

Changes in Women's Reproductive Health in Georgia

By John Ross



Tbilisi, 2012

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ICPD =

International Conference on
Population and Development
Beyond 2014



Changes in Women's Reproductive Health in Georgia Report

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The opinions expressed in this publication are those of authors and do not necessarily reflect the views of UNFPA

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Foreword

The efforts to improve the health of women, youth and children are at the core of the health care reforms in Georgia. The Georgia Reproductive Health surveys (1999, 2005, 2010), the nationally representative surveys to collect comprehensive information on reproductive health status and utilization of reproductive health and maternal and child health care services in the country, provide the wide range of audience, including decision makers, public health professionals, reproductive health experts and more broadly, the “development community”, with much needed information to track progress in policy and program outcomes, formulate targeted interventions, monitor the national development programs, and report on progress toward the International Conference on Population and Development (ICPD) Programme of Action and Millennium Development Goals (MDGs). Furthermore, the analysis of the survey data gives an ability to identify gaps, elaborate recommendations and apply the evidence-based advocacy for improved national policies and programmes in the area of reproductive health. Therefore it is of crucial importance that high quality analytical papers on a range of aspects of reproductive health are made available serving the needs of various target audiences listed above.

During 2011-2012 the Georgia Reproductive Health Survey-2010 (GERHS10) Preliminary and more comprehensive Final Reports have been developed on both English and Georgian languages and widely disseminated among decision makers, public health professionals, RH experts.

Considering the need for more analytical papers based on GERHS10 data and having in mind the global action related to ICPD beyond 2014 review, UNFPA Country Office in Georgia commissioned in 2012 development of a sharp analytical report highlighting the most important findings of the GERHS10 and trends in the reproductive health status of women in Georgia. Moreover, this report includes the set of recommendations, or actions needed to address the challenges identified.

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Significant improvements in family planning (FP) and reproductive health (RH) service provision have marked the last few years in Georgia. The Government with the support of international and local NGO communities is increasingly supporting staff retraining, education, and infrastructure development. Public health interventions also include TB, HIV/AIDS, immunization, as well as mother and child health (MCH) to achieve universal access to antenatal care, along with breast and cervical cancer screening services. However challenges still exist to integrate family planning and other reproductive health services into health insurance plans. An insurance-based system of financing for the poor has been partially implemented, but costs to individuals remain a serious obstacle to adequate health services.

Chapter 1. Background and Methodology

To understand changes since 1999 a series of three national reproductive surveys (1999, 2005, and 2010)¹ has been conducted to document changes in reproductive behavior including abortion. Questionnaire instruments, survey methodology, and data analyses were developed in collaboration with the US Centers for Disease Control and Prevention, and the Georgia National Center for Disease Control and Public Health, with field implementation by the Georgia Ministry of Labor, Health, and Social Affairs (MoLHSA). In the most recent survey (2010) 6,292 women aged 15-44 were interviewed, yielding separate estimates by rural/urban residence and by 11 regions. A stratified, multi-stage sampling design was used, similar to that in the 1999 and 2005 cycles. Funding assistance for the surveys, as well as for program action improvements, has been provided by donors, primarily by UNFPA, USAID and UNICEF. In addition, a national survey of males aged 15-49 was conducted,² which can be referred to for comparisons with the results for females reported here.

The aim of the 2010 survey was to obtain national and regional estimates of basic demographic and reproductive health indicators, in order to set targets for improvements, allocate resources, and monitor performance of family planning and maternal and child health programs.

The survey was specifically designed to meet the following objectives:

- to assess the current situation in Georgia concerning fertility, abortion, contraception and 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;

1. *Reproductive Health Survey Georgia 2010 Final Report. 2012.*
Reproductive Health Survey Georgia 2005 Final Report. 2007.
Women's Reproductive Health Survey Georgia, 1999-2000. 2001.

2. *Male Reproductive Health Survey. Tbilisi, Georgia: UNFPA, 2005.*

- to measure changes in fertility and contraceptive prevalence rates and study reasons for 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 measure knowledge, attitudes, and behavior of young adults ages 15–24 and assess their exposure to sex education and health promotion programs;
- to identify topics of special interest regarding reproductive health among high risk groups.

All this information can be used by International bilateral and multilateral donors (e.g., UNFPA, USAID, UNICEF, World Bank, and EU) and various government partners, particularly MoLHSA, the Ministry of Economic Development, and Ministry of Finance, to develop new health strategies and health sector reforms, as well as to monitor and evaluate progress toward achieving the UN Millennium Development Goals.

The following chapters are based upon the *Reproductive Health Survey Georgia 2010: Final Report*, containing 18 chapters in 329 pages. It provides extensive text discussion and numerous charts and tables for each of the topics covered in this report.

The fertility rate rebounded between the 2005 and 2010 surveys, while the abortion rate declined. Contraceptive use has increased, so more pregnancies are wanted pregnancies, yet many women do not use contraception or use high-failure methods. After an abortion few women receive contraceptive assistance. Access to services is worse, and abortions more frequent, among rural, less educated groups. Future fertility intentions depend closely upon family size, but the desire for more children has increased.

Changing Rates of Fertility, Abortion, and Contraception

In Georgia, as in much of the former USSR, the fertility and abortion rates are closely linked, due to the extensive use of abortion. Historically, modern contraceptive methods were generally not available. However, fertility is low in Georgia for other reasons besides abortion. The causes of low fertility are numerous:

Chapter 2. Fertility and Abortion

- 40% of women aged 15-49 are not married; and non-marital fertility is nearly zero,
- 90% of adolescents (aged 15-19) are not married,
- And their fertility rate before marriage is also nearly zero.
- Many married men are away from home, seeking work elsewhere.
- Married couples desire small families.

Also, in recent years contraceptive use has increased. Modern methods in 2010 were used by 34% of couples, in addition to 19% who used the traditional methods of rhythm or withdrawal, totaling over half of couples (53%).

The TFR (total fertility rate)¹ calculated from the 2010 survey, of 2.0 births per woman for the period 2007–2010, is the highest survey-based TFR ever reported for Georgia. It is 25% higher than the TFR of 1.6 births per woman observed for 2002–2005. In the main age groups from 20 to 34 the TFR rose by 30% to 35%. That is a remarkable shift, which is consistent with a “catch-up” in delayed childbearing as economic conditions improved. Note that this can “bunch-up” births within a few years, which elevates the fertility rate above its longer term trend. Thus 2.0 may or may not represent the future TFR.

The interplay between fertility, abortion, and contraceptive use appears in **Figure 2.1**. Contraceptive use (CPR)² rose from 41% to 47% of couples using a method between 1999 and 2005, which helped fertility to decline even though the abortion rate was falling. Then from 2005 to 2010 contraceptive use continued to rise, to 53% of couples, but the abortion rate³ fell very sharply, so the net effect was that fertility rose from 1.6 TFR to 2.0 TFR

-
1. TFR: Total Fertility Rate. The lifetime number of births a woman will have, based upon current age-specific rates. Note that this is a parallel to the TIAR.
 2. CPR: Contraceptive Prevalence Rate. The percentage of married/in union women aged 15-44 who currently use a method of contraception.
 3. TIAR: Total Induced Abortion Rate. The lifetime number of abortions a woman will have, based upon current age-specific rates.

The clear link between changes in abortion and fertility appears in **Figures 2.2 and 2.3**. Between the 2005 and 2010 surveys the fertility rate rose markedly at every age except 15-19, while the abortion rate fell substantially. The age patterns also appear in these figures. Note that the curves for fertility peak rather sharply at 20-24 whereas the abortion curves are spread out more widely and peak in 2010 at 25-29 and 30-34.

Figure 2.1 Changes in Fertility, Abortion Rate and Contraceptive Prevalence between 1999 and 2010 .

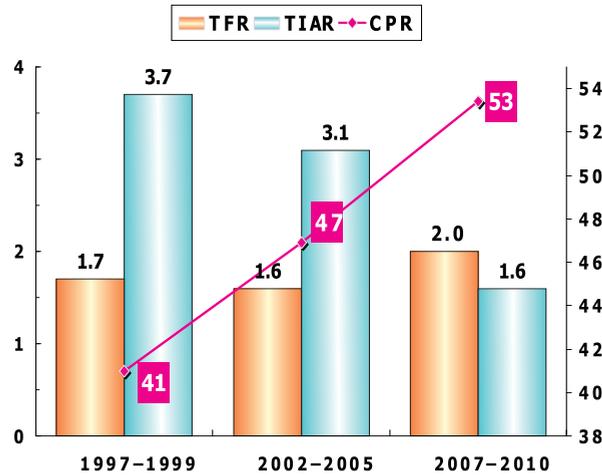
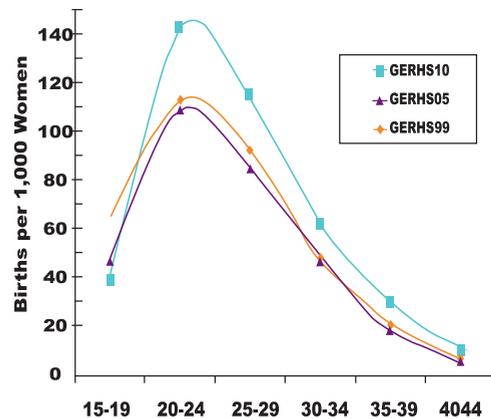


Figure 2.2 Three-Year Period Age-Specific Fertility Rates 1999, 2005, 2010



Traditionally, Georgian women initiate and complete child-bearing at an early age, as reflected in age-specific fertility rates for young women. The highest fertility levels were at ages 20-24 and 25-29, accounting for 36% and 29%, respectively, of the TFR. Fertility among adolescent women was low (39 births per 1,000 women aged 15-19), contributing to only 10% of the TFR. Fertility among women aged 30-34 was the third-highest rate, contributing 15% of the TFR (**Figure 2.4**)

Figure 2.3 Three-Year-Period Age-Specific Abortion Rates for Three Time Periods among All Women Aged 15-44 Georgia 1999, 2005, 2010

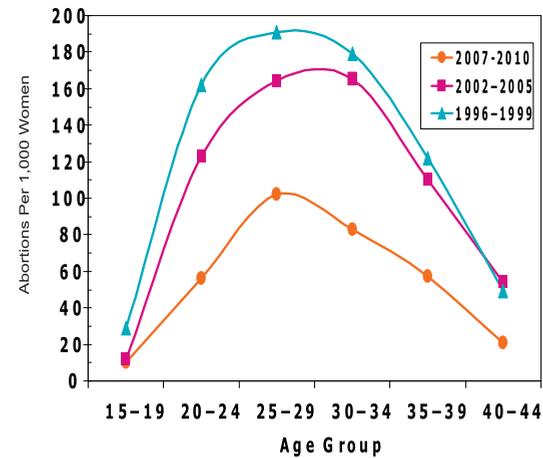
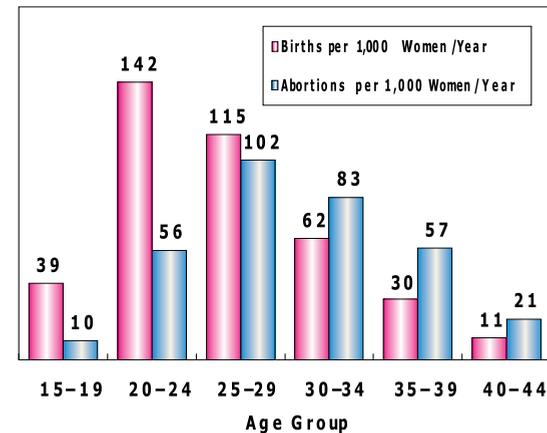


Figure 2.4 Three-Year-Period (2007-2010) Age-Specific Fertility and Abortion Rates per 1,000 Women Aged 15-44



Peak fertility occurred later, at ages 25–29, among women with the highest educational attainment, whereas at lower educational levels it occurred at ages 20–24. This partially reflects differences in the age at marriage; also lower education women are more rural, and rural fertility exceeds urban fertility.

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

In summary, current fertility has risen to 2.0 births per woman but is still below replacement and may reflect a temporary catching up from postponed childbearing. The average desired family size is small and cannot be expected to increase substantially. Increasing contraceptive use tends to replace abortions, and improved economic conditions lead to more wanted, planned births.

