other Urban	39.4	193
Rural	24.1	431
Age Group		
15–19	23.0	130
20–24	39.9	642
Education		
Secondary incomplete or less	24.1	167
Secondary complete	33.8	304
Technicum	39.3	88
University/Postgraduate	49.8	213
Used Condom at Last Intercourse		
Yes	95.3	97
No	28.9	675
Used Withdrawal at Last Intercourse		
Yes	40.1	58
No	36.7	714

Chapter **8**

Maternal and Child Health

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

A number of factors can have a considerable impact on the health of a woman, the health of her baby, and the outcome of her pregnancy, including utilization of health care services related to pregnancy, location and type of assistance at delivery, and postpartum behaviors, including breastfeeding. Similar to previous survey rounds in Georgia, GERHS10 collected detailed information regarding the actual experiences of respondents during pregnancy, delivery, and the postpartum period. These topics, as well as infant and child mortality, are examined in this chapter. All estimates reported here are based on respondents' reports as recorded in a lifetime pregnancy history and a detailed birth history for all births carried to term since January 2005. Because the sample size and fertility and mortality levels, which are not very high, the maternal mortality cannot be directly estimated using a survey-based approach (i.e. the sisterhood method). Figures presented here are based on official reports and the nationwide Reproductive Age Mortality Survey (RAMOS) of female deaths aged 15-49 in 2006 (Serbanescu et al., 2009).

8.1 Maternal Mortality Statistics

Five years before the deadline to achieve the Millennium Development Goals, the reduction of maternal mortality by three-quarters and childunder-five mortality by two-thirds between 1990 and 2015 remain elusive targets for most countries. In Georgia, for example, the official maternal mortality ratio has increased by almost 20% between 1990 and 2000 (from 41 to 49 maternal deaths per 100,000 live births), with a peak rate in 1997 (70.6 maternal deaths per 100,000 live births). From 2000-2008, the rate fell substantially, only to increase abruptly in 2009 to 51 deaths per 100,000 live births, higher than in 1990 (Figure 8.1). The official source for maternal mortality levels and trends is the civil registration system, which records deaths by cause on a continuous basis.



The Georgian Ministry of Labor, Health, and Social Affairs (MoLHSA), which monitors the number of maternal deaths in the health management information system, generally reports similar figures. The recent RAMOS conducted in 2008-2009 showed that both under-reporting of all deaths and misclassification of causes of death are important sources of error in the measurements of maternal mortality. The study identified deaths using multiple sources and investigated these deaths by completing detailed family questionnaires with relatives of the deceased women and conducting interviews and record reviews at the medical facilities that provided care prior to death. The study identified 2.8 times more maternal deaths in 2006 than officially reported (MMR=66/100,000); 68% of maternal deaths followed deliveries, 16% followed other pregnancy outcomes, and 16% were undelivered. Hemorrhage, puerperal infection, and pregnancy-induced hypertension accounted for most direct obstetric maternal deaths; about 40% of deaths were due to indirect causes, most of them not captured in the official statistics (Serbanescu et al., 2009).

8.2 Prenatal Care

Prenatal care is important for preventing, identifying, and treating conditions that can affect the health of an expectant mother or her baby. To ensure the optimal health of mother and child, experts recommend that prenatal care is initiated during the first trimester of pregnancy, continues throughout gestation at specified intervals, and is comprehensive (i.e., includes risk assessment, risk reduction or treatment of medical conditions, and counseling). Comprehensive prenatal care can decrease perinatal maternal and infant morbidity and mortality by identifying and addressing potential risk factors that contribute to poor outcomes. Population-based surveys conducted in former Soviet-bloc countries since the breakup of the Soviet Union documented very high prenatal care coverage in the region, with only one country (Azerbaijan) reporting a relatively high proportion of pregnant women with no prenatal care (Figure 8.2.1) (CDC and Macro, 2003; Macro DHS 2005–2010).

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

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

complications requiring medical attention; and counseling on nutrition, birth preparedness, breastfeeding, and post-partum family planning.

Under the 1997 Georgian Law on Health Care, Article 132, maternity care is currently covered through mandatory medical insurance (Government of Georgia, 1997). In accordance with the new WHO protocol, the basic-benefit package for obstetric care covers four free-of-charge prenatal visits per pregnancy (at 13, 20–22, 30–32 and 36 weeks of pregnancy). The protocol for each visit includes oral history, clinical examination, laboratory tests, ultrasound examination (at 20-22 weeks), screening (for syphilis, Rh isoimmunization, and HIV), and counseling. Women who are identified as having risk factors during the first visit are referred for more specialized care and/or further testing. A free-of-charge delivery voucher in the amount of 400 Georgian Lari (GEL), or about USD 228.00, is provided to socially vulnerable populations; vouchers for other pregnant women cover only 200 GEL (about USD 114.00) toward delivery costs (CoReform Project, 2005). Women seeking delivery vouchers are required to be enrolled at a Women's Consultation Center and must complete the four minimum prenatal visits.

Although recommended by the WHO model, postpartum care is not covered under the state program. Once the health reform process is complete,



it is anticipated that family practitioners will provide most postpartum care and will refer mothers with any signs of complications to specialized care.

Table 8.2.1 presents the percentage of births (live births and stillbirths) from January 2005 to date of interview for which the respondents reported that they received prenatal care. Although differences in prenatal care may exist between women having stillbirths and those having live births, the small number of stillbirths reported for the period under consideration does not allow the separate study of pregnancies ended in stillbirth.

Use of prenatal care was almost universal: 98% of pregnant women received at least one prenatal examination. The percentage of pregnant women that received no prenatal care ranged from less than one percent in Imereti and Tbilisi to 7% in the Kakheti region. The probability of not receiving prenatal care was highest among rural residents, women whose maternal age was less than 20 years at time of delivery (4%), women with less than a secondary complete education (6%), women living in households with the lowest wealth quintile (6%), and those for whom the child's birth order was third or higher (5%). Women with a minority ethnic background were more likely to report they received no prenatal care compared to Georgian women (Figure 8.2.2).

Prenatal care coverage had improved significantly since 1999. According to the results of the 1999 Reproductive Health Survey, 9% of mothers who gave birth in the 5 years prior to the survey received no prenatal care, compared to only 5% in 2005 and 2% in 2010 (Figure 8.2.3).





Compared to 1999, the greatest reductions in the number of women receiving no prenatal care in 2010 were in rural areas (from 14% to 3%), among women with less than complete secondary education (from 30% to 6%), and among Azeri women (from 28% to 4%) (Figures 8.2.3 and 8.2.4).

The majority (90%) of respondents initiated prenatal care during the first trimester of their pregnancy (Table 8.2.1). Urban women were more likely than rural women to initiate prenatal care during the first trimester (93% vs. 86%), as were women living in the regions of Tbilisi (94%), Adjara (93%) and Imereti (92%), compared to those living in the other regions of the country. Receipt of prenatal care in the first trimester increased directly with maternal education and the wealth quintile of the households. Overall, initiation of prenatal care in the first trimester increased from 63% in 1999 to 71% in 2005, to 90% in 2010 and the improvement was consistent across all subgroups (Figure 8.2.5).

Overall, the majority (90%) of pregnant women received four or more prenatal care examinations, including 12% who received 10 or more visits (Table 8.2.1). On average, pregnant women received 6.5 prenatal care visits (data not shown). Completion of a minimum of four prenatal visits was more common in rural areas than in urban areas (86% vs. 95%) and in the regions of Shida-Kartli (98%), Tbilisi and Imereti (96%) and Adjara (91%) and least common in the regions of Racha-Svaneti (78%) and Kvemo Kartli (80%) (Figure 8.2.6). The mean number of prenatal care visits also varied by region (from over 7 visits per pregnancy









in Tbilisi and Imereti to 5 in Samtskhe-Javakheti and Guria, but no region reported less than 5 visits, on average (data not shown).

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

The percentage of pregnancies receiving 10 or more prenatal examinations was the highest in Tbilisi and Imereti and increased as the educational attainment and socioeconomic status of the expectant mothers increased.

In 2010, all prenatal care indicators have improved compared to 1999; the overall use of prenatal care and the initiation of care in the first trimester increased from 91% to 98% and from 63% to 90%, respectively, and the percentage of pregnant women receiving four or more examinations increased from 76% to 90%. Contrary to previous surveys, the improvements included some of the most disadvantaged groups of women, rural residents, those with less than a complete secondary education, and residents of the southern regions (Figures 8.2.7 and 8.2.8). The improvements in antenatal care are likely due to a shift in the proportion of pregnant women who



reported no or low attendance in 1999 and 2005 to the categories reporting receipt of 4–6 and 7–9 prenatal care visits in 2010, a shift facilitated by early onset of prenatal care visits in 2010 (Figure 8.2.9).

As shown in Figure 8.2.10, one in two women with births in 2005–2010 received most of their prenatal care from women's consultation clinics (49%); 44% received their care from raional or regional maternity hospitals. Only 7% of the women received care from primary health care or family medicine centers, while 1% received care from other sources.

Similar to the previous surveys, the GERHS10 included additional questions to assess adequacy of prenatal care content. Specifically, respondents were asked about what types of counseling they received and which assessments were performed during the prenatal visits. Dissemination of health messages is an important component of prenatal care visits. In the absence of routine preconception care, the first prenatal visit is a critical opportunity to screen women for behavioral risk factors (e.g., tobacco and alcohol use), medical and genetic risks, occupational risks and provide and to comprehensive counseling. Counseling should cover maternal behaviors and exposures that may affect the health of the fetus, nutrition, the importance of rest, and early signs and symptoms of pregnancy complications. In addition, as the time of delivery approaches, counseling should prepare women for what they will face when giving birth and provide accurate information regarding labor, delivery, and techniques to reduce pain and anxiety during labor.







Also, counseling about breastfeeding and family planning after birth should be initiated during the prenatal period and reinforced during postpartum care.

As shown in Table 8.2.2, 89% of women who attended prenatal care clinics received some counseling about nutrition during pregnancy; 81% received information about delivery; and 79% received information about breastfeeding. One in 3 women received information on potential complications during pregnancy and their early signs; 63% of pregnant women and 60%, respectively, received information on the negative effects of smoking and alcohol use during pregnancy; 59% of women received information about postnatal care; and 39% of women received information about family planning after birth. characteristics that appear to be Maternal associated with lower levels of counseling for most of the topics include rural residence, residence in Samtskhe-Javakheti and Samegrelo, less than complete secondary education and residing in households within the lowest wealth quintile. The proportion of women receiving information during prenatal care visits was directly correlated with the number of prenatal visits.

Compared to 1999 and 2005, the overall level of counseling improved in 2010 for all topics. The highest rate of improvement occurred in the proportion of women who received counseling on family planning after birth —which almost doubled from 20% in 1990 to 39% in 2010—and in the proportion of women who received information about postpartum care—which increased by 0.6 times, from 37% to 59%. The proportion of women who were counseled about warning signs of pregnancy complication increased from 48 to 66%. Despite the substantial increase, these topics are still lagging behind among the array of information offered during antenatal care (Figure 8.2.11).



In addition to counseling, prenatal care should include a detailed medical history of the woman and her family, including information about risk factors and genetic disorders; a detailed obstetrical history; clinical and obstetrical examination; measurements of maternal weight, height, and blood pressure; urine tests; basic blood tests; an ultrasound exam (during the second visit); and tests for various types of infection (e.g., syphilis and HIV). Tables 8.2.3 and 8.2.4 show the percentage of women receiving prenatal care who underwent selected examinations and measurements. Overall, almost all women (96%-99%) had at least one routine measurement of maternal weight, height, and blood pressure; urine tests; and basic blood tests; 65% had an HIV test during the prenatal period, compared to 46% in 2005 (a 50% increase); and 97% had at least one ultrasound exam.

Compared previous GERHS10 to surveys, documented that not only the overall practice of measurements and lab work during pregnancy had improved, but also their utilization by the pregnant women in the most disadvantaged groups. Contrary to previous surveys, the receipt of measurements and tests during prenatal care in 2010 varied little by maternal characteristics. The only notable exception remains HIV screening during pregnancy, which was much more likely to be performed in urban areas than in rural areas (75% vs. 55%), it varied by region (with the lowest coverage in Samtskhe-Javakheti and Adjara), was directly correlated with education and socio-economic status, and was the least likely to be performed when most of the prenatal care was obtained in a primary care or family medicine center.

More than three-fourths of women (77%) reported receiving their first ultrasound exams during the first trimester of pregnancy, a substantial increase from 2005, when only 44% of women received the test during the first three months of pregnancy. This finding suggests that ultrasound examination is now increasingly used as part of the initial pregnancy assessment—to confirm pregnancy, ensure it is neither molar nor ectopic, assess gestational age, and determine due date.

8.3 Intrapartum Care

The vast majority of births since January 2005 were delivered in health care facilities; only 2% of the births were delivered at home (Table 8.3.1). All births in urban areas were delivered in medical facilities. The percentage of home births was uniformly very low, with the exception of Kakheti region (8%), women with less than complete secondary education (6%) and those residing in households within the lowest wealth quintile (4%), and women of Azeri or other ethnic group background (5% and 9%, respectively).

Overall, between the 2005 and 2010 surveys, the percentage of births attended at home dropped precipitously (from about 8% to 2%). The largest declines were noticeable in regions with high home delivery rates (Figure 8.3.1). Deliveries at home among residents of Kakheti were almost 4 times less likely to occur in 2010 compared to 5 years ago. Home deliveries in Kvemo-Kartli and Guria, where in 2005 they represented 15% and 12% of all births, were almost eliminated.

Steep declines were also reported among women of a minority ethnic group (Figure 8.3.2). Among Azeri women, there was a significant decline in home deliveries, from 40% in 2005 (95%CI=30%-50%) to 5% in 2010 (95%CI=0.2%-9%).

Table 8.3.2 shows the amount of time spent in a medical facility prior to delivery and the length of stay after delivery. The average time spent in a medical facility prior to delivery was about 4 hours and varied little by the characteristics of the mothers or deliveries. Considering that the average duration of labor is between ten hours for nulliparous women and six hours for multiparous women, most women were admitted for delivery around or right after the onset of labor.

Standards of care in Georgia stipulate 4 days of postpartum hospital care after uncomplicated deliveries, 5 days after pregnancy or delivery complications, and 6 days after deliveries by cesarean section. GERHS10 data show that 56% of women who gave birth in a medical facility were discharged in the first 4 days after delivery, while 25% were discharged after 5 days and 15% after 6 or 7 days (right panel of Table 8.3.2). A small proportion of women (4%) were discharged 8 or more days after delivery. Almost one in two (48%) women who delivered by cesarean section and 29% of women who had pregnancy complications had hospital stays of 6 days or more. Among the births that took place in a medical facility, 24% were delivered by cesarean section, ranging from a high of 33% in the region of Samegrelo to a low of 9% in the region of Samtskhe-Javakheti (Table 8.3.3 and Figure 8.3.3).





As is the case in many countries, the probability of delivering by cesarean section increases as maternal age, educational attainment, and socioeconomic Women status increases. who reported complications during pregnancy were significantly more likely to deliver by cesarean section than women without complications: 36% (95%CI=29%-42%) vs. 22% (95%CI=17%-19%). Forty-one percent of women who reported being in labor for more than 12 hours had delivered by C-section, compared to only 8% of women who were in labor for shorter durations.

Respondents were asked to identify the most important reason why they had delivered by cesarean section (Figure 8.3.4). The most frequent reasons given by the respondents included previous C-section (20%), fetal malpresentation (17%), cesarean section performed on request (16%), fetal distress (13%); prolonged labor (11%); fetopelvic disproportion (10%); and severe bleeding (2%); 11% reported that they received a cesarean section due to "other" factors. According to the Georgian Obstetrics and Gynecology Association, patient request of cesarean section delivery is not considered a medical indication. Compared to the 1999 survey, the prevalence of cesarean deliveries more than tripled in all regions; the greatest percentage increase was in the North-East region (5 times higher prevalence in 2010 than in 1999) and in Imereti (4 times higher prevalence in 2010 than in 1999) (Figure 8.3.5). Most of these increases are attributable to the adoption of more inclusive indications for cesarean delivery into clinical practice.







In Georgia, almost all deliveries (88%) assisted by skilled birth attendants are performed for a fee, which varies by type of facility and type of delivery (Table 8.3.4). At the time of the survey, mean delivery charges were almost 453 GEL (about USD 260.00). Reported delivery payments were lower among rural women than urban women, and among abortions performed outside of Tbilisi, and increased directly with education and SES. The amount paid for a delivery ranged from no payment to over 800 GEL. Only 11.8% of deliveries incurred no charge while 28% required payments of 600 or more lari; deliveries by C-section were 1.7 times more expensive than vaginal deliveries and more than half required payments of 600 or more lari.

8.4 Postpartum Care

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

As shown in Table 8.4.1, only 23% of mothers received postpartum care after they left the hospital; although this is an improvement compared to the 1999 level, there was almost no change compared to the percentage found in the 2005 Reproductive Health Survey (Figure 8.4.1). Georgia ranks last in the region with regard to the percentage of women receiving such care, which highlights the need to include postpartum care coverage under the state maternal and child care program (Figure 8.4.1).

Rates of postpartum care ranged from a low of 16% in the regions of Guria, Samegrelo and Shida Kartli to a high of 32% in the region of Mtskheta-Mtianeti (Figure 8.4.2). Rates increased with increases in the educational attainment and socioeconomic levels of respondents and were significantly higher only among women who experienced postpartum complications compared to those without complications: 44% (CI=36%-52%) vs. 21% (95%CI=18%-23%). About three out of four women who received postpartum care (73%-79%) were counseled at least once on breastfeeding, breast care, child care, and nutrition. Notably, only 43% of the women counseling on received family planning. Compared to 1999, rates of counseling on breastfeeding, self-care, child care, and especially immunization and nutrition declined in 2005 and 2010; only family planning counseling rates

increased (from 20% in 1999, to 31% in 2005 and 43% in 2010) (Figure 8.4.3).

WHO recommends that the first postpartum visit take place within one week after birth (WHO, 2002) As shown in Table 8.4.2, 31% of respondents reported making a postpartum visit during the first six days after delivery, while an additional 42% made their initial visit one to two weeks after delivery; 27% of the women who received postpartum care made their initial visit more than two weeks after delivery.

Each mother was asked if a health professional checked the baby's health and, if so, how soon after delivery the examination was made. As shown in Table 8.4.3, overall, 84% of newborns received a well-baby checkup. The use of wellbaby care was higher among urban than rural residents (90% vs. 79%) and ranged from a low of 72% in the region of Racha-Svaneti to a high of 92% in the region of Tbilisi (Figure 8.4.4). As has been the case with other indicators discussed in this chapter, the likelihood of receiving well-baby care increases as the educational attainment and socioeconomic status of the mother increases. Of the respondents who took their newborn to a health professional to be examined, 22% took their infant during the first six days following delivery, while 53% made their initial visit one to two weeks after delivery. An additional 24% took their newborn for an examination more than two weeks following delivery.







As shown in Table 8.4.4, virtually all (97%) babies born alive in 2005–2010 were registered, according to the mother. The majority of mothers registered their births during the first six days following delivery (81%), while an additional 16% did so one to four weeks after delivery. Urban women were more likely than rural women to register their births soon after delivery.

8.5 Smoking and Drinking During Pregnancy

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

Respondents who gave birth during the five years prior to the 2010 survey were asked "On average, how many cigarettes did you smoke per day after you found out you were pregnant?" and "How many times per week did you drink alcoholic



beverages during the pregnancy?" As shown in Table 8.5, only 4.2% of the women were smokers at the time that they discovered they were pregnant, but less than half of them (1.8%) continued to smoke after they found out they were pregnant. The proportion of women who continued to smoke during pregnancy was highest in Tbilisi (4.6%), among women whose households were within the highest wealth quintile (3.4%), and among women of "other" ethnicity (5.4%). Most of the mothers who smoked during pregnancy smoked 1–4 cigarettes per day. Only 1.1% of women reported drinking during pregnancy; most of these women (61%) consumed alcohol less than once per week (data not shown).

8.6 Pregnancy and Postpartum Complications

As shown previously in Table 8.2.3, routine measurement of blood pressure was almost always (96%) reported as being part of the risk assessment during prenatal visits. Of the women whose blood pressure was measured, 10% were identified as having high blood pressure (Table 8.6.1). The prevalence of reported high blood pressure during pregnancy was highest among women whose maternal age at delivery was 35–44 years (21%). Overall, 1% of the women were hospitalized due to high blood pressure; higher hospitalization levels were reported by women residing in Kakheti (2%) and those who had most of their prenatal care visits in city maternity hospitals (2%).

Nearly 16% of women with births in the last five years reported pregnancy complications requiring medical attention (Table 8.6.2). The conditions mentioned most often were risk of preterm delivery (8%), anemia related to pregnancy (4%), water retention or edema (3%), high blood pressure (3%), and bleeding (3%). Pregnancy complications requiring medical attention were slightly more prevalent among women living in Mskheta-Mtianeti (24%), Shida Kartli (22%) and Imereti (21%) and women whose maternal age at delivery was 35–44 years (20%). Almost one in three women with pregnancy complications reported that they had been hospitalized for these conditions (data not shown).

Postpartum complications reported by women who gave birth in the five years prior to the survey are shown in Table 8.6.3. Overall, 11% of the women reported at least one postpartum complication. The complications mentioned most often were severe bleeding, painful uterus, high fever, breast infection, infectious vaginal discharge, painful urination, and infection of the surgical wound.

8.7 Poor Birth Outcomes

As in the previous rounds, the GERHS10 collected complete pregnancy histories asking each woman about her lifetime pregnancy experiences, including information about pregnancies resulting in fetal death. Multiple definitions are in use in different settings based on different parameters (i.e. gestational age or weight at birth) and standards of viability. For international comparability, the survey have used the WHO recommendation and included in the calculation of stillbirth rate all infants born dead after 28 completed weeks of gestation (roughly weighing 1,000 grams or more at birth). Thus, stillbirth rate data presented here refer to late fetal deaths i.e. the number of babies born dead after 28 weeks of gestation per 1,000 total births. Of all births that occurred during the five years prior to the survey, 8 per 1,000 (CI=3.1– 13 per 1,000) were stillbirths (Table 8.7). This rate is slightly lower than the rate of 13.4 per 1,000 reported by governmental sources for the 2005–2010 period (WHO, 2011a).

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

Overall, the low birth weight rate, which is the percentage of live births with birth weight under 2,500 grams, was 4.2% among infants born alive. Slightly higher rates were reported by women living in the regions of Mtskheta-Mtianeti (7.6%), women with a maternal age of 35–44 years (11.1%), women who delivered by cesarean section, and women who experienced complications during their pregnancies.

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

8.8 Breastfeeding

WHO recommends that all infants are fed exclusively on breast milk from birth to 6 months of age followed by continued breastfeeding, together with appropriate complementary feeding, for up to two years of age or beyond (WHO, 2002). An infant is considered to be "exclusively" breastfed if he or she receives only breast milk and is predominantly breastfed if he or she receives breast milk accompanied by water, water-based drinks, fruit juice or other liquids (except non-human milk and foodbased fluids) (WHO, 1991). Children with exclusive or predominant breastfeeding are considered to be "fully" breastfed.

Table 8.8.1 and Figure 8.8.1 show that 87% of infants born since January, 2005 were breastfed. This rate is essentially unchanged from the 1999 and 2005 surveys. Differences in breastfeeding by residence, region, maternal age, educational attainment, and birth order were slight, although Georgian women reported lower rates of breastfeeding than women of other ethnicities. Among babies who weighed less than 2,500 grams at birth, only 64% were reported to have been breastfed.

According to WHO recommendations, early breastfeeding (i.e., within the first hour of life) should be encouraged after all spontaneous deliveries. However, 20% of infants were breastfed within the first hour following birth. The percentage of infants that were breastfed within the first hour ranges from a high of 33% in the region of Samtskhe-Javakheti to a low of 9% in the region of Adjara. An additional 55% of infants were breastfed within 1-23 hours after birth. Thus, overall, 75% of the infants were breastfed within the first day. Among infants delivered by cesarean section, only 50% were breastfed within the first day, while 25% were breastfed for the first time 48 or more hours following birth. Since the 1999 survey, the proportion of babies who were breastfed within the first hour after birth increased by 4 times (from 5% in 1999 to 10% in 2005 and 20% in 2010), while the proportion of those who received breast milk 1-23 hours after birth doubled, from 28% to 55% (Figure 8.8.2).

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

Table 8.8.2 and Figure 8.8.3 show data on the mean duration of breastfeeding. The mean duration of any breastfeeding was 12.1 months, 2 months longer from the 10.1 months recorded in the 2005 survey. The mean duration of full breastfeeding (either exclusive breastfeeding or predominantly breastfeeding) was 4.1 months, longer than the 3.7 months documented in the 1999 and 2005 surveys.

Perhaps the most important gain was in the duration of exclusive breastfeeding (only breast milk), which doubled from the level documented in the 1999 survey (from 1.5 to 3 months).





60%

80%

100%

0%

20%

40%



Patterns for "any breastfeeding" were similar across all of the categories shown in Table 8.8.2, excepting birth order: breastfeeding increases as birth order increases.

8.9 Infant and Child Mortality

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

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

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

Similar to the previous surveys, GERHS10 data were used to calculate mortality levels among respondents' children, specifically, infant mortality (i.e., deaths before the first birthday), child mortality (i.e., deaths between 12 and 59 completed months of age), and child-under-5 mortality (i.e., deaths before the fifth birthday). Infant mortality was further divided into two periods: neonatal (0-28 days) and post-neonatal (29 days to 11 completed months). The survey estimates levels of and trends in infant and child mortality based on birth histories and child survival information obtained from a representative sample of Georgian women. The survey questionnaire included a series of questions for each live birth: date of birth, sex of child, survival status, and for children who had died, age at death. This information allows a direct calculation of infant and child mortality rates for precise periods of time, by means of life tables.

Survey data-based mortality estimates should be viewed as minimum estimates because they may be subject to underreporting. For example, information on a deceased child whose mother has also died will simply not be gathered; some mothers may not acknowledge a child who died shortly after birth; others may not recall the exact date of birth or may be unwilling or unable to recall at what age a child has died. Despite these limitations, population-based survey estimates of infant and child mortality are quite robust and have proved instrumental in countries where official birth and death rates are incomplete or inaccurate. Because surveys count events experienced by a randomly selected sample, rather than the entire population, the resulting estimates are subject to a certain degree of sampling error (see Appendix B). To adjust for sampling error, 95% confidence intervals around survey estimates were calculated; consequently, we can say with certainty that the true value of a statistic lies within the boundaries of the 95% confidence interval.

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

Figure 8.9.1 presents changes in the mortality rate of children younger than one year (i.e. infant mortality rate) in Georgia using data from all available surveys and official statistics. The most recent available figures for 2009 are in good agreement among all sources (14.1–14.9 deaths per 1,000 live births) and represent the lowest rates since 1990.



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

Table 8.9.1 presents mortality estimates for a 5 year period prior to the 2010, 2005 and 1999 surveys.

The estimated infant mortality rate for the period January 2005–December 2009 was 14.1 per 1,000 live births, and the child-under-5 mortality rate was 16.4 per 1,000. The neonatal mortality rate was estimated at 9.5 per 1,000, while the post-neonatal mortality rate was estimated at 4.5 per 1,000. Thus, the neonatal rate is twice as high as the post-neonatal rate and constitutes 67% of the infant mortality rate and 58% of under-5 mortality rate for the period 1995–2004. This finding is not unexpected: child mortality after the first month of life declines faster than the neonatal mortality; hence, the proportion of deaths that occur in the first 4 weeks of life (neonatal period), particularly in the first 7 days (early neonatal period) increases over time (Lawn et al., 2005).