Fertility Changes Seen in Population Pyramids

The series of three population pyramids (Figure 2.5) for 1990, 2000, and 2010, reveals the historic changes in fertility in Georgia. In the 1990 pyramid the lower bars are of similar length and reflect generally stable conditions of both fertility

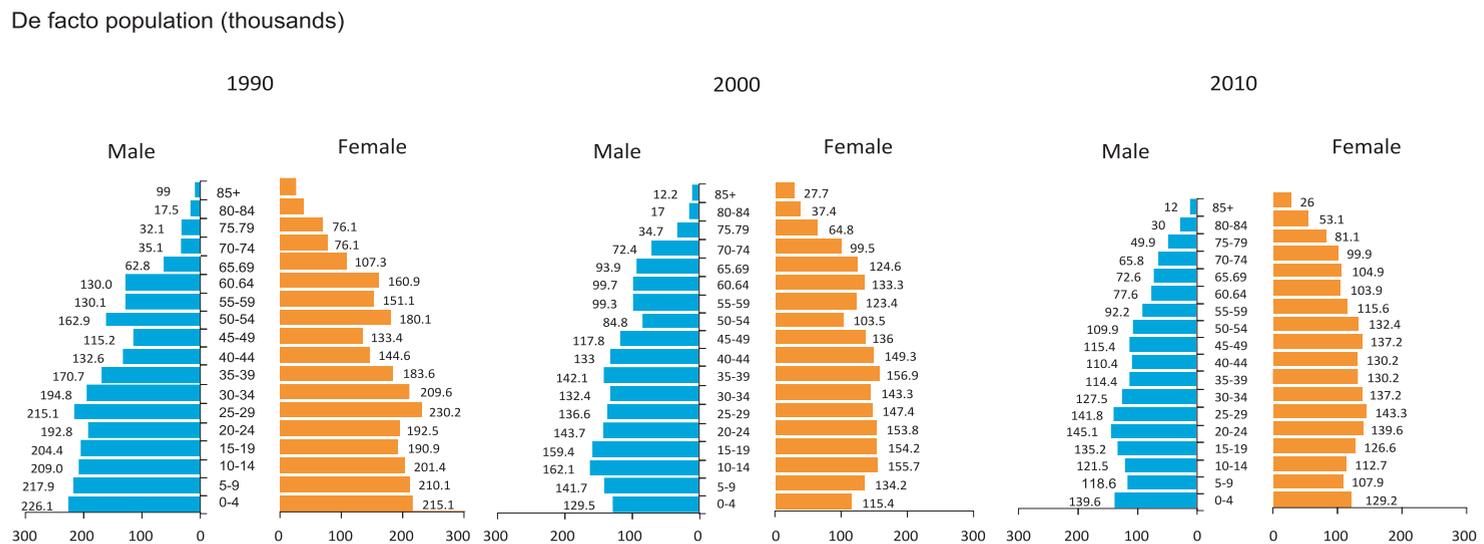
and mortality, with no great change (although the irregular bars higher up, starting at age 40, show the great dislocations due to World War II and the preceding decade).

By 2000 however the bottom two bars were shrunken, with drastically fewer children aged 0-9, due to a major drop in childbearing during the ten years after the breakup of the USSR. There were even fewer births in the 1995-2000 period (bottom bar) than in 1990-1995. The bottom bar is the smallest of any others until ages 50-54, a most unusual national picture.

The 2010 pyramid shows a partial reversal, as the bottom bar, for the 2005-2010 period, is longer than the bar above for 2000-2005. Thus there has been a modest resurgence of childbearing, one that is probably continuing. The recent trend is reflected in the TFRs discussed in this above.

(Note that the lower bars can reflect mortality changes and out-migration of parents hence fewer births, but the overriding determinant is clearly the fertility rate.)

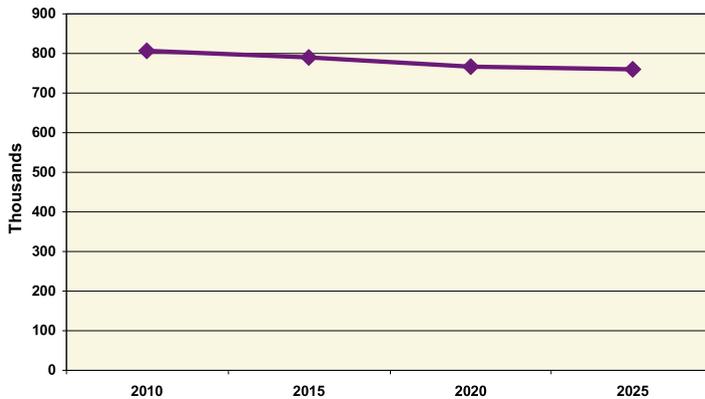
Figure 2.5. Population pyramids for 1990, 2000 and 2010



Future Shift to Older Women

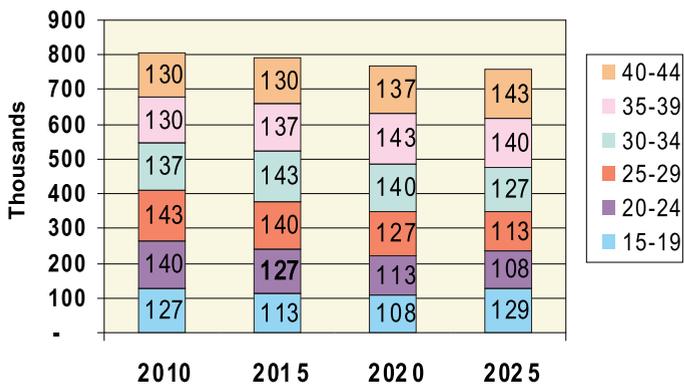
Using all women (not only married women) **Figure 2.6** shows that the total number of women aged 15-44 will not change much before 2025. In 2025 it will be 94% of its size in 2010, still high at about 750,000.

Figure 2.6 Number of Females Aged 15-44, Projected to 2025



However, the future age mix changes greatly (**Figure 2.7**), due to the very irregular population pyramids. Especially, there are decided declines in the youngest women. Ages 15-19 decline by about 19,000 between 2010 and 2020. Only in the final period, to 2025, do they recover, rising by 21,000 (thanks to the recovery of births in 2005-2010).

Figure 2.7. Number of Females by Age, Projected to 2025



The next higher age groups, 20-24 and 25-29 also decline, without any reversals before 2025. Then next, ages 30-34 are level till 2025. Finally the two older groups increase steadily. All this means that within the full age range 15-44 there will be a decided shift away from younger women, toward older women.

This does not consider the proportions married, which are only 11% at ages 15-19, 49% at 20-24, and about 78% thereafter. So within the shifts above, the absolute numbers of young married women will be smaller than the above numbers.

Because young married women will be fewer as the years go by, that tends toward fewer first births, and fewer unwanted pregnancies and abortions. Of course the desired family size may increase and make for more births, but only as a minor effect compared to the above. Finally, any rise in the marriage age (probably small) will increase the effect of fewer young married women.

Abortion Patterns

Basic patterns of abortion have, as noted, been changing rapidly, with a historic decline over the last decade. The decline in the TIAR was a full 57%, from 3.7 to 1.6. That downward trend appears in two other measures as well: the ratio of abortions to births fell from 2.1:1 to 1.5:1 and 0.8:1 across the three surveys. Also, the general abortion rate (abortions per year per 1000 women aged 15-44) dropped from 125 to 104 to 56, again a decline of over half (55%).

The age pattern follows that of fertility, but with some differences, since births concentrate at an earlier age than abortions do. More than one-half of Georgian women obtaining abortions in 2007-2010 were aged 25-29 (102 abortions per 1,000 women) and 30-34 (83 abortions per 1,000 women). The third highest age specific abortion rate, contributing to 25% of the TIAR, occurred among women aged 35-39. The abortion rate was significantly higher than the fertility rate 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 resort to an induced abortion.

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

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

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

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

Complications as reported by respondents amounted to 10% of all procedures: 6% immediate and 4% late sequelae. Complications were more common with D&C procedures than with mini-abortions, and increased with the length of gestation. Symptoms included pelvic pain, severe bleeding, and infectious vaginal discharge.

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

Finally, the 2005 survey shows that better access to contraception, with more reliance on modern methods, has helped to lead to a reduction in the national abortion rate. Still, greater efforts for better access are needed, especially since half of abortions are because the woman does not want any more children. If access to a variety of modern contraceptive methods can be improved, more women will become pregnant only when they wish to, and the abortion rate will decline.

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.

Sexual Activity, Pregnancy Intentions, and Future Fertility Preferences

Sexual activity before marriage is rare; 99.7% of never married women report never having had intercourse. Among currently married women, 80% report sex within the last month, and another 13% are pregnant or postpartum. Another 5% had sex within 3 to 12 months, and the rest over a year. Finally, among the previously married group 12% had sex within the last three months and another 12% within the last year; it is unclear whether some of these were still married at the time. The overall picture is one of fairly regular sexual activity among cohabiting couples.

Intentions: Most pregnancies in the last five years were planned, but a full third (36%) were not: eleven percent were mistimed, and 26% were not wanted at all. This compares to the higher levels in 2005 of 51% of women reporting their last pregnancy as unplanned and 59% in 1999, so the downward trend is favorable (**Figure 2.8**). Nevertheless, reliable contraception is not used by many women at risk, and accidental pregnancies occur frequently.

Figure 2.8. Number of Married Females by Age, Projected to 2025

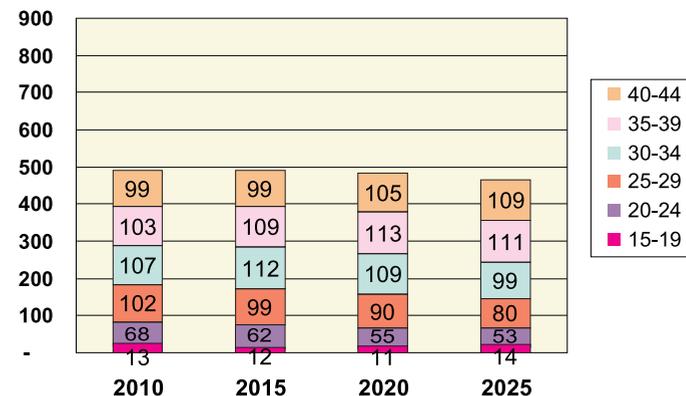
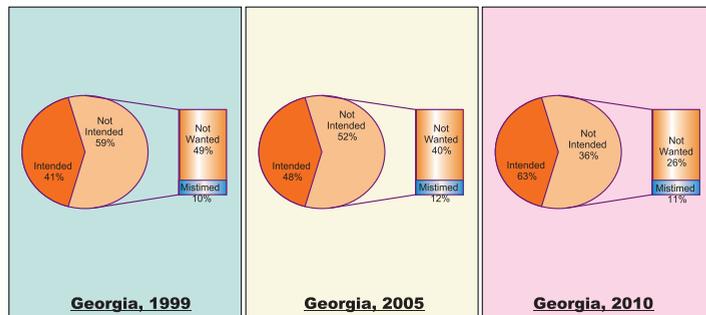


Figure 2.9 Planning Status of the Last Pregnancy Among All Women Aged 15–44 Years: 1999, 2005, 2010



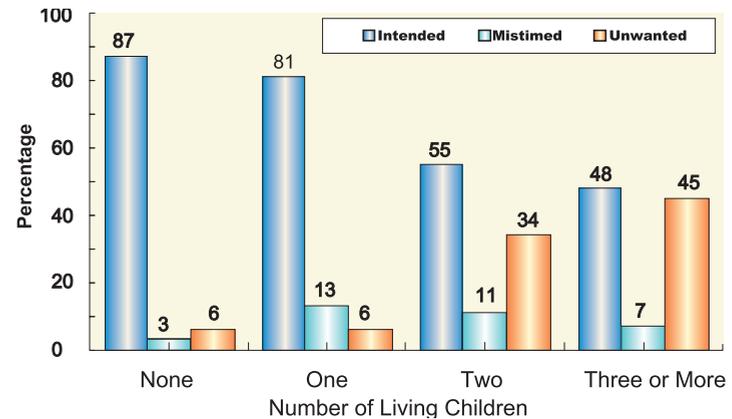
Unintended pregnancies are more likely to be associated with elective termination of pregnancy, inadequate prenatal care, unfavorable maternal behaviors, and pregnancy or perinatal complications (Brown and Eisenberg, 1995).⁴

Most pregnancies are intended when they occur to women who have no children yet or only one child (Figure 2.9). But only about half of pregnancies (55%) are intended among women with two children, and less than half for those with three or more. Most of the rest were unwanted, not merely mistimed. The age pattern echoes this trend: at ages 35–44, a high 54% of pregnancies were unwanted and only 42% were intended. The result is a large number of induced abortions.