A comparison with previous survey estimates shows that there has been a significant decline in both the neonatal and post-neonatal mortality rate, which in turn significantly lowered the infant and child under-5 mortality over the past 15 years (Table 8.9.1 and Figures 6.9.2–6.9.4). Neonatal mortality declined from 25 per 1,000 in 1999 to 19.1 per 1,000 in 2005 to 9.5 per 1,000 in 2010. Infant mortality declined from a rate of 41.6 per 1,000 live births in 1995–1999 to 21.1 per 1,000 live births in 2000–2004 and 14.1 in 2005– 2009; the child-under-5 mortality rate dropped from 45.3 per 1,000 to 25 per 1,000 and 16.4 per 1,000 births, respectively —a nearly 64% decline.

Thus, according to the survey estimates, Georgia has almost achieved MDG 4 by 2010 (Figure 8.9.5).

Focusing on the 2010 survey results for 2000-2009, the highest infant and under-5 mortality rates were found among children living in rural areas and those born to in households within the lowest two wealth quintiles (Table 8.9.2). Previous RHS surveys showed that the infant mortality rate for babies born to Azeri and Armenian mothers was much higher than that of their Georgian counterparts, but GERHS10 data no longer document this gap. At the first glance, both the infant and child under 5 mortality rates for ethnic minorities had declined between 1999 and 2009 more abruptly than the rates among Georgian children-from 51.0 deaths 1,000 per

(95%CI=30.7-71.2)and 53.9per 1,000 (95%CI=33.6–74.2) to 23.5 deaths 1,000 per (95%CI=8.7-38.3) and 26.3 deaths per 1.000 (95%CI=10.5-42.1), respectively. Given the comparatively fewer number of deaths among other ethnic groups than among Georgians, the decline did not reach statistical significance. However, the decline in infant and under 5 mortality rates for Georgian children was significant, from 38.3 deaths per 1,000 (95%CI=31.6-45.0) and 42.4 per 1,000 (95%CI=35.9-49.8) to 23.8 deaths per 1,000 (95%CI=17.8-29.9) and 25.9 deaths per 1,000 (95%CI=19.5-32.1), respectively (Figure 8.9.6).

Although the differences were not statistically significant, the lowest infant mortality rates were reported in Racha Svaneti, Tbilisi and Imereti while the highest rates were reported in Samegrelo, Shida Kartli, Kakheti and Adjara (Figure 8.9.7).

Both infant mortality and under-5 mortality increased with birth order. Specifically, the children at highest risk of dying were those born to women with at least two previous births. Gender differentials in mortality rates were obvious in the neonatal and postneonatal periods, probably because girls have a well-known biological survival advantage soon after birth (Ulizzi and Zonta, 2002).







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







Characteristic		Trimeste	r of First Prer	natal Visit				Number of Pr	renatal Visits			Tatal	
Characteristic	No Visits	1st	2nd	3rd	DK	No Visits	1-3	4–6	7–9	10+	DK	Iotal	NO. OF Cases
Total	1.6	89.8	7.5	0.3	0.7	1.6	7.3	54.3	23.9	12.0	0.9	100.0	2,617
Residence													
Urban	0.6	93.1	5.8	0.2	0.2	0.6	4.2	52.3	26.2	16.1	0.7	100.0	1,193
Rural	2.7	86.4	9.2	0.5	1.2	2.7	10.5	56.4	21.5	7.8	1.1	100.0	1,424
Region													
Kakheti	7.1	79.6	7.8	1.2	4.3	7.1	6.7	60.8	17.3	5.5	2.7	100.0	224
I bilisi	0.6	93.6	5.4	0.2	0.3	0.6	3.7	50.8	27.1	17.6	0.2	100.0	567
Shida Kartli	0.0	91.4	8.6	0.0	0.0	0.0	2.2	62.7	23.8	11.4	0.0	100.0	168
Kvemo Kartli	4.7	86.4	8.5	0.0	0.4	4.7	14.0	50.8	21.7	7.0	1.9	100.0	234
Samtskhe–Javakheti	0.0	89.8	8.1	1.2	0.8	0.0	18.7	63.8	10.6	6.1	0.8	100.0	214
Adjara	0.5	93.2	5.4	0.0	1.0	0.5	7.8	65.9	17.1	8.3	0.5	100.0	176
Guria	0.0	86.2	13.2	0.0	0.6	0.0	9.4	76.1	8.8	3.8	1.9	100.0	140
Samegrelo	1.4	91.9	5.7	0.5	0.5	1.4	12.0	50.7	26.8	7.7	1.4	100.0	184
Imereti	0.3	90.0	9.5	0.3	0.0	0.3	3.3	45.0	32.2	18.7	0.5	100.0	349
Mtskheta-Mtianeti	2.6	84.3	12.2	0.9	0.0	2.6	10.0	52.4	26.6	7.9	0.4	100.0	200
Racha–Svaneti	1.5	87.2	10.7	0.5	0.0	1.5	20.4	43.9	26.0	8.2	0.0	100.0	161
Age Group at Birth													
< 20	3.8	88.3	5.7	0.0	2.2	3.8	6.0	57.5	24.0	8.3	0.4	100.0	313
20–24	1.1	89.2	8.7	0.4	0.6	1.1	7.5	58.8	22.6	9.3	0.7	100.0	956
25–34	1.3	90.9	7.0	0.3	0.5	1.3	7.0	51.1	24.2	15.5	0.9	100.0	1,164
35–44	2.9	88.9	7.2	1.0	0.0	2.9	10.8	45.2	28.3	10.3	2.4	100.0	184
Education													
Secondary incomplete or less	5.8	79.6	11.3	0.2	3.1	5.8	13.9	56.0	18.4	4.9	0.9	100.0	422
Secondary complete	2.0	89.2	8.1	0.5	0.2	2.0	9.7	55.4	20.8	11.2	0.9	100.0	738
Technicum/University	0.3	93.0	6.1	0.3	0.3	0.3	4.3	53.3	26.9	14.4	0.8	100.0	1,457
Wealth Quintile													
Lowest	5.9	82.5	11.2	0.3	0.1	5.9	15.1	53.2	17.0	8.2	0.6	100.0	428
Second	1.4	87.6	8.6	0.7	1.8	1.4	10.9	56.0	23.0	7.5	1.3	100.0	628
Middle	1.5	89.4	7.8	0.4	0.9	1.5	6.9	61.2	20.8	8.5	1.1	100.0	587
Fourth	1.2	89.9	7.9	0.2	0.7	1.2	3.9	52.4	26.6	14.6	1.2	100.0	413
Highest	0.0	96.0	4.0	0.1	0.0	0.0	2.6	49.1	29.1	19.0	0.2	100.0	561
Birth Order													
First birth	0.9	93.3	5.0	0.1	0.7	0.9	4.5	54.0	26.0	14.0	0.7	100.0	1.293
Second birth	1,5	87.3	9.8	0.7	0.7	1.5	8.9	55.7	22.7	10.5	0.7	100.0	937
Third or higher	4.6	83.6	10.7	0.2	0.8	4.6	13.3	52.3	19.3	8.5	1.9	100.0	387
Ethnicity				•	0.0			v 1		0.1			
Georgian	0.7	91.5	7.1	0.3	0.3	0.7	5.7	54.5	25.3	13.0	0.8	100.0	2.248
Azeri	60	81.7	7.8	0.0	4.5	6.0	15.9	55.6	15.8	4.5	22	100.0	145
Armenian	3.6	80.7	11.5	0.0	33	3.6	23.7	53.0	11.0	73	0.5	100.0	145
Other	12.2	77 1	10.1	0.5	0.0	12.2	9.0	48.9	22.3	7.6	0.0	100.0	79
Bahy's Weight at Birth [*]	12.2	,,	10.1	0.0	0.0	12.2	0.0	10.0	22.0	1.0	0.0	100.0	10
< 2500 grome	20	07.0	0.0	0.0	10	20	12.0	10.2	10.0	20.5	47	100.0	125
	2.0	01.0	0.2	0.0	1.2	2.0	13.0	40.Z	10.0	20.0	4./	100.0	120
>= 2500 grams	1.4	90.1	1.4	0.4	0.7	1.4	1.0	55.Z	24.2	11.0	0.7	100.0	2,481

Table 8.2.1 Initiation of Prenatal Care by Pregnancy Trimester and Number of Prenatal Visits, by Selected Characteristics Among Births in 2005–2010 Reproductive Health Survey: Georgia, 2010

* Excludes 11 births with unknow weight at birth.

Table 8.2.2

Specific Types of Information Received During Prenatal Care Visits by Selected Characteristics Women with Births in 2005–2010 Who Had Any Prenatal Care Reproductive Health Survey: Georgia, 2010

Characteristic	Nutrition	Delivery	Breastfeeding	Pregnancy Complications	Effects of Smoking	Effects of Alcohol	Postnatal Care	Family Planning	No. of Cases
Total	89.4	81.2	78.6	66.0	62.6	59.6	58.6	39.2	2,575
Residence									
Urban	02.1	8/1 7	83.1	70.6	67 9	63.8	63.1	/21	1 18/
Rural	86.6	77.6	73.8	61.2	57.1	55.0	53.8	36.1	1,104
Region	00.0	11.0	10.0	01.2	07.1	00.1	00.0	00.1	1,001
Kakheti	857	80.2	74 7	66 7	64 6	64 1	59.1	44 7	211
Tbilisi	91.2	84.3	83.7	68.4	66.1	62.4	60.9	37.3	563
Shida Kartli	93.5	74.1	68.6	64.3	57.3	50.8	54.6	20.0	168
Kvemo Kartli	81.7	79.3	74.8	54.9	56.1	54.1	50.0	33.7	223
Samtskhe–Javakheti	78.9	59.3	61.0	42.7	50.8	49.6	42.3	22.4	214
Adjara	94.6	82.8	78.9	57.4	62.7	57.4	52.0	40.2	175
Guria	87.4	84.9	83.0	71.1	62.9	61.6	62.3	22.6	140
Samegrelo	93.7	80.1	79.1	67.0	49.0	44.2	55.3	31.6	181
Imereti	90.5	86.4	83.6	80.0	72.6	71.3	71.8	60.0	348
Mtskheta-Mtianeti	89.2	83.0	78.0	68.6	63.7	60.5	57.0	42.2	194
Racha–Svaneti	88.1	83.4	78.2	72.0	55.4	55.4	64.8	43.0	158
Education									
Secondary incomplete or less	82.5	73.5	69.0	60.3	50.8	50.0	50.6	30.9	400
Secondary complete	89.3	80.6	80.6	62.8	62.8	59.9	57.6	36.2	724
Technicum/University	91.4	83.5	80.2	69.0	65.7	62.0	61.2	42.8	1,451
Wealth Quintile									
Lowest	83.6	72.2	72.5	58.4	53.2	52.4	49.3	28.1	410
Second	86.3	78.4	72.2	62.6	58.8	54.3	53.9	39.4	619
Middle	90.0	81.7	77.7	65.6	60.3	58.9	59.4	39.0	579
Fourth	92.7	86.4	84.9	69.6	70.7	66.7	60.8	41.9	406
Highest	92.5	84.3	83.6	70.7	67.2	63.6	65.1	43.0	561
Birth Order									
First birth	89.8	81.3	79.8	67.1	64.6	60.9	58.6	39.2	1,285
Second birth	90.5	82.5	78.4	66.0	61.9	59.3	59.4	38.5	924
Third or higher	85.7	77.5	74.6	61.9	57.1	55.4	56.4	40.5	366
Number of Prenatal Visits*									
1–3	81.6	68.0	67.6	56.7	53.7	49.9	52.1	26.3	223
4–6	87.7	79.2	76.2	63.5	58.5	54.6	55.1	36.1	1,445
7–9	93.2	86.0	83.2	70.6	68.7	67.7	63.8	45.2	604
10+	95.0	89.5	87.4	75.1	75.1	72.0	68.6	49.3	279
Place of Prenatal Care [†]									
Primary care	91.2	81.2	73.1	58.0	56.0	57.1	56.1	43.0	172
Women's consultation clinic	90.9	82.8	79.5	68.7	67.2	62.4	60.3	38.9	1,206
Raional maternity/hospital	83.4	76.4	74.9	56.0	51.8	50.5	52.2	35.5	471
City maternity/hospital	90.5	81.4	80.7	69.6	62.9	61.0	60.2	41.3	715

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

† Excludes 11 births with other source of prenatal care.

Table 8.2.3Selected Measurements Performed During Prenatal Care Visits by Selected CharacteristicsAmong Births in 2005–2010 with Any Prenatal CareReproductive Health Survey: Georgia, 2010

Characteristic	Basic Blood	Urine Test	Weight	Height	Blood Pressure	HIV Test	No. of Cases
	Test		Measured	Measured	Measured		
Total	99.2	99.3	99.0	98.1	96.2	65.1	2,575
Residence							
Urban	99.3	99.2	99.2	98.6	96.5	74.5	1,184
Rural	99.2	99.3	98.8	97.7	95.8	55.4	1,391
Region							
Kakheti	97.5	98.3	98.7	96.6	96.2	58.6	211
Tbilisi	99.4	99.4	99.2	98.5	97.5	78.9	563
Shida Kartli	100.0	100.0	100.0	98.4	94.1	74.6	168
Kvemo Kartli	99.6	99.2	99.2	97.6	97.6	54.9	223
Samtskhe-Javakheti	98.8	98.8	95.5	96.3	92.3	43.9	214
Adjara	99.5	99.5	99.5	97.1	92.2	46.6	175
Guria	99.4	99.4	98.7	99.4	93.7	56.0	140
Samegrelo	99.5	99.5	99.5	99.5	97.1	68.9	181
Imereti	99.2	99.2	98.7	99.0	97.4	70.0	348
Mtskheta-Mtianeti	100.0	100.0	99.1	99.1	96.4	53.4	194
Racha-Svaneti	97.4	97.9	97.4	95.3	95.9	49.2	158
Age Group at Birth	98.8	99.0	98.8	97.7	95.7	61.4	1.251
< 25						-	, -
25-34	99.6	99.5	99.2	98.5	96.3	69.0	1 145
35-44	99.9	99.9	98.3	99.0	98.0	66.4	179
Education	00.0	00.0	00.0	00.0	00.0	00.1	
Secondary incomplete or less	98.2	98.7	98 5	95 5	94 7	46.6	400
Secondary complete	99.6	99.6	99.2	99.0	96.5	40.0 60.0	724
	00.0 00 /	00.3	99.2 99.0	08.4	96.0 96.1	72.5	1 /51
Wealth Quintile	55.4	33.5	33.0	30.4	30.4	12.0	1,401
	08.4	08 /	08 /	07.2	05.6	54.0	410
Second	00.0	00.4	00.4	07.5	05.0	56.2	410 610
Second	99.0	99.4	99.5	97.0	90.Z	00.Z	619 570
Fourth	99.4 00.5	99.4 00 5	90.4	90.Z	90.9	00.1 67.5	379
	99.0 00.5	99.5	99.1	97.9	90.2	07.5	400
Hignest	99.5	99.4	99.4	99.2	96.1	80.7	1 00
Birth Order	00.4	00.0	00.0	00.4		05.0	4.005
FIRST DIRTN	99.1	99.Z	98.9	98.4	95.7	05.8	1,285
Second birth	99.4	99.3	99.3	98.6	96.6	65.2	924
I hird or higher	99.5	99.5	98.3	96.1	96.7	62.3	366
Number of Prenatal Visits							
1–3	98.4	97.8	97.2	96.0	95.5	47.2	223
4–6	99.0	99.1	98.7	97.7	95.3	63.3	1,445
7–9	99.8	99.8	99.8	99.4	97.4	68.1	604
10+	99.7	99.7	99.3	98.9	97.9	79.6	279
Place of Prenatal Care [†]							
Primary care clinic/Fam.med.center	96.5	97.1	97.1	94.7	91.4	49.3	172
Women's consultation clinic	99.5	99.5	99.0	98.7	95.5	68.6	1,206
Raional maternity/hospital	99.6	99.6	99.1	96.7	97.3	50.6	471
City maternity/hospital	99.3	99.3	99.3	98.8	97.7	71.7	715
	00.0						, , , ,

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

† Excludes 11 births with other source of prenatal care.

Table 8.2.4

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

	Had Ultra	sound Exam	ו	ime of First l	Jitrasound Ex	am (in Weel	(s)		
Characteristic	%	No. of Cases	≤ 13	14–19	20–26	27+	Does Not Remember	Total	No. of Cases
Total	97.4	2,575	77.2	11.4	8.3	2.2	0.9	100.0	2,489
Residence									
Urban	98.9	1,184	84.4	9.1	5.3	1.1	0.1	100.0	1,167
Rural	95.7	1,391	69.5	13.8	11.4	3.4	1.8	100.0	1,322
Region									
Kakheti	92.0	211	77.1	7.3	12.4	1.4	1.8	100.0	194
Tbilisi	99.2	563	88.5	8.5	2.5	0.5	0.0	100.0	558
Shida Kartli	99.5	168	73.4	15.2	10.9	0.5	0.0	100.0	167
Kvemo Kartli	96.7	223	73.9	8.4	12.6	4.2	0.8	100.0	215
Samtskhe–Javakheti	96.3	214	67.9	17.3	11.4	3.0	0.4	100.0	206
Adjara	98.5	175	63.2	16.4	10.4	4.0	6.0	100.0	172
Guria	98.1	140	63.5	22.4	10.9	3.2	0.0	100.0	137
Samegrelo	97.6	181	84.6	7.5	6.5	1.5	0.0	100.0	176
Imereti	96.9	348	73.8	13.8	8.5	3.7	0.3	100.0	337
Mtskheta–Mtianeti	96.4	194	74.0	11.2	12.6	2.3	0.0	100.0	188
Racha–Svaneti	87.6	158	63.9	12.4	20.7	3.0	0.0	100.0	139
Age Group at Birth									
< 25	96.8	1,251	74.7	12.3	9.2	2.4	1.4	100.0	1,205
25–34	98.2	1,145	80.2	10.3	7.3	1.7	0.4	100.0	1,115
35–44	95.6	179	76.2	11.9	7.4	3.8	0.6	100.0	169
Education									
Secondary incomplete or less	92.5	400	68.7	9.7	13.5	2.6	5.5	100.0	367
Secondary complete	97.7	724	69.5	15.1	11.9	3.3	0.2	100.0	702
Technicum/University	98.5	1,451	83.0	10.1	5.2	1.6	0.1	100.0	1,420
Wealth Quintile									
Lowest	95.6	410	68.0	14.3	14.2	3.5	0.0	100.0	386
Second	96.1	619	71.1	11.6	11.0	4.4	2.0	100.0	591
Middle	96.6	579	73.8	13.9	7.7	2.2	2.3	100.0	557
Fourth	98.8	406	76.8	13.4	8.2	1.5	0.0	100.0	400
Highest	99.0	561	89.6	6.5	3.6	0.2	0.0	100.0	555
Birth Order									
First birth	97.6	1,285	81.8	9.4	6.5	1.8	0.5	100.0	1,246
Second birth	97.1	924	73.6	13.9	9.0	2.6	1.0	100.0	891
Third or higher	97.0	366	69.6	12.3	12.9	2.7	2.4	100.0	352
Number of Prenatal Visits [*]									
1–3	92.2	223	47.6	24.0	18.2	9.6	0.6	100.0	200
4–6	97.6	1.445	75.9	11.8	9.5	1.5	1.2	100.0	1.410
7–9	98.2	604	82.5	9.0	5.9	2.0	0.6	100.0	586
10+	99.3	279	89.5	6.9	2.0	1.6	0.0	100.0	276
Place of Prenatal Care [†]		-							-
Primary care clinic/Fam med center	92.0	172	77.5	11.5	7.3	24	12	100.0	159
Women's consultation clinic	98.0	1 206	77.0	11.0	8.6	1 /	1.4	100.0	1 171
Paional maternity/beenitel	06.9	1,200	60.2	11.4	12.0	5.0	0.7	100.0	1,171
City maternity/hospital	90.0 07.0	4/1 715	09.Z Q1.0	11.2	13.0	1.0	0.7	100.0	402
Gity maternity/hospital	97.0	CI 1	01.9	11.7	4.4	1.0	0.2	100.0	090

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

† Excludes 11 births with other source of prenatal care.

Table 8.3.1Place of Delivery for Births in 2005–2010 by Selected CharacteristicsReproductive Health Survey: Georgia, 2010

		Place of deliver	y			
Characteristic	City Maternity,	Raional Maternity,	Other	At home	Total	No. of Cases
	Hospital	Hospital	other	At nome		
Total	54.7	43.6	0.5	1.2	100.0	2,617
B						
Residence	50.0	40.0	0.0	0.0	400.0	4.400
Urban	56.8	42.6	0.6	0.0	100.0	1,193
Rura	52.0	44.0	0.5	Ζ.4	100.0	1,424
Keyloll	47.1	11 7	0.8	7.5	100.0	224
Thiliei	47.1 55.0	44.7	0.0	7.5	100.0	224 567
Shida Kartli	74 0	25.9	0.2	0.0	100.0	168
Kvemo Kartli	37.6	60.9	0.0	0.0	100.0	234
Samtskhe_ lavakheti	30.1	69.9	0.0	0.0	100.0	214
Adiara	45.3	52.2	0.0	24	100.0	176
Guria	40.0 53.5	46 5	0.0	2.4	100.0	170
Samegrelo	78.5	18 7	14	0.0 1 <i>4</i>	100.0	140
Imereti	62.4	36.3	13	0.0	100.0	349
Mtskheta_Mtianeti	51.9	47.6	0.0	0.0	100.0	200
Racha_Svaneti	68.9	28.1	2.0	1.0	100.0	161
Age Group at Birth	00.5	20.1	2.0	1.0	100.0	101
< 20	50.7	45.8	03	32	100.0	313
20-24	57 1	40.0	0.0	0.8	100.0	956
25-34	55.2	43.6	0.7	0.0	100.0	1 164
35-44	46.4	50.6	17	1 1	100.0	184
Education	-10.4	00.0	1.7	1.1	100.0	104
Secondary incomplete or less	41.8	51.4	12	56	100.0	422
Secondary complete	54.4	44.3	0.5	0.8	100.0	738
Technicum/University	58.6	41.0	0.4	0.1	100.0	1,457
Wealth Quintile						.,
Lowest	49.9	45.8	0.3	4.1	100.0	428
Second	54.7	41.7	1.2	2.4	100.0	628
Middle	53.1	46.1	0.5	0.3	100.0	587
Fourth	57.4	42.4	0.3	0.0	100.0	413
Highest	56.9	42.7	0.3	0.0	100.0	561
Ethnicity						
Georgian	59.1	39.8	0.5	0.5	100.0	2,248
Azeri	24.0	70.1	1.3	4.6	100.0	145
Armenian	20.1	78.3	0.0	1.6	100.0	145
Other	51.8	39.2	0.0	9.1	100.0	79
Birth Order						
First birth	57.6	41.5	0.5	0.4	100.0	1,293
Second birth	54.1	44.0	0.6	1.4	100.0	937
Third or higher	46.1	50.0	0.6	3.3	100.0	387
Baby s Weight at Birth [*]						
< 2500 grams	55.1	43.0	0.0	1.9	100.0	125
>= 2500 grams	54.8	43.7	0.6	0.9	100.0	2,481
Looo grame	0110		0.0	0.0	100.0	_,

* Excludes 11 births with unknow weight at birth.

Table 8.3.2 Average Time between Admission and Delivery and Nights Spent in a Medical Facility by Selected Characteristics: Births in 2005–2010 Delivered in Health Facilities Reproductive Health Survey: Georgia, 2010

%No.of Cases*5.45.6-78+/************************************	Characteristic	Average Tir	ne (in Hours)	Nights Spe	nt in a Medical F Disc	acility Between I harge	Delivery and	Total	No. of
Total 3.8 2.077 56.3 25.1 14.7 4.0 100.0 2.589 Residence		%	No. of Cases*	≤ 4	5	6–7	8+		Cases
Residence Uthan 3.9 946 55.9 26.9 13.8 3.4 100.0 1.193 Rural 3.9 946 55.9 26.9 13.8 3.4 100.0 1.193 Region - <td< td=""><td>Total</td><td>3.8</td><td>2,077</td><td>56.3</td><td>25.1</td><td>14.7</td><td>4.0</td><td>100.0</td><td>2,589</td></td<>	Total	3.8	2,077	56.3	25.1	14.7	4.0	100.0	2,589
Uban 3.9 9.46 55.9 26.9 13.8 3.4 100.0 1.193 Region .	Residence								
Rural 3.8 1,131 56.6 23.3 15.5 4.5 100.0 1,396 Region 65.3 17.4 14.0 3.4 100.0 209 Tbits 4.0 469 60.3 26.0 10.7 2.9 100.0 567 Shida Kartli 3.3 141 57.8 28.1 12.4 1.6 100.0 232 Samsthe-Javakheti 3.4 194 67.9 23.2 7.3 1.6 100.0 121 Guria 4.1 109 47.2 23.9 24.5 4.4 100.0 140 Samegreio 3.8 133 51.9 20.2 17.5 4.4 100.0 140 Samegreio 3.6 128 43.3 34.0 17.5 52 100.0 349 Mishtata-Milaneti 3.0 169 57.9 20.2 13.6 13.4 100.0 159 C20 4.5 254 99.9 7	Urban	3.9	946	55.9	26.9	13.8	3.4	100.0	1,193
Region v </td <td>Rural</td> <td>3.8</td> <td>1,131</td> <td>56.6</td> <td>23.3</td> <td>15.5</td> <td>4.5</td> <td>100.0</td> <td>1,396</td>	Rural	3.8	1,131	56.6	23.3	15.5	4.5	100.0	1,396
Kakheti 4.0 159 65.3 17.4 14.0 3.4 100.0 209 Tblisi 3.0 4.0 469 60.3 26.0 10.7 2.9 100.0 667 Shida Kartii 4.0 189 64.8 21.9 10.0 2.33 100.0 232 Samiskhe-Javakheti 3.4 136 40.5 24.5 26.5 8.5 100.0 171 Guria 4.1 109 47.2 23.9 24.5 4.4 100.0 140 Samegreio 3.8 133 51.9 28.6 17.5 3.4 100.0 140 Samegreio 3.6 128 43.3 34.0 17.5 5.2 100.0 140 Samegreio 3.6 128 43.3 34.0 17.5 5.2 100.0 159 Racha-Svaneti 3.6 128 43.3 34.0 17.5 4.4 100.0 1.152 25-34 <t< td=""><td>Region</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	Region								
Tbilsi 4.0 469 60.3 26.0 10.7 2.9 10.0.0 567 Shida Kartli 3.3 141 57.8 28.1 12.4 1.6 100.0 168 Kverno Kartli 3.4 194 67.9 23.2 7.3 1.6 100.0 214 Adjara 3.1 136 40.5 24.5 26.5 8.5 100.0 171 Guria 4.1 109 47.2 23.9 24.5 4.4 100.0 140 Sametshea-Mianeti 3.0 169 57.9 20.2 17.5 5.2 100.0 181 Immerei 3.6 128 43.3 3.0 175 5.2 100.0 159 Age Group at Birth	Kakheti	4.0	159	65.3	17.4	14.0	3.4	100.0	209
Shida Karlii 3.3 141 57.8 28.1 12.4 1.6 100.0 168 Kvemo Karlii 4.0 189 64.8 21.9 10.9 2.3 100.0 232 Samishe-Javakheti 3.4 136 40.5 24.5 26.5 8.5 100.0 171 Gura 4.1 109 47.2 23.9 24.5 4.4 100.0 171 Gura 4.1 109 47.2 23.9 24.5 4.4 100.0 171 Gura 4.1 109 47.2 23.9 24.5 4.4 100.0 171 Mishtef-Mianeli 3.6 128 43.3 34.0 17.5 52 100.0 349 Mishtef-Svaneti 3.6 128 43.3 34.0 17.5 52 100.0 307 Racha-Svaneti 3.6 128 55.1 22.4 15.1 53 100.0 1152 25-34 3.8	Tbilisi	4.0	469	60.3	26.0	10.7	2.9	100.0	567
Kvemo Karlii 4.0 189 64.8 21.9 10.9 2.3 100.0 232 Samiskhe-Javakheii 3.4 194 67.9 23.2 7.3 1.6 100.0 214 Adjara 3.1 136 40.5 24.5 26.5 8.5 100.0 171 Guria 4.1 109 47.2 23.9 24.5 4.4 100.0 140 Samegrelo 3.8 133 61.9 28.6 17.4 5.9 100.0 349 Mitscheat-Mianeti 3.0 169 57.9 20.2 17.5 4.4 100.0 199 Acaba-Svaneti 3.6 128 43.3 34.0 17.5 5.2 100.0 307 20-24 3.9 797 57.9 26.2 13.6 23.0 100.0 11.52 Scondary incomplete or less 3.6 326 63.3 23.5 10.4 2.8 100.0 1418 Secondary incompl	Shida Kartli	3.3	141	57.8	28.1	12.4	1.6	100.0	168
Samtshe-Javakheti 3.4 194 67.9 23.2 7.3 1.6 100.0 214 Adjara 3.1 136 40.5 24.5 26.5 8.5 100.0 171 Guria 4.1 109 47.2 23.9 24.5 4.4 100.0 140 Samegralo 3.8 133 51.9 28.6 15.5 3.9 100.0 181 Imereti 4.5 250 48.1 28.6 17.4 5.9 100.0 184 Racha-Svaneti 3.6 128 43.3 34.0 17.5 5.2 100.0 199 Racha-Svaneti 3.6 128 45.3 25.4 15.1 5.4 10.0 307 20-24 3.9 797 57.9 26.2 13.6 2.3 100.0 182 Education 152 55.0 14.2 4.3 100.0 175 Secondary	Kvemo Kartli	4.0	189	64.8	21.9	10.9	2.3	100.0	232
Adjara3.113640.524.526.58.5100.0171Guria4.110947.223.924.54.4100.0140Samegrelo3.813351.926.615.53.9100.0349Inereti4.525048.128.617.45.9100.0181Inereti3.016957.920.217.54.4100.0199Racha-Svaneti3.612843.334.017.55.2100.0349Age Group at Birth< 20	Samtskhe–Javakheti	3.4	194	67.9	23.2	7.3	1.6	100.0	214
	Adjara	3.1	136	40.5	24.5	26.5	8.5	100.0	171
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	Guria	4.1	109	47.2	23.9	24.5	4.4	100.0	140
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$	Samegrelo	3.8	133	51.9	28.6	15.5	3.9	100.0	181
Mtskheta-Mtianeti 3.0 169 57.9 20.2 17.5 4.4 100.0 199 Racha-Svaneti 3.6 128 43.3 34.0 17.5 5.2 100.0 159 Age Group at Birth	Imereti	4.5	250	48.1	28.6	17.4	5.9	100.0	349
Racha-Svaneti 3.6 128 43.3 34.0 17.5 5.2 100.0 159 Age Group at Bith - <th< td=""><td>Mtskheta–Mtianeti</td><td>3.0</td><td>169</td><td>57.9</td><td>20.2</td><td>17.5</td><td>4.4</td><td>100.0</td><td>199</td></th<>	Mtskheta–Mtianeti	3.0	169	57.9	20.2	17.5	4.4	100.0	199
Age Group at BirthIII<	Racha–Svaneti	3.6	128	43.3	34.0	17.5	5.2	100.0	159
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Age Group at Birth		-						
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	< 20	4.5	254	59.9	27.0	11.4	1.6	100.0	307
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	20–24	3.9	797	57.9	26.2	13.6	2.3	100.0	948
35-44 2.7 124 55.0 14.5 22.5 8.0 100.0 182 Education <td>25–34</td> <td>3.8</td> <td>902</td> <td>54.1</td> <td>25.4</td> <td>15.1</td> <td>5.4</td> <td>100.0</td> <td>1.152</td>	25–34	3.8	902	54.1	25.4	15.1	5.4	100.0	1.152
Education International and the secondary incomplete or less 3.6 326 63.3 23.5 10.4 2.8 100.0 401 Secondary complete 3.9 599 56.5 25.0 14.2 4.3 100.0 733 Technicum/University 3.9 1,152 54.2 25.6 16.0 4.2 100.0 1,455 Wealth Quintile Image: Complete or less 3.8 340 55.1 22.4 18.5 4.0 100.0 416 Second 3.7 489 56.2 23.5 16.0 4.3 100.0 614 Middle 3.7 472 58.8 24.6 13.0 3.6 100.0 585 Fourth 4.2 239 54.6 25.4 15.3 4.7 100.0 413 Birth Order	35–44	2.7	124	55.0	14.5	22.5	8.0	100.0	182
Secondary incomplete or less 3.6 326 63.3 23.5 10.4 2.8 100.0 401 Secondary complete 3.9 599 56.5 25.0 14.2 4.3 100.0 733 Technicum/University 3.9 1,152 54.2 25.6 16.0 4.2 100.0 1,455 Wealth Quintile University 3.8 340 55.1 22.4 18.5 4.0 100.0 416 Second 3.7 489 56.2 23.5 16.0 4.3 100.0 614 Middle 3.7 472 58.8 24.6 13.0 3.6 100.0 585 Fourth 4.2 329 54.6 25.4 15.3 4.7 100.0 413 Highest 3.9 447 55.9 28.2 12.5 3.4 100.0 277 Third or higher 3.1 30.4 57.3 22.6 14.8 5.4 100.0 2707	Education						0.0		
Secondary complete 3.9 599 56.5 25.0 14.2 4.3 100.0 733 Technicum/University 3.9 1,152 54.2 25.6 16.0 4.2 100.0 1,455 Weath Quintile	Secondary incomplete or less	3.6	326	63.3	23.5	10.4	2.8	100.0	401
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	Secondary complete	3.9	599	56.5	25.0	14.2	4.3	100.0	733
Wealth QuintileImage of the second of the seco	Technicum/University	3.9	1.152	54.2	25.6	16.0	4.2	100.0	1.455
Lowest 3.8 340 55.1 22.4 18.5 4.0 100.0 416 Second 3.7 489 56.2 23.5 16.0 4.3 100.0 614 Middle 3.7 472 58.8 24.6 13.0 3.6 100.0 585 Fourth 4.2 329 54.6 25.4 15.3 4.7 100.0 413 Highest 3.9 447 55.9 28.2 12.5 3.4 100.0 561 Birth Order	Wealth Quintile		.,						.,
Second 3.7 489 56.2 23.5 16.0 4.3 100.0 614 Middle 3.7 472 58.8 24.6 13.0 3.6 100.0 585 Fourth 4.2 329 54.6 25.4 15.3 4.7 100.0 413 Highest 3.9 447 55.9 28.2 12.5 3.4 100.0 561 Birth Order	Lowest	3.8	340	55.1	22.4	18.5	4.0	100.0	416
Niddle 3.7 472 58.8 24.6 13.0 16. 10.0 585 Fourth 4.2 329 54.6 25.4 15.3 4.7 100.0 413 Highest 3.9 447 55.9 28.2 12.5 3.4 100.0 561 Birth Order	Second	3.7	489	56.2	23.5	16.0	4.3	100.0	614
Hindsor And Highest And Highest And Highest And Honor Highest Birth Order Highest A.5 1.028 54.6 25.4 15.3 4.7 100.0 413 Birth Order Highest A.5 1.028 54.1 26.3 16.1 3.5 100.0 1.289 Second birth 3.2 745 59.0 24.4 12.5 4.1 100.0 927 Third or higher 3.1 304 57.3 22.6 14.8 5.4 100.0 373 Baby's Weight at Birth	Middle	37	472	58.8	24.6	13.0	3.6	100.0	585
Highest 3.9 447 55.9 28.2 12.5 3.4 100.0 164 Birth Order First birth 4.5 1,028 54.1 26.3 16.1 3.5 100.0 1,289 Second birth 3.2 745 59.0 24.4 12.5 4.1 100.0 927 Third or higher 3.1 304 57.3 22.6 14.8 5.4 100.0 927 Baby's Weight at Birth	Fourth	4.2	329	54.6	25.4	15.3	47	100.0	413
Birth Order Infinition Infinit Infinition <td>Highest</td> <td>3.9</td> <td>447</td> <td>55.9</td> <td>28.2</td> <td>12.5</td> <td>3.4</td> <td>100.0</td> <td>561</td>	Highest	3.9	447	55.9	28.2	12.5	3.4	100.0	561
First birth 4.5 1,028 54.1 26.3 16.1 3.5 100.0 1,289 Second birth 3.2 745 59.0 24.4 12.5 4.1 100.0 927 Third or higher 3.1 304 57.3 22.6 14.8 5.4 100.0 373 Baby's Weight at Birth	Birth Order	0.0		00.0	20.2	12.0	0.1	100.0	001
Second birth 3.2 745 59.0 24.4 12.5 4.1 100.0 927 Third or higher 3.1 304 57.3 22.6 14.8 5.4 100.0 373 Baby's Weight at Birth	First birth	4.5	1 028	54 1	26.3	16 1	3.5	100.0	1 289
Third or higher 3.1 304 57.3 22.6 14.8 5.4 100.0 373 Baby's Weight at Birth -<	Second birth	32	745	59.0	24.4	12.5	4 1	100.0	927
Baby's Weight at Birth 3.5 79 38.4 16.1 23.5 21.9 100.0 123 >= 2500 grams 3.9 1,994 57.1 25.6 14.2 3.1 100.0 2,461 Unknown † 4 † † † † 100.0 5 Type of Delivery Vaginal 3.8 1,911 65.8 24.7 7.9 1.6 100.0 2,001 Cesarean Section 4.8 166 25.9 26.3 36.3 11.5 100.0 588 Pregnancy Complications 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 4.2 278 39.5 31.7 20.6 8.2 100.0 379	Third or higher	31	304	57.3	22.6	14.8	54	100.0	373
< 2500 grams	Baby's Weight at Birth	0.1	001	01.0	22.0	11.0	0.1	100.0	010
>= 2500 grams 3.9 1,994 57.1 25.6 14.2 3.1 100.0 2,461 Unknown † 4 † † † † 100.0 57.1 Type of Delivery Vaginal 3.8 1,911 65.8 24.7 7.9 1.6 100.0 2,001 Cesarean Section 4.8 166 25.9 26.3 36.3 11.5 100.0 588 Pregnancy Complications 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 3.8 1.796 59.3 23.9 13.6 3.2 100.0 379	< 2500 grams	3.5	79	38.4	16 1	23.5	21.9	100.0	123
Loss grand tots	>= 2500 grams	3.9	1 994	57.1	25.6	14.2	31	100.0	2 461
Type of Delivery 3.8 1,911 65.8 24.7 7.9 1.6 100.0 2,001 Cesarean Section 4.8 166 25.9 26.3 36.3 11.5 100.0 588 Pregnancy Complications	Linknown	+	4	+	20.0	+	+	100.0	2,101
Appendication 3.8 1,911 65.8 24.7 7.9 1.6 100.0 2,001 Cesarean Section 4.8 166 25.9 26.3 36.3 11.5 100.0 588 Pregnancy Complications 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 4.2 278 39.5 31.7 20.6 8.2 100.0 379		I		1	I	I	I	100.0	Ũ
Cesarean Section 4.8 166 25.9 26.3 36.3 11.5 100.0 588 Pregnancy Complications 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 3.8 1.766 59.3 23.9 13.6 3.2 100.0 379	Vaginal	38	1 911	65.8	24 7	79	16	100.0	2 001
Pregnancy Complications 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 3.8 1.796 59.3 23.9 13.6 3.2 100.0 379	Cesarean Section	4.8	166	25.9	26.3	36.3	11.5	100.0	588
Any Complication 4.2 278 39.5 31.7 20.6 8.2 100.0 379 No Complication 3.8 1.796 59.3 23.9 13.6 3.2 100.0 379	Pregnancy Complications	1.0	100	20.0	20.0	00.0	11.0	100.0	000
No Complication 3.8 1706 50.3 23.0 13.6 3.2 100.0 2.307	Any Complication	4.2	278	39.5	31.7	20.6	8.2	100.0	379
	No Complication	3.8	1,796	59.3	23.9	13.6	3.2	100.0	2,207
Does not remember † 3 † † † 100.0 3	Does not remember	†	3	†	1	†	†	100.0	3

* Excludes 406 women who had C-section before labor and 106 with unknown duration of labor.
Table 8.3.3Percentage of Births Delivered by Cesarean Section by Selected CharacteristicsAmong Births in 2005–2010 Delivered in Health FacilitiesReproductive Health Survey: Georgia, 2010

Ye Ye Total 2,589 Residence	Characteristic	Cesarean Deliveries	No. of Cases
Total 23.9 2,589 Residence		%	
Residence v Urban 26.0 1,193 Rural 21.7 1,396 Region 1 1 Kakheti 19.5 209 Tbilisi 22.8 567 Shida Kartii 19.5 168 Kvemo Kartii 16.4 232 Samtskho-Javakheti 8.9 214 Adjara 23.3 140 Samegrelo 33.0 181 Imerefi 32.5 349 Mtskheta-Mianeti 21.5 199 Racha-Svaneti 25.3 159 -20 15.5 307 20-24 19.3 948 25-34 27.2 1,152 35-44 40.4 182 Education	Total	23.9	2,589
Nestorice 1,193 Urban 26.0 1,193 Rural 21.7 1,396 Region 0 0 Kahteti 19.5 209 Tbilis 22.8 567 Shida Kartli 19.5 168 Kvemo Kartli 19.5 168 Adjara 23.3 140 Samespielo 33.0 181 Imereti 32.5 349 Misheta-Mianeti 21.5 199 Reacha-Svaneti 25.3 159 Age Group at Birth	Desidence		
Autal 20.0 1,133 Region - - Kakheti 19.5 209 Diblisi 22.8 567 Shida Kartli 19.5 168 Kveno Kartli 164 232 Samtskhe-Javakheti 8.9 214 Adjara 28.5 171 Guria 23.3 140 Samgrelo 33.0 181 Imereti 22.5 349 Miskheta-Mianeti 21.5 199 Racha-Svaneti 22.5 307 20-24 19.3 948 25-34 27.2 1,152 25-34 29.7 1,452 Secondary incomplete or less 16.4 401 Secondary incomplete or less 16.4 <td< td=""><td>Kesidence</td><td>26.0</td><td>1 102</td></td<>	Kesidence	26.0	1 102
Nutai 2.1.7 1,330 Region	Dural	20.0	1,195
Negron Addres 195 209 Tbilisi 22.8 567 Shida Kartii 19.5 168 Kverno Kartii 16.4 232 Sartiskhe-Javakheti 8.9 214 Adjara 23.3 140 Guria 23.3 140 Sartiskhe-Javakheti 22.5 349 Miskheta-Mtianeti 22.5 349 Miskheta-Mtianeti 21.5 199 Racha-Svaneti 25.3 319 Age Group AB lith	Ruia	21.7	1,590
Rahieu 13.3 20.9 Shida Kartii 19.5 168 Kvemo Kartii 19.5 168 Kvemo Kartii 16.4 232 Samtskhe-Javakheti 8.9 214 Adjara 28.5 171 Guria 23.3 140 Samegrelo 33.0 181 Imereti 32.5 349 Mtskheta-Mtianeti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth	Keyloli	10.5	200
Julis' 22.5 307 Shida Kartii 195 168 Kvemo Kartii 164 232 Samtskhe-Javakheii 8.9 214 Adjara 23.3 140 Samegrelo 33.0 181 Imereti 32.5 349 Mtskheta-Mtianeti 21.5 199 Racha-Svaneti 22.5 307 Age Group at Birth	Thiliai	19.0	209
Sind ratur 15.3 000 Kvemo Kartli 16.4 232 Samtshke-Javakheti 8.9 214 Adjara 28.5 171 Guria 23.3 140 Samtshke-Javakheti 32.5 349 Imereti 32.5 349 Mishteta-Mitaneti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth	I DIIISI Shida Kartli	22.0 10.5	007 168
Nomin Carlin 10+ 202 Adjara 28,5 171 Guria 23,3 140 Samegrelo 33,0 181 Imereti 32,5 349 Mtskheta-Mtianeti 21,5 199 Racha-Svaneti 25,3 159 Age Group at Birth	Kyomo Kartli	15.5	100
Samithe-backheid 0.3 214 Guria 23.3 171 Guria 23.3 140 Samegrelo 33.0 181 Imereti 22.5 349 Mtskheta-Miianeti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth	Somtakha lavakhati	0.4	232
Adjara 20.5 111 Guria 23.3 140 Samegrelo 33.0 181 Immereti 32.5 349 Mishketa-Mianeti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth	Samuskne-Javakneu	0.9	214
Sumagrelo 140 Samegrelo 33.0 181 Imereti 32.5 349 Mtskheta-Mtianeti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth - - < 20	Aujara	20.0	171
Same of the second se	Samagrala	20.0	140
Interior 32.3 349 Mishketa-Mitaneti 21.5 199 Racha-Svaneti 25.3 159 Age Group at Birth	Jmoroti	30.U 20 5	240
Mickle-mitalieu 21.3 193 Age Group at Birth 25.3 159 < 20	Mtekhota Mtianati	02.0 01 5	549 100
Age Group at Birth Image of the second	Nilskileid-Mildileii Doobo Svopoti	21.0	199
Age Broup at bit if307 $20-24$ 19.394825-3427.21,15235-4440.4182Education U Secondary incomplete or less16.4401Secondary complete20.5733Technicum/University27.51,455Wealth Quintile U Lowest20.0416Second22.5614Middle22.6585Fourth26.9413Highest26.1561Birth Order U U First birth25.71,289Second birth23.9927Third or higher $T.2$ 373Pregnarcy Complications 21.7 2,207Any Complication35.7379No Complication21.72,207Does not memeber*3Saby's Weight at Birth U U $v = 2500$ grams23.22,461Urknown*5Declared Labar*5	Age Group at Birth	20.0	159
20^{-24} 13.3 30^{-1} 20^{-24} 19.3 948 25^{-34} 27.2 1,152 35^{-44} 40.4 182 Education		15 5	207
25-34 27.2 1,152 $35-44$ 40.4 182 Education Secondary incomplete or less 16.4 401 Secondary complete 20.5 733 Technicum/University 27.5 1,455 Wealth Quintile Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 72 373 Pregnancy Complication 25.7 1,289 2927 Third or higher 17.2 373 379 Pregnancy Complication 25.7 379 39 No Complication 21.7 2,207 379 Does not remember 3 3 3 Baby's Weight at Birth 3 3 3 < 2500 grams	< 20 20, 24	10.0	048
27.2 1,132 $35-44$ 40.4 182 Education 1 Secondary incomplete or less 16.4 401 Secondary complete 20.5 733 Technicum/University 27.5 1,455 Wealth Quintile 1 1 Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 1 1289 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 3 3 Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth 4 4 < 2500 grams	20-24	13.0	540
35-44 40.4 102 Education	25-54	27.2	1,152
Secondary incomplete or less 16.4 401 Secondary complete 20.5 733 Technicum/University 27.5 1,455 Wealth Quintile U U Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order U U First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications U U Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember X 3 Baby's Weight at Birth Z Z < 2500 grams	55-44 Education	40.4	102
Secondary inclupies of less 10.4 401 Secondary complete 20.5 733 Technicum/University 27.5 1,455 Wealth Quintile u u Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order u u u First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnarcy Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth 123 123 < 2500 grams 37.5 123 < 2500 grams 23.2 2,461 Unknown * 5 5	Secondary incomplete or less	16 /	401
Secondary complete 20.3 7.33 Technicum/University 27.5 1,455 Wealth Quintile 20.0 416 Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 7.5 1,289 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 7.5 3 Any Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth 23.2 2,461 Unknown * 5	Secondary incomplete of less	20.5	722
Wealth Quintersity 27.3 1,433 Wealth Quintile 1 Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 7 1,289 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 3 7 Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth - 3 < 2500 grams		20.0	1 455
Lowest 20.0 416 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 7 1,289 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 35.7 379 Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth (23.2) 2,461 < 2500 grams 23.2 2,461 Unknown * 5 Destened abas ⁴ 5 5	Wealth Quintile	21.5	1,455
Lowest 20.0 410 Second 22.5 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 7 7 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 3 3 Any Complication 35.7 3.79 No Complication 21.7 2,207 Does not remember $*$ 3 Baby's Weight at Birth 123 2,207 <		20.0	416
Second 22.3 614 Middle 22.6 585 Fourth 26.9 413 Highest 26.1 561 Birth Order 7 1,289 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 3 3 Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth 23.2 2,461 Vinknown * 5	Socord	20.0	410
Nincure22.0303Fourth26.9413Highest26.1561Birth Order 1 2 First birth25.7 $1,289$ Second birth23.9927Third or higher17.2373Pregnancy Complications 35.7 379 Any Complication21.72,207Does not remember*3Baby's Weight at Birth 23.2 2,461 < 2500 grams23.22,461 $> = 2500$ grams 37.5 5	Middle	22.0	585
Highest 26.3 413 Highest 26.1 561 Birth Order 7172 $1,289$ First birth 23.9 927 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 35.7 379 Any Complication 21.7 $2,207$ Does not remember* 3 Baby's Weight at Birth 413 < 2500 grams 37.5 123 $> = 2500$ grams 23.2 $2,461$ Unknown* 5	Fourth	22.0	413
Birth Order 25.7 301 First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 35.7 379 Any Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth	Highest	20.5	561
First birth 25.7 1,289 Second birth 23.9 927 Third or higher 17.2 373 Pregnancy Complications 35.7 379 Any Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth 23.2 2,461 < 2500 grams	Birth Order	20.1	501
Second birth23.9927Third or higher17.2373Pregnancy Complications 35.7 379Any Complication21.72,207Does not remember*3Baby's Weight at Birth 42500 grams37.5< 2500 grams	First birth	25.7	1 289
Third or higher 17.2 373 Pregnancy Complications 35.7 379 Any Complication 35.7 2,207 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth * 3 < 2500 grams	Second hirth	23.7	927
Pregnancy Complications 35.7 379 Any Complication 35.7 379 No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth * 3 < 2500 grams	Third or higher	20.0	373
Any Complication 35.7 379 Any Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth * 3 < 2500 grams	Pregnancy Complications	17.2	515
No Complication 21.7 2,207 Does not remember * 3 Baby's Weight at Birth - - < 2500 grams	Any Complication	35.7	370
No completation 21.7 Does not remember * Baby's Weight at Birth < 2500 grams	No Complication	21.7	2 207
Baby's Weight at Birth 37.5 123 < 2500 grams	Does not remember	*	2,201
< 2500 grams	Baby's Weight at Birth		6
>= 2500 grams 23.2 2,461 Unknown * 5	< 2500 grams	37.5	123
Unknown * 5	>= 2500 grams	23.2	2 461
Drelen red Lehev [†]	Unknown	*	2,701 ج
Wronongen i Spor	Prolonged Labor [†]		5
		8.0	2.045
		0.0	∠,∪ 4 0 30
Does not remember 10.4	Noes not remember	41.1	52 106

* Fewer than 25 cases in this category.

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

Table 8.3.4 Cost a Procedure for Delivery by Selected Characteristics Among Deliveries Ended in 2005–2010 Reproductive Health Survey: Georgia, 2010

				Co	ost of Deliv	very					No. of
Characteristic	Mean Payment	None	< 200	200-299	300-399	400-499	500-599	600 +	Does not Remember	Total	Cases
Total	452.7	11.8	10.0	10.8	11.4	15.0	11.8	28.0	1.2	100.0	2,583
Residence											
Tbilisi	589.9	8.9	5.4	6.7	6.4	11.5	16.2	43.6	1.2	100.0	567
Other Urban	454.8	9.5	8.9	11.0	13.8	16.4	10.8	28.2	1.4	100.0	621
Rural	377.6	14.6	13.1	12.9	12.8	16.2	9.8	19.3	1.2	100.0	1.395
Mother's Age at birth											,
15-24	442.0	10.7	10.8	11.9	12.1	15.5	12.5	25.8	0.7	100.0	1,253
25-34	456.6	12.3	9.6	10.3	10.6	14.8	11.4	29.1	1.9	100.0	1,149
35-44	501.4	16.3	8.0	6.9	10.9	12.8	8.6	35.5	1.0	100.0	181
Order of Live Births											
1	481.6	10.3	8.8	10.3	10.7	16.1	12.1	30.7	1.0	100.0	1,286
2	439.2	12.0	11.1	10.5	11.7	15.6	11.5	26.3	1.2	100.0	924
3	375.4	15.2	13.4	11.5	12.7	11.9	11.9	21.0	2.4	100.0	282
4	399.0	21.6	7.8	18.0	14.1	4.0	8.3	24.7	1.4	100.0	91
Education Level											
Secondary incomplete or less	341.3	15.0	14.6	13.5	16.3	12.3	10.4	15.3	2.7	100.0	400
Secondary complete	405.8	9.9	12.8	12.3	13.9	17.8	12.1	20.7	0.6	100.0	732
Technicum/University	505.1	11.9	7.5	9.4	8.8	14.4	12.0	34.9	1.2	100.0	1,451
Wealth Quintile											,
Lowest	312.7	17.9	14.4	14.2	13.7	15.0	10.5	12.5	1.7	100.0	416
Second	365.2	12.9	12.9	13.3	14.4	15.8	10.4	19.1	1.3	100.0	611
Middle	431.0	12.3	13.4	11.8	13.0	16.1	9.4	23.0	1.0	100.0	584
Fourth	498.8	9.9	7.0	10.6	9.5	16.1	12.7	33.0	1.3	100.0	412
Highest	585.8	8.7	4.6	6.3	7.5	12.7	14.9	44.2	1.2	100.0	560
Ethnicity											
Georgian	460.7	11.7	10.1	10.0	10.5	15.7	12.1	28.8	1.0	100.0	2,230
Azeri	377.4	12.8	10.2	17.3	16.2	9.4	11.5	18.6	4.1	100.0	136
Armenian	356.6	10.8	11.1	19.8	20.5	10.9	7.0	18.6	1.2	100.0	143
Other	522.4	13.2	6.3	5.8	11.3	13.6	10.6	38.0	1.3	100.0	74
Place of Delivery											
Raional hospital, maternity	413.5	13.7	10.2	11.1	12.9	14.4	13.4	22.8	1.5	100.0	1,156
City hospital	484.5	9.7	10.0	10.7	10.0	16.1	10.5	32.1	1.0	100.0	1,345
Referral hospital	454.5	19.0	10.2	8.6	10.7	7.3	10.5	31.1	2.6	100.0	73
Other medical facility	†	†	†	†	†	†	†	†	†	100.0	9
Type of Delivery											
Vaginal Delivery	385.2	12.5	12.7	12.8	13.0	15.6	12.3	19.5	1.5	100.0	2,000
Cesarean section	667.2	9.6	1.5	4.4	6.1	13.0	9.9	55.1	0.3	100.0	583

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

† Fewer than 25 cases in this category.