The improved economic conditions by 2010 probably meant that more pregnancies were sought, or were continued once they occurred. In 2010 a third (35%) of married/in union women wanted more children, up from only 25% in 1999. That was consistent across all family sizes, and especially among women with two or more children (21%, up from 12% in 1999). The effect is dual: when pregnancies occur more of them are regarded as wanted, and additional pregnancies are actively sought. This tips the ratio of wanted pregnancies to total pregnancies, away from the unwanted share.

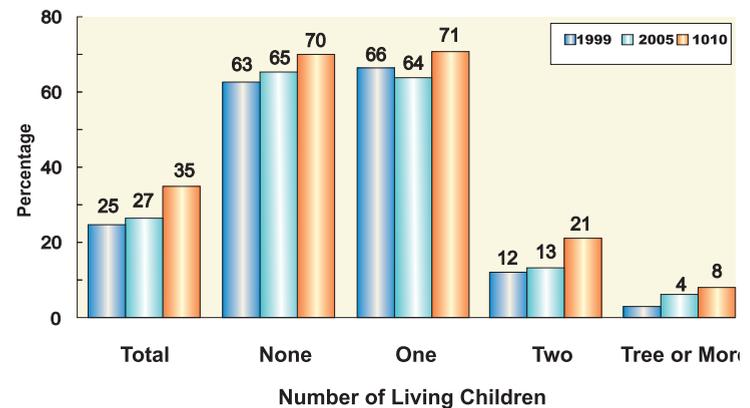
4. Brown, SS, and Eisenberg L., editors (1995). *The Best Intentions. Unintended Pregnancy and the Well-Being of Children and Families.* Washington, DC (USA): National Academy Press.

Figure 2.10 Planning Status of the Most Recent Pregnancy by Number of Living Children Among



Future Fertility Preferences: whether a married woman intends to have another child depends strictly upon the number she already has. Figure 2.10 shows the pattern: by far most (70%) married women with no children or only one child intend to have more, but that figure plummets to only 21% among those who already have two children. Notice however that the time trend is up in all groups by a considerable margin.

Figure 2.11 Intention to Have More Children by Number of Living Children, for Married Women Aged 15–44: 1999, 2005, 2010



There is an interesting range in the desired family size. Probably every woman with no child would prefer to have one or more, yet the figure shows that only 70% of married women with no child intend to have one. However another 29% of childless women reported that they are subfecund or infecund (that is why they have no children), and they say they lack an intention to have one.

Among women with only one child, one in six (17%) say they want no more. Among those with two children, that figure jumps to 64% saying they want no more, and to 81% among those with three children.

On the other hand, one in five (21% above) of those with two children intend to have at least three, and 8% of those with three children intend to have at least four. So the range of the desired family size is broad, from one to four or more.

The age pattern agrees: even at ages 35-39 one in six (17%) want a(nother) child, and 7% at ages 40-44 say they do so. That is balanced by 66% and 73% respectively who want no more. Most of the rest are subfecund or infecund.

On average, for all married women aged 15-44, 35% want more children, but with variable timing. Ten percent want a pregnancy right away, 4% within a year, 7% within 1-2 years,

and 14% after two or more years. That may relate to the age of the youngest child already living, to allow for birth spacing. Also, those saying they want pregnancy only later may be less motivated to have it.

(The ideal family size is discussed in a later chapter).

Infecundity

The 2010 survey also asked about impaired fecundity and services received for them. This reflected a growing concern about possible increases in sexually transmitted infections and PID cases. It is thought that infertility cases have increased and that the strong cultural pressure for conception soon after marriage leads to more women seeking diagnoses of delayed pregnancy.

Ten percent of respondents in the survey reported “ever” having received infertility services; this percentage was highest in Tbilisi, which offers more medical services that can diagnose fecundity impairments. Five percent of respondents reported current impairments; this was highest in rural areas. Impairments increased with age from only 1.5% at ages 20-24 to 13% at ages 40 and older. Elevated levels of impairment were reported by women with past PID episodes.

Chapter 3. Maternal and Child Health

Maternal mortality remains higher than it should be in Georgia, and maternal morbidity cases are too numerous. Better health depends partly upon women's choice of when to have a birth, and that requires better contraceptive availability, discussed in the next chapter. Child health and survival too are affected by the mother's health and survival. This chapter presents current conditions and action needs for the following features of maternal and child health.

- Maternal Mortality
- Prenatal Care
- Intrapartum Care -- means during delivery and postpartum/ Caesarean
- Postpartum itself
- Smoking and Drinking while Pregnant (cross ref. to Health Behavior chapter)
- Pregnancy and Postpartum Complications
- Breastfeeding
- Poor Birth Outcomes
- Infant and Child Mortality

Maternal Mortality

The leading cause of death for women of reproductive age in developing countries is complications from pregnancy and birth. If the mother dies the infant often dies as well, and sick mothers cannot care well for their children. In Georgia it is difficult to know the exact maternal mortality level since the number of deaths is small in each year, but a special study for 2008-2009 put the maternal mortality ratio at 66 deaths per 100,000 live births,¹ well below the European average of 21.² The official statistics show a long term downward trend after the mid-1990s but probably omit some events and show the latest ratio well below the special study.

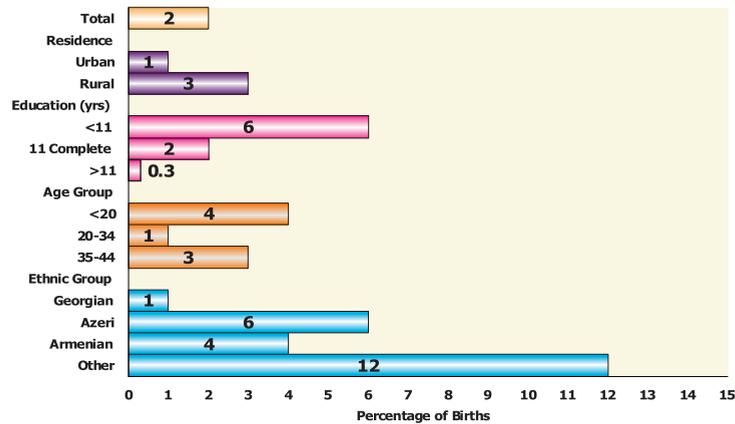
Prenatal Care

Georgia, like most former USSR republics, has had a comprehensive system of maternal care with good coverage of prenatal visits. As **Figure 3.1** shows, only 2% of births in the 2010 survey lacked prenatal care of some type. Care was less frequent for women with less education, for the youngest women, for the Azeri group, and for the "other ethnic" group. Among the regions, only Kakheti was notable, with 7% having no care (not shown).

1. Serbanescu, F. et al. 2009. *Reproductive Age Mortality Study, Georgia, 2008 -- Part II: Maternal Mortality*. Georgian National Center for Disease Control, JSI Research & Training Institute, Inc. and CDC, Atlanta, Georgia, USA. The study was of the RAMOS type.

2. *Time Trends in Maternal Mortality 1990 to 2008: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*. WHO, 2010.

Figure 3.1 Percentage of Women Receiving No Prenatal Care by Selected Characteristics—Births in 2005–2010



- Trend: The movement toward universal care since 1999 is favorable (**Figures 3.2 and 3.3**) especially in rural areas, where the percent with no care fell from 14% to 3%. The low education group showed a dramatic decline from 30% to 6%, as did the Azeri group with a nearly equal decline from 28% to 6%.

Figure 3.2 Percentage of Women Receiving No Prenatal Care by Residence Births in the 5 Years Prior to GERHS: 1999,2005,2010

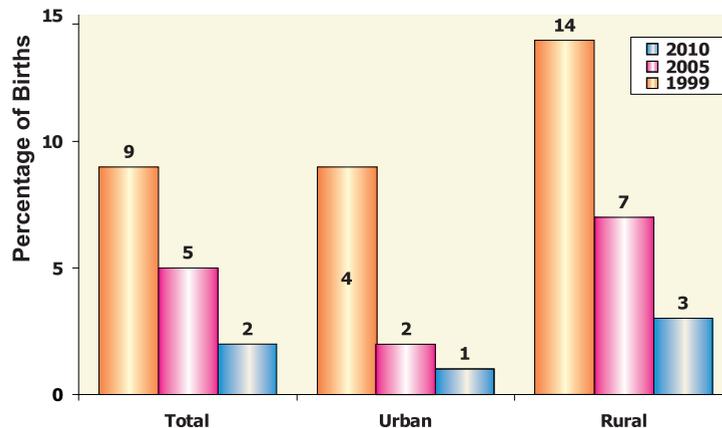
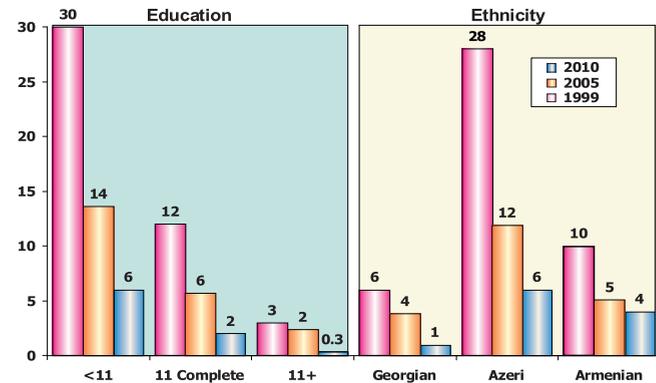


Figure 3.3 Percentage of Women Receiving No Prenatal Care by Selected Characteristics Births in the 5 Years Prior to GERHS: 1999, 2005, 2010

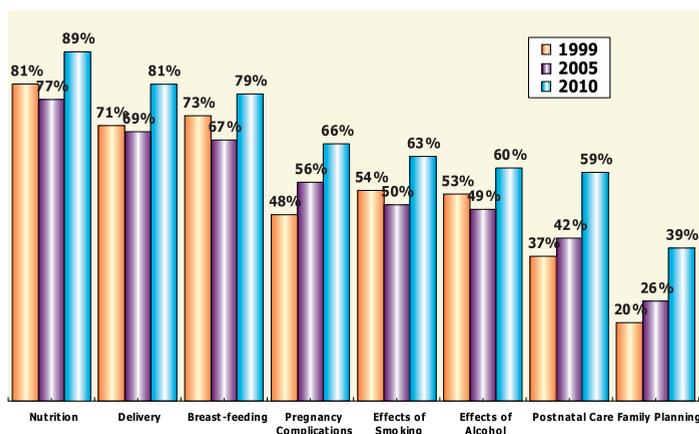


- The timing of care also improved: in 1999 only two thirds (63%) of cases were seen in the first trimester, and that rose to a full 90% by 2010. Moreover the improvement was fairly consistent across all population subgroups.
- The frequency of visits per woman also improved. The percent receiving four or more examinations rose from 76% in both 1999 and 2005 to 90% in 2010. Moreover the improvements included some of the most disadvantaged subgroups such as rural women, the low education group, and those in the southern regions. However birth order mattered: only 80% of third or higher order births received four or more examinations compared to 94% among first order births.
- The source of care is predominantly the Women's Consultation Clinics (WCC). Half (49%) of births in the last five years occurred there, with second place going to City Maternity Hospitals (27%) and third place to Regional Maternity Hospitals (17%). Primary Care Centers covered 7% of cases.
- Counseling is vital in the first prenatal visit, to catch danger signs, and to give advice on the best behaviors during gestation. Most pregnant women received counseling on various topics (**Figure 3.4**) and the greatest improvements were for family planning, postnatal care, and pregnancy complications. However family planning

counseling still went to only 39% of women seen. That is a serious shortfall since many women accidentally conceive again soon after the current pregnancy ends.

- Recent changes: Interestingly, little change in all these indicators occurred in the first period, 1999 to 2005, but considerably more in the latest five years. This pattern also appeared for changes in both the fertility rate and the abortion rate. The precise reasons are unclear but possibly include better socioeconomic conditions, higher family incomes, and changes in service networks, with continuing assistance from donors and from local NGO agencies.