Table 8.4.1

Use of Postpartum Care and Information Received during Postpartum Visits by Selected Characteristics Among Births in 2005–2010—Reproductive Health Survey: Georgia 2010

	PostPai	rtum Care			Information Rec	eived During Po	stpartum Care		
Characteristic	%	No. of Cases	Breast Feeding %	Breast Care %	Child Care %	Inmunization %	Nutrition %	Family Planning %	No. of Cases
Total	23.0	2,617	78.6	74.9	9.77	75.6	73.2	43.0	611
Residence									
Tbilisi	27.6	567	85.0	81.7	84.4	85.6	82.8	46.1	160
Other Urban	28.6	626	77.4	74.6	75.5	72.7	72.5	47.7	172
Rural	17.9	1,424	74.4	69.6	74.4	69.6	66.1	37.0	279
Age Group at Birth									
< 20	20.1	313	81.1	75.6	80.4	81.4	74.8	39.1	65
20–24	21.8	956	77.9	72.9	73.7	71.0	71.2	39.2	212
25–34	24.9	1,164	75.8	73.3	78.0	75.2	72.1	43.9	290
35-44	23.1	184	96.2	93.2	93.3	90.9	87.8	61.7	44
Education									
Secondary incomplete or less	16.6	422	7.77	68.9	74.3	74.5	72.9	32.2	76
Secondary complete	18.0	738	78.1	72.3	79.2	71.2	67.5	33.7	134
Technicum/University	27.3	1,457	78.9	76.7	78.1	77.1	75.1	47.9	401
Wealth Quintile									
Lowest	12.3	428	73.7	67.0	73.7	67.9	65.3	36.2	69
Second	16.3	628	81.7	77.5	81.4	77.2	72.8	35.9	110
Middle	23.3	587	76.7	70.8	74.0	67.5	65.3	41.8	143
Fourth	30.7	413	74.6	70.2	73.5	72.3	71.9	41.4	118
Highest	29.4	561	82.3	81.3	82.7	84.0	81.4	49.9	171
Birth Order									
First birth	25.4	1,293	74.2	69.8	72.5	73.1	70.3	38.6	335
Second birth	22.1	937	83.8	80.3	83.3	76.3	75.9	46.0	206
Third or higher	17.3	387	85.1	84.3	88.6	85.8	79.9	56.8	70
Pregnancy Complications*									
Any Complication	27.6	380	71.6	71.9	68.9	68.6	62.3	36.3	112
No Complication	22.2	2,234	80.2	75.5	79.9	77.1	75.7	44.5	498
Postpartum Complications									
Any Complication	43.6 22 5	296 2.20	64.1	64.6 0	65.5 24.0	62.3	56.4	26.3	132
No Complication	20.5	2,321	82.5	77.6	81.2	79.1	77.7	47.5	479

Chapter 8: Maternal and Child Health

Table 8.4.2Time Between Delivery and First Postpartum Visit by Selected CharacteristicsAmong Live Births in 2005–2010 with Any Postpartum CareReproductive Health Survey: Georgia, 2010

	Time Betwer	Delivery and Firs	t Postpartum Vis	sit (in Weeks)		
Characteristic	< 1	1–2	> 2	Does Not Remember	Total	No. of Cases
Total	30.8	42.0	26.6	0.6	100.0	611
Residence						
Tbilisi	27.8	39.4	32.2	0.6	100.0	160
Other Urban	29.2	44.9	25.3	0.5	100.0	172
Rural	34.4	41.9	23.1	0.6	100.0	279
Age Group at Birth						
< 20	31.8	37.7	30.6	0.0	100.0	65
20–24	33.8	37.4	28.4	0.5	100.0	212
25–34	28.1	44.6	26.4	0.8	100.0	290
35–44	31.5	54.3	14.1	0.0	100.0	44
Education						
Secondary incomplete or less	53.5	33.2	13.3	0.0	100.0	76
Secondary complete	24.8	45.3	28.8	1.0	100.0	134
Technicum/University	28.7	42.5	28.3	0.5	100.0	401
Wealth Quintile						
Lowest	35.5	44.4	15.0	5.1	100.0	69
Second	39.7	38.1	22.1	0.0	100.0	110
Middle	32.9	40.7	26.4	0.0	100.0	143
Fourth	26.6	46.2	27.1	0.0	100.0	118
Highest	26.9	41.4	31.2	0.5	100.0	171
Place of Delivery						
Raional maternity, hospital	35.1	45.8	18.7	0.5	100.0	287
City maternity, hospital	27.4	39.3	33.0	0.4	100.0	294
Other	*	*	*	*	100.0	23
At home	*	*	*	*	100.0	7
Birth Order						
First birth	29.1	41.5	29.0	0.4	100.0	335
Second birth	29.1	45.8	24.1	1.0	100.0	206
Third or higher	44.3	33.2	22.5	0.0	100.0	70

* Fewer than 25 cases in this category.

Table 8.4.3 Use of Well-baby Care and Time Between Delivery and First Visit by Selected Characteristics Among Live Births in 2005–2010 Delivered in Health Facilities Reproductive Health Survey: Georgia, 2010

Characteristic	Well-Ba	ıby Visit	Time W	Betwen Deliver Vell-Baby Clinic	y and First Pos Visit (in Week	stnatal s)	Total	
Characteristic	%	No. of Cases $^{^{\star}}$	<1	1–2	> 2	Does Not Remember	TOLAI	NO. OF Cases
Total	84.1	2,624	21.7	53.4	23.7	1.2	100.0	2,369
Residence								
Urban	89.5	1,199	26.0	56.2	17.3	0.5	100.0	1,131
Rural	78.7	1,425	16.8	50.2	30.9	2.1	100.0	1,238
Region								
Kakheti	79.6	223	19.8	53.7	24.2	2.2	100.0	200
Tbilisi	91.9	572	28.6	56.7	14.0	0.8	100.0	553
Shida Kartli	87.0	168	7.0	46.5	44.2	2.3	100.0	157
Kvemo Kartli	74.7	233	19.3	55.0	24.3	1.4	100.0	196
Samtskhe-Javakheti	72.6	215	7.6	41.1	49.7	1.5	100.0	173
Adjara	81.7	179	28.8	59.9	11.3	0.0	100.0	150
Guria	86.2	141	11.4	60.4	27.5	0.7	100.0	132
Samegrelo	82.5	186	20.9	42.9	32.5	3.7	100.0	167
Imereti	85.7	349	19.5	56.3	23.4	0.8	100.0	325
Mtskheta–Mtianeti	83.5	197	26.5	41.7	31.8	0.0	100.0	185
Racha-Svaneti	72.4	161	15.5	36.6	47.8	0.0	100.0	131
Age Group at Birth	04.0	4 000	00.0	50 5	04.7	4.0	400.0	4.440
< 24	84.3	1,266	20.0	53.5	24.7	1.8	100.0	1,143
25-34	84.7	1,170	24.0	52.9	22.3	0.8	100.0	1,062
35–44	79.6	188	19.0	55.2	25.8	0.0	100.0	164
Education	70.0	100	04.0	40.0	00.4	0.0	400.0	054
Secondary incomplete or less	78.8	420	21.8	46.6	29.1	2.6	100.0	354
Secondary complete	79.3	743	16.4	53.7	27.4	2.5	100.0	639
lechnicum/University	88.0	1,461	24.0	55.0	20.7	0.3	100.0	1,376
Wealth Quintile	75.4	400	40.7	40.4	05.4	4.0	400.0	050
Lowest	75.4	430	16.7	46.4	35.1	1.8	100.0	353
Second	79.9	627	17.2	51.5	28.2	3.1	100.0	549
	82.1	588	17.4	51.9	30.1	0.6	100.0	532
Fourth	80.0	414	27.0	53.2	18.8	1.0	100.0	383
Rignest	92.4	202	21.3	59.2	13.3	0.2	100.0	202
Place of Delivery	00.0	1 160	20 F	EC E	01 7	1 /	100.0	1 0 1 9
City meternity, hearite	0Z.Z	1,100	20.5	50.5 51.1	21.7	1.4	100.0	1,010
City maternity, nospital	87.4 65.5	1,340	22.8	51.1 51.0	25.0	1.0	100.0	1,200
Referral hospital	00.0	/0	20.5	51.2	20.3	0.0	100.0	03
	F2 0	9	T 14 0	10 P	7	14.2	100.0	9 10
At nome	53.9	21	14.9	49.8	21.1	14.3	100.0	Ö
Ollier Birth Ordor	T	Ö	T	T	Т	T	100.0	Ö
Eiret	85.0	1 205	21.4	F4 1	22 2	1 /	100.0	1 207
i list Casand	00.9	1,303	21.4	54.1	23.Z	1.4	100.0	1,207
	04.3	943 276	21.0	04.0 46.7	22.5	1.0	100.0	040 216
i mila of more	11.3	3/0	23.0	40.7	29.1	1.2	100.0	310

* Includes 29 twins.

† Fewer than 25 cases in this category.

Table 8.4.4 Percentage of Babies with Birth Certificates and Time Between Delivery and Issuance of the Certificate by Selected Characteristics Among Live Births in 2005–2010—Reproductive Health Survey: Georgia, 2010

	Baby Re	gistered	I	nterval Betwen De	livery and Birth Ce	rtificate (in Weeks	;)		
Characteristic	%	No. of Cases [*]	<1	1–2	3–4	> 4	Does Not Remember	Total	No. of Cases
Total	97.3	2,624	81.2	14.0	2.4	1.1	1.4	100.0	2,558
Pasidanca									
Urhan	98.1	1 199	84 0	12.5	18	0.7	10	100.0	1 176
Rural	96.5	1,100	78.2	15.4	3.0	14	1.0	100.0	1,382
Region	00.0	1,120	10.2	10.1	0.0	1.1	1.0	100.0	1,002
Kakheti	92.5	223	72.0	18.6	3.0	1.3	5.1	100.0	210
Tbilisi	98.2	572	83.9	13.2	1.9	0.6	0.5	100.0	562
Shida Kartli	98.4	168	76.4	19.2	4.4	0.0	0.0	100.0	165
Kvemo Kartli	95.7	233	82.9	10.6	4.1	1.6	0.8	100.0	223
Samtskhe–Javakheti	98.8	215	88.6	2.9	2.0	2.4	4.1	100.0	212
Adjara	98.1	179	78.4	19.6	1.5	0.0	0.5	100.0	175
Guria	94.4	141	82.1	11.3	0.7	4.6	1.3	100.0	137
Samegrelo	97.6	186	75.4	19.3	1.9	1.9	1.4	100.0	181
Imereti	98.5	349	85.0	10.4	2.1	0.8	1.8	100.0	344
Mtskheta-Mtianeti	97.3	197	78.4	16.5	2.8	1.4	0.9	100.0	193
Racha–Svaneti	96.9	161	82.1	10.5	3.7	3.7	0.0	100.0	156
Age Group at Birth									
< 24	97.4	1,266	80.0	14.6	2.5	1.5	1.4	100.0	1,240
25–34	97.3	1,170	84.0	12.2	2.2	0.6	1.1	100.0	1,137
35–44	96.3	188	72.3	20.2	3.2	0.6	3.7	100.0	181
Education									
Secondary incomplete or less	92.2	420	77.8	15.2	2.8	2.0	2.1	100.0	394
Secondary complete	97.5	743	81.9	12.5	2.3	1.1	2.2	100.0	724
Technicum/University	98.7	1,461	81.7	14.3	2.3	0.8	0.9	100.0	1,440
Wealth quintile									
Lowest	93.8	430	77.9	16.0	3.4	1.8	1.0	100.0	412
Second	97.4	627	76.5	17.9	2.0	1.0	2.6	100.0	612
Middle	98.1	588	80.1	12.7	2.8	2.1	2.4	100.0	574
Fourth	96.4	414	81.4	15.4	2.5	0.3	0.5	100.0	401
Highest	99.0	565	87.4	9.8	1.8	0.5	0.5	100.0	559
Place of Delivery									
Raional maternity, hospital	97.6	1,160	82.0	13.2	2.0	1.2	1.7	100.0	1,131
City maternity, hospital	97.7	1,346	82.5	13.6	2.5	0.9	0.6	100.0	1,317
Referral hospital	96.2	76	65.5	28.0	1.5	0.0	5.0	100.0	74
Other medical facility	†	9	1	t	t	t	t	100.0	9
At home	67.3	27	14.2	20.7	25.3	10.0	29.8	100.0	21
Other	†	6	†	†	†	†	†	100.0	6
Birth Order		(007						(00.0	=
First	97.2	1,305	80.3	14.9	2.6	1.2	1.0	100.0	1,274
Second	97.8	943	82.5	13.3	2.4	0.6	1.2	100.0	923
I hird or more	96.3	3/6	80.9	12.4	1./	1.6	3.4	100.0	361

* Includes 29 twins.

† Fewer than 25 cases in this category.

Table 8.5 Smoking and Drinking during Pregnancy and Number of Cigarettes Smoked by Selected Characteristics Among Births in 2005–2010—Reproductive Health Survey: Georgia, 2010

	% Who Smoked	% Who Smoked	Number of	Cigarretes Smok	ed (per Day)	% Who Drank		
Characteristic	Before	During			Does Not	During	Total	No. of Cases
	Pregnancy	Pregnancy	1–4	5+	Remember	Pregnancy		
Total	4.2	1.8	1.2	0.5	0.0	1.1	100.0	2,617
D :								
Residence	<u> </u>	0.0	1.0	0.0	0.4	4.0	100.0	4 400
Urban	6.9	2.8	1.9	0.8	0.1	1.2	100.0	1,193
Rurai	1.4	0.7	0.4	0.3	0.0	0.9	100.0	1,424
Kegion	1.0	1.0	0.0	1.0	0.0	0.0	100.0	004
	1.0	1.2	0.0	1.2	0.0	0.0	100.0	224
I DIIISI Obiala Kaatti	10.7	4.6	3.2	1.2	0.2	1.5	100.0	567
Shida Kartii	0.5	0.0	0.0	0.0	0.0	1.1	100.0	168
Kvemo Kartli	2.3	1.9	1.6	0.4	0.0	1.6	100.0	234
Samtskhe–Javakheti	0.0	0.0	0.0	0.0	0.0	0.0	100.0	214
Adjara	3.4	0.5	0.5	0.0	0.0	2.9	100.0	1/6
Guna	0.0	0.0	0.0	0.0	0.0	0.6	100.0	140
Samegrelo	1.9	1.9	1.4	0.5	0.0	0.5	100.0	184
Imereti	1.8	0.0	0.0	0.0	0.0	0.0	100.0	349
Mtskheta–Mtianeti	3.9	1.3	0.4	0.9	0.0	1.7	100.0	200
Racha–Svaneti	0.5	0.0	0.0	0.0	0.0	0.5	100.0	161
Age Group at Birth								
< 20	1.6	0.7	0.7	0.0	0.0	0.7	100.0	313
20–24	5.0	2.5	2.0	0.4	0.1	1.1	100.0	956
25–34	4.0	1.5	0.7	0.9	0.0	1.0	100.0	1,164
35–44	5.5	1.6	1.1	0.5	0.0	1.8	100.0	184
Education								
Secondary incomplete or less	0.8	0.2	0.0	0.2	0.0	0.6	100.0	422
Secondary complete	2.8	1.7	1.2	0.3	0.1	1.2	100.0	738
Technicum/University	5.8	2.3	1.5	0.8	0.0	1.1	100.0	1,457
Wealth Quintile								
Lowest	2.0	1.8	1.3	0.5	0.0	0.0	100.0	428
Second	1.4	0.2	0.2	0.0	0.0	1.2	100.0	628
Middle	1.7	0.4	0.0	0.4	0.0	1.1	100.0	587
Fourth	6.8	3.1	1.9	1.2	0.0	1.1	100.0	413
Highest	8.1	3.4	2.5	0.7	0.2	1.4	100.0	561
Ethnicity		•••		•				
Georgian	4.4	1.8	1.2	0.5	0.0	1.0	100.0	2,248
Azeri	11	0.9	0.9	0.0	0.0	0.6	100.0	145
Armenian	2.6	0.0	0.0	0.0	0.0	0.0	100.0	145
Other	6.5	5.0	23	3.1	0.0	3.4	100.0	79
Birth Order	0.0	0. т	2.0	0.1	0.0	U.T	100.0	10
First	4.5	17	11	0.5	0.1	0.9	100.0	1 293
Second	30	19	13	0.6	0.0	1.0	100.0	937
Third or more	3.8	1.5	1.0	0.5	0.0	1.5	100.0	387
	5.0	1.0	1.1	0.0	0.0	1.0	100.0	507

 Table 8.6.1
 Routine Measurement of Blood Pressure (BP) During Pregnancy, Reported High Blood Pressure (HBP)

 During Pregnancy, and Hospitalization Rate for HBP by Selected Characteristics

 Among Births in 2005–2010 with Any Prenatal Care—Reproductive Health Survey: Georgia, 2010

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

* Fewer than 25 cases in this category

Pregnancy Complications That Required Medical Attention by Selected Characteristics among Births in 2005–2010 with Any Prenatal Care Reproductive Health Survey: Georgia 2010 Table 8.6.2

	At Least One	Complication					regnancy Con	plication				
Characteristic	%	No. of Cases	Risk of Preterm Delivery	Anemia Related to Pregnancy	Water Retention or Edema	High BP Related to Pregnancy	Weak Cervix	Bleeding During First 6 Months	Urinary Tract Infection	Bleeding After 6 Months	Rh Isoimmunization	Other
Total	15.7	2,575	6.7	3.6	3.3	3.0	2.1	1.9	1.5	1.1	1.0	1.6
Residence												
Urban	15.0	1,184	7.1	3.7	3.1	2.7	2.6	2.1	1.4	1.4	0.9	1.6
Rural	16.3	1,391	8.6	3.6	3.6	3.4	1.6	1.6	1.7	0.8	1.1	1.5
Region												
Kakheti	12.7	211	6.8	5.9	2.5	2.5	1.7	1.3	0.4	1.3	2.1	0.8
Tbilisi	13.6	563	6.8	3.5	2.0	3.1	2.6	2.2	0.6	1.5	0.6	0.9
Shida Kartli	22.2	168	9.2	3.8	2.7	4.3	2.7	5.9	2.2	1.1	3.2	2.2
Kvemo Karti	14.2	223	8.5	3.3	4.9	2.4	1.6	1.6	1.2	0.4	0.4	1.2
Samtskhe-Javakheti	14.2	214	6.5	0.8	2.4	3.7	2.0	2.0	1.2	0.4	1.2	0.4
Adjara	17.2	175	10.3	0.5	4.4	3.9	1.0	1.5	2.9	1.5	0.5	2.0
Guria	4.4	140	0.6	1.3	1.3	0.6	0.6	1.3	0.6	0.0	0.0	0.0
Samegrelo	11.7	181	7.8	2.4	2.9	2.4	2.4	0.5	1.0	1.0	1.0	1.0
Imereti	20.8	348	9.2	6.2	4.9	3.3	1.5	1.3	3.1	1.0	1.0	3.6
Mtskheta-Mtiane f	23.8	194	9.4	5.8	5.8	2.2	6.3	1.8	0.9	0.4	0.4	2.7
Racha–Svaneti	7.3	158	3.1	2.6	1.6	0.0	2.1	2.1	4.1	0.0	0.0	0.0
Age Group at Birth												
< 24	14.2	1,251	7.4	3.1	2.3	2.2	2.2	1.4	1.3	0.8	0.8	1.2
25-34	16.6	1,145	7.9	4.2	4.2	3.2	1.9	2.7	2.0	1.4	1.0	2.3
35-44	19.8	179	11.0	4.1	4.8	8.2	3.0	0.0	0.2	0.7	2.6	0.0
Education												
Secondary incomplete or less	13.2	400	7.1	1.6	4.2	2.0	2.4	0.0	1.2	0.6	0.7	1.9
Secondary complete	15.9	724	7.3	4.1	2.9	2.8	2.1	2.1	2.2	1.2	1.2	1.5
Technicum/University	16.2	1,451	8.4	4.0	3.3	3.4	2.0	2.3	1.3	1.1	1.0	1.6
Wealth Quintile												
Lowest	15.0	410	6.4	3.2	3.6	3.1	1.4	1.0	2.3	0.8	2.4	1.8
Second	15.8	619	8.2	3.0	2.7	2.5	1.5	1.9	1.5	1.3	0.5	1.5
Middle	15.8	579	7.4	4.1	4.7	4.1	1.8	1.6	1.9	6.0	1.1	2.1
Fourth	17.7	406	10.6	4.7	4.7	2.3	4.4	2.8	1.5	2.8	0.5	1.7
Highest	14.5	561	7.0	3.3	1.8	3.0	1.7	1.9	0.8	0.2	1.0	1.0
Birth Order												
First	17.1	1,285	9.1	3.7	3.2	3.3	2.5	2.3	1.8	1.4	0.7	1.6
Second	13.7	924	6.4	3.3	3.4	2.8	1.6	1.5	1.2	0.9	0.9	1.3
Third or more	15.3	366	6.9	4.4	3.7	2.7	1.9	1.4	1.3	0.5	2.4	2.1

	At 1 2224 Out	a framilantian					of and an of a second				
Characteristic	%	No. of Cases	Severe Bleeding	Painful Uterus	High Fever	Breast Infection	Bad-smelling Vaginal Discharge	Painful Urination	Infection of Surgical Wound	Faint/coma	Other
Total	11.2	2,617	3.5	3.5	3.3	2.5	2.0	1.9	1.7	0.7	0.6
Residence											
Urban	12.6	1,193	4.6	3.8	3.8	3.2	2.2	2.2	1.9	0.8	0.8
Rural	9.7	1,424	2.4	3.1	2.7	1.8	1.8	1.7	1.5	0.6	0.3
Region											
Kakheti	13.3	224	3.5	4.3	3.5	2.7	2.0	2.7	1.6	0.0	0.0
Tbilisi	13.0	567	3.5	4.1	4.0	4.3	2.5	2.5	2.6	0.8	6.0
Shida Kartli	10.8	168	0.5	3.8	3.2	3.2	3.8	0.5	1.1	1.1	0.0
Kvemo Kartli	9.3	234	3.5	5.0	3.1	1.2	1.2	2.3	0.8	0.8	0.8
Samtskhe–Javakheti	6.1	214	3.7	1.6	0.4	0.4	0.4	0.4	1.2	0.4	0.4
Adjara	10.2	176	2.9	2.0	4.4	1.5	2.0	2.0	2.4	1.5	0.5
Guria	5.0	140	0.6	0.6	3.1	0.6	0.6	0.6	1.3	0.0	0.6
Samegrelo	5.7	184	0.5	1.9	1.9	1.0	1.0	0.5	1.9	0.5	0.0
Imereti	12.8	349	6.1	2.8	3.1	2.3	1.5	2.0	1.0	0.5	0.8
Mtskheta-Mtjaneti	16.2	200	6.1	6.6	3.5	2.2	6.6	3.5	0.4	1.7	0.9
Racha–Svaneti	15.8	161	5.6	3.6	2.6	5.1	4.1	1.5	2.0	0.0	0.0
Age Group at Birth											
< 24	10.2	1,269	2.5	3.4	2.6	2.2	1.8	1.4	1.2	0.4	0.6
25-34	12.8	1,164	4.4	4.0	4.3	3.1	2.3	2.5	2.2	1.0	0.6
35-44	8.1	184	4.9	1.2	1.6	0.8	1.6	1.7	1.8	0.6	0.2
Education											
Secondary incomplete or less	8.4	422	2.9	2.2	2.4	1.6	1.5	0.5	1.3	0.7	0.3
Secondary complete	10.2	738	2.6	2.7	2.7	1.4	1.9	1.5	1.1	0.5	0.4
Technicum/University	12.4	1,457	4.1	4.2	3.8	3.3	2.3	2.5	2.1	0.8	0.7
Wealth Quintile											
Lowest	9.2	428	3.4	2.4	2.1	0.7	1.2	0.7	1.7	0.5	0.8
Second	8.0	628	2.7	2.8	1.8	1.3	1.2	1.2	1.3	0.7	0.0
Middle	11.7	587	3.6	3.9	3.8	2.3	2.7	2.6	1.7	1.1	0.4
Fourth	14.4	413	3.8	3.9	4.9	4.0	2.0	1.9	1.2	0.5	0.7
Highest	12.4	561	4.0	4.0	3.7	3.6	2.6	2.7	2.3	0.7	1.0
Birth Order											
First	11.4	1,293	2.9	3.5	3.9	2.9	2.0	2.1	2.1	0.8	0.7
Second	10.3	937	3.3	3.2	2.8	2.0	1.7	1.7	1.1	0.5	0.6
Third or more	12.2	387	6.0	3.9	2.3	2.1	2.8	2.1	1.7	1.1	0.3

Table 8.7Poor Birth Outcomes by Selected Characteristics among Births in 2005–2010Reproductive Health Survey: Georgia, 2010

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	7.8	2,617	4.2	3.8	2,595
Residence					
Urban	10.3	1,193	3.9	4.2	1.181
Rural	5.2	1,424	4.4	3.5	1,414
Region					
Kakheti	11.8	224	3.6	5.6	221
Tbilisi	10.7	567	3.4	4.3	562
Shida Kartli	5.4	168	4.9	4.9	167
Kvemo Kartli	7.8	234	5.1	3.5	232
Samtskne-Javakneti	8.1	214	4.9	3.7	212
Adjara	0.0	170	5.9 5 1	2.9	170
Gulla Samogrolo	0.3	140 184	0.1 2.4	4.4	109
Imereti	4.0	3/0	2.4	2.4	347
Mtskheta_Mtianeti	21.8	200	7.6	3.5	197
Racha–Svaneti	10.2	161	4 1	10	159
Age Group at Birth	10.2	101		1.0	100
< 20	9.2	313	3.8	4.1	310
20–24	3.6	956	2.8	2.5	951
25–34	10.4	1,164	4.2	4.5	1,152
35–44	10.8	184	11.1	5.8	182
Education					
Secondary incomplete or less	2.8	422	4.5	2.6	420
Secondary complete	8.7	738	4.2	4.5	730
Technicum/Universitv	8.8	1.457	4.0	3.9	1.445
Wealth Quintile					
Lowest	6.3	428	4.4	3.9	425
Second	5.3	628	5.5	3.2	623
Middle	8.9	587	3.4	3.7	582
Fourth	16.9	413	3.5	4.0	407
Figuest Ethnicity	3.0	100	3.9	ა.0	000
Goorgian	87	2 248	11	11	2 227
Δτοτί	0.7	2,240	4.1	3.1	145
Armenian	0.0	145	4.5	14	145
Other	10.8	79	4.4	2.1	78
Birth Order	10.0				10
First	5.3	1,293	3.5	4.0	1,285
Second	8.8	937	4.4	3.3	929
Third or more	13.9	387	5.8	4.7	381
Prenatal Care Visits					
Yes	7.1	2.575	4.1	3.8	2.555
No	50.0	42	5.6	5.5	40
Pregnancy Complications					
No	3.1	2,237	3.0	2.9	2,229
Yes	33.5	380	10.9	9.2	366
Prolonged Labor	E O	2.004	2.0	0.0	2.052
	5.3	2,064	3.Z	2.8	2,052
TUS C-Section before labor	29.0	32 106	1./	1./ 7 0	31 102
Does not remember	3.1 31.1	400 115	1.1	0.5	402 110
	04.4	IIJ	0.5	9.0	ΠU

 Table 8.8.1
 Percentage of Children Born in 2005–2010 Ever Breastfed and Initiation of Breastfeeding by Selected Characteristics—Reproductive Health Survey: Georgia, 2010

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

* Includes 29 twins.

* Fewer than 25 cases in this category.

Table 8.8.2Mean Duration of Breastfeeding in Months, by Type of Breastfeeding
and by Selected Characteristics among Live Births Age 0–59 months
Reproductive Health Survey: Georgia, 2010

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

Table 8.9.1Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)Among Children Born During the 5 Years Before the SurveyReproductive Health Surveys: Georgia 1999, 2005 and 2010

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

Table 8.9.2Infant and Child Mortality Rates (Infant and Child Deaths per 1,000 Live Births)
by Selected Characteristics
Among Children Born Between January 2000 and December 2009
Reproductive Health Survey: Georgia, 2010

Charactoristic		Infant Mortality	,	Child Mortality Under–5 Mortality		No. of Casos
Gildidelensie	Total	Neonatal	Postneonatal	1–4 Year	0–4 Years	NO. OF Cases
Total	23.8	17.5	6.3	2.2	26.0	4,015
Dania d of European						
Period of Exposure	05.7	07.0	0.5	0.0	27.0	4.045
January 2000/December 2004	35.7	21.2	8.5	2.2	37.9	1,845
Besidence	14.1	9.5	4.5	2.3	10.4	2,170
lirban	01.0	16.2	5.6	0.5	20 A	1 770
Rural	21.0 25.7	10.5	5.0 7.0	0.0	22.4	1,112
Region	23.1	10.0	7.0	5.9	23.4	2,243
Kakheti	27 0	16.0	10.9	59	32.8	345
Tbilisi	16.9	14.7	21	0.0	16.9	830
Shida Kartli	28.2	21.2	7.0	7.5	35.5	257
Kvemo Kartli	20.2	16.5	11.6	24	30.0	384
Samtskhe–Javakheti	21.8	13.6	83	3.1	24.9	329
Adiara	26.6	19.8	6.8	37	30.3	261
Guria	21.3	14.2	7.1	0.0	21.3	251
Samegrelo	34.1	31.0	31	0.0	34.1	293
Imereti	19.7	12.4	72	1.9	21.6	515
Mtskheta-Mtianeti	38.0	34.8	3.2	0.0	38.0	281
Racha–Svaneti	6.8	3.4	3.3	0.0	6.8	260
Age Group at Birth	010	••••		010	0.0	
< 25	18.2	12.9	5.3	1.5	19.7	2.118
25–44	30.1	22.6	7.5	3.2	33.2	1,897
Education Level						,
Secondary incomplete or less	22.8	16.6	6.3	1.6	24.4	730
Secondary complete	28.4	22.1	6.3	2.8	31.2	1,132
Technicum/university	21.8	15.4	6.4	2.2	23.9	2,153
Ethnic Group						
Georgian	23.8	17.5	6.4	2.1	25.9	3,395
Other	23.5	17.3	6.2	2.9	26.3	620
Socioeconomic Status						
Low	26.0	19.9	6.1	1.6	27.5	1,685
Medium/High	22.4	16.0	6.4	2.6	25.0	2,330
Birth Order						
First	20.4	14.9	5.5	0.7	21.2	1,978
Second	23.1	16.1	7.0	3.5	26.5	1,464
I hird or more	36.7	29.3	7.4	3.9	40.4	573
Length of Birth Interval	/					
First Birth	20.4	14.9	5.5	0.7	21.2	1,978
~ 24 months	22.4	20.0	2.4	3.0	25.4	637
24-47 MONTINS	34.8	29.5	5.3	6.2	40.7	689
40 MOUNS OF MORE	24.0	11.5	12.5	1.7	25.6	/11
Sex of Unita	00.0	40 5	0.4	4.0	00.4	0.4.40
	20.0 20.5	18.5	8.1 4.2	1.0	28.1 22.5	2,142
	20.0	10.2	4.3	3.0	23.3	1,073

Chapter 9

Health Behaviors

he practice of health-promoting behaviors influence health can greatly and complement health care. Behaviors such as getting regular exams, avoiding cigarette smoke and drinking alcohol in moderation are instrumental in protecting health and preventing chronic disease. Chapter 9 reports on important health behaviors and knowledge among women of reproductive age in Georgia. In particular, the Georgia RHS 2010 explores health care utilization, breast and cervical cancer screening, tuberculosis, smoking and alcohol use. These issues are examined attention with women's demographic to characteristics, to help explain the changing and varied health care needs of different subgroups.

A particular attention was given to documenting preventive practices that help lower the risk of breast and cervical cancer. Despite recent advancements in prevention, diagnosis, and treatment, gynecologic malignancies continue to be a leading cause of death in women of reproductive age in both the developed and developing world. Among reproductive system cancers, breast and cervical cancer are the most common. Early diagnosis and treatment are essential for cancer therapy to be highly effective. Unfortunately, a substantial proportion of these cancers in Eastern Europe are detected at an advanced and incurable stage as a result of women's lack of awareness or reluctance to access preventive care services; provider's lack of interest, time, or expertise for health promotion; and a health system that allocates more of its limited resources to curative care than to prevention. Breast cancer

accounted for most deaths among women aged 15-44 in Georgia in 2006 (14%) and cervical cancer ranked 4th, accounting for 5% of deaths. Crude casespecific mortality rates for breast cancer among these women was higher than the European average (7.9 per 100,000 vs. 5.4 per 100,000 women aged 15-44) (Serbanescu et al., 2009).

9.1 Utilization of Health Care Services

The interaction between client and health provider is an important opportunity for health promotion and disease prevention. During patient encounters, health care providers can provide general health counseling and advice for risk behavior change. Patients' attitudes and behaviors regarding health care visits are important determinants of whether they receive health counseling and routine screening, including cervical and breast cancer screening. Respondents were asked a series of questions that explored health care-seeking behaviors and barriers to health care.

Having a usual place for care— a location or source where one regularly receives their health care—is associated with fewer delays in getting care, better preventive care, and better treatment. The majority of respondents (79%) reported having a usual place where they obtain their health care (Table 9.1.1). This was more often the case for women who had health insurance (85%) and those employed (83%). There appears to be a direct correlation between having a usual place of care and educational attainment. The proportion of women with a usual

place for care increased with education from 73% of women who had not completed secondary school to 83% of women with university or postgraduate education. Having a consistent place for care was less common for adolescents aged 15-19 (71%), young adults aged 20-24 (76%), women residing in households in the lowest wealth quintile (74%), and ethnic minorities (70%). Women who reported they had a usual place of care, obtained most of the care in hospitals (38%) and ambulatory clinics (i.e. policlinics and women's consultation clinics) (26%). Only a minority obtained usual care in primary health care (PHC) facilities (14%). In rural areas, the most common place for usual care was a raional/city hospital (46%) while in urban areas, comparable proportions of women attended policlinics and women's consultation clinics or raional/city hospitals (33% and 31%, respectively) Figure 9.1.1).

Over a third of women (37%) reported that they had visited a health care facility (either for treatment or for preventive services, including family planning) during the 12 months before the interview (Table 9.1.2). That is an increase from the previous survey, in which only a quarter (25%) of women had visited a health care facility in the past year (data not shown). Health care visits were more common among urban residents (39%), residents of Tbilisi (41%) and Imereti (43%). Of those who had at least one health visit, one half (51%) were seen for acute care while 41% were seen for preventive care and 20% for a care of a chronic condition. Compared to their rural counterparts, a higher proportion of respondents living in urban areas had preventive health visits (43% versus 39%) and a lower proportion had acute care visits (49% versus 53%) (Figure 9.1.2). There was no urban/rural difference in the proportion who received care for chronic conditions.

When asked if they had to delay getting medical care in the last 12 months, either preventive or for an illness, a quarter (25%) of respondents indicated they had done so (Table 9.1.3). The overwhelming majority of women (82%) who had delayed care reported that the cost of health care services was the most important deterrent. This was particularly true for women with multiple children (84% and higher), women with the least education (91%) or wealth quintile (90%), and ethnic minority women (91%).

In this context, GERHS10 examined the health insurance coverage among women of reproductive age at the time of interview. A woman was defined as insured if either directly or through a spouse or parent she had any government paid insurance (e.g. insurance for vulnerable population, "5 Lari" insurance), other government-sponsored health plan or private health insurance through employer (i.e. insurance for civil servants and governmental employees; private insurance partially funded), or self-funded private insurance.

Only 22% of women had any health insurance at the time of the interview (Table 9.1.4). This proportion varied little by urban or rural residence and was the lowest among residents of Kvemo Kartli (14%).





Given the unequal distribution of the population under poverty level, insured women in rural areas were much more likely to have governmentsupported health insurance than urban women (70% vs. 29%) and less likely to have private insurance (Figure 9.1.3). Women aged 35 or older were slightly more likely to report being insured and more likely to have private insurance than younger women. Health insurance coverage was higher among women with post-graduate education (27%), who were mostly covered by private insurance, than among women with lower education (18%–19%). Women residing in households with the lowest wealth quintile reported higher coverage (28%) than women in other wealth groups; virtually all of them had government-funded insurance for the vulnerable population. Employed women were more than twice as likely as unemployed women to have insurance (39% vs. 18%); more than half of those with insurance had an insurance plan partially or fully supported by the employer. Twenty-four percent of Georgian women compared to only 11% of women belonging to ethnic minorities had health insurance; among insured women the source of insurance did not differ by ethnic background.



9.2 Prevalence of Routine Gynecologic Visits

The American College of Obstetrics and Gynecology has recently updated its guidelines to recommend that women have а routine gynecologic examination every year after age 21; however, guidelines vary throughout the world. The Georgia 2010 survey shows an increase in the proportion of women who have had routine gynecologic exams in the last year (25%, up from 20% in 2005); however, this is still lower than in 1999 when 30% of women reported having had one in the last year (Table 9.2 and Figure 9.2). There was an inverse correlation between age and having had a gynecologic exam in the past 12 months, ranging from 32% of 15-24 year-olds to

only 17% of 40-44 year-olds. In fact, 38% of women aged 40-44 years had their last routine gynecological exam more than 3 years prior to the interview and 19% had never had a routine exam. A direct relationship existed between wealth quintiles and gynecologic exams with fewer women in the lowest quintile having ever had an exam and more women in the highest two quintiles having had one (18% vs. 29%). Since screening for cervical and breast cancer are generally provided or prescribed during the routine gynecologic visits, a low prevalence of routine gynecologic exams inevitably has an impact on early detection and treatment of the gynecologic cancers. It also has a substantial negative effect on family planning counseling and dissemination of other health messages.



9.3 Breast Cancer Screening

Breast cancer far exceeds all cancer diagnoses among women with an estimated 1.38 million new cancer cases diagnosed in 2008 (23% of all cancers), and ranks second overall (10.9% of all cancers). Breast cancer has become the most common cancer both in developed and developing regions with approximately 690 000 new cases estimated in each region (population ratio 1:4) (Ferlay et. al., 2010). The age-standardized incidence rate of reported new cases of breast cancer in Georgia (38.5 new cases per 100,000) is higher than others in Western Asia (as categorized by GLOBOCAN 2008 cancer registry) but is lower than the average in Central and Eastern Europe, North America, and Western Europe, the region with the highest incidence rate in the world (Ferlay et al., 2010) (Figure 9.3.1). Crude cause specific mortality due to breast cancer in Georgia in 2006 (7.9 deaths from cancer per 100,000 women aged 15–44) was slightly higher than the European average, perhaps reflecting late detection and treatment.

Recently, Georgia has been aggressively seeking to increase the screening of reproductive tract cancers. Through the new national screening program and under the patronage of the First Lady of Georgia, early breast and cervical cancer detection has been promoted through free access screening, education of clinicians, and to increased public awareness. Since 2006, the Georgian National Screening Center was opened collaboration in Tbilisi through between MoLHSA, Tbilisi Municipality, and UNFPA. While the Center has initially targeted women in



Tbilisi, the success of the program prompted the government to scale it up to the national level. The Center was awarded with "Pearl of Wisdom" Award in 2009 at the European Parliament Cervical Cancer Prevention Summit Meeting in Brussels. The Center also promoted the formation of the Black Sea Countries Coalition on Breast and Cervical Cancer Prevention, with support from UNFPA and the First Lady. Efforts to increase awareness of breast and cervical cancer and promote screening practices were also the focus of the USAID-supported projects, starting with the Healthy Women in Georgia project. Through these efforts, several "Race for the Cure" awareness campaigns were organized in Tbilisi. The current project implemented by JSI (SUSTAIN), covers a broad range of social mobilization activities and breast cancer clinical training for health providers.

Currently available practices for detecting breast cancer include breast self-examination (BSE), clinical breast examination (CBE), and mammography. Guidelines for the early detection of breast cancer in average-risk women consist of a combination of regular clinical breast examination (CBE) and counseling to raise awareness of breast symptoms beginning at age 20 years, and annual mammography beginning at age 40 years (American Cancer Society, 2005). BSE is a very simple self-care procedure that can detect changes in the breast over time and can be performed by women in the privacy of their homes after minimal instruction. BSE is recommended as a supportive detection system to be used in conjunction with CBE and mammography. Women should be told about the benefits and limitations of BSE and the importance of the prompt reporting of any new breast symptoms to a healthcare professional. Women who choose to do BSE should receive instructions and have their technique reviewed on the occasion of a periodic health examination. Appropriate follow-up by a physician should be available and accessible for women who detect breast changes through self-examination. At that point, CBE and, when indicated, mammography should be conducted.

The Georgia 2010 RHS explored the level of experience with BSE and how often the exam was performed. Overall, 42% of sexually experienced women had ever performed BSE (Table 9.3.1), which is higher than in 2005 (29%), but still indicates significant room for improvement. In terms of BSE frequency, 17% of sexually experienced women reported doing one every month, 12% every 2-5 months, 12% every 6-12 months or less, and 58% never. Levels of BSE usage were lower among women in rural areas, younger women, the poorest women, and ethnic minority women. Also, having ever conducted a BSE was correlated with having the experience of a routine gynecological exam. This likely reflects the fact that a gynecological exam is-an important opportunity for a clinician to encourage and instruct a woman on how to perform a BSE.

As mentioned previously, BSE is not adequate on its own; consequently, women were also asked about the utilization of CBE and mammography. A CBE – a physical examination of the breast done by a health professional to detect abnormalities – can be part of a routine health examination. Table 9.3.2 illustrates that less than a fifth (18%) of sexually experienced women had ever had a CBE and a disparity existed between urban and rural women (22% vs. 13%, respectively). The proportion of women who had ever had a CBE increased with age, educational attainment, and wealth, for women with and without sexual experience. Among sexually experienced women, almost twice as many ethnic Georgian women as women of other ethnic background had a CBE in their lifetime (19% vs. 10%).

Due to the fact that breast cancer risk increases with age, mammography screening is primarily targeted to older women. As such, women in the oldest age group surveyed (40–44 years) were more likely to report mammography screening compared to their younger counterparts. In Tbilisi, where the Georgian cancer screening program was initially focused, the utilization of mammography was at least double that of other regions. Thirteen percent of sexually experienced women in Tbilisi had ever had a mammography, whereas the proportions in all other regions ranged from 3% in Samtskhe-Javakheti to a little over 6% in Mtskheta-Women who had never had a Mtianeti. mammogram were asked the main reason why and responses were divided almost evenly into three categories: no doctor had ever recommended it (33%), they had never heard of mammography (32%), and they did not think it was necessary (30%) (Figure 9.3.2). Awareness of mammography was greater in Tbilisi, where only 22% of women had never heard of it. A fifth of women aged 35-44, a group who are in or soon will be in the target group for mammogram screening in Georgia, still had never heard of this screening practice.



9.4 Cervical Cancer Screening and HPV Awareness

Cervical cancer is the third most common cancer of women, with an estimated 530,000 new cases in 2008 (Ferlay et al., 2010). Both the ageadjusted incidence (9.4 new cases of cervical cancer per 100,000) and the age-adjusted mortality (4.7 deaths due to cervical cancer per 100,000) reported in Georgia for 2008 were higher than those in industrialized countries and other Western Asia countries, but lower than those in Central and Eastern Europe (Figure 9.4.1). The Georgian study of the main causes of death among women of reproductive age documented that cervical cancer was the fourths cause of death among these women in 2006 (Serbanescu et al., 2009).

The Papanicolaou (Pap) smear is the primary method of screening for cervical cancer and while guidelines vary by country, often dependent on available resources, most recommend that women who are sexually active should have a Pap smear test at least once every 3 to 5 years. In industrialized nations screenings are recommended as early as 18 years old but in resource-poor settings, the core group that should be targeted is usually women aged 30-60 years. The age group targeted for cervical cancer screening by the Georgian screening program mentioned in the prior section is 25-60 years the recommended frequency of performing the screening tests is every 3 years.



Note: Rates are age-standardized, meaning they permit international comparison in spite of varying age structures. Source: Ferlay J, et. al. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 2010. Survey reports are a useful way to estimate the extent of cervical screening in the general population. All of the reproductive health surveys in Georgia have included a series of questions regarding Pap test history to determine if the respondents had ever had a Pap smear test and, if so, when they had had their most recent test. In the current survey, 12% of sexually experienced women aged 15-44 years, reported ever having had a Pap smear test; still very low, but a sizeable increase from the 4% reported in both 2005 and 1999 (Figure 9.4.2). Five percent have had one in the past 12 months, also an improvement over the last two The low prevalence of cervical cancer surveys. screening does not allow the study of potential determinants of this preventive practice in Georgia (Table 9.4.1). As shown in Table 9.4.2, the higher prevalence of Pap tests in the 25-34 and 35-40 year old age groups in Tbilisi (15% and 22%, respectively) suggest that the targeted screening campaign on reproductive cancers may have had a positive impact and as it expands nationally, could make cervical cancer screening more widely practiced in other regions as well.

One of the major risk factors for cervical cancer is the infection with human papilloma virus (HPV). The development of HPV vaccines in the last decade has provided a safe and effective tool for the prevention of cervical cancer. For the first time, GERHS10 explored the level of awareness and use of the HPV vaccine in Georgia. Women surveyed were asked a series of questions about their awareness of HPV, knowledge that a vaccine to prevent cervical cancer exists, and their interests (or disinterest) in getting the vaccine.



Only a quarter (25%) of sexually experienced women had ever heard of HPV, 21% had heard of the vaccine, and once told about the vaccine's effectiveness in preventing cervical cancer, 29% expressed an interest in receiving the vaccine (Table 9.4.3). Awareness of HPV was twice as high in Tbilisi as any other region (44% compared to 23% or less elsewhere). Awareness of the vaccine was also highest in Tbilisi. While awareness increased with age, interest in receiving the vaccine was inversely correlated with age, perhaps because the vaccine is recommended for use in young girls who are less likely to be sexually experienced and to have been Interest did, however, increase with infected. education. Awareness of HPV and the vaccine were considerably lower among ethnic minorities (7%), indicating an important area for improvement in outreach efforts. Once informed, many women in these groups expressed an interest in getting vaccinated.

9.5 Tuberculosis Awareness and Exposure

According to WHO, 1.7 million people died from TB (including 380,000 women) in 2009, including 380,000 people with HIV, equal to 4,700 deaths a day (WHO, 2010b). In 2009, there were an estimated 9.4 million incident cases of TB globally (equivalent to 137 cases per 100,000 population). The deterioration of health systems in the early 1990s, including TB control efforts, contributed to a major TB problem in Georgia specifically and elsewhere in the former Soviet Union. WHO estimates that in 2009, Georgia had an incident rate of 107 cases per

100,000 population. Multidrug resistant TB (MDR-TB) is particularly problematic in Georgia, accounting for 10% of all new cases and 31% of retreatment cases. Georgia has been identified as one of the 27 high MDR-TB burden countries and has been included in the EXPAND-TB (Expanding Access to New Diagnostics for TB) project within the global Stop TB Partnership. After identifying TB as one of the nation's greatest public health threats in the early 1990s, the Ministry of Labor, Health, and Social Affairs established the National TB Control Program (NTCP) in 1995. In 1997, pilot sites for Directly Observed Therapy short-course (DOTS) implementation were created and gradually the DOTS strategy was introduced countrywide. Since 2003, USAID Georgia supports the NTCP to improve the DOTS coverage, increase treatment success rates and reduce treatment default rates, strengthen clinical and laboratory services for TB patients, and promote linkages between HIV/AIDS and TB treatment efforts (USAID Georgia, 2009).

Almost all women surveyed (95%) were aware of tuberculosis (TB) (Table 9.5.1, left panel). Over twothirds (67%) correctly indicated that it is transmitted through the air when coughing (Table 9.5.1, middle Correct knowledge of transmission was panel). higher among urban women and increase directly with the SES of the household (and Figure 9.5). Women aged 15-19 (53%), those with less than complete secondary education (50%), and minority women (45%) were the least likely to know that TB is transmitted through coughing. Over half of respondents (57%) mentioned other ways of TB transmission, including 15% who were not aware that it can be transmitted through the air when coughing. Almost one in eight women (12%) had no knowledge about how TB can spread. A substantial proportion of women had been exposed to TB either

from a family member who has had TB (9%) or from frequent contact with someone who has had TB (12%) (Table 9.5.1, left panel). Residents of Kvemo-Kartli (17%) and Kakheti (15%), women with the lowest education (17%), and minority women (23%) were the most likely to report they have been exposed to TB in their households.

When asked their knowledge of specific symptoms of TB, most women knew of prolonged and sever coughing (71%); fewer women were aware of fever (28%), blood in sputum (27%), weight loss (24%) and others (Table 9.5.2). Knowledge of various symptoms was consistently lower in rural parts of the country than in urban areas. Knowledge generally increased with age and education.

Despite the nearly universal awareness of TB, only three-quarters (75%) of women were aware that TB can be completely cured (Table 9.5.3). Women with technicum or university/ postgraduate education (83% and 85%, respectively), those who were ages 30 to 44 years (83%), those who were employed (87%), or were residing in households with the wealthiest quintiles (85%) most frequently were aware that TB was curable. When asked the most appropriate treatment for TB-infected people, the vast majority (82%) said they should be hospitalized, 14% said they should be hospitalized initially and then treated at home, and 2% said they should be treated entirely at home. These preceptions were fairly similar across demographic groups.



9.6 Cigarette Smoking

Tobacco contains potent human carcinogens that have been shown to be related to many cancers, including those of the respiratory and digestive tracts, bladder, cervix and kidney. Worldwide, approximately 5 million deaths are attributable to tobacco use; a number expected to double by 2020 (WHO, 2003). Tobacco smoking accounts for an estimated 22% of cancer deaths per year, including 70% of lung cancer deaths. Aside from cancer, smoking can also be linked to a variety of other health issues such as atherosclerosis, asthma, emphysema, pneumonia, and osteoporosis. Maternal smoking has been linked to low birth-weight babies, pre-term deliveries, miscarriages, sudden infant death syndrome, and infant respiratory problems (DiFranza and Lew, 1996). Several questions were posed to women to assess their cigarette-smoking status. It was determined that only a very small percentage of women aged 15-44 were current tobacco smokers (6%) (Table 9.6.1). Five percent of them were daily smokers and 1% were occasional smokers. Not only did 95% of women indicate that they were not current smokers, 92% stated that they had never smoked. There was a higher proportion of current smokers among the young women in Tbilisi (13%) and a very low proportion among rural young women (2%). In rural areas, a full 98% of young women had never smoked at all.

Across all age groups, reports of ever, current and past smoking were low with only 8% of women having ever smoked, 6% being current smokers and 2% past smokers (Table 9.6.2). Increased prevalence of smoking was correlated with age up to 34; however, women in the 35-39 and 40–44 year age group had similar smoking experience as women aged 30–34 (Figure 9.6).



As with young women, there was a higher prevalence of smoking among women of all ages in urban areas. Almost a tenth (9%) of urban women reported being current smokers, 13% of Tbilisi women in particular, compared to only 2% of women in rural areas.

For individuals who do not use tobacco themselves, there are still the risks associated with second hand smoke (SHS). There is no safe level of exposure to SHS and it can still cause lung cancer in nonsmokers. It has also been associated with heart disease in adults and sudden infant death syndrome, ear infections, and asthma attacks in children (US DHHS, 2006; US DHHS 2010). A recent study showed that worldwide, over 600,000 deaths each year are attributable to SHS, 165,000 of which are children, (Öberg et al., 2011). It also found that Eastern Europe is one of the regions with the highest exposures to SHS, and the Georgia RHS 2010 confirms those high numbers. Although the majority of women surveyed did not smoke, one in two reported high levels of current (in the past 30 days) SHS both at home and at work. The level of SHS in the home was high for everyone, reported by 52% of women aged 15-44 and 50% of non-smokers (Table 9.6.3).

Georgia has taken steps to combat second hand smoke, by developing and recently updating national tobacco control legislation, and by signing on to the WHO Framework Convention on Tobacco Control (FCTC) in 2006 (WHO, 2003).

The WHO FCTC calls for the protection of all people from exposure to tobacco smoke and asserts the importance of demand reduction strategies as well as supply issues.

9.7 Alcohol Use

As a result of gender differences in absorption and metabolism of alcohol, women achieve higher concentrations of alcohol in the blood and become more impaired than men after drinking equivalent amounts of alcohol, making them more vulnerable to alcohol's long term health effects.

Heavy drinking is associated with a number of chronic health conditions, including liver disease, cancer, cardiovascular disease, and neurological damage, as well as a variety of psychiatric problems. Binge drinking in particular has been most commonly associated with unintentional injuries, violence. alcohol poisoning, hypertension, myocardial infarction, sexually transmitted diseases, meningitis and poor control of diabetes (Naimi et al., 2003). Alcohol abuse additional pregnant women has among significance because of its potential harm to the No amount of alcohol is safe to drink fetus. during pregnancy, nor is there a safe period during pregnancy for alcohol consumption. The result of doing so could be birth defects (fetal alcohol spectrum disorders), physical and mental developmental problems and even miscarriage, stillbirth, and premature delivery (Wilsnack et al., 1984; Kesmodel et al., 2002).

The Georgia RHS measures alcohol use by asking respondents about the frequency and quantity of their drinking in the past three months. Drinking at least one drink daily or almost every day was considered current drinking; consuming in excess of one drink per day, on average, was considered current frequent drinking; and the consumption of five or more drinks in a row at a given time was defined as episodic heavy drinking or "binge" drinking. Because data are based on self-report, they might be subject to reporting bias, especially among pregnant respondents who may have been aware that alcohol use in pregnancy is discouraged.

On average, 31% of women have ever drunk alcohol and 17% are current drinkers, but only 2% are current frequent drinkers (Table 9.7). Eight percent of women reported binge drinking in the three months preceding the survey. As was the case in the 2005 survey, drinking correlated with age group, with the exception of binge drinking (Figure 9.7). Of note is the relatively higher prevalence of frequent and binge drinking (6% and 14%, respectively) among women who were previously married. Binge drinking in particular was more common among urban women (9%), especially in Tbilisi (12%), and women in the wealthiest quintile (12%). Frequent and binge drinking were rarely reported by Azeri women (0% and 1%, respectively) suggesting that there may be protective factors against alcohol abuse among this population.