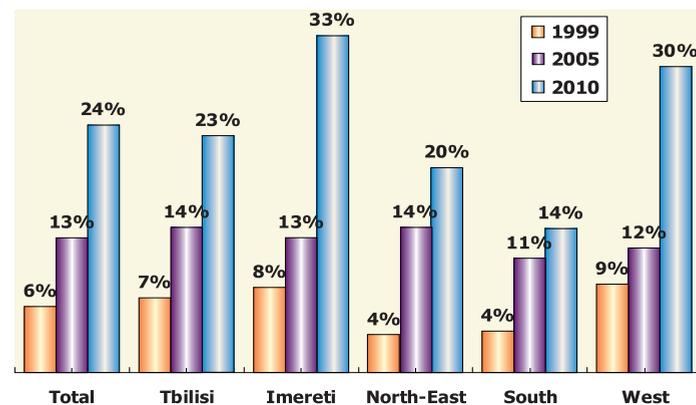
Figure 3.4 Type of Counseling Received during Prenatal Care
Births in the 5 Years Prior to GERHS: 1999, 2005 and 2010



Care during delivery

Cesarean deliveries accounted for a high one-fourth (24%) of all births in medical facilities in the five years prior to the 2010 survey (99% of all births were in medical facilities). Cesarean deliveries have actually tripled since 1999, in every region but one. The average rose from 6% in 1999 to 13% in 2005 and to 24% in the 2010 survey (Figure 3.5).

Figure 3.5 Percentage of Caesarean Deliveries by Region
Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



Remarkably, the percentage of cesarean deliveries was 40% at ages 35-44. It was understandably high among women with any complication (36%), and in cases of prolonged labor (41%). It was lowest in the least educated group (16%) and at third or higher birth orders. Reasons given by respondents for cesarean deliveries were most often a previous cesarean procedure, the respondent's own request, and the usual medical indications.

Home deliveries have nearly disappeared in Georgia. In general they carry more risks than facility deliveries. Comparing births in the five years before the 2005 and 2010 surveys, the decline was from about 8% to 2% of deliveries occurring at home. Large declines occurred where home deliveries were most frequent, for example from 30% to 8% in Kakheti region and from 40% to 5% among Azeri women. Consequently the low 2010 average was fairly uniform across population sub-groups.

Postpartum Care

Georgia has lagged behind other countries in the region in the prevalence of postpartum care; only 23% of mothers received any postpartum care in the 2010 survey (for births in the previous five years), and this was about the same as found in the 2005 survey. Postpartum care increased with education and wealth quintiles but especially so among mothers with postpartum complications (44%). Of women receiving any postpartum care, about three-fourths received counseling on breastfeeding and child care. Unfortunately, only 43% received counseling on family planning; that is 43% of the 23% who received any postpartum care, or a mere 10% of all new mothers.

About one in six mothers (16%) did not take the infant for a well-baby check. Among those who did so, 22% did so within six days and another 53% within two weeks after delivery, the rest somewhat later.

Smoking and Drinking During Pregnancy

Smoking and drinking while pregnant elevate the risks of unfortunate outcomes for the infant, and drinking increases the chance of a miscarriage, stillbirth, premature delivery, or birth defect.³ In Georgia relatively few women were either smoking (4%) or drinking (1%) at the time they became pregnant. Less than half of the smokers continued to smoke while pregnant. (See separate chapter on Health Behaviors.)

Pregnancy and Postpartum Complications

Complications while pregnant affected 16% of mothers (births in the last five years) sufficiently to require medical attention, and almost one in three of these were hospitalized. Complications rose with age and affected 20% of women 35-44. Also, 21% of these older women reported high blood pressure during pregnancy. Most pregnancy complications were due to preterm delivery, anemia, water retention or bleeding.

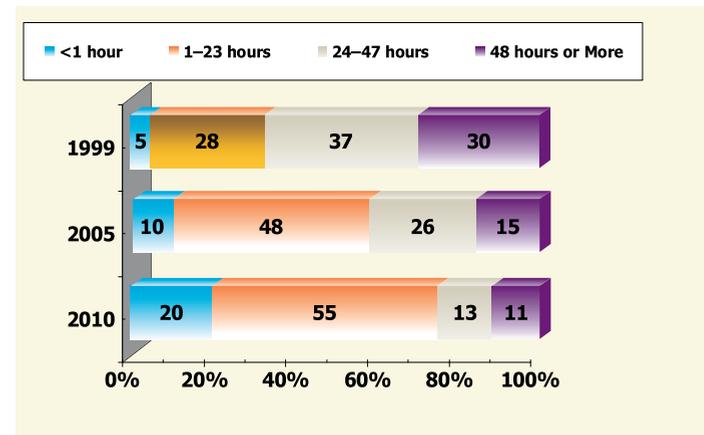
3. Wilsnack SC et al., 1984. *Drinking and Reproductive Dysfunction among Women in a 1981 National Survey*. *Alcohol, Clinical and Experimental Research*; 8(5):451-458. See also Kesmodel U et al., 2002. *Moderate Alcohol Intake in Pregnancy and the Risk of Spontaneous Abortion*. *Alcohol & Alcoholism*; 37(1):87-92.

Complications after birth (postpartum) affected 11% of mothers. Most often reported were severe bleeding, painful uterus, high fever, breast infection, infectious vaginal discharge, painful urination, or infection of the surgical wound.

Breastfeeding

Some breastfeeding is common, as it is used by seven-eighths of mothers (87%), and there is a favorable trend in its early initiation (**Figure 3.6**). Among breastfeeding mothers, since 1999 the percent initiating it within the first hour has risen markedly from 5% to 20%, and the percent starting within the first 24 hours has jumped from only 33% to 75%. WHO recommends that all newborns should be breastfed within the first hour, so the 20% figure is still far below that standard. Cesarean deliveries (23% of all births) cause a delay in initiation, as only 60% of cesarean infants were fed within the first 24 hours.

Figure 3.6 Initiation of Breastfeeding Following Birth (in Hours)
Live Births in the 5 Years Prior to GERHS: 1999, 2005, 2010



Some level of breastfeeding continues for an average of 12 months in the 2010 survey, up from 10%-11% in the two previous surveys. However “exclusive” breastfeeding (only breast milk) lasts only three months, and “full” breastfeeding (exclusive or with some liquid supplementation) lasts only 4 months. That pattern, of a relatively brief period of full breastfeeding, is common in most developing countries.

Poor Birth Outcomes

Three types of poor outcomes were measured in the 2010 survey, concerning births in the previous five years:

- Stillbirths occurred in 8 of 1,000 pregnancies (lower than the rate of 13 per 1,000 reported by governmental sources to WHO). However the rate was twice as high in urban areas as in rural areas, and was highest among women not receiving prenatal care (50/1000), women who suffered complications during pregnancy (33/1000) and women with prolonged labor (30/1000). Clearly, stillbirths cannot be overlooked when they cause a loss of the infant in 3% or more of pregnancies among some subgroups of mothers.
- Low birth weight (under 2,500 grams) occurred for 4% of infants born alive; this was higher for older mothers (11%), those having cesarean deliveries (8%), and those with complications during pregnancy (11%).
- Premature births (before 37 weeks of gestation) occurred among 4% of all births. Higher rates were associated with the same maternal and pregnancy characteristics as for the risk of low birth weight.

Infant and Child Mortality

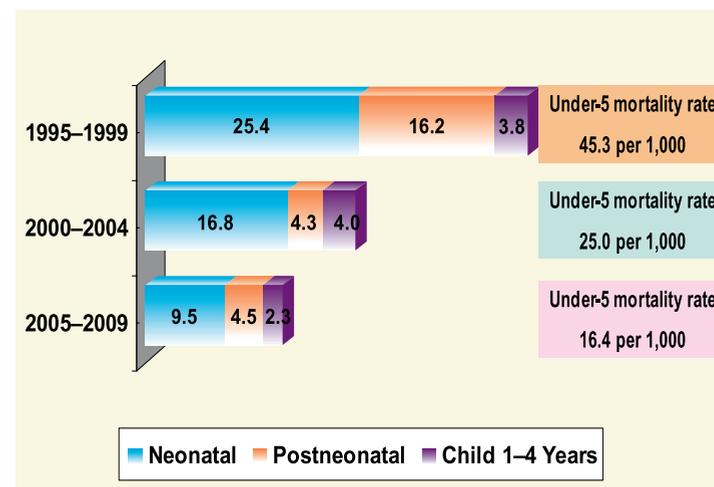
By the latest estimates (2009) infant mortality in Georgia has fallen to about 1.4% of all births (14.1 - 14.9 per 1000 live births). It is made up of two parts: neonatal (first 28 days), and post neonatal (29 days to 11 completed months). In addition is child mortality (1 to 4.9 years). The sum of all three parts is "Under 5" mortality: the death rate during the first five years of life.

The long term trend, from the 1999 to the 2010 survey, is an impressive decline of two-thirds (64%) in the Under-5 rate: from 45.3 to 16.4 (**Figure 3.7**). Note that the third part, for deaths after the first year of life, was already a minor factor in 1995-1999 and remained a small part thereafter.

Most deaths are in the first year, and by 2005-2010 most were in the first month of life (9.5 rate out of 16.4 per 1000). The main decline for post neonatal deaths occurred before that, falling to a stable, low level of 4.3 and 4.5 in the last

two surveys. However, as in other countries, neonatal deaths are more resistant, and less subject to general nutrition and environmental improvements. Instead, in most developing countries they reflect deaths from such causes as early infection, prematurity, and asphyxia. Consequently, their proportion of total deaths increases as the overall rate falls.

Figure 3.7 Mortality Rates Under Age five in the 5 Years Prior to GERHS: 1999, 2005, 2010



Further advances against neonatal deaths depend especially upon measures taken in the first seven days (which account for most neonatal deaths), addressed to birth asphyxia, prematurity, and maternal morbidity during labor, as well as to close postpartum monitoring. Later neonatal deaths, due more to infections, can respond to better access to emergency obstetric and neonatal care.

All infant/child death rates can be lowered by increased contraceptive use, which is selective in the pregnancies it averts; for example, infant mortality is especially elevated at third and higher birth orders (one-half higher than the overall average), which tend to decline as contraceptive use increases.

Chapter 4. Contraception

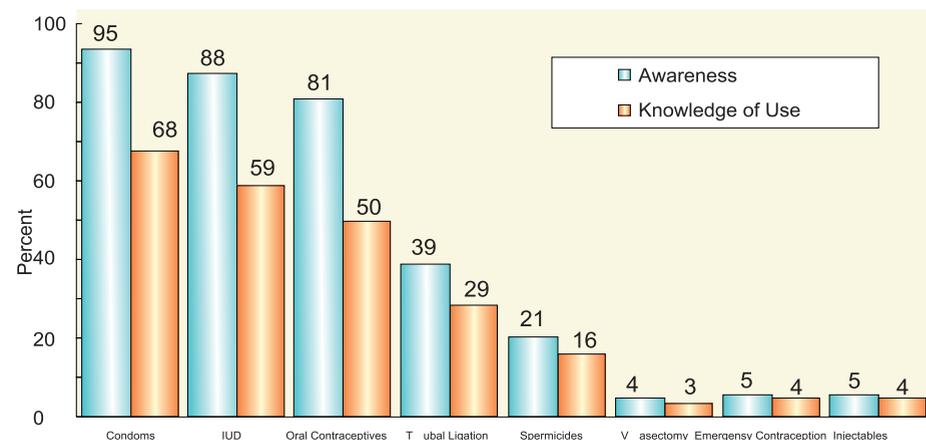
Contraceptive use has been increasing in Georgia, but only to 53%, and a third of this is for traditional methods with their high failure rates that frequently end in abortions. Knowledge of modern contraceptive methods is uneven and often erroneous, especially regarding how to actually use each method. One in eight (12%) married women wish to avoid pregnancy but are not using a method (“unmet need”). When these are added to the 19% who use traditional methods the total unmet need, for a modern method, is 31% of all married women. So triple actions are required: better public information, better postabortion and postpartum counseling, and better access to a full range of modern methods.

Contraceptive Awareness and Knowledge. Knowledge about contraception is uneven, especially for knowledge of how to use each method. Virtually all respondents (96%) had heard of at least one modern method -- particularly the condom (95%), IUD (88%), and oral contraceptives (81%), but only 39% of women had heard of tubal ligation and very few (4%) had heard of vasectomy. A sizeable gap exists for every method between awareness of the method and knowledge of how it is used (**Figure 4.1**).

Also, most women do not know how effective the methods are. The failure rates (accidental conceptions) vary widely. While 3% of women correctly stated that IUDs are very effective in preventing pregnancy, only 16% believed that sterilization is very effective. Most women incorrectly thought that pills were not very effective.