Table 9.1.1 Percentage of Women Aged 15–44 Years Who Had a Usual Place of Care and Percentage Distribution by Usual Place for Health Care by Selected Characteristics Reproductive Health Survey: Georgia, 2010

	Had a Us	ual Place	ce						
	of C	Care		Usual Place for	Health Care (Perco	entage D	Istributio	n)	
Characteristic	%	No. of Cases	Raional/ City Hospital	Policlinic/ Women's Consultation Clinic	Primary Health Care/ Family Medicine Center	Other	None	Total	No. of Cases
Total	79.4	6,292	37.9	25.6	14.4	1.4	20.6	100.0	6,292
Residence Urban Rural Region Kakheti Tbilisi Shida Kartti	80.7 77.9 79.7 78.0 86 8	2,975 3,317 498 1,426 392	30.5 46.3 39.4 20.2 60.4	32.9 17.4 20.9 34.8 18 7	16.2 12.4 17.1 21.6 7 7	1.1 1.7 2.4 1.3 0.0	19.3 22.1 20.3 22.0 13.2	100.0 100.0 100.0 100.0 100.0	2,975 3,317 498 1,426 392
Kvemo Karti Samtskhe–Javakheti Adjara Guria Samegrelo	73.7 78.3 75.8 74.4 89.2	546 481 419 401 477	40.0 49.4 37.5 40.0 60.0	23.1 17.9 29.3 26.4 23.9	10.1 10.4 8.5 7.8 3.9	0.4 0.6 0.5 0.2 1.5	26.3 21.7 24.2 25.6 10.8	100.0 100.0 100.0 100.0 100.0	546 481 419 401 477
Imereti Mtskheta–Mtianeti Racha–Svaneti Age Group 15–19	80.2 78.9 84.7 71.0	805 393 454 861	40.2 34.0 62.9 31.0	19.3 23.4 9.4 26.4	17.8 20.5 6.9 12.6	2.9 1.0 5.5 1.0	19.8 21.1 15.3 29.0	100.0 100.0 100.0 100.0	805 393 454 861
20–24 25–29 30–34 35–39 40–44	76.0 81.5 82.4 85.0 82.2	1,099 1,191 1,168 1,051 922	35.2 40.1 42.0 40.1 40.7	26.1 25.6 25.3 25.9 24.0	13.2 14.5 13.6 17.1 16.2	1.5 1.2 1.4 1.8 1.2	24.0 18.5 17.6 15.0 17.8	100.0 100.0 100.0 100.0 100.0	1,099 1,191 1,168 1,051 922
Number of Living Children 0 1 2 3 or more Education	75.0 82.6 82.7 81.4	2,276 1,286 2,069 661	33.8 37.5 42.2 42.9	26.3 27.3 25.2 21.3	13.6 16.3 13.9 15.6	1.2 1.5 1.4 1.5	25.0 17.4 17.3 18.6	100.0 100.0 100.0 100.0	2,276 1,286 2,069 661
Secondary incomplete or less Secondary complete Technicum University/Postgraduate Wealth Quintile	73.1 77.6 82.3 83.1	1,330 1,568 903 2,491	37.4 40.1 45.3 34.4	23.7 24.9 24.8 27.5	11.2 11.4 10.8 19.4	0.9 1.2 1.4 1.8	26.9 22.4 17.7 16.9	100.0 100.0 100.0 100.0	1,330 1,568 903 2,491
Lowest Second Middle Fourth Highest Employment	73.7 78.9 80.7 79.5 81.7	1,093 1,385 1,413 1,037 1,364	47.8 46.6 44.2 31.1 25.5	17.2 18.4 22.0 32.8 33.8	7.3 12.2 13.0 14.6 21.2	1.5 1.7 1.5 0.9 1.3	26.3 21.1 19.3 20.5 18.3	100.0 100.0 100.0 100.0 100.0	1,093 1,385 1,413 1,037 1,364
Working Not working Ethnicity Georgian Other	82.5 78.5 80.8 69.8	1,410 4,882 5,488 804	36.1 38.4 37.7 39.3	25.2 25.8 26.5 20.1	19.1 13.2 15.1 9.7	2.1 1.2 1.5 0.7	17.5 21.5 19.2 30.2	100.0 100.0 100.0 100.0	1,410 4,882 5,488 804
Has Health Insurance Yes No	85.1 77.7	1,548 4,744	35.3 38.7	23.2 26.3	24.2 11.7	2.4 1.1	14.9 22.3	100.0 100.0	1,548 4,744

Table 9.1.2Receipt of Any Medical Care the Last 12 Months and Type of Care by Selected Characteristics
Among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

Characteristic	Any Medical Car Mor	re in the Last 12 hths	ast 12 Type of Medical Care				
Characteristic	%	No. of Cases	Preventive Care	Acute Care	Care for Chronic Conditions	No. of Cases	
Total	36.6	6,292	41.1	50.7	20.0	2,353	
Residence							
Urban	38.7	2,975	42.6	49.4	20.1	1,172	
Rural	34.3	3,317	39.1	52.5	20.0	1,181	
Region							
Kakheti	39.2	498	46.8	46.4	27.0	205	
Tbilisi	40.7	1,426	43.1	51.6	18.0	580	
Shida Kartli	34.9	392	36.7	56.5	19.8	142	
Kvemo Kartli	32.7	546	43.7	48.0	20.1	187	
Samtskhe–Javakheti	30.9	481	34.7	58.3	13.6	159	
Adjara	25.9	419	31.5	47.9	26.7	119	
Guria	33.0	401	57.0	50.3	7.9	139	
Samegrelo	35.0	477	41.3	51.0	16.8	174	
Imereti	43.0	805	39.0	50.9	20.9	352	
Mtskheta–Mtianeti	29.7	393	39.7	44.2	25.6	124	
Racha–Svaneti	38.9	454	30.6	53.4	24.7	172	
Age Group							
15–19	30.6	861	27.1	61.3	16.3	273	
20–24	36.6	1,099	47.8	45.7	14.3	428	
25–29	40.1	1,191	45.8	43.7	18.5	475	
30–34	38.6	1,168	44.7	51.3	17.4	454	
35–39	36.0	1,051	42.4	51.1	25.5	379	
40–44	38.6	922	35.5	54.0	30.0	344	
Number of Living Children							
0	32.6	2,276	32.9	56.0	19.5	776	
1	42.1	1,286	54.5	39.8	16.2	541	
2	39.9	2,069	40.6	53.4	21.2	807	
3 or more	33.1	661	44.0	46.6	27.1	229	
Education		4 000		0	40 -	(07	
Secondary incomplete or less	30.3	1,330	32.9	55.0	19.7	427	
Secondary complete	35.5	1,568	43.0	46.8	21.6	563	
lechnicum	38.8	903	34.6	57.8	23.7	348	
University/Postgraduate	40.2	2,491	45.7	48.8	18.1	1,015	
Wealth Quintile	04.7	1 000	07.0	54 7	00.0	0.07	
Lowest	31.7	1,093	37.6	54.7	23.3	367	
Second	34.0	1,385	42.0	49.5	18.5	483	
Middle	37.7	1,413	37.4	52.1	20.1	547	
Fourth	39.4	1,037	42.7	44.6	23.9	411	
	38.5	1,364	44.0	53.1	16.6	545	
Employment	40.7	1 110	45.0	40.7	40.0	570	
vvorking	40.7	1,410	45.0	46.7	18.3	572	
	35.5	4,002	39.9	52.0	20.5	۱,/۵۱	
	27.4	E 400		E0 4	10.0	2,000	
Georgian	37.4	5,488	41.5	50.4	19.9	2,092	
	31.2	804	37.8	53.9	20.9	201	
Has Health Insurance	40.7	1 5 4 9	40.0	FO O	10.0	700	
	40.7	1,548	42.0	52.2	19.0	1 30	
INO	33.Z	4,744	40.7	50.1	20.2	1,017	

Table 9.1.3Delayed Medical Care and Main Reason for Delay in the Last 12 Months
by Selected Characteristics among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

Characteristic	Delayed M the Last	the Last 12 Months Main Reason to Delay Care			Delayed Medical Care in the Last 12 Months		Total	No. of Cases
	%	No. of Cases	Cost Related	Other Reasons	Does not Remember	Total		
Total	25.2	6,292	82.0	17.8	0.2	100.0	1,672	
Residence								
Urban	22.3	2,975	75.5	24.2	0.4	100.0	682	
Rural	28.6	3,317	87.7	12.2	0.1	100.0	990	
Region								
Kakheti	21.2	498	84.3	15.7	0.0	100.0	109	
Tbilisi	23.4	1,426	67.6	31.7	0.7	100.0	339	
Shida Kartli	29.6	392	94.7	5.3	0.0	100.0	118	
Kvemo Kartli	30.1	546	85.3	14.7	0.0	100.0	168	
Samtskhe–Javakheti	25.5	481	89.0	10.4	0.6	100.0	130	
Adjara	22.6	419	89.0	11.0	0.0	100.0	93	
Guria	24.8	401	87.1	12.9	0.0	100.0	100	
Samegrelo	26.9	477	87.5	12.5	0.0	100.0	135	
Imereti	24.0	805	84.9	15.1	0.0	100.0	193	
Mtskheta–Mtianeti	35.4	393	82.3	17.2	0.5	100.0	140	
Racha–Svaneti	31.4	454	79.1	20.9	0.0	100.0	147	
Age Group								
15–19	10.1	861	80.6	19.4	0.0	100.0	88	
20-24	16.8	1 099	77 1	22.9	0.0	100.0	186	
25-29	22.0	1 191	80.0	19.8	0.0	100.0	272	
30-34	32.1	1 168	82.5	17.2	0.3	100.0	383	
35-39	33.2	1,100	83.3	16.0	0.7	100.0	352	
40-44	42.3	922	84.5	15.5	0.0	100.0	391	
Number of Living Children	42.0	522	04.0	10.0	0.0	100.0	001	
	16.4	2 276	76.9	23.0	0.1	100.0	391	
1	23.8	1 286	81.1	18.8	0.1	100.0	313	
2	33.2	2 069	84.0	15.6	0.1	100.0	701	
3 or more	40.8	661	86.6	13.0	0.0	100.0	267	
Education	40.0	001	00.0	10.4	•	100.0	201	
Secondary incomplete or less	25.4	1,330	91.1	8.9	0.0	100.0	351	
Secondary complete	26.4	1.568	88.1	11.8	0.1	100.0	437	
Technicum	31.7	903	86.9	13.1	0.0	100.0	294	
University/Postgraduate	22.2	2,491	69.1	30.3	0.6	100.0	590	
Wealth quintile		_,			0.0			
l owest	33.0	1.093	90.1	99	0.0	100.0	373	
Second	27.7	1,385	88.6	11.4	0.0	100.0	400	
Middle	26.6	1 413	86.9	12.9	0.1	100.0	382	
Fourth	22.4	1,110	80.4	19.2	0.4	100.0	237	
Highest	19.9	1,364	63.2	36.1	0.7	100.0	280	
Employment		.,	00.2		•			
Working	26.3	1 4 1 0	65.2	34.3	0.5	100.0	386	
Not working	24.9	4 882	86.8	13.1	0.0	100.0	1,286	
Ethnicity	24.0	4,002	00.0	10.1	0.1	100.0	1,200	
Georgian	25.1	5 488	80.6	19.2	0.2	100.0	1 462	
Other	25.8	804	91.0	8.7	0.2	100.0	210	
Has Health Insurance	20.0		01.0	0.1	0.2	100.0	210	
Yes	29.0	1.548	69.3	30.4	0.2	100.0	462	
No	24.2	4 744	86.3	13.5	0.2	100.0	1 210	
	_ T.2	1,1 17	00.0	10.0	0.2		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	

Table 9.1.4Percentage of Women Aged 15–44 Years with Health Insurance Coverage at the Time
of the Interview and Main Sources of Health Insurance by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

	Has Health Insurance		Sourc	e of Health Insur		No. of	
Characteristic	%	No. of Cases	Government- funded	Private (Through Employer)	Private (Self- funded)	Total	Cases *
Total	22.1	6,292	49.1	32.6	18.3	100.0	1,542
Residence (urban/rural)							
Urban	21.4	2,975	28.8	42.1	29.0	100.0	659
Rural	23.0	3,317	70.4	22.7	6.9	100.0	883
Region							
Kakheti	20.1	498	69.3	19.7	11.0	100.0	110
Tbilisi	23.3	1,426	19.7	45.8	34.5	100.0	333
Shida Kartli	24.9	392	71.4	19.8	8.7	100.0	101
Kvemo Kartli	14.1	546	49.0	22.9	28.1	100.0	77
Samtskhe-Javakheti	19.1	481	34.1	61.8	4.1	100.0	98
Adjara	25.4	419	55.9	26.6	17.5	100.0	105
Guria	26.6	401	75.2	18.0	6.8	100.0	109
Samegrelo	21.2	477	66.7	26.2	7.1	100.0	98
Imereti	21.1	805	56.0	34.4	9.6	100.0	181
Mtskheta-Mtianeti	33.7	393	74.6	16.9	8.5	100.0	132
Racha-Svaneti	42.1	454	81.4	15.7	3.0	100.0	198
Age Group							
15–19	16.8	861	73.8	13.1	13.1	100.0	150
20–24	18.2	1,099	51.1	30.1	18.9	100.0	212
25–29	23.2	1,191	47.3	34.1	18.6	100.0	307
30–34	22.5	1,168	45.9	36.1	18.0	100.0	298
35–39	24.5	1,051	43.7	37.1	19.3	100.0	298
40–44	29.7	922	39.5	40.0	20.4	100.0	277
Number of Living Children	10.0		- / -			100.0	1=0
0	18.8	2,276	51.6	27.7	20.7	100.0	472
1	23.4	1,286	40.4	37.9	21.7	100.0	316
2	24.0	2,069	47.3	35.9	16.8	100.0	547
3 or more	27.9	661	60.0	29.8	10.3	100.0	207
Education							
Secondary incomplete or less	19.3	1,330	81.9	9.5	8.6	100.0	294
Secondary complete	18.2	1,568	80.6	10.4	9.0	100.0	333
	19.8	903	56.3	29.2	14.5	100.0	204
University/Postgraduate	27.0	2,491	20.5	52.4	27.1	100.0	711
wealth quintile	07.7	1 000	01.0	5.0	2.4	100.0	245
Lowest	21.1	1,093	91.0	5.0	3.4	100.0	345
Second	22.7	1,300	67.2 54.0	20.0 24 E	1.Z	100.0	300
	20.0	1,413	54.0 26.7	34.5	11.5	100.0	321
Foultin Highogt	10.7	1,03/	30.7	51.4 51.5	20.9	100.0	001
Employment	24.5	1,304	12.0	51.5	30.0	100.0	554
Working	38.6	1 / 10	12 /	50.2	27 4	100.0	571
Notworking	30.0 17.7	1,410	70.3	16.0	27.4 12.8	100.0	071
Ethnicity	17.7	4,002	70.5	10.9	12.0	100.0	<i>31</i> 1
Georgian	23.9	5 488	48 5	32.8	18 7	100.0	1 442
Other	10.6	804	58.0	29.7	12.3	100.0	100

* Excludes 6 women who did not know the type of health insurance coverage.

Table 9.2Time of Last Routine Gynecologic Exam by Selected CharacteristicsAmong Women Aged 15–44 Years Who Had Ever Had Sexual IntercourseReproductive Health Survey: Georgia, 2010

	Timing of Last Routine Gynecologic Exam (Percentage Distribution)					No. of	
Characteristic	During the Past 12 Months	Within 1–3 Years	More than 3 Years Ago	Never Had	Total	Cases*	
Total	24.6	26.1	20.1	29.3	100.0	4,473	
Residence							
Urban	28.2	27.6	19.8	24.5	100.0	2,039	
Rural	20.8	24.5	20.4	34.3	100.0	2,434	
Region	40.0	00.0	oo -		400.0	077	
Kakhet	19.8	29.6	20.7	29.8	100.0	377	
	30.8	28.3	19.6	21.4	100.0	941	
Shida Karti	23.1	24.6	26.0	26.3	100.0	285	
Kvemo Kartli	23.7	21.9	16.8	37.7	100.0	416	
Samtskhe-Javakheti	21.8	19.9	18.4	40.0	100.0	349	
Adjara	20.7	30.4	16.6	32.2	100.0	314	
Guria	16.9	24.4	19.0	39.8	100.0	288	
Samegrelo	21.9	24.9	22.4	30.9	100.0	325	
Imereti	26.8	24.4	22.1	26.8	100.0	584	
Mtskheta-Mtianeti	15.6	26.7	20.0	37.8	100.0	290	
Racha-Svaneti	20.6	22.1	22.3	35.0	100.0	304	
Age Group							
15–24	31.8	19.6	3.2	45.3	100.0	770	
25–29	28.5	27.4	10.5	33.6	100.0	908	
30–34	25.5	27.1	18.5	29.0	100.0	1,027	
35–39	20.7	29.4	28.4	21.5	100.0	941	
40–44	17.2	26.0	37.5	19.3	100.0	827	
Number of Living Children							
0	38.3	13.2	9.9	38.6	100.0	477	
1	26.0	26.1	15.7	32.1	100.0	1,283	
2	22.9	28.4	22.5	26.2	100.0	2,057	
3 or more	17.1	28.1	28.2	26.6	100.0	656	
Education							
Secondary incomplete or less	18.3	25.3	19.6	36.9	100.0	794	
Secondary complete	22.6	23.2	19.3	34.9	100.0	1,192	
Technicum	24.9	26.3	23.3	25.4	100.0	738	
University/Postgraduate	28.5	28.2	19.6	23.8	100.0	1,749	
Wealth Quintile	47.0	04.0	10 7	<u> </u>	100.0	700	
Lowest	17.6	24.2	19.7	38.5	100.0	786	
Second	21.4	24.1	21.1	33.4	100.0	1,025	
Middle	23.5	24.0	20.7	31.8	100.0	1,013	
Fourth	28.4	27.7	18.4	25.5	100.0	706	
Highest	29.6	29.4	20.1	20.8	100.0	943	
Ethnicity							
Georgian	24.9	26.2	21.1	27.8	100.0	3,847	
Other	22.5	25.3	14.2	38.0	100.0	626	
Current Use of							
Contraception							
Modern	25.3	31.5	20.4	22.8	100.0	1,429	
Traditional	20.0	26.9	21.2	31.9	100.0	797	
No method	25.6	22.4	19.5	32.4	100.0	2,247	

* Excludes 20 women who did not remember when they had the last routine gynecologic examination.

Table 9.3.1Frequency of Breast Self-Examination (BSE) by Selected Characteristics
Among Women Aged 15–44 Years Who Had Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

	Frequ		No. of			
Characteristic	Every Month	Every 2–5 Months	Every 6–12 Months or Less	Never Had	Total	Cases
Total	17.1	12.4	12.4	58.1	100.0	4,493
Residence						
Urban	19.9	14 1	14 4	51.6	100.0	2 048
Rural	14.3	10.6	10.3	64.9	100.0	2,040
Region	11.0	10.0	10.0	0110	100.0	2,110
Kakheti	17.9	13.8	12.9	55.4	100.0	380
Tbilisi	22.8	13.4	14.8	49.0	100.0	943
Shida Kartli	15.1	14.8	10.9	59.2	100.0	285
Kvemo Kartli	13.4	8.4	12.0	66.1	100.0	420
Samtskhe–Javakheti	7.4	5.7	11.7	75.2	100.0	350
Adjara	9.6	11.7	11.7	67.0	100.0	317
Guria	15.6	10.2	8.1	66.2	100.0	290
Samegrelo	15.8	15.3	9.3	59.7	100.0	326
Imereti	20.4	13.3	11.8	54.5	100.0	586
Mtskheta-Mtianeti	18.8	11.9	16.0	53.3	100.0	292
Racha–Svaneti	11.5	14.3	10.3	63.9	100.0	304
Age Group						
15–19	10.1	2.2	3.5	84.2	100.0	130
20–24	9.4	8.9	8.7	73.0	100.0	642
25–29	12.9	11.3	10.7	65.1	100.0	910
30–34	17.7	10.8	13.0	58.5	100.0	1,036
35–39	20.0	15.9	15.7	48.4	100.0	946
40–44	24.4	15.5	14.0	46.1	100.0	829
Number of Living Children						
0	12.5	7.9	6.3	73.3	100.0	477
1	17.3	13.0	11.7	58.1	100.0	1,286
2	18.1	13.1	13.8	55.1	100.0	2,069
3 or more	17.2	12.4	14.1	56.3	100.0	661
Education					100.0	
Secondary incomplete or less	8.5	7.5	7.6	76.4	100.0	802
Secondary complete	13.4	11.7	10.9	63.9	100.0	1,196
l echnicum	19.9	13.8	15.4	50.9	100.0	/40 4 755
University/Postgraduate	22.3	14.4	14.4	49.0	100.0	1,755
	40 F	0.0	0.0	<u> </u>	100.0	700
Lowest	12.5	9.0	9.6	00.3	100.0	1 0 2 2
Middle	19.6	10.9	9.9	07.3 EG 0	100.0	1,032
Fourth	17.7	11.0	13.4	58.0	100.0	710
Highest	22.5	16.1	15.4	16 1	100.0	0/5
Employment	22.5	10.1	15.5	40.1	100.0	343
Working	24.8	17 4	14.6	43.2	100.0	1 013
Notworking	14.9	10.9	11.8	62.4	100.0	3 480
Ethnicity	11.0	10.0	11.0	02.1	100.0	0,100
Georgian	18.8	13.3	13.0	55.0	100.0	3.859
Other	7.3	7.0	9.1	76.6	100.0	634
Current Use of Contraception	-					
Modern	19.3	14.7	14.8	51.3	100.0	1,436
Traditional	18.9	12.8	10.2	58.2	100.0	798
No method	15.2	10.8	11.7	62.4	100.0	2.259
Ever Had a Routine						,
Gynecologic Exam						
Yes	19.5	14.2	13.8	52.5	100.0	3,099
No	11.3	8.0	9.1	71.6	100.0	1,394
Table 9.3.2Prevalence of BSE, CBE and Mammography Screening by Selected Characteristics
Among All Women and Sexually Experienced Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

	Ever	Had BSE	Ever	Had CBE	Ever Had	l a Mamogram	Numbe	r of Cases
Characteristic	All	Sexually	All	Sexually	All	Sexually	All	Sexually
	Women	Experienced	Women	Experienced	Women	Experienced	Women	Experienced
Total	32.1	41.9	13.1	17.7	4.9	6.8	6.292	4.493
		-	-		-		-, -	,
Residence		<i>ia i</i>						
Urban	36.2	48.4	15.8	21.9	6.9	9.7	2,975	2,048
Rural	27.5	35.1	10.1	13.4	2.8	3.8	3,317	2,445
Region								
Kakheti	35.0	44.6	13.4	18.3	4.1	5.9	498	380
	37.0	51.0	19.0	26.7	8.8	12.6	1,426	943
Shida Kartli	31.8	40.8	9.9	13.9	3.2	4.7	392	285
Kvemo Kartil	27.3	33.9	11.3	14.4	4.6	6.0	540	420
	17.Z	24.8	0.5	10.0	2.2	3.3	481	350
Adjara	25.0	33.0	9.4	13.5	2.8	4.1	419	317
Guila	29.0	33.0 40.2	0.4	11.4	3.Z 2.7	4.2	401	290
Samegreio	29.9	40.5	0.1	10.1	2.1	J.O 4 0	4//	520
Makhata Mitanati	30.4	40.0	10.0	17.9	3.0	4.0 6.4	202	200
Rocho Svonoti	34.4 20.2	40.7	12.4	10.9	4.0	0.4	393	292
	29.5	30.1	10.0	14.0	2.1	4.0	404	504
Age Gloup	5.4	15.8	3.0	7 0	0.4	0.0	861	130
20.24	10.4	27.0	7.6	11.2	17	0.0	1 000	642
20-24	31.6	27.0	10.5	11.2	1.7	2.0	1,099	042
20-20	40.2	11 5	16.2	17.7	6.5	5.0 6.9	1,151	1 036
35-30	51.0	51.6	22.3	23.3	0.0	0.5 Q /	1,100	946
40-44	52.6	53.9	22.5	23.5	10.2	5.4 11 0	922	829
Number of Living Children	02.0	00.0	22.4	20.1	10.2	11.0	522	020
0	15.6	26.7	58	13.4	1.8	4.3	2,276	477
1	41.9	41.9	18.9	18.9	7.1	7.1	1,286	1,286
2	44.9	44.9	18.8	18.8	8.1	8.1	2.069	2.069
3 or more	43.7	43.7	15.3	15.3	4.2	4.2	661	661
Education								
Secondary incomplete or less	14.2	23.6	5.7	8.7	1.9	3.2	1,330	802
Secondary complete	28.0	36.1	9.1	11.9	2.7	3.7	1.568	1,196
Technicum	41.8	49.1	17.4	20.6	6.5	7.9	903	740
University/Postgraduate	41.7	51.0	18.4	24.4	7.5	10.0	2.491	1.755
Wealth Quintile							,	
Lowest	24.5	31.7	7.8	10.5	1.9	2.6	1,093	788
Second	25.5	32.7	9.4	12.1	3.1	4.3	1,385	1,032
Middle	33.5	43.8	11.6	15.9	3.0	4.4	1,413	1,018
Fourth	31.0	42.0	12.6	18.0	4.7	6.6	1,037	710
Highest	40.9	53.9	20.6	28.1	9.8	13.6	1,364	945
Ethnicity								
Georgian	34.2	45.0	14.0	19.1	5.4	7.5	5,488	3,859
Other	18.1	23.4	7.3	9.8	2.0	2.7	804	634
Current Use of Contraception								
Modern	48.7	48.7	20.0	20.0	8.3	8.3	1,436	1,436
Traditional	41.8	41.8	14.3	14.3	6.2	6.2	798	798
No method	25.4	37.6	10.8	17.4	3.7	6.1	4,058	2,259
Ever Had a Routine								
Gynecologic Exam	45.0	47 -	04 7	00.0	0.4		0.000	0.000
Yes	45.9	47.5	21.7	22.0	8.4	8.6	3,322	3,099
NO	18.0	28.4	4.3	7.4	1.4	2.3	2,970	1,394

Table 9.3.3Most Commonly Cited Reasons for Never Having Had a Mammography by Selected
Among Women Aged 15–44 Years Who Had Ever Had a Mammography
Reproductive Health Survey: Georgia, 2010

		Main Reason fo	r Never Having Had a	Mammography (Per	centage Distr	ibution)	
Characteristic	Doctor Never Recommended it	Never Heard of Such Exam	Did Not Think it Was Necessary/Too Young	Cost/No Insurance/Not Covered by Insurance	Other*	Total	No. of Cases
Total	33.4	31.7	29.8	3.0	2.1	100.0	5,984
Residence							
Urban	35.0	24.6	35.8	2.9	1.8	100.0	2,768
Rural	31.6	39.5	23.4	3.2	2.4	100.0	3,216
Region							
Kakheti	37.6	38.3	20.5	0.8	2.8	100.0	475
Tbilisi	34.5	21.9	39.0	2.2	2.4	100.0	1,300
Shida Kartli	33.0	36.7	25.1	4.1	1.2	100.0	381
Kvemo Kartli	31.9	35.9	25.6	3.7	2.8	100.0	519
Samtskhe-Javakheti	18.7	56.3	24.1	0.5	0.3	100.0	470
Adjara	30.5	29.6	29.3	9.3	1.3	100.0	404
Guria	23.6	26.9	39.0	6.2	4.3	100.0	389
Samegrelo	30.1	45.9	22.1	1.0	0.9	100.0	462
Imereti	41.4	25.8	29.1	1.6	2.1	100.0	772
Mtskheta-Mtianeti	28.7	24.8	36.3	5.6	4.6	100.0	372
Racha-Svaneti	33.6	44.2	19.7	1.3	1.3	100.0	440
Age Group							
15-24	19.4	45.8	33.1	0.6	1.1	100.0	1,938
25-34	39.0	25.1	31.4	2.4	2.1	100.0	2,256
35-44	45.6	20.5	23.6	6.9	3.4	100.0	1,790
Number of Living Children							
0	19.1	42.5	36.4	0.8	1.2	100.0	2,229
1	43.6	22.7	28.0	3.7	2.0	100.0	1,203
2	45.0	22.8	24.7	4.7	2.7	100.0	1,919
3 or more	41.5	28.1	19.9	6.4	4.1	100.0	633
Education	/						
Secondary incomplete or less	20.4	51.5	23.9	2.5	1.6	100.0	1,303
Secondary complete	31.0	36.3	26.8	4.1	1.8	100.0	1,525
	39.6	21.8	31.5	5.5	1.6	100.0	847
University/Postgraduate	40.7	20.0	34.9	1.7	2.7	100.0	2,309
wealth Quintile	00.5	45.0	00.0	2.4	0.0	100.0	4 070
Lowest	28.5	45.8	20.0	3.4	2.3	100.0	1,072
Second	33.2	38.3	24.6	2.3	1.6	100.0	1,342
	32.2	35.9	25.2	4.4	2.3	100.0	1,360
Fourm	35.4	25.5	34.8	2.5	1.8	100.0	983
	30.0	10.7	40.3	2.5	2.4	100.0	1,227
Coordian	24.0	00 E	24 E	2.4	0.1	100.0	E 107
Othor	34.8	20.0	01.5 10.2	3. I 0. 0	2.1	100.0	0,197 707
Current lies of Controportion	24.1	5Z.Z	19.5	2.3	2.2	100.0	101
Modern	10 1	19.0	07.0	2.0	2.0	100.0	1 202
Traditional	40.1	10.0	21.2	3.9 3.7	2.9	100.0	1,323
No method	40.0	20.0	27.0	3.7	1.9	100.0	3 000
	20.0	50.5	50.9	2.0	1.9	100.0	5,909

* Includes negligence, not knowing where the test is offered and fear of results.

Table 9.4.1History of Cervical Cancer Screening by Selected CharacteristicsWomen Aged 15–44 Years Who Have Ever Had Sexual IntercourseReproductive Health Survey: Georgia, 2010

	Timin	ig of Last Cervic	al Cancer Screeni	ing (Percentage	Distribution)	
Characteristic	During the Past	Within 1–3	More than 3	Never Had	Total	No. of
	12 Months	Years	Years Ago	Nevernau	Total	Cases*
Total	5.0	4.0	3.1	87.8	100.0	4,491
						, -
Residence						
Urban	7.1	5.1	3.1	84.8	100.0	2,047
Rural	2.9	3.0	3.2	91.0	100.0	2,444
Region						
Kakheti	3.9	3.4	3.6	89.1	100.0	379
Tbilisi	10.0	7.0	3.3	79.7	100.0	942
Shida Kartli	3.0	1.5	4.4	91.1	100.0	285
Kvemo Kartli	3.2	3.4	3.0	90.4	100.0	420
Samtskhe–Javakheti	1.9	1.4	2.6	94.0	100.0	350
Adjara	4.3	4.6	2.8	88.3	100.0	317
Guria	4.8	5.4	4.5	85.3	100.0	290
Samegrelo	1.6	0.8	0.0	97.5	100.0	326
Imereti	3.7	3.4	4.2	88.7	100.0	586
Mtskheta–Mtianeti	4.4	2.5	1.1	92.0	100.0	292
Racha–Svaneti	2.3	3.7	2.9	91.1	100.0	304
Age Group						
15–24	6.5	3.1	0.8	89.5	100.0	772
25–29	4.7	4.4	2.9	88.1	100.0	910
30–34	3.9	3.5	3.2	89.4	100.0	1.035
35–39	54	4.1	42	86.2	100.0	946
40-44	4.8	5.0	4.2	86.0	100.0	828
Number of Living Children						
0	65	3.3	1.9	88.2	100.0	477
1	6.0	4.3	2.6	87.1	100.0	1 285
2	4.8	4.1	3.5	87.6	100.0	2,069
- 3 or more	29	3.6	3.8	89.7	100.0	660
Education	2.0	0.0	0.0	00.1	100.0	000
Secondary incomplete or less	20	1.3	17	95.0	100.0	802
Secondary complete	3.6	2.4	2.6	91.4	100.0	1 196
Technicum	5.6	49	3.5	86.0	100.0	739
University/Postgraduate	7 1	6.0	4.0	83.0	100.0	1 754
Wealth Quintile		010				.,. • ·
Lowest	12	17	28	94 4	100.0	788
Second	3.7	2.8	3.8	89.6	100.0	1 032
Middle	3.0	3.4	24	91.2	100.0	1,002
Fourth	5.0	4 Q	2.4	87.6	100.0	710
Highest	10.0	63	4 1	79.6	100.0	944
Fthnicity	10.0	0.0	7.1	70.0	100.0	011
Georgian	5.6	<i>A</i> 1	35	86.8	100.0	3 857
Other	1.0	3.5	0.8	00.0	100.0	634
Current Use of Contracention	1.5	0.0	0.0	33.3	100.0	004
Modorn	5.0	11	2.2	97 5	100.0	1 126
Traditional	3.0	4.1	0.0 2 0	80.0	100.0	700
No mothod	5.4	3.9	2.0	09.9	100.0	190
	5.0	4.0	3.1	07.4	100.0	2,201
	6.2	4.0	26	95.0	100.0	2 007
	0.3	4.9	3.0	03.2	100.0	3,097
INU	1.9	2.0	1.9	94.1	100.0	1,394

* Excludes 2 women who did not remember if they had cervical cancer screening.

Table 9.4.2Receipt of Cervical Cancer Screening in the Last 3 Years by Selected Characteristics
and Age among Women Aged 15–44 Years Who Have Ever Had Sexual Intercourse
Reproductive Health Survey: Georgia, 2010

	Had Cervical	Cancer Screening in the	Last 3 Years	
Characteristic	15–24	25–34	35–44	No. of Cases*
Total	9.6	8.1	9.7	4,491
Residence				
Urban	10.4	11.0	14.0	2,047
Rural	8.8	5.2	5.1	2,444
Region				
Kakheti	7.7	5.7	8.4	379
Tbilisi	11.1	14.8	21.6	942
Shida Kartli	7.1	5.2	2.7	285
Kvemo Kartli	9.4	7.1	4.9	420
Samtskhe–Javakheti	2.3	2.9	4.4	350
Adjara	16.7	4.2	9.3	317
Guria	15.7	11.2	7.1	290
Samegrelo	0.0	3.3	2.2	326
Imereti	10.7	7.7	5.1	586
Mtskheta–Mtianeti	6.6	5.5	8.3	292
Racha–Svaneti	12.8	7.1	3.4	304
Education				
Secondary incomplete or less	3.7	1.4	5.0	802
Secondary complete	8.2	6.1	3.9	1,196
Technicum	17.9	10.4	8.8	739
University/Postgraduate	12.7	11.4	14.8	1,754
Wealth Quintile				
Lowest	4.0	3.7	1.7	788
Second	12.5	4.0	5.9	1,032
Middle	3.9	6.9	6.9	1,017
Fourth	8.5	10.8	10.7	710
Highest	15.9	13.3	19.2	944
Ethnicity				
Georgian	10.6	8.6	10.3	3,857
Other	5.7	5.5	4.8	634
Current Use of Contraception				
Modern	11.0	7.5	10.4	1,436
Traditional	4.3	6.3	9.0	798
No method	9.9	9.3	9.6	2,257
Ever Had a Routine				
Gynecologic Exam				
Yes	12.5	10.4	11.4	3,097
No	6.2	3.1	3.0	1,394

* Excludes 2 women who did not remember if they had cervical cancer screening.

Table 9.4.3Awareness of Human Papilloma Virus (HPV) and HPV Vaccine and Interest
in the HPV Vaccine by Selected Characteristics Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

	Awarene	esss	Interest	
Characteristic	Of the Human Papilloma Virus (HPV)	Of the HPV Vacine	In Getting the HPV Vacine	No. of Cases
Total	20.8	18.3	29.3	6,292
				,
Residence				
Urban	28.3	24.1	29.7	2,975
Rural	12.3	11.8	28.8	3,317
Region				
Kakheti	19.1	19.1	30.9	498
	34.3	28.8	30.3	1,426
Shida Karti	16.4	11.4	29.4	392
Kvemo Karti	15.0	12.6	30.4 12 F	546
Samiskne-Javaknet	7.6	8./	13.5	481
Adjara	14.9	17.4	34.8 24.0	419
Guria	13.0	11.4	34.0	401
	10.3	6.9	22.7	4//
Imereti Malakata Mianati	20.3	18.2	30.9	805
Miskneta-Mitanet	18.4	18.4	20.0	393
	9.8	C.11	20.4	454
Age Group	5 7	0 0	21.0	961
10-19	5.7	0.9	20.7	1 000
20-24	21.5	14.7	30.7 20.7	1,099
20-29	21.5	21.0	29.7	1,191
25 20	21.1	21.0	29.1	1,100
35-39 40 44	20.0	25.0	20.4	1,001
40-44 Number of Living Children	29.9	24.0	23.0	922
	15.0	15.2	29.5	2 276
1	26.8	22.8	20.0	1 286
2	24.8	19.9	28.3	2 069
3 or more	24.0	18.4	26.0	661
Education		10.1	20.1	001
Secondary incomplete or less	47	67	27 5	1 330
Secondary complete	12.0	12.1	25.3	1,568
Technicum	26.5	20.2	28.1	903
University/Postgraduate	33.6	28.3	33.2	2.491
Wealth guintile				, -
Lowest	7.6	7.8	24.2	1,093
Second	13.1	11.5	28.1	1,385
Middle	14.1	13.9	29.8	1,413
Fourth	21.7	19.3	31.4	1,037
Highest	38.9	32.5	31.1	1,364
Ethnicity				
Georgian	22.8	20.1	30.7	5,488
Other	7.2	6.9	19.8	804
Current Use of Contraception				
Modern	30.4	24.5	32.3	1,436
Traditional	22.4	18.5	29.6	798
No method	17.5	16.4	28.3	4,058
Ever Had a Routine				
Gynecologic Exam				
Yes	27.7	21.7	30.2	3,322
No	13.8	14.9	28.3	2,970

Table 9.5.1Knowledge of Tuberculosis (TB) and the Way TB Is Transmitted and Exposure to TBBy Selected Characteristics among All Women Aged 15–44 YearsReproductive Health Survey: Georgia, 2010

	Have Heard of TB	Know	ledge of Transmi	ssion	Exposi	ure to TB	
Characteristic	%	Through the Air When Coughing	Other Way	Does not Know How TB Spreads	From a Family Member Who Has Had TB [*]	From Frequent Contact with Someone Who Has Had TB	No. of Cases
Total	94.5	67.3	56.6	12.1	8.7	11.8	6,292
Residence							
Urban	96.9	74.3	59.2	7.9	6.0	12.3	2,975
Rural	91.7	59.4	53.7	16.8	11.7	11.2	3,317
Region							
Kakheti	87.0	61.2	46.5	22.0	15.3	12.2	498
Tbilisi	97.1	77.3	63.3	6.9	5.8	13.1	1,426
Shida Kartli	97.0	71.6	65.1	5.7	8.1	7.7	392
Kvemo Kartli	86.1	57.6	45.3	24.6	17.7	11.4	546
Samtskhe–Javakheti	90.2	44.9	39.3	23.6	12.1	9.0	481
Adjara	98.6	73.9	43.9	4.6	4.1	14.9	419
Guria	97.2	72.4	62.4	7.2	6.6	16.0	401
Samegrelo	96.0	74.3	72.6	6.1	6.7	9.4	477
Imereti	95.6	57.1	57.9	15.3	7.5	10.4	805
Mtskheta–Mtianeti	97.5	65.8	58.7	10.3	7.6	12.9	393
Racha–Svaneti	96.4	63.8	67.9	10.1	6.9	12.3	454
Age Group							
15–19	89.2	52.9	40.0	23.5	13.3	8.3	861
20–24	92.4	61.7	51.4	16.1	10.7	10.4	1,099
25–29	95.5	70.2	59.1	10.1	6.9	13.9	1,191
30–34	96.6	72.4	63.6	6.9	6.1	11.6	1,168
35–39	97.4	75.0	64.0	7.3	5.9	13.1	1,051
40–44	97.1	75.0	65.3	6.0	8.3	14.2	922
Number of Living Children	92.7	63.4	51.1		9.7	11.1	2,276
0				15.6			
1	95.5	71.2	62.6	9.6	8.4	12.8	1,286
2	96.4	69.8	60.2	8.9	6.7	11.9	2,069
3 or more	94.3	68.6	57.4	11.6	10.8	12.4	661
Education							
Secondary incomplete or less	86.3	49.6	41.0	25.1	17.1	7.6	1,330
Secondary complete	94.9	62.2	54.0	13.6	8.5	11.7	1,568
Technicum	97.6	75.8	65.5	5.6	6.4	13.0	903
University/Postgraduate	97.9	77.9	64.2	5.8	4.7	13.8	2,491
Wealth Quintile							
Lowest	90.7	54.3	55.1	17.9	13.6	13.8	1,093
Second	91.4	59.0	50.0	17.2	11.7	9.6	1,385
Middle	94.6	66.8	56.7	12.6	8.7	10.0	1,413
Fourth	97.1	73.5	55.6	8.3	6.4	13.5	1,037
Highest	97.1	76.9	63.1	7.2	5.3	12.5	1,364
Ethnicity							
Georgian	96.7	70.6	60.1	9.0	6.6	12.1	5,488
Other	79.7	45.2	33.4	32.5	22.6	9.6	804

* Includes 36 women who were not sure if they were exposed to TB from a family member.

Women Aged 15–44 Years	
Awareness of Symptoms of TB by Selected Characteristics among	Reproductive Health Survey: Georgia, 2010
Table 9.5.2	

						the second second	men and the second s	11.000 A					
Chamber in the second of the s			:		s ymptom		ontaneously Men	tioned					No. of
CIIIalacteristic	Prolonged and Severe Cough	Fever	Blood in Sputum	weignt Loss	liredness/ Fatigue	Night Sweating	Cougning More Than 3 Weeks	Loss of Apetite	Pain in Chest	Lethargy	Other	Loes Not Know	Cases
Total	70.5	28.0	27.2	24.3	20.4	13.6	13.1	12.8	4.6	1.5	1.2	11.7	6,292
Residence													
Urban	75.7	30.4	32.1	27.2	21.6	15.3	16.0	14.7	5.4	1.9	0.8	7.4	2,975
Rural	64.6	25.2	21.7	21.0	19.1	11.7	9.9	10.6	3.7	1.1	1.6	16.6	3,317
Region													
Kakheti	57.8	17.7	22.3	15.7	16.3	8.9	8.9	8.5	3.3	1.4	0.2	22.9	498
Tbilisi	79.7	32.0	34.7	29.4	23.4	15.6	14.8	15.6	6.3	2.7	0.6	6.3	1,426
Shida Kartli	7.77	34.1	17.0	22.3	23.7	13.6	7.7	7.9	5.3	0.6	3.0	6.3	392
Kvemo Kartli	58.9	19.3	19.4	20.9	12.6	10.9	11.0	8.4	3.1	1.1	1.6	24.7	546
Samtskhe–Javakheti	53.9	17.2	15.7	12.4	21.1	5.6	1.7	5.7	2.2	0.3	2.2	22.4	481
Adjara	75.0	26.5	30.2	29.3	13.0	16.3	30.4	20.8	8.5	1.6	0.7	3.7	419
Guria	0.67	20.8	36.8	32.0	12.2	21.8	7.6	18.6	4.6	1.2	0.4	6.6	401
Samegrelo	74.1	42.4	35.0	25.9	22.7	12.3	11.4	10.9	1.5	1.7	1.3	5.9	477
Imereti	65.2	28.2	23.3	22.1	26.0	15.7	11.0	12.7	3.7	0.5	1.7	15.1	805
Mtskheta-Mtianeti	72.1	22.6	24.0	24.1	20.5	8.6	13.9	11.0	2.9	0.6	0.6	5.9	393
Racha–Svaneti	74.2	37.1	25.4	21.8	27.5	14.6	10.8	12.8	2.8	1.6	1.8	8.9	454
Age Group													
15–19	58.0	17.8	17.8	15.6	10.9	6.0	8.4	7.4	2.6	1.0	0.3	23.2	861
20–24	65.3	22.2	23.8	21.6	18.0	10.3	11.7	10.4	3.2	0.7	1.4	15.3	1,099
25–29	70.8	29.7	30.7	26.8	22.0	15.3	13.2	12.5	5.6	2.3	0.9	9.7	1,191
30–34	74.7	33.3	30.1	25.5	22.6	14.6	13.6	13.0	4.8	0.8	1.4	7.3	1,168
35–39	76.6	33.4	33.0	27.5	24.1	17.7	17.3	16.2	5.7	1.7	1.7	7.1	1,051
40-44	80.9	34.3	29.6	31.0	27.3	19.8	15.8	18.7	9.9	2.7	1.5	5.0	922
Number of Living Children													
0	65.6	24.9	24.9	21.9	17.9	10.1	11.4	10.2	3.4	1.3	1.0	15.6	2,276
-	74.5	32.1	32.3	26.1	23.4	16.7	14.6	16.0	5.6	2.2	0.5	9.2	1,286
2	74.3	29.5	28.0	25.1	21.6	15.6	13.6	14.2	5.4	1.1	2.0	8.6	2,069
3 or more	71.6	28.1	24.7	28.2	22.0	16.3	16.2	13.2	5.8	2.0	1.0	9.6	661
Education	r L					1	0	0 1	d		L C	0	000 1
Secondary incomplete or less	/.cc	18.7	1.cl	14.9	0.11	0.7	0.8	5.7 	2.4	0.9 7	0.5 1	25.3	1,330
Secondary complete	66.0	22.7	23.1	22.1	15.8	11.4	12.9	11.4	4.5	1.3	1.7	13.4	1,568
Technicum	74.7	33.9	31.6	31.5	27.7	16.8	16.2	17.5	7.4	1.5	2.2	5.2	903
University/Postgraduate	80.4	34.5	34.9	28.7	26.1	17.7	15.3	15.2	5.1	2.0	0.9	5.1	2,491
		0 L C	1	0	0	0	0	r T	c			0	000
Lowest	62.3	8.CZ	21.7	17.3	14.8	0.11	0.01	1.4	3.2	1.	Q.	7.71	1,093
Second	62.2	24.4	19.5	19.1	16.7	9.0	9.2	9.0	2.9	0.6	2.2	18.3	1,385
Middle	69.3	24.0	23.9	25.1	24.0	13.7	11.3	13.3	4.0	1.3	1.2	12.0	1,413
Fourth	74.4	28.8	30.6	25.7	18.6	16.4	17.4	16.3	5.7	1.5	0.3	7.7	1,037
Highest	20.62	34.6	36.4	30.5	24.9	16.4	16.1	15.7	6.6	2.4	0.7	6.3	1,364
Ethnicity													
Georgian	73.8	30.3	29.1	25.7	21.7	14.8	14.4	13.8	4.8	1.7	1.2	8.5	5,488
Other	48.5	12.6	14.7	15.4	12.1	5.9	5.0	6.1	3.7	0.3	1.2	32.6	804

Table 9.5.3Awareness That TB Can Be Completely Cured and Perception About the Most Appropriate Treatment
Approach for a Person with TB by Selected Characteristics among All Women Aged 15–44 Years
Reproductive Health Survey: Georgia, 2010

	Awareness Be Comple	That TB Can etely Cured	Perception	n About the Most	Appropiate Treat	ment Approach foi	r a Person wi	ith TB
Characteristic	%	No. of Cases	Hospitalization	Treatment at Home	Hospitalization Followed by Home Treatment	Does Not Know	Total	No. of Cases
Total	75.2	6,292	77.8	1.4	12.8	8.0	100.0	6,292
Residence								
Urban	81.7	2,975	80.7	1.2	13.6	4.5	100.0	2,975
Rural	67.9	3,317	74.5	1.6	11.9	12.0	100.0	3,317
Region		100				10.1		
	60.0	498	68.8	2.1	10.8	18.4	100.0	498
	82.3	1,426	81.9	1.0	13.1	4.0	100.0	1,426
Shida Kartli	83.2	392	83.0	1.6	11.6	3.7	100.0	392
	61.7	546	71.4	1.4	9.7	17.4	100.0	540
Samskne-Javaknet	58.9 74.0	461	00.0	1.2	11.0	21.1	100.0	461
Aujara	74.Z	419	70.J	2.1	17.0	2.0	100.0	419
Samarala	78.8	401	80.7	0.4	17.0	4.2	100.0	401
Imereti	70.0 70 /	477 805	70.2	1.0	13.3	5.0	100.0	477 805
Miskheta_Mijaneti	76.0	303	78.7	1.4	12.0	1.4	100.0	303
Racha–Svaneti	77.3	454	80.8	1.0	13.7	4.5	100.0	454
Age Group	11.0	-0-1	00.0		10.1	-11	100.0	101
15–19	58.5	861	72.5	2.0	8.9	16.6	100.0	861
20–24	69.8	1.099	75.9	1.3	12.4	10.4	100.0	1.099
25–29	78.8	1.191	78.3	1.1	13.9	6.7	100.0	1.191
30–34	82.6	1,168	82.2	0.8	12.5	4.5	100.0	1,168
35–39	82.6	1,051	80.3	1.2	14.3	4.2	100.0	1,051
40–44	82.7	922	78.7	1.8	15.4	4.1	100.0	922
Number of Living Children								
0	69.0	2,276	74.4	1.7	13.4	10.4	100.0	2,276
1	80.4	1,286	80.3	1.2	11.8	6.7	100.0	1,286
2	79.6	2,069	80.1	1.1	13.2	5.6	100.0	2,069
3 or more	78.1	661	80.0	1.4	10.7	8.0	100.0	661
Education								
Secondary incomplete or less	56.7	1,330	72.5	1.1	7.7	18.7	100.0	1,330
Secondary complete	72.1	1,568	77.2	1.9	12.3	8.6	100.0	1,568
	83.1	903	82.0	1.5	13.6	2.9	100.0	903
University/Postgraduate	85.3	2,491	79.8	1.2	15.7	3.3	100.0	2,491
Wealth Quintile	CE 0	1 000	74 7	1.0	10.4	10.0	100.0	1 000
Lowest	05.0	1,093	/ \./ 75 7	1.9	13.4	12.9	100.0	1,093
Second	07.2	1,303	70.7	1.9	10.5	0.1	100.0	1,300
Fourth	80.4	1,413	80.3	1.5	12.5	9.1	100.0	1,413
Highest	84.7	1,037	81.7	0.0	14.1	4.5	100.0	1,037
Fmnlovment	04.7	1,304	01.7	0.9	13.4	4.1	100.0	1,304
Working	86.6	1 4 1 0	77.0	1 2	18.6	3.2	100.0	1 4 1 0
Notworking	72.2	4 882	78.0	1.2	11.2	9.4	100.0	4 882
Ethnicity	12.2	1,002	10.0	1.4		0.1	100.0	1,002
Georgian	79.6	5,488	79.9	1.4	13.6	5.1	100.0	5.488
Other	46.4	804	63.6	1.3	7.6	27.5	100.0	804

Smoking Status	Total		Residence	
Smoking Status	TOtal	Tbilisi	Other Urban	Rural
Current tobbaco smoker	5.5	13.4	4.1	1.7
Daily smoker	4.6	11.3	3.5	1.2
Occasional smoker	0.9	2.1	0.6	0.4
Non-smoker	94.5	86.6	95.9	98.3
Former daily smoker	1.3	3.5	0.8	0.2
Never daily smoker	1.1	2.4	0.8	0.5
Never smoker	92.2	80.7	94.3	97.6
Total	100.0	100.0	100.0	100.0
No. of Cases *	6,279	1,417	1,547	3,315

Table 9.6.1Percentage of Women Aged 15–44 Years, by Detailed Smoking StatusReproductive Health Survey: Georgia 2010

* Exclude 13 women who refused to answer

Table 9.6.2Percentage of Women Aged 15–44 Years Who Have Ever Smoked
and Who Currently Smoke by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Ever Smoked	Current	Status	No. of Coope
Characteristic	Ever Smoked	Current Smoker	Past Smoker	NO. OF Cases
Total	7.8	5.5	2.3	6,292
				, , , , , , , , , , , , , , , , , , ,
Residence				
Urban	12.7	8.9	3.8	2,975
Rural	2.4	1.7	0.7	3,317
Region				
Kakheti	4.5	3.6	0.9	498
Tbilisi	19.2	13.3	5.9	1,426
Shida Kartli	2.8	1.4	1.4	392
Kvemo Kartli	3.1	2.1	1.0	546
Samtskhe–Javakheti	1.4	1.1	0.3	481
Adjara	6.1	4.3	1.8	419
Guria	1.0	0.6	0.4	401
Samegrelo	2.8	1.8	1.0	477
Imereti	3.0	2.6	0.4	805
Mtskheta–Mtianeti	5.7	3.2	2.5	393
Racha–Svaneti	2.5	0.9	1.6	454
Age Group				
15–19	2.6	2.2	0.4	861
20–24	7.3	4.7	2.6	1.099
25–29	8.4	6.4	2.0	1,191
30–34	10.3	7.0	3.3	1,168
35–39	9.8	6.9	2.9	1.051
40-44	9.5	6.3	3.2	922
Number of Living Children		0.0	0.2	
0	7.0	5.6	1.4	2.276
1	13.0	8.4	4.6	1,286
2	6.5	4.2	2.3	2.069
3 or more	5.4	3.2	2.2	661
Education	-			
Secondary incomplete or less	2.5	2.3	0.2	1.330
Secondary complete	5.7	3.8	1.9	1.568
Technicum	5.6	3.9	1.7	903
University/Postgraduate	13.0	8.9	4.1	2.491
Wealth Quintile		0.0		_,
Lowest	2.1	1.6	0.5	1.093
Second	2.5	1.8	0.7	1,385
Middle	4.0	2.5	1.5	1 413
Fourth	9.6	6.7	2.9	1,037
Highest	16.9	12.0	4.9	1,364
Ethnicity				.,
Georgian	8.4	5.8	2.6	5.488
Other	4.0	3.3	0.8	804
Current Use of Contraception	1.0	0.0	0.0	
Modern	93	59	34	1 4 3 6
Traditional	4.5	3.2	1.3	798
No method	7.0	5.7	2.2	4 058
	1.5	0.1	2.2	7,000

Table 9.6.3

Secondhand Smoking at Home and at Work (Indoors) by Selected Characteristics Among All Women and Women Not Currently Smoking Aged 15–44 Years Reproductive Health Survey: Georgia, 2010

		AII W	omen			Non-	3 moker	
Characteristic	Exposed to Tobbaco Smoke at Home	No. of Cases	Exposed to Tobbaco Smoke at Work	No. of Cases	Exposed to Tobbaco Smoke at Home	No. of Cases	Exposed to Tobbaco Smoke at Work	No. of Cases
Total	51.6	6,292	43.6	1,352	49.6	5,823	40.3	1,167
Residence								
Urban	48.9	2,975	47.0	872	45.4	2,588	43.4	703
Rural	54.5	3,317	35.3	480	53.9	3,235	33.9	464
Age Group								
15–24	51.0	1,960	47.3	169	49.8	1,871	43.9	154
25–29	56.0	1,191	40.8	250	54.0	1,102	36.3	217
30–34	52.2	1,168	45.9	260	48.9	1,057	43.2	222
35–39	49.3	1,051	40.8	352	47.5	955	36.2	298
40-44	49.7	922	44.7	321	47.3	838	42.9	276
Education								
Secondary incomplete or less	52.9	1,330	59.4	48	52.1	1,295	56.0	41
Secondary complete	55.7	1,568	55.7	108	54.3	1,493	52.9	95
Technicum	54.4	903	44.4	199	53.0	850	42.6	182
University/Postgraduate	47.2	2,491	41.2	266	43.7	2,185	37.4	849
Wealth Quintile								
Lowest	52.9	1,093	39.3	87	52.1	1,063	37.2	84
Second	56.3	1,385	33.1	200	55.7	1,353	31.0	194
Middle	51.7	1,413	39.9	314	50.5	1,356	37.5	296
Fourth	51.0	1,037	47.9	280	48.6	936	46.3	246
Highest	47.5	1,364	46.5	471	42.6	1,115	41.9	347
Ethnicity								
Georgian	51.7	5,488	43.7	1,252	49.7	5,054	40.2	1,072
Other	50.4	804	41.5	100	49.1	769	41.6	95

Table 9.7Percentage of Women Aged 15–44 Years Who Used AlcoholDuring the Previous Three Months by Selected CharacteristicsReproductive Health Survey: Georgia, 2010

	AI	chol Use During	the Past Three Months	1	
Characteristic	Ever Drank	Current Drinkers	Current Frequent Drinkers	Binger	No. of Cases
Total	30.5	16.6	1.8	8.0	6,292
Residence					
Urban	33.9	18.5	2.3	9.2	2,975
Rural	26.7	14.5	1.2	6.7	3,317
Region				• •	100
Kakheti	32.8	21.8	3.2	8.2	498
Tbilisi	40.9	23.2	3.1	12.3	1,426
Shida Kartli	36.5	15.8	1.4	9.5	392
Kvemo Kartli	19.3	8.9	0.7	5.7	546
Samtskhe-Javakheti	18.6	7.6	0.3	3.1	481
Adjara	13.7	7.3	0.9	3.4	419
Guria	19.8	10.4	0.4	6.2	401
Samegrelo	33.4	19.2	2.2	8.6	477
Imereti	30.7	16.8	0.8	6.4	805
Mtskheta-Mtianeti	34.2	16.5	1.9	6.8	393
Racha-Svaneti	33.Z	16.9	2.3	8.5	454
Age Group	20.0	444	1.0	0.0	1 000
15-24	29.0	14.4	1.0	0.0 0.0	1,960
25-34	29.4	10.4	1.4	8.6	2,359
35-44	33.7	19.0	3.3	0.9	1,973
Marital Status	26.0	14.0	1 4	6.2	4 009
Married	20.9	14.0	1.4	0.3	4,098
Previously married	30.0 25.7	ZI.7 10 0	0.0 1.7	14.0	309
Never married	35.7	10.0	1.7	9.9	1,005
Education	24.5	12.0	1.0	6.0	1 3 3 0
Secondary incomplete or less	24.0	12.0	1.0	0.0	1,550
Secondary complete	20.7	10.2	2.0	0.1	1,500
lechnicum	36.2	10.9	1.0	0.0	903
University/Postgraduate	30.2	19.4	2.2	9.0	2,491
vveaith quintile	26.8	12.0	0.6	65	1 003
Lowest	20.0	12.5	1.0	5.6	1,095
	24.7	14.5	2.0	73	1,303
	20.0	14.8	2.2 1 <i>1</i>	7.5	1,413
Fourth	20.1 40.4	22.2	3.0	11.6	1,007
Hignest	40.4	22.2	5.0	11.0	1,504
Ethnicity	32.6	17.6	20	8.8	5 488
Georgian	16.7	9.8	0.7	3.1	804
Ouner Employment	10.7	5.0	0.1	0.1	004
	39.6	22.5	24	87	1 4 1 0
vvorking Net werking	00.0	15.0	1.5	7.0	4,000
NOT WORKING	20.1	15.0	0.1	7.9	4,002

Chapter **10**

Domestic Violence

iolence against women includes a wide range of behaviors and acts perpetrated against women by their partners or other assailants. Domestic violence-also known as intimate partner violence (IPV), "battering," or spousal abuse—is the most common form of violence against women. It occurs in all cultures and affects women of all ages and all socioeconomic and educational backgrounds. Although violence is not a primary focus of the reproductive health surveys, they provide a unique opportunity to study prevalence of violence and characteristics of women who experience it. In addition to documenting IPV in the context of maternal and child health, survey findings can be used to raise awareness at the individual and community level, to educate law enforcement and social service agencies, to influence current public health policies, to develop laws to protect and benefit battered women and, ultimately, to predict future needs for support services and interventions for abused women.