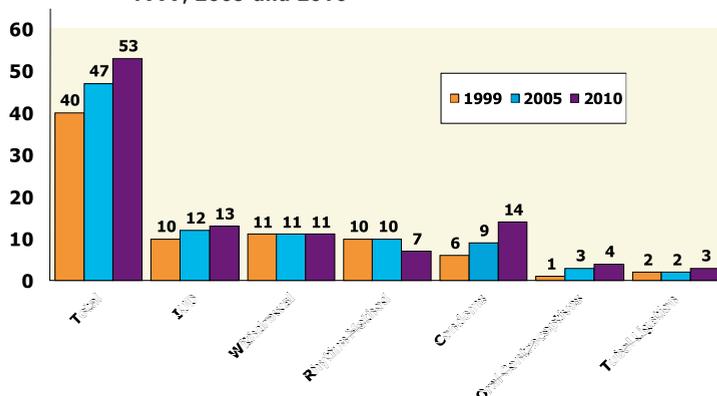
Traditional method users (about a third of all users) are mistaken about the reliability of their method. About 75% of them considered their method equally effective or even more effective than modern methods. As to why they use it (rhythm or withdrawal) instead of a modern method, many cited fear of side effects, cost, poor availability, or lack of knowledge. These point to the need for more vigorous information and education on the pros and cons of each modern method and where to obtain it.

Figure 4.1 Awareness and Knowledge of How to Use Modern Contraceptive Methods among Women Aged 15–44 Years



Contraceptive Use. Nearly all contraceptive use is among married women aged 15-44. More than half of them in 2010 (53%) were currently using contraception, including 35% using modern methods. The use of modern methods rose sharply from 20% in 1999 to 35% in 2010. For the first time, the prevalence of modern methods exceeded the prevalence of traditional methods, which declined. The greatest increases were for the IUD and condom (Figure 4.2)

Figure 4.2 Trends in Contraceptive Prevalence, by Specific Methods among Married Women Aged 15–44 Years; 1999, 2005 and 2010



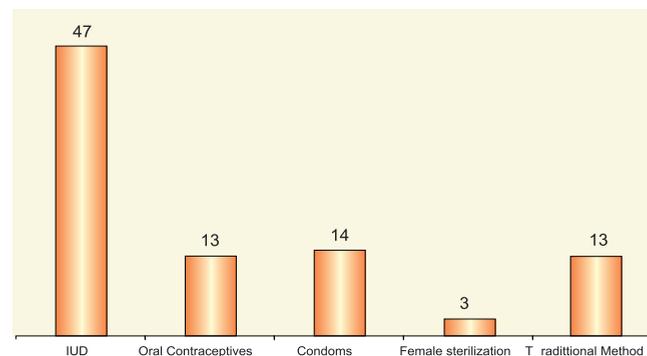
Method Mix. (The following percentages add to 100%, for all users). Among all current contraceptive users 26% were using the condom, followed by 25% using the IUD, 21% using withdrawal, 13% using periodic abstinence, 7% using the pill, 5% using tubal ligation, and 3% using spermicides.

Preferences. Many users would prefer a different method from the one they are using. Fully a third of condom users are dissatisfied, but nearly all IUD users were satisfied. Only 3% of IUD users desired a change. Pill users were intermediate at 17% and spermicides at 19% preferring a change. The most frequently cited reasons women gave for dissatisfaction with their current method included inconvenience, “nuisance” factors, low effectiveness thus risking pregnancy, and proneness to forgetfulness. In some cases users have tried alternative methods but find them even less satisfactory than the one they use.

The popularity of the IUD appears in another way: among women desiring to switch methods, over two-thirds (68%) pre-

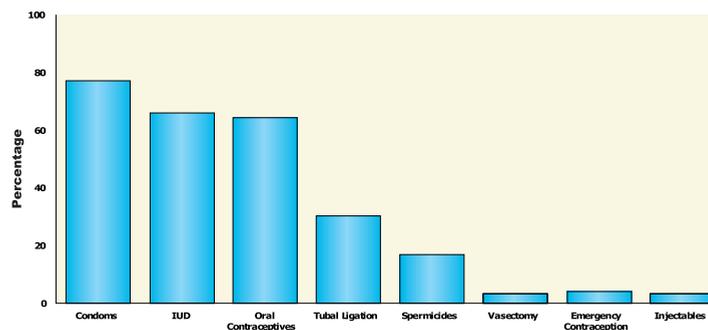
ferred the IUD. Family size mattered, as interest in female sterilization rose with the number of children. Yet another sign of the IUD’s popularity came from women using no method at all but who plan to do so in the future: 47% preferred the IUD compared to only 13% to 14% for the condom or pill (Figure 4.3). This may reflect the history of the former USSR, in which the health system favored the IUD over such alternatives as the pill.

Figure 4.3 Preferred Method of Contraception Among Fecund Married Women Aged 15–44 Who Are Not Currently Using Contraception and Desire to Use in the Future



Sources of Supply. Many women do not know where to go to obtain contraception. Even condom sources are known by only 77% of women, leaving 23% apart. The percentage declines for each additional method shown in Figure 4.4, to only two thirds of women for the IUD and pill, and a mere one third for tubal ligation and much less for the other methods shown.

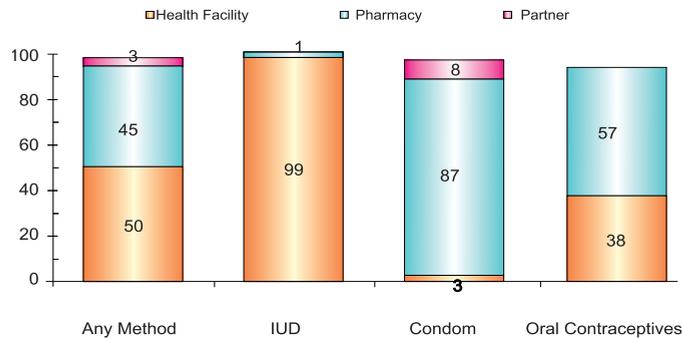
Figure 4.4 Knowledge about a Source for Specific Modern Contraceptive Methods Women Aged 15–44 Years



About half of women receive their contraceptives from facilities such as health care clinics/centers, women's consultation clinics (WCC) and city or regional hospitals with gynecology wards. Commercial sales, specifically pharmacies, were the second largest source (45%). About 5% used other sources such as partners, friends, relatives, and the open market (**Figure 4.5**).

This varies significantly by method: 87% of condom users go to pharmacies, as do 57% of pill users, while 99% of IUDs are obtained from health facilities, along with 38% of pill supplies. Pharmacies have gained since 1999: only 37% of users patronized them in 1999 but 45% did so in 2010. Most probably condom purchases at pharmacies are by husbands and most pill purchases by wives. Use of both condoms and withdrawal reflect the husband's role and perhaps reinforce his sense of being the decision maker.

Figure 4.5 Source of Supply for Modern Contraceptive Methods Among Married Women Aged 15–44 Currently Using a Method



Reasons for not using a method: about half of married women (47%) do not currently use a method, and the reasons differ greatly across the age groups. In the youngest group (15-24) 55% are currently pregnant and another 24% wish to become pregnant. In the oldest group (35-44) 37% report female infecundity, 16% are not sexually active, and 12% rely on douching. Thus the population is complex regarding who is interested in using a method, or switching methods, or feeling in need of a method. Two groups are of particular importance: those using traditional methods, at considerable risk of an accidental conception, and those wanting protection against conception but who for various reasons have “unmet need,” discussed below.

Failure and Discontinuation Rates. Of all women who start on a method, a certain percentage will become accidentally pregnant, or stop using the method for other reasons. These percentages can be calculated as of one year after starting, or two years, or three years, etc.

Merging all methods, the percentage becoming pregnant during use is 10%, 17%, and 22% at one, two, and three years respectively. Considering pregnancies along with all other reasons for discontinuing use, a total of 35%, 53%, and 64% stopped by one, two, and three years respectively. Thus accidental pregnancies account for about a third of all discontinuations.

The data do not show what women do after stopping a method, but the possibilities include the following.

- Some switch to another method, either one they used previously or a new one.
- Some use nothing, and some of those have an unplanned pregnancy and chose an abortion (along with some who became pregnant while using and chose an abortion.)
- Some who stop using a method intend to adopt another one, but while they delay they have an unplanned pregnancy. The most fecund couples conceive quickly, so an interruption of protection often leads to an early conception.

Unplanned pregnancy rates are worst for rhythm and withdrawal: about a fifth (18% to 21%) of users encounter a pregnancy with a year, and 30% to 33% do so within two years. The IUD has the lowest pregnancy rate: only 0.9% within a year and only 1.7% within two years. The pill is higher at 7.5% and 10.0% respectively; if actual use by the woman was perfect the pill should not fail, but in practice there are lapses in perfect use. The condom fails for 5% of users in the first year and 10% by the second year; these figures are considerably lower than in many countries and may reflect some under-reporting.

Thus no method is entirely satisfactory, though the IUD comes closest both in practice and in its general popularity. Sterilization is used by only 3% of married women, but this rises to

6% at ages 40-44 and to 8% for those with three or more children. Those sterilizations occurred over past years, so the number of adoptions each year has been small. However half (49%) of married women say they have heard of tubal ligation and 37% say they know how it is applied, so there is future potential for its adoption by more women who wish to entirely stop childbearing.

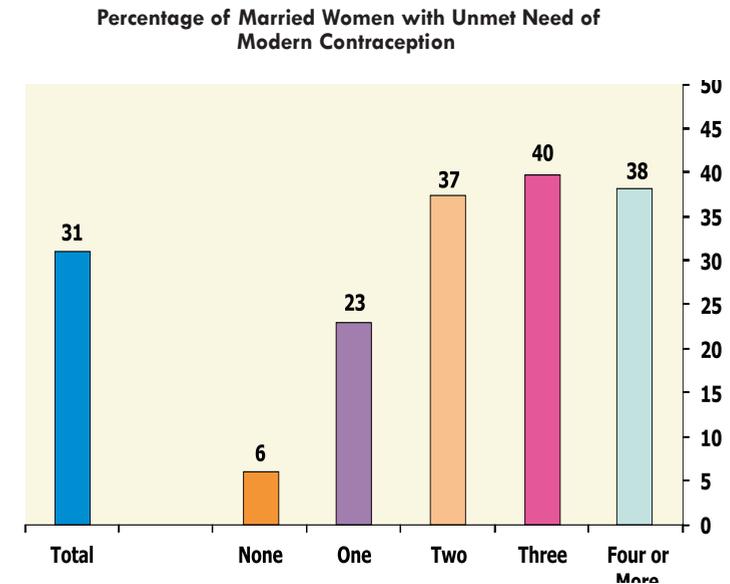
Need and Demand for Contraceptive Use. One in eight (12%) married women wish to avoid pregnancy but are not using a method (“unmet need”). When these are added to the 19% who use traditional methods the total unmet need, for a modern method, is 31% of all married women.

“Demand” includes unmet need. It is simply the sum of unmet need and current contraceptive prevalence. The 2010 survey found 53% prevalence and 12% unmet need, so the total of 65% represents “demand.” That indicates the total percent of married women who would be using a method if all the unmet need were satisfied. When the traditional method users are assumed to be also in need (of a modern method) they are shifted out of the using group and into the unmet need group, which then rises to 31% of married women, with only the modern users (34%) kept as the prevalence group.

Unmet need in 2010 was only half of the level documented eleven years ago, in 1999 (12% vs. 24%), since contraceptive use has increased; also some increase has probably occurred in women wanting the next birth. As of 2010 unmet need rises with rural residence, low education, and poor wealth quintiles. Most is for limiting rather than spacing, in a 2 to 1 ratio.

The size of the group in need differs sharply according to the woman’s number of children (**Figure 4.6**). At no children most women are young and want their first child. At one child this jumps to 23%, and then levels off at the high levels of 37% to 40% for larger numbers of children. The figure testifies to the large proportions of married women who are exposed to an unwanted pregnancy and lack contraception.