The first two reproductive health surveys (in 1999 and 2005) and a nationwide survey of domestic violence conducted in 2009 with UNFPA support demonstrated that domestic violence is seldom reported in Georgia (Serbanescu et al., 2001 and 2007; Chitashvili et al., 2010). The first Georgian law on domestic violence came into effect on June 9, 2006. In this law, the definition of domestic violence include beyond physical violence to goes and sexual violence: psychological, economic,

"domestic violence refers to violation of constitutional rights and freedoms committed by one family member in relation to other family member, through physical, psychological or sexual violence, coercion or threat to undertake such actions" (Government of Georgia, Law on Prevention of Domestic Violence, Protection and Support of Domestic Violence Victims, June 2006). The adoption of the law was then followed by the development and approval of 2 periodic Action Plans on Elimination of Domestic Violence, Protection and Support to its Victims (2006-2008 and 2009-2010). Despite new legal regulations and increased efforts to raise awareness on domestic violence, formal reporting of acts of domestic abuse to the authorities remained relatively unchanged -the lifetime and current IPV reported by women of reproductive age in 2009 were comparable with the 2005 levels.

Since 2008, a coordination body (the State Interagency Coordination Council on Domestic Violence) was established by presidential decree to ensure the implementation of the domestic violence law. The Council, in partnership with the Young Lawyers Association of Georgia (GYLA) and UNFPA support, developed the National Referral Mechanisms (NRM) for victims of domestic violence. In 2010 UNIFEM with the support of the Swedish International Development Cooperation Agency (Sida) and in collaboration with local NGOs and government agencies implemented the project "Enhancing Prevention and Response to Domestic Violence" or SHiEld, which included building of two shelters for victims of domestic violence in Tbilisi and Gori. Currently, numerous non-governmental organizations, such as the Anti-Violence Network of Georgia, Georgian Young Lawyers' Association, the Women's Center, and Women for Democracy, in partnerships with donor organizations and governmental agencies are very active in pursuing gender equality and violence prevention projects in Georgia.

The GERHS10 included a series of questions to assess the burden of domestic violence in Georgia. The questions, which focus principally on IPV, explore acts of violence perpetrated by current or former husbands and male partners with whom the respondent had lived together as a couple. IPV, which can take a variety of forms including physical abuse, psychological abuse, and coercive sex, was documented using a modified version of the eightitem Conflict Tactic Scale (Straus, 1979). IPV in GERHS10 was defined as psychological, physical, and sexual abuse towards ever-married (whether legally or consensually) women. Psychological abuse includes insults, curses, psychological threats, and gestures with intent of physical harm. Physical violence includes pushing, shoving, and slapping, kicking, hitting with the fist or an object, being beaten up, and being threatened with a knife or other weapon. Women who experienced recent physical abuse were further asked about the severity of physical injuries and whether they sought help from law enforcement agencies, family, friends, or health care providers. Sexual abuse is defined as any episode when the intimate partner "physically forced [the woman] to have sex against her will." In addition, all respondents were asked about their history of witnessing physical abuse between parents or experience of abuse as a child or adolescent.

10.1 History of Witnessing or Experiencing Parental Physical Abuse

Research on violence against women has identified experiencing and witnessing parental abuse as a child as strong independent predictors of being in an abusive relationship as an adult (Hotaling and Sugarman, 1986). As shown in Table 10.1, 8% of all respondents reported having heard or seen abuse between their parents, and 8% reported that they had experienced parental physical abuse. The proportion of respondents who reported they had experienced physical abuse declined from 14% in the previous survey, GEHRS05. In GERHS10, the highest prevalence of witnessing or experiencing parental abuse was reported by women residing in Mtskheta-Mitaneti (12.4%), Adjara (11.1%), and Kvemo Kartli (10.7%) and by women belonging to Azeri (12.7%) and "other" (minority) ethnic groups (15%).

Comparatively higher proportions of having experienced physical abuse were found in these same regions, but prevalence of having experienced abuse was also high in Racha-Svaneti (14.8%), Samtskhe-Javakheti (13.6%), and Shida Kartli (10.2%).

Among women who reported having witnessed abuse in the home as a child, prevalence of having been psychologically and physically abused in the 12 months prior to the survey was 3 to 4 times as high as among those who had not witnessed abuse in their childhood home (Figure 10.1). Similarly, those who



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

10.2 Prevalence of Intimate Partner Violence

The two basic measures of the prevalence of intimate partner violence are lifetime abuse by a formal or consensual partner and current abuse (in the last 12 months). As was found in previous surveys, the GEHRS10 shows that prevalence of IPV reported by women in Georgia remains low and relatively unchanged (Figure 10.2.1). Less than 20% of women reported lifetime psychological abuse in all RHS surveys. Lifetime exposure to physical abuse by an intimate partner (including physical and sexual acts of violence) was reported by 7%-8% of women of reproductive age. A similar proportion of women reported lifetime physical violence in the National Survey of Domestic Violence against Women in Georgia (Serbanescu et al., 2001 and 2007; Chitashvili et al., 2010)

GERHS10 documented a level of lifetime verbal abuse of 14.8% and current exposure to verbal abuse (during the last 12 months) of 8.4%. The levels of current physical violence were quite low, with 5% reporting lifetime physical abuse, 2% reporting lifetime sexual abuse, and under 2% reporting physical or sexual IPV in the past 12 months (Table 10.2 and Figure 10.2.2).





Despite overall low prevalence of IPV on a differences were national basis, observed according to women's' characteristics. Overall, women who had been previously married or in union had the highest lifetime prevalence of all three types of violence, and of physical violence in the past 12 months. Verbal abuse and physical violence were also greater, in general, among women with lower levels of formal education (Figure 10.2.3), lowest socioeconomic status, and among women of Azeri or "other" ethnic background. Also important to note is higher prevalence of recent physical violence reported by young women aged 15 to 19 years. Surveys in other countries have indicated that younger women are often at greater risk of current violence compared to older ones.

Compared with currently married women, previously married women experienced much more verbal abuse, physical abuse, sexual abuse, suggesting that domestic abuse is a common factor associated with separation and divorce (Figure 10.2.4).

10.3 Help-Seeking for Intimate Partner Violence

About one in four Georgian women who were subjected to physical IPV never sought help or disclosed their experience to anyone (Table 10.3). Among the 71% who did seek help, the majority turned to a family member or a friend, rather than







seeking law enforcement, legal, or medical help. Only 5% reported the abuse to the police, 3% sought medical help, and 2% sought legal counsel (Figure 10.3.1). Although there was little difference by individual characteristics, slightly greater help-seeking was found among women who were urban residents, younger, and previously married or in union.

The most common reasons cited by a battered woman for not seeking formal help were feeling that it would not do any good (23%) and embarrassment associated with disclosing the abuse (28%) (Figure 10.3.2). Other reasons mentioned were concerns that reporting violence would negatively affect the family's reputation (10%), belief that the physical abuse was not very severe (7%), and a fear of more beating (5%) or that the marriage would end as a result (3%).

10.4 Aspects of Intimate Partner Relationships and Gender Norms

Intimate partner violence is often triggered by a perceived transgression of gender norms in a family. In contrast, gender norms that are conducive to gender equity guarantee that men and women are in an equal position to use basic social services and make social, economic, and health-related decisions. The GERHS10 sought to characterize the perceived roles and responsibilities of husbands and wives in Georgia and their correlates with IPV.

Ever-married respondents were asked about several aspects of their relationship with their husband or partner, including expression of affection, tolerance of wife's contact with her family and friends, sharing of household chores, and whether or not the husband insists on making all decisions (i.e., demands the "final say") (Table 10.4.1). Most respondents reported that their husbands were usually sharing household chores (71.5%). However, about half of women interviewed (49.6%) reported that their husbands frequently insist on having the final say; 39.8% of women said their husbands need to know where they are all the time (Table 10.3.1). Very few women stated their husbands get angry if they speak with other men, limit their contacts with family and friends, or get very suspicious that the wife may be unfaithful. Behaviors of husbands that promote gender equity (e.g., sharing household chores, never insisting on having the final word in household decisions, never limiting wife's contacts with family and friends, not being suspicious or angry if she may speak with other men) were summed to create a score to classify the "gender norms status" of a family. Equal values were assigned for reports of each "positive" norm; possible scores ranged from 0 (no norm associated with gender equity in the household) to 5 (all 5 positive norms existed in the family). Respondents who reported 0 or 1 positive norm were classified as having relationships with low gender equity, those with 2 or 3 positive norms were classified as having average gender equity, and those with 4 or 5 positive norms were considered as having high gender equity in their relationships. Women spousal living in households with low gender equity were much more likely to be subjected to any type of violence

than those who had high gender equity in their households (Figure 10.4.1).

Another set of questions explored women's acceptance of justification for wife-beating under certain circumstances (Table 10.4.2). Overall, almost 20 percent of ever-married women agreed with at least one specified circumstance in which they consider wife-beating justifiable. The large majority of these were women who thought that the husband would be justified in hitting his wife if he found out that she had been unfaithful (18.7%). Consideration that wife-beating is justifiable in the other circumstances included in the table was affirmed by 1%-5% of ever-married women. The percent of women who were in agreement that wife-beating is justifiable in each of the circumstances was greater among those who reported lifetime physical or sexual abuse compared to those who had never been abused (Figure 10.4.2). These findings suggest that lack of empowerment may leave them more vulnerable to physical or sexual intimate partner violence.





Table 10.1Percentage of Women Aged 15–44 Years Who Have Witnessed or
Experienced Parental Physical Abuse as a Child by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

Characteristic	Witnessed Abuse	Experienced Abuse	No. of Cases*
Total	8.1	8.4	6,268
Residence (urban/rural)			
Urban	7.6	7.5	2.967
Rural	8.7	9.3	3.301
Residence			-,
Tbilisi	6.6	6.4	1,422
Other Urban	8.7	8.7	1,545
Rural	8.7	9.3	3,301
Region			
Kakheti	9.3	6.7	493
Tbilisi	6.6	6.4	1,422
Shida Kartli	4.3	10.1	392
Kvemo Kartli	10.7	9.7	546
Samtskhe-Javakheti	8.3	13.6	479
Adjara	11.1	10.2	417
Guria	6.3	6.7	395
Samegrelo	6.7	5.0	477
Imereti	8.3	9.6	804
Mtskheta-Mtianeti	12.4	10.1	391
Racha-Svaneti	7.1	14.8	452
Education			
Secondary incomplete or less	9.4	10.0	1,321
Secondary complete	9.7	8.6	1,562
Technicum	8.2	9.1	898
University/Postgraduate	6.3	7.0	2,487
Wealth quintile			
Lowest	9.6	10.9	1,088
Second	9.4	9.3	1,378
Middle	7.8	7.9	1,406
Fourth	9.2	9.1	1,035
Highest	5.7	6.1	1,361
Ethnicity			
Georgian	7.5	7.8	5,467
Azeri	12.7	13.7	276
Armenian	10.6	8.3	363
Other	15.0	17.2	162

* Excludes 24 women who reported that they did not grow up with their parents.

Table 10.2Percentage of Ever Married Women Aged 15–44 Years Who Reported Intimate
Partner Violence (IPV) in Their Lifetime and Percentage Who Reported IPV
in the Last Year by Type of Abuse and by Selected Characteristics
Reproductive Health Survey: Georgia, 2010

		Lifetime IPV		IPV Duri	ng the Last 12	2 Months	
	Verbal	Physical	Sexual	Verbal	Physical	Sexual	No. of
Characteristic	Abuse	Abuse	Abuse	Abuse	Abuse	Abuse	Cases
Total	14.8	4.5	1.7	8.4	1.4	0.5	4,487
Residence							
Urban	13.9	4.5	2.0	7.0	1.4	0.4	2,044
Rural	15.7	4.5	1.4	10.0	1.4	0.5	2,443
Residence							0.40
	13.8	4.8	2.1	6.6	2.3	0.5	940
Other Urban	14.0	4.2	2.0	7.3	0.6	0.4	1,104
Rural	15.7	4.5	1.4	10.0	1.4	0.5	2,443
Age Group		- 0		7.0			100
15–19	7.9	5.0	0.0	7.3	5.0	0.0	130
20-24	9.0	2.6	1.0	5.7	1.7	0.5	639
25–29	13.1	2.7	1.3	8.9	1.1	0.6	909
30–34	15.6	4.7	2.2	8.0	1.4	0.4	1,036
35–39	18.6	6.9	2.1	9.9	1.5	0.2	944
40-44	16.9	4.9	2.2	9.0	0.8	0.8	829
Marital Status			4.0	<u>.</u>	4.0	<u>.</u>	4 0 0 0
Currently married or in union	11.4	2.4	1.0	8.4	1.0	0.4	4,098
Not currently married or in union	45.8	23.5	8.1	8.4	4.9	0.9	389
Number of Living Children	40.0				4.0	o -	470
0	12.9	6.1	2.8	5.8	1.9	0.5	472
1	13.6	5.2	1.9	6.4	1.6	0.3	1,285
2	15.8	3.7	1.2	10.7	1.1	0.5	2,069
3	13.5	3.2	2.0	6.7	1.2	0.6	539
4 or more	23.3	10.3	3.8	11.3	3.9	1.5	122
Education <3g>	20.7	6.4	2.0	10.0	0.0	0.0	001
Secondary incomplete or less	20.7	0.4	2.0	12.0	2.2	0.2	1 1 0 0
Secondary complete	15.8	4.7	1.8	10.3	2.2	0.8	1,196
	12.4	3.8	1.6	6.2	0.8	0.4	2,490
Socioeconomic Status	00.0	0.0	0.0	44.4	0.5	0.0	400
	23.9	8.2	2.0	14.4	2.5	0.6	462
	15.0	4.7	1.7	8.2	1.3	0.5	2,011
High	12.7	3.5	1.6	7.4	1.2	0.4	2,014
wealth Quintile	20.0	C F	1.0	12.0	4 7	0.4	707
	20.9	0.5	1.9	13.0	1.7	0.4	/8/
	14.9	4.2	1.0	10.0	1.4	0.6	1,032
	13.0	3.9	1.3	7.1	0.8	0.3	1,017
Fourm	13.5	4.8	1.8	6.9	1.8	0.5	710
	13.4	3.8	2.0	6.6	1.5	0.5	941
Ethnicity	12.4	2.0	4 7	77	1.0	0.5	2.054
Georgian	13.4	3.9	1.7	1.1	1.2	0.5	3,854
Azeri	29.0	0.9	2.3	10.1	2.5	0.4	234
Amenian	13.2	0.0	1.9	5./ 15.0	1.1	0.0	269
Outer	20.8	10.3	2.3	15.2	4./	0.0	130

Table 10.3

by an Intimate Partner and Discussed Abuse with Others by Selected Characteristics Reproductive Health Survey: Georgia, 2010 Percentage of Ever-Married Women Aged 15–44 Years Who Were Physically Abused

	E Concept			Source	of Heln			
Characteristic	Ever sougrit	Respondent's Family	Friend	Husband's Family	Police	Health Provider	Legal Adviser	No. of Cases
Total	71.2	54.4	42.3	19.3	5.4	3.4	2.3	222
Residence								
Urban	76.3	55.3	48.3	19.7	5.1	3.5	2.8	100
Rural	65.7	53.5	35.9	18.8	5.7	3.3	1.7	122
Residence								
Tbilisi	73.3	55.0	48.3	21.7	5.0	5.0	3.3	46
Other Urban	79.4	55.6	48.2	17.5	5.3	1.8	2.2	54
Rural	65.7	53.5	35.9	18.8	5.7	3.3	1.7	122
Age Group								
15-24	82.4	54.6	52.5	22.4	0.0	0.0	0.0	18
25–34	63.7	48.4	36.8	21.8	5.0	3.2	1.4	84
35-44	73.4	58.4	43.5	16.8	7.0	4.4	3.4	120
Marital Status								
Currently married or in union	64.8	48.7	37.4	19.3	5.3	5.9	3.4	129
Not currently married or in	77.9	60.3	47.5	19.2	5.5	0.8	1.1	93
union								
Number of Living Children								
0-1	79.7	63.7	43.3	24.8	6.4	2.4	3.1	94
2	65.9	46.8	44.5	15.0	5.2	5.1	1.3	86
3+	59.1	45.0	34.9	13.0	3.0	2.4	2.0	42
Education								
Secondary complete or less	73.5	59.4	42.6	17.7	7.7	4.7	3.5	120
Technicum/University	68.7	49.0	42.1	21.0	2.9	2.0	0.9	102
Socioeconomic Status								
Low	71.6	58.9	40.1	29.4	10.3	3.2	1.9	45
Medium/High	71.2	53.5	42.8	17.2	4.4	3.4	2.3	177
Wealth Quintile								
Lowest	70.6	57.9	40.7	22.6	7.0	2.6	0.0	57
Second	60.7	51.7	26.6	14.9	7.1	3.7	2.6	45
Middle	74.7	58.3	37.3	23.0	0.0	2.1	0.0	47
Fourth	83.2	62.0	55.0	18.9	6.2	6.9	4.1	36
Highest	67.6	43.9	50.7	17.0	6.5	2.0	4.5	37
Ethnicity								
Georgian	71.4	52.8	45.0	18.6	5.7	4.5	3.0	168
Other	70.8	59.3	34.4	21.4	4.7	0.0	0.0	54

Table 10.4.1

Percentage of Ever Married Women Aged 15–44 Years Who Reported Gender Norms in the Household by Specific Gender Norms and Selected Characteristics

Reproductive Health Survey: Georgia, 2010

			Gender	. Norms			
Characteristic	Husband Usually Shares Household Chores	Husband Wants to Have the Final Say	Husband Insists on Knowing Where Wife/Partner is at All Times	Husband Gets Angry If Wife/Partner Speaks With Another Man	Husband Tries to Limit Wife/Partner's Contact with Family and Friends	Husband Often Suspicious That Wife/Partner is Unfaithful	No. of Cases
Total	71.5	49.6	31.8	6.3	4.9	4.2	4,487
Residence							
Urban	72.7	46.1	29.7	7.4	5.2	5.1	2,044
Rural	70.4	53.2	34.1	5.1	4.6	3.2	2,443
Residence							
Tbilisi	70.4	40.6	31.6	9.4	6.0	6.2	940
Other Urban	74.9	51.5	27.9	5.5	4.4	3.9	1,104
Rural	70.4	53.2	34.1	5.1	4.6	3.2	2,443
Age Group							
15-24	74.4	50.1	36.6	7.6	5.3	5.2	769
25–34	72.2	48.8	32.6	6.2	4.9	3.4	1,945
35-44	69.7	50.2	29.1	5.7	4.8	4.5	1,773
Marital Status							
Currently married/in union	74.8	48.5	29.8	3.8	2.7	2.2	4,098
Not currently married/in union	41.4	59.7	50.6	29.0	24.7	22.3	389
Number of Living Children							
0-1	69.3	45.6	33.3	8.8	6.3	0.9	1,757
2	72.2	51.2	31.2	4.6	4.0	2.8	2,069
3 or more	75.4	55.1	30.0	4.5	4.1	3.4	661
Education							
Secondary complete or less	68.7	54.5	36.4	7.1	6.6	4.7	1,997
Technicum/University	73.8	45.7	28.3	5.6	3.6	3.7	2,490
Socioeconomic Status							
Low	63.4	54.0	35.7	8.7	5.9	6.7	462
Medium/High	72.5	49.1	31.4	6.0	4.8	3.9	4,025
Wealth Quintile							
Lowest	69.1	56.2	38.9	6.0	5.0	3.9	787
Second	68.8	54.2	35.0	5.8	5.7	3.5	1,032
Middle	72.1	51.6	28.5	4.0	3.3	2.8	1,017
Fourth	74.6	46.5	30.6	6.9	6.2	4.7	710
Highest	72.6	42.3	28.7	8.4	4.8	5.8	941
Ethnicity							
Georgian	73.5	47.8	30.0	5.3	4.0	3.5	3,854
Other	59.7	60.3	43.0	12.0	10.6	8.1	633

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Percentage of Ever Married Women Aged 15–44 Years by Whether They Had Ever Experienced Physical or Sexual Intimate Partner Violence in Their Lifetime According to Their Agreement with Different Reasons That May Justify Wife-Beating Reproductive Health Survey: Georgia, 2010

Agreement with a Specific Reason	Total	Physical or Sexual Intimate I	Partner Violence in Lifetime
		Never Abused	Ever Abused
The husband finds out that the wife had been unfaithful	18.7	18.6	21.0
The wife neglects the children	5.2	4.8	11.5
The wife argues with the husband	3.5	3.4	6.7
The wife asks her husband whether he has other girlfriends	2.5	2.4	4.2
The wife goes out without telling the husband	1.8	1.7	4.5
The wife refuses to have sex with her husband	1.6	1.5	4.6
The husband is not happy with the wife's household work or cooking	1.3	1.2	4.4
Agreement with any reason	19.3	19.1	22.6
No. of Cases	4,487	4,265	222

ANNEX A: Institutional Participation

National Center for Disease	Natalia Avaliani, Director General
Control and Public Health	Paata Imnadze, Head of Science Board
(NCDC)	George Kandelaki, Deputy Director
	Maia Butsashvili, Deputy Director
	Neli Chakvetadze. Academic Secretary
	Khatuna Zakhashvili Head of Communicable
	Diseases Division
	Lela Sturua, Head of Noncommunicable Diseases Division
	Marina Shakhnazarova, Chief Specialist
	Nana Mebonia, Chief Specialist
Georgia Ministry of Labor	Andria Unuchadaa Ministan
Health, and Social Affairs	Michael Dolidze, Deputy Minister
(MoLHSA)	Wienael Bolidze, Deputy Winister
National Reproductive Health	Sandra Elisabeth Roelofs, Chair
Council	
Zhordania Institute of Human	Giorgi Tsagareishvili, Head, Department of In-
Reproduction	vitro Fertilization
-	Jenaro Kristesashvili, Head, Reproductive Function
	Formation Department
Georgian Association of	Tengiz Asatiani. Vice President
Obstetricians and	Zaza Bokhua, Secretary General
Gynecologists	
Institute of Demography and	Giorgi Tsuladze, Head of Department
Sociology	olorgi Touluaze, freud of Zepal ellent
National Medical Center after	Zaza Sinauridze, Director General
Gudushauri	

John Snow Institute, Inc (JSI)	Nino Berdzuli, Senior Technical Advisor for
	Reproductive Health
	Kartlos Kankadze, Country Director
Curatio International Foundation	Ketevan Chkhatarashvuli, President
USAID/Georgia	Tamara Sirbiladze, Project Officer for GERHS10 Jonathan Conley, Mission Director Anne Patterson, Director of Health and Social Development Nana Chkonia, Administrative Officer
UNFPA/Georgia	Zahidul Huque, UNFPA Country Director for Armenia, Georgia and Azerbaijan and the Representative in Turkey Tamar Khomasuridze, Assistant Representative Lela Bakradze, Program Analyst Marina Tsintsadze, Admin/Finance Assistant
UNICEF/Georgia	Roeland Monasch, UNICEF Representative in Georgia Tinatin Baum, Social Policy Specialist
Centers for Disease Control and Prevention, Division of Reproductive Health (CDC/DRH), Atlanta	Florina Serbanescu, Survey Principal Investigator Vasili Egnatashvili, Survey Consultant Mary Goodwin, Epidemiologist Paul Stupp, Sampling Statistician (Demographer) Danielle Suchdev, Public Health Analyst (ORISE) Alicia Ruiz, System Programmer (SAIC) Fernando Carlosama, System Programmer (SAIC) Leo Morris, Survey Consultant (SAIC) Jose Luis Carlosama, System Programmer (McKing Corp.)

ANNEX B: Field and Data Entry Personnel

Field Coo	ordinators:
Khatuna Zakhashvili	Marina Shakhnazarova
Team Su	pervisors:
Olga Tarkhan-Mouravi (Team I)	Khatuna Aladashvili (Team V)
Nato Tsereteli (Team II)	Rusudan Etsadashvili (Team VI)
Tea Niniashvili (Team III)	Sopo Datukishvili (Team VII)
Dali Trapaidze (Team IV)	Ia Kochiashvili (Team VIII)
	•
Team Int	terviewers:
	Team V
Leli Urushadze	Marika Khatashvili
Rusudan Chumburidze	Marıam Natsvlishvili
Natalia Tskipurishvili	Keti Sanadze
Lela Sabadze	Nana Gabriadze
Ana Nemsadze	Tina Gabrichidze
	Eka Chubabria
Team II	Team VI
Nino Shubladze	Rusudan Chlikadze
Tamila Lemonjava	Lia Sanodze
Sopo Dolbadze	Maka Tevzadze
Nona Papukashvili	Eliso Iobashvili
Eka Nodia	Ketevan Napireli
Team III	Team VII
Eka Tsertsvadze	Marina Chubinidze
Lia Shirtladze	Mariam Kuparadze
Tea Gognadze	Eka Khmaladze
Tamar Dzodzuashvili	Lali Kudukhova
Irma Iremashvili	Shorena Komladze

Team Int	erviewers:
Team IV	Team VIII
Marina Baidauri	Marina Lashkarashvili
Marina Tsereteli	Anna Kasradze
Nino Tsintsadze	Khatuna Lomashvili
Ketevan Galdavadze	Khatuna Kutateladze
Pikria Shavreshiani	Sopo Guramishvili
	-
Data Entry	Supervisors:
Irina Kocharova	Konstantin Kazanjian
Data Entry	Operators:
Natela Gognadze	Larisa Sedykh
Gulnazi Lomsadze	Susanna Shakhbudagian
Liana Khuchua	Irina Tkhinvaleli
Tamar Pilauri	Tsimi Chabukashvili-Chanadiri

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