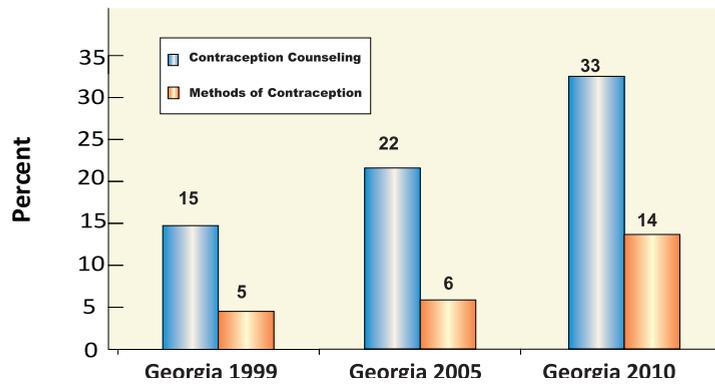
Figure 4.6 Current Unmet Need for Modern Contraception by Number of Living Children Among Married Women Aged 15-44



in summary, besides the 53% of married women who use a method, 12% are currently pregnant or postpartum, 8% are seeking to become pregnant, 9% are infecund, 6% are not sexually active, totaling 88%. The other 12% have an unmet need, or 31% do so including traditional method users. (Note also that some who are postpartum will soon be exposed to an unwanted conception and will join the group in need.)

Contraceptive Counseling. Counseling for contraception often falls short of the need for full information about a range of methods. Two groups are especially critical, postpartum and postabortion women, since they identify those women most subject to unwanted conceptions in the future. For abortion cases the counseling trend is upward since 1999 but only to a mere third (33%) of cases (**Figure 4.7**), and only 14% received counseling for specific methods.

Figure 4.7 Receipt of Contraceptive Counseling at the Time of an Abortion in the Last 5 Years Georgia, 1999, 2005, and 2010



Sources of contraceptive advice vary widely. Over half of past or current users (55%) mentioned an Ob/Gyn, but others started using their last method at the partner's suggestion (24%), at their own counsel (9%), at the suggestion of a friend (5%), or relative (4%), bypassing any potential family planning counseling. About a tenth (9%) said that nobody had advised them.

The source depended largely upon the particular method. Nearly all IUD (94%) and sterilization (90%) users received advice from an Ob/Gyn, as did 78% of pill users. At the other extreme, only 12% of condom users did so. They were advised by partners (57%), nobody (20%), or friends/relatives (7%).

Chapter 5. Women's Health Behaviors

Women's own habits control much of their health, but both private and public services need improvement, especially for disadvantaged groups in the population. Costs remain a serious barrier, causing delays in obtaining medical care. Insurance covers only a fifth of the population. Routine gynecological visits are uncommon; only a tenth of women have had a mammogram and only a fifth have heard of the HPV infection or the vaccine for it. Smoking and drinking are lesser problems but levels are higher in some subgroups.

The right personal practices can reinforce formal medical care to enhance women's health. Getting regular exams and screenings, and avoiding smoking and excessive drinking, can go far to reduce illness and improve health. This chapter presents a variety of information on women's practices that impinge on their well-being.

Basic picture: About 37% of women aged 15-44 reported visiting a health care facility in the last year. Among these one half (51%) were seen for acute care, 41% for preventive care including family planning services, and 20% for care of a chronic condition (summing to over 100% due to multiple visits). Most (79%) reported having a usual place where they obtain most of their health care; among these most obtained the care in hospitals (38%) and ambulatory clinics (i.e. polyclinics and women's consultation clinics) (26%). Only a minority obtained their usual care in primary health care (PHC) facilities (14%).

Delays in getting medical care occur often, and are often due to costs. 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.

Health insurance is uncommon: only 22% of women had any health insurance at the time of the interview. Due to the unequal geographical distribution of the population below the poverty level, insured women in rural areas were much more likely to have government-supported health insurance (70%) rather than private insurance (30%), compared to urban women (29% and 71% respectively.)

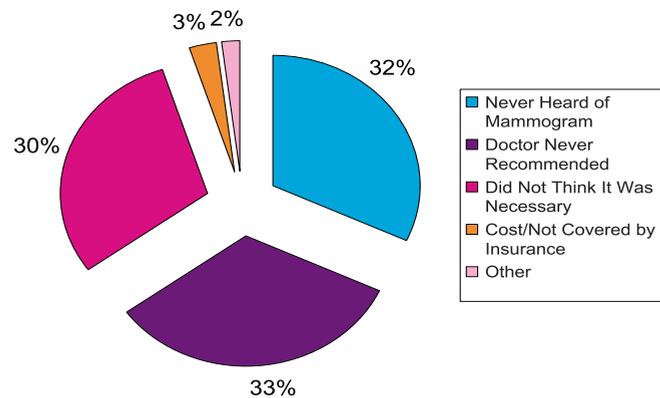
Cancer Screening: Routine gynecological visits remain too infrequent in Georgia, since only 24% of women with sexual experience had accessed this preventative service. ("Sexually experienced" refers primarily to all married women.) The low prevalence of routine gynecologic exams inevitably has an impact on the early detection and treatment of gynecologic cancers, since screenings for cervical and breast cancer are generally provided or prescribed during the routine gynecologic visits. This also has a substantial negative effect on family planning counseling and on dissemination of other health messages.

Self breast exams can help detect cancer, but only 42% of sexually experienced women had ever performed BSE (breast self exam). This was higher than in 2005 (29%), but still too low. Regarding BSE frequency, 17% of sexually experienced women reported doing one every month, 12% every 2-5 months, 12% every 6-12 months or more, and 58% never.

BSE is not adequate on its own; consequently, women were also asked about the utilization of CBE (clinical breast exam) and mammography. Less than one in five (18%) of sexually

experienced women had ever had a CBE (done by a health professional to detect abnormalities). Since breast cancer increases with age, mammography screening is oriented more to older women, but only 10% of women aged 40-44 have ever had a mammography. Among all women 15-44 the three most important reasons women gave for never having a mammogram were lack of a recommendation from their health provider, saw no need for it, and never heard of it, totaling 85% of all reasons. (Figure 5.1)

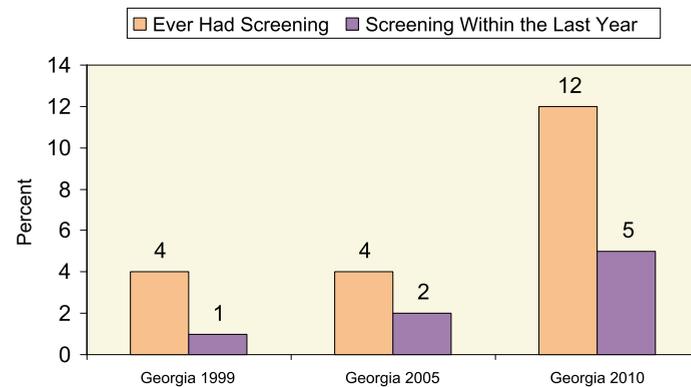
Figure 5.1 Most Commonly Cited Reasons for Never Having Had a Mammogram Among Sexually Experienced Women Aged 15-44



The prevalence of screening for cervical cancer was also low: only 12% of sexually experienced women ever had a Pap smear test; however, that represents a three-fold increase from the 4% reported in both 2005 and 1999 (Figure 5.2). A major campaign to increase cancer screening has been launched in recent years, which began in Tbilisi and spread outward. A study of the early experience (eight months ending in December 2008) was conducted¹ to relate the number of screenings to the costs, in order to project an expansion of the program into the future, to 2015. Screenings for cervical cancer and for breast cancer were analyzed separately, taking into account that most (77%) women had both. The cost per screening in the study was about \$15 per cervical case and about \$12 for breast case, figures that now need updating due to the much enlarged scope of the program.

1. J. Ross, 2009. "Reproductive Health in Georgia: Contraception, Abortion and Costs." Tbilisi: United Nations Population Fund (UNFPA).

Figure 5.2 Prevalence of Cervical Cancer Screening Tests Among Sexually Experienced Women Aged 15-44

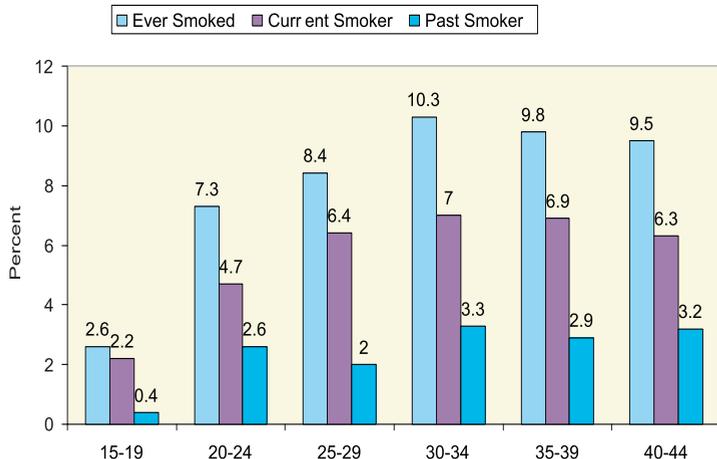


The HPV vaccine (for human papilloma virus) is becoming better known in Georgia, but in the 2010 survey only a fifth (21%) of all women aged 15-44 had ever heard of the infection, and only 18% had heard of the vaccine. Once told about the vaccine's effectiveness in preventing cervical cancer, 29% expressed an interest in receiving it.

Tuberculosis (TB) was known by almost all women surveyed (95%), but only 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 had TB (9%) or from frequent contact with someone else who 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.

Smoking is relatively uncommon among Georgian women. 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 who stopped. ("Current and past" sum to "ever".) (Figure 5.3). These figures were higher in urban areas than in rural areas. For example, 9% of urban women were current smokers (13% of Tbilisi women), compared to only 2% of rural women.

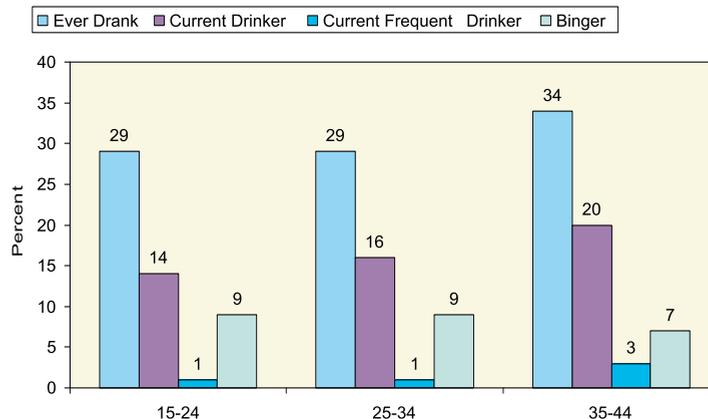
Figure 5.3 Lifetime, Current, and Past Smoking Prevalence by Age Group among Women Aged 15-44



Secondhand smoke is a problem for some women since they are exposed to smoking by men or other women. One in two reported high levels of current (in the past 30 days) second-hand smoke (SHS), both at home and at work. The level of SHS in the home was high, reported by 52% of all women.

Drinking is a separate problem. 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 (**Figure 5.4**). Binge drinking is more frequent among urban women (9%), especially in Tbilisi (12%).

Figure 5.4 Current Drinking Percentages by Age Group Among Women Aged 15-44



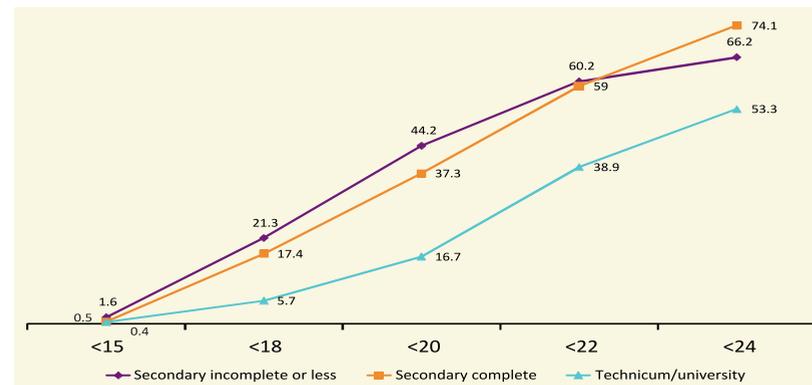
Note: This brief chapter covers selected features pertaining to the reproductive health of young women, but a full treatment is reserved to appear in a companion publication entirely devoted to this topic.

Young women have special needs for their reproductive health, and these differ somewhat for those not yet married. Both those and those married have defective knowledge concerning their bodies, their sexuality, and their contraceptive needs. Some in-school programs address the information needs of youth, and these need expansion. Most of those married want their first child relatively soon, but after that many have unplanned conceptions.

Chapter 6. Young Adults

- Premarital sexual experience is very uncommon. Nearly a third of young women (aged 15–24 years) in Georgia reported sexual experience (32%); the overwhelming majority (31%) reported sexual initiation only after marriage.
- One of the most noticeable differences in age at first sex (reflecting marriage) is across education levels; over half of women with secondary education or less had sexual experience prior to age 22, compared to only 39% of young women with university or technicum education (**Figure 6.1**).
- 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%). In general, condoms are widely known but regarded with ambivalence by young women.
- School programs in sex education are reported by about half of respondents but with wide variation by region and wealth quintile. Topics range from how pregnancy occurs to contraception to STIs (sexually transmitted infections).
- Among young women who had their first sexual intercourse (reflecting marriage) before age of 18, more than half had partners who were five to ten or more years older, reflecting a substantial difference in spousal ages at marriage for the youngest women.

Figure 6.1 Percentage of Young Adult Women Who Became Sexually Experienced before Selected Ages, by Educational Attainment



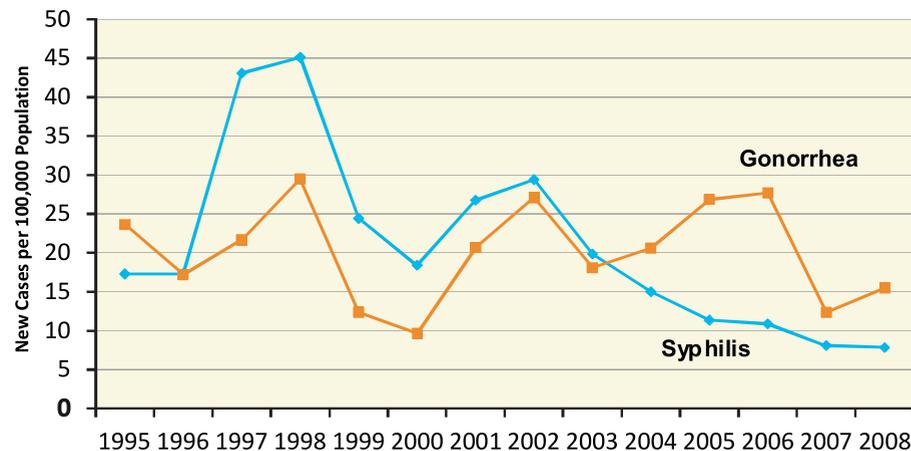
Chapter 7. Sexually Transmitted Infections (STIs) and HIV

STIs differ in their prevalence, and in public knowledge about them and their prevention. Both knowledge and testing for STIs have in fact declined and are inadequate. Rates of HIV and AIDS are low but increasing, and early action is vital to limit their spread into the heterosexual population.

STIs. This chapter begins with information about STIs, followed by a discussion of HIV/AIDS. The World Health Organization estimates that as of 2005 448 million new cases of curable sexually transmitted infections were occurring annually worldwide among adults aged 15-49. Women suffer more frequent and severe long-term consequences from STIs than men. Untreated gonococcal and chlamydial infections in women will result in pelvic inflammatory disease in up to 40% of cases. One in four of these will result in infertility according to WHO. In addition, STIs increase the susceptibility to and the spread of HIV infection.

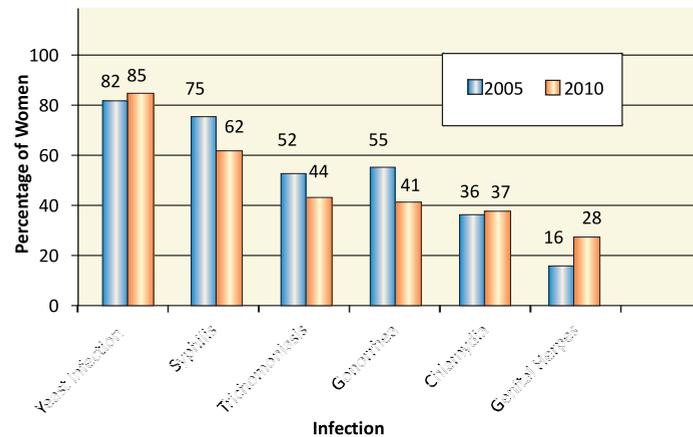
During the past 20 years, many former Soviet countries experienced major epidemics of STIs, particularly syphilis. Georgia has the highest syphilis incidence rates among Caucasus countries. A rapid increase in the syphilis rate occurred in 1995-1998 and 2000-2002. The gonorrhea incidence rate reached a peak of around 30 new cases per 100,000 several times, in 1998, 2002 and 2006 (Figure 7.1).

Figure 7.1 Syphilis and Gonorrhea Infections Newly Diagnosed per 100,000 Population in Georgia:1995-2008



All respondents were asked if they had ever heard of the most common STIs in Georgia, other than HIV/AIDS. Eighty-eight percent had heard of at least one STI; this was higher in the urban areas (92%), among ages 25-44 (over 93%), in the top wealth quintiles (91%-94%), at high education levels (96%), and among women with sexual experience (94%). Awareness of yeast infection ranked highest, at 85%, and syphilis ranked next, at 62% (Figure 7.2). However awareness of trichomoniasis, gonorrhea and chlamydia infections was poor: only 37% to 44%. Ranking lowest was awareness of genital herpes (28%).

Figure 7.2 Awareness of Selected STIs Among Women Aged 15-44; 2005 and 2010

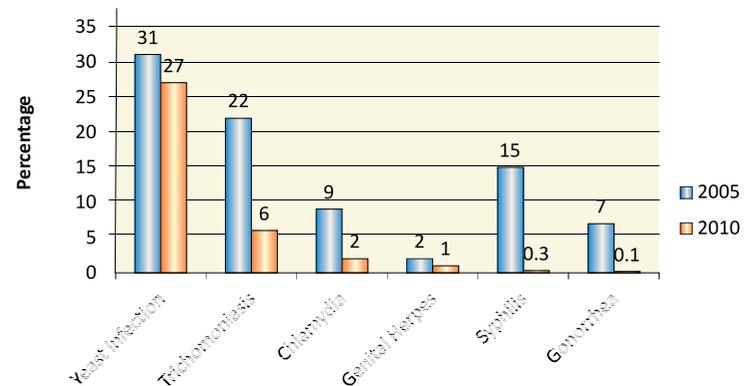


Respondents who were aware of at least one STI were asked to spontaneously name the actual symptoms that a woman with an STI might experience. About 20% were unable to list any symptom; most mentioned only one or two (25% and 26% respectively), such as vaginal discharge or genital itching. Responses were fewer among the less educated and lower wealth quintiles, and in rural areas, as well as among Azeri and Armenian women and those lacking sexual experience.

Another interesting topic is the perception of risk that women have of acquiring an STI. Respondents who were aware of at least one STI symptom were asked to rate their own risk of contracting an STI. Most (55%) considered themselves at no risk at all; about 38% felt they were at low risk, and 3% felt their risk to be moderate. More urban than rural women considered themselves at risk of a STI; also the sense of risk increased with higher educational attainment and at upper wealth quintiles.

Testing for STIs was also explored. Women with sexual experience (essentially the ever-married group) were asked if they had ever been tested for each of several STIs. Overall, 29% reported being tested for at least one STI, not including HIV/AIDS. The most frequently tested STI was yeast infection (27%) followed by trichomoniasis (7%), chlamydiasis (3%), and genital herpes (1%). Syphilis and gonorrhoea were the most rarely tested STIs. As **Figure 7.3** shows, testing was far less common in 2010 than it had been in 2005, for unclear reasons.

Figure 7.3 Percentage Ever Tested for STIs Among Sexually Experienced Women Aged 15-44; 2005-2010



Symptoms were also investigated: All sexually active respondents were asked whether they had experienced any of the symptoms associated with STIs during the 12 months prior to the interview. Interestingly, one fifth reported that they had had a vaginal discharge with bad smell, 13% had itching or burning in genital area, 9% reported burning pain upon urination, 6% experienced pain during sexual intercourse, and 3% had sores, ulcers or warts in the genital area. All of these symptoms were more common in women from rural areas than from urban areas. Symptoms diminished regularly at higher wealth quintiles. Otherwise there were only irregular differences in symptoms according to population subgroups.

Treatments sought were an additional topic. More than half of women who experienced at least one of the STI symptoms in the past 12 months sought treatment. This percentage rose with educational attainment and wealth quintile. The majority of those seeking treatment (80%) were treated by an obstetrician or gynecologist, while 15% relied on self treatment.

Reasons for not seeking any treatment varied. Two thirds said they could not afford to pay for the service or treatment. This reason was especially predominant at ages 35-44, in rural areas, at the three lowest educational levels, and for the lowest wealth index. About 12% of women declared that their symptoms disappeared over time; another 6% reported that they did not think they had an STI, and 4% feared knowing the

diagnosis. Inability to pay was the predominant reason among all categories of women.

Sources of information on STIs were explored among respondents who were aware of at least one STI. When asked for their most important single source of information about STIs, including HIV/AIDS, television was dominant by far (43%). It was followed by friends/colleagues (15%) and health care workers (14%), specialty books (7%) and print media (6%). Less than 1% of women mentioned a husband or a partner. Other minor sources were parents (4%), other relatives (5%), teachers (2%), and the internet (2%); however these sum to an important 14%, or one in seven women. Also it must be remembered that these are primary sources. In reality many women are affected by multiple sources of information.

Respondents were also asked if in the past 6 months they had seen, heard, or read any public announcement or message about STIs on television, by radio, or in newspapers. Unfortunately two thirds (67%) of women reported none: they had not seen, heard, or read any message about STIs in media sources. Among the rest of the women, a public announcement or a message was remembered by 11% of respondents only on TV, was read by 3% only in newspapers, and was heard by less than 1% only on radio.

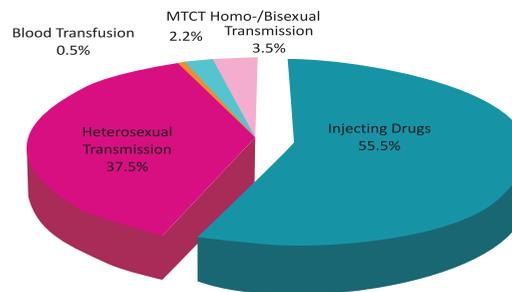
Overall, the surveys show the lack of awareness and accurate knowledge about STIs among most groups of reproductive age women in Georgia. As a result many underestimate their risk of acquiring these infections. It is important to develop and disseminate culturally appropriate information, education, and communication programs for the young, the less educated, and those living in rural areas and in the lowest wealth quintiles. Appropriately integrated interventions can help prevent further spread of STI infections among these groups.

HIV/AIDS

Countries of Eastern Europe and Central Asia continue to have expanding HIV/AIDS epidemics. The HIV infection rate is growing faster in these countries than in any other region of the world. Injection drug use is the main route of HIV transmission in these countries, but sexual transmission is increasing, especially between drug users and their partners. Georgia is still considered a low HIV prevalence country, with an estimated prevalence of 0.087%, but HIV incidence increased steadily over the last decade.

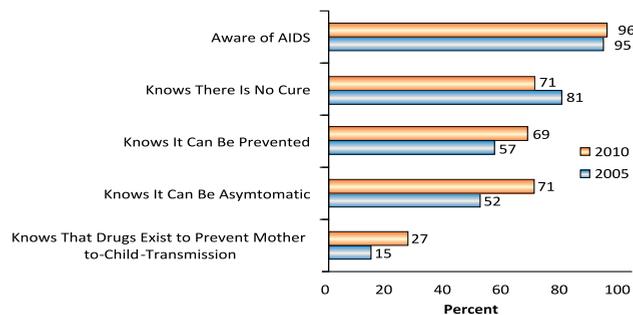
A rapid spread of HIV infection may occur due to high prevalence of injection drug use, sexually transmitted infections (STIs), Hepatitis B and C, and increased migration to neighboring countries, such as Russia and Ukraine, which are now experiencing growing HIV epidemics. The major route of HIV transmission in Georgia is injection drug use (55.5%), but in recent years heterosexual transmissions significantly increased, to 37.5% of all transmissions (Figure 7.4).

Figure 7.4 HIV/AIDS Transmission Routes Among Cases Reported to the Georgian HIV Surveillance System



To assess awareness and correct knowledge of HIV/AIDS all respondents were asked if they had ever heard about HIV/AIDS. Even though the vast majority of women (96%) were aware of it, much lower percentages knew about the detailed items in Figure 7.5. Overall, 71% of women believed that no cure exists for HIV/AIDS. That was a decline from 2005, but the other indicators showed definite improvements from 2005. Still, only 69% of respondents knew that HIV can be prevented, and only 71% knew that HIV infection can be asymptomatic. A mere 27% knew that drugs exist to prevent mother-to-child transmission.

Figure 7.5 Awareness and Knowledge of HIV/AIDS Among Women Aged 15-44



Poor knowledge is very important, since unknowing women are at special risk of HIV transmission if they have sex with an otherwise healthy HIV-positive partner. Informational and educational interventions aimed to improve correct knowledge about HIV/AIDS are needed for the general population, together with special efforts in the subgroups where the level of HIV knowledge is especially low.

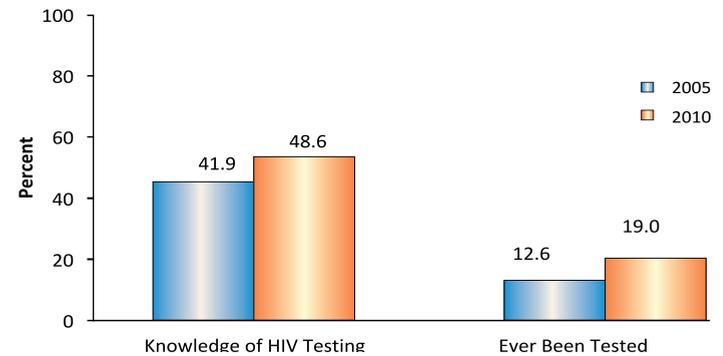
Testing locations for HIV were known by about half (49%) of respondents, and nearly a fifth (19%) said that they had in fact been tested in the past. Both figures rose by 6%-7% over the 2005 result (**Figure 7.6**). Most were tested during antenatal care, which is nearly universal; and most (61%) tests occurred at the Women's Consultation Centers. Women in the 15-19 age group, those without sexual experience, and Azeri women were less likely to know about a place for HIV testing. As with most indicators, knowledge is better in urban areas, and it increases with educational attainment and wealth quartiles.

Testing has apparently been increasing. The share of all tests done in the last 12 months increased from only 15% in the 2005 survey to 26% in 2010. A fourth (27%) occurred from 13 to 24 months ago, leaving about half of tests (48%) done more than two years ago.

Television is clearly the primary source of information about HIV/AIDS. During the last six months it was mentioned as the sole source by 43% of respondents, and another 19% mentioned it in combination with newspapers (18%). Radio alone or newspapers alone were rarely mentioned, and 28% of the respondents reported having no exposure to media messages on HIV/AIDS.

The need for improved public information was exposed when many respondents were confused about causes of HIV transmission. All were asked to identify which of several modes of transmission were false possibilities, such as witchcraft (only 82% scored it as a false mode, so 18% were unsure or claimed it as a cause). Other modes with disappointingly low rejection percentages were by shaking hands (82%), using a public toilet (68%), kissing (62%), sharing food plates (70%), or mosquito bites (51%). However all these were decided improvements over the 2005 replies; nevertheless only 14% rejected manicures, pedicures, or haircuts as a true mode, and only 5% rejected dental or surgical treatment. The latter may

Figure 7.6 Knowledge and Experience of HIV-Testing Among Women Aged 15-44



be partly due to the influence of correct knowledge, namely that HIV can indeed be transmitted via contaminated sharp objects, and may be related to the widespread distrust of the general public about the sterilization procedures conducted at health care facilities and beauty salons.

Mother to-child HIV transmission (MTCT) is an area of special interest. About half of the women (49%) knew about all three means of transmission: during pregnancy, during birth, and through breast milk. Regarding each mode separately, only 53% knew that HIV can be transmitted through breastfeeding, compared to during pregnancy (75%) and during delivery (67%). These results were only slightly improved from 2005 to 2010.

Many respondents were unaware of any way to avoid HIV transmission. A full 21% said they did not know whether such ways existed, and another 10% denied that they existed. When asked to spontaneously name specific ways, 31% could not do so. However half (51%) mentioned condoms, a sharp improvement over the 2005 replies (35%). Others mentioned having only one partner, abstaining from sexual intercourse, avoiding prostitutes, and non-sharing of needles or syringes.

The self-perceived risk of contracting HIV/AIDS was measured across a scale from no risk to high risk, plus "don't know." More than half (54%) considered themselves under no risk of getting HIV. Thirty eight percent believed that they were at low risk, and 3% thought they were at moderate risk. Feeling at high

risk was reported by less than 1% of respondents. In 2010 the self perceived risk of getting HIV infection remained very similar to that in the 2005 survey. The percentage feeling at no risk of contracting HIV was higher among rural women, women aged 15-19 years, women at the two lowest education levels and three lowest wealth quintiles, and those of Azeri ethnicity.

In summary, the 2010 survey established that particular sub-groups lack awareness of and correct knowledge about HIV/AIDS. These include young adults, rural residents, women with less education, and those in the lower wealth quintiles, as well as sexually inexperienced and Azeri women. The survey also showed that the rate of HIV testing still remains a challenge.

Moreover, the level of awareness is too low about places where HIV testing is provided.

To improve knowledge about HIV/AIDS, intensive information and educational campaigns are urgently needed, in particular for the special groups named above. Common misconceptions about HIV transmission need to be addressed. Careful attention should be directed to educating women about their personal risks of acquiring HIV infection, to help them avoid risky behavior. To raise the level of knowledge and influence public behavior, information and education campaigns must be organized in multiple ways: through mass-media, family doctors, and non-medical professionals trained as peer-educators.

Chapter 8. Domestic Violence

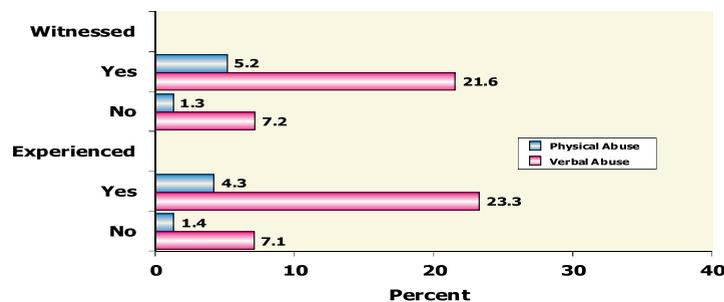
Domestic violence by partners affects women in adulthood, but they are also affected by their memories of parental abuse. Verbal abuse is more common than physical abuse, but both occur much more among women who have poor gender status regarding their partners. Abuse is partially imbedded in the culture, as some women agree that wife beating is justified for certain reasons.

Information about spousal abuse comes from the three surveys for 1999, 2005, and 2010, and also from a large, specialized national survey in 2009 focused just on domestic violence.¹ In the 2010 survey, overall reports by ever-married women of violence by an intimate partner were low: few women reported experience of physical and/or sexual abuse, either during the last 12 months (2%) or during their lifetime (5%). Verbal abuse was more common: 8% in the last 12 months and 15% lifetime. These percentages remained relatively unchanged since 1999. Moreover, the patterns of formal reports of abuse to the authorities did not change significantly.

Physical abuse by an intimate partner occurred in all subgroups regardless of socioeconomic and educational backgrounds. It was the highest (23%) among previously married women; no doubt the violence helped to end some of the marriages. 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% recalled being physically abused by their parents during childhood. Also, witnessing or experiencing abuse as a child increases the likelihood of becoming a victim of intimate partner violence as an adult: among women who had experienced parental abuse, the prevalence of recent psychological abuse was three times as high and prevalence of physical abuse twice as high as among those who had not experienced parental abuse (**Figure 8.1**).

Figure 8.1 Recent Physical and Verbal Abuse by Having Witnessed or Experienced Parental Physical Abuse as a Child Among Ever-Married Women Aged 15–44

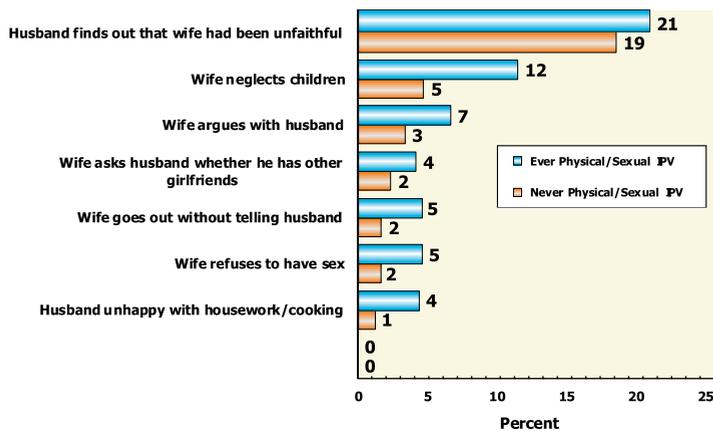


1. M. Chitashvili, N. Javakhishvili, L. Arutiunov, L. Tsuladze, and S. Chachanidze. 2010. *National Research on Domestic Violence Against women in Georgia. Final Report*. Tbilisi, Georgia. UNFPA. This survey used WHO methods and yielded results comparable to results from other countries.

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.

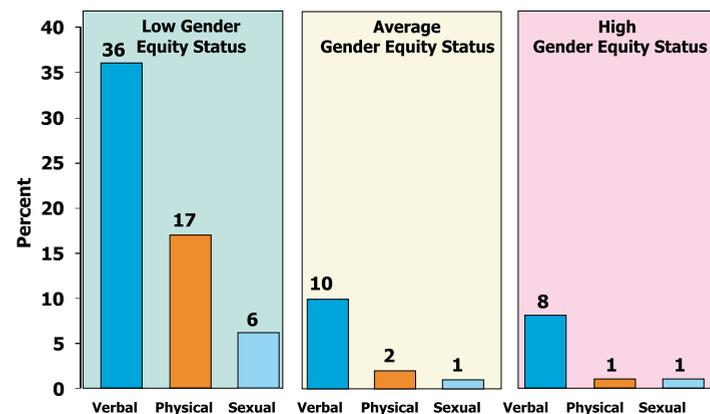
Women themselves agree that wife punishment is justified under some circumstances (**Figure 8.2**). Overall, about 20% of ever-married women agreed with at least one circumstance in which they consider wife-beating justifiable, most especially in cases of the wife's infidelity.

Figure 8.2 Agreement with Selected Justifications for Wife-beating by Experience of Physical Abuse Among Ever-Married Women Aged 15–44



Percentages were 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 violence by an intimate partner. In fact, poor gender equality by the wife was associated with far more abuse: 36% with low equality reported verbal abuse compared to only 8% among those with high equality (**Figure 8.3**).

Figure 8.3 Prevalence of Lifetime Physical or Sexual Abuse by Gender Equity Status of the Household Among Ever-Married Women Aged 15–44



For Further Reading

Reproductive Health Survey Georgia 2010 Final Report. 2012. Issued by National Center for Disease Control and Public Health (NCDC), Ministry of Labor, Health, and Social Affairs (MoLHSA), National Statistics Office of Georgia, Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, USAID, and UNICEF.

Reproductive Health Survey Georgia 2005 Final Report. 2007. Issued by National Center for Disease Control and Public Health (NCDC), Ministry of Labor, Health, and Social Affairs (MoLHSA), Department of Statistics in Ministry of Economic Development, Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, and USAID.

Women's Reproductive Health Survey Georgia, 1999-2000, Final Report. 2001. Issued by National Center for Disease Control (NCDC), Center for Medical Statistics and Information (CMSI), Ministry of Health and Social Affairs (MOH&SA), State Department of Statistics (SDS), Centers for Disease Control and Prevention (CDC) Atlanta, Georgia USA, UNFPA, UNICEF, USAID, UN High Commission for Refugees (UNHCR), and American International Health Alliance, Inc. (AIHA).

Male Reproductive Health Survey. Tbilisi, Georgia: UNFPA, 2005, by Archil Khomasuridze, Jenaro Kristesashvili, and Giorgi Tsuladze.

Reproductive, Maternal, and Child Health in Eastern Europe and Eurasia: A Comparative Report. 2003. Issued by Centers for Disease Control and Prevention, Atlanta, Georgia USA and ORC Macro DHS, Calverton, Maryland USA.

Georgia Further Analysis: The Relationship Between Contraception and Abortion in the Republic of Georgia: Further Analysis of the 1999 and 2005 Reproductive Health Surveys. 2008. By Charles F. Westoff and Florina I. Serbanescu. Calverton, Maryland USA: Macro International Inc.