



# Reproductive Behavior and Needs of Young Women in Georgia

By John Ross



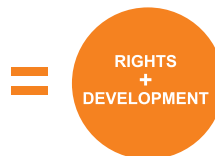
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International Conference on  
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Beyond 2014



## **Reproductive Behavior and Needs of Young Women in Georgia**

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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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## HIGHLIGHTS

Several positive results emerge from the trends documented in the 1999, 2005, and 2010 Reproductive Health Surveys. Certain gaps and deficiencies also emerged. For young women aged 15-19 and 20-24 here are some of the highlights.

The abortion rate has fallen sharply, while contraceptive use has risen. Fewer women now favor the use of abortion. Unwanted births are less frequent.

The fertility rate for women aged 20-24 has risen, and they are having more wanted births. Their ideal family sizes have risen somewhat.

The fertility rate for the youngest women, aged 15-19, has fallen slightly, due apparently to the postponement of marriage. Premarital sexual relations are quite uncommon, as are extramarital sexual relations.

Due to low fertility in the past the numbers of young women at ages 15-24 will decline between now and the year 2025. The age mix will move toward older women, changing the mix of health services needed with implications for costs.

Prenatal care is now nearly universal in Georgia, and nearly all deliveries are professionally attended.

Serious gaps remain, since only low proportions of new mothers receive postpartum care.

Similarly, serious gaps remain in the proportions who receive any family planning advice at any time during pregnancy or at delivery. Also, too few women having abortions receive any contraceptive advice or supplies.

Young women lack adequate information from any source about sex education including contraception. "Family Life Education" in the schools appears to be increasing but still covers too few students.

Health behaviors need improvement. Delays in getting medical care are due primarily to cost, and insurance coverage is still incomplete.

Knowledge about sexually transmitted diseases (STIs) and HIV/AIDS is quite deficient, with some women believing there is no way to avoid the risk of getting HIV.

Domestic violence remains a problem for a significant minority of young women.

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## Chapter 1. Background and Methodology

This publication draws on national surveys in 1999, 2005, and 2010<sup>1</sup> to present the special needs of young women. These surveys, all nationally representative, were conducted to document changes in reproductive behavior including abortion, covering all women aged 15-44. 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. Funding assistance for the surveys, as well as for program action improvements, has been provided by donors, primarily by UNFPA, USAID and UNICEF.

These surveys provide valuable information concerning young women and their evolving needs as they move from the late teenage years into their twenties. They are different from the general population because they face for the first time in their lives the changes in their bodies, their growing interest in the opposite sex, and their first-time needs for learning about reproductive health. Some women marry early, most without adequate sex education or contraceptive instruction. Soon after marriage come first births and first experiences in childrearing, sometimes in competition with work outside the home.

While the three surveys interviewed only women, a separate survey interviewed men aged 15-49,<sup>2</sup> and it can be used for comparison with the results reported here. For example it has important supplementary information on condom use as reported by men rather than women.

Significant improvements in family planning and reproductive health have marked the last few years in Georgia. The Government with the support of international and local non-governmental communities is increasingly supporting staff retraining, education, and infrastructure development. Public health interventions also include TB, HIV/AIDS, and immunization, as well as mother and child health interventions 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 in the health insurance schemes. An insurance-based system of financing for the poor and other groups has been partially implemented, but costs to individuals remain a serious obstacle to adequate health services.

The aim of the 2010 survey, as before, was to help document such changes, by obtaining national and regional estimates of basic demographic and reproductive health indicators. Related purposes were to set targets for improvements, to allocate resources, and to monitor performance of family planning and maternal and child health programs.

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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.*  
*The survey was specifically designed to meet the following objectives:*
  2. *Male Reproductive Health Survey. Tbilisi, Georgia: UNFPA, 2005.*

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;
- 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 women 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.

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 MoL-HSA, 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.

This report, for ages 15-24, condenses information primarily from the full 2010 report, and the reader should consult it for the detailed tables and numerous interpretative charts. They cover all women aged 15-44. The focus here is on the needs of young women, both unmarried and married, stressing policy and program implications.

A companion report, also abbreviated from the full 2010 report, concerns all ages 15-44. It gives many breakdowns for subgroups that were not available separately for youth, such as geographic variations and contrasts by education, wealth quintiles, ethnicity, and number of living children.



## Chapter 2. Fertility, Abortion, Pregnancy Experience, and Future Intentions

This chapter begins with the relationships of fertility and abortion. In Georgia, as in much of the former USSR, these two rates are closely linked. Historically, modern contraceptive methods were generally not available, and women frequently turned to abortion to avoid unwanted births. That depressed the fertility rate; in addition overall fertility rates were low partly because young women usually postponed marriage, and there is very little premarital sexual activity. Only 11% of women aged 15-19 are married or in union.

Also, young married women have increased their use of contraception. The percentage aged 15-24 who use some method has risen over time (1999 to 2005 to 2010) from 29% to 32% to 39%, a ten point increase in 11 years. (Details in the Contraception Chapter.)

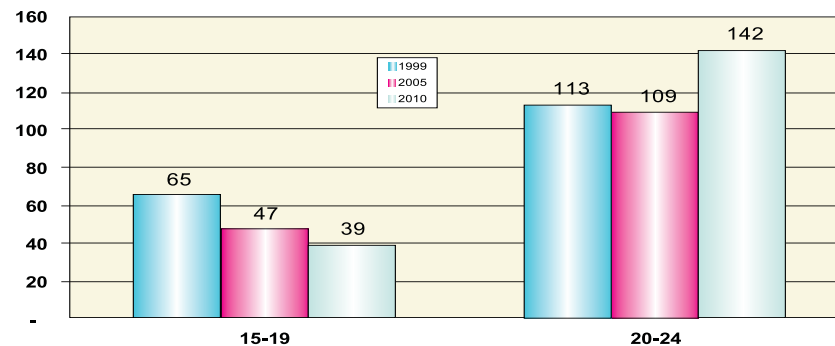
### Fertility

Traditionally, soon after Georgian women marry they initiate childbearing, and complete it fairly early, as reflected in the high age-specific fertility rates among women in their twenties. The highest fertility levels are at ages 20-24 and 25-29, accounting for 36% and 29%, respectively, of the total fertility rate.

Interestingly, the fertility rate has taken two different paths since 1999 (**Figure 2.1**). The youngest women, aged 15-19, show declining fertility, due probably to the postponement of marriage, related perhaps to a desire for more educational attainment. From 1999 to 2005 to 2010 the percentage of women at ages 15-19 who were married fell from 16% to 12% to 11%.

The opposite occurred for women at ages 20-24. While the percentage married stayed constant at 49% in the three dates, the birth rate rose, from 109 to 142 births/1000 women/year, a remarkable thirty percent increase. Higher age groups also showed fertility increases during the last five years, related probably to improved economic conditions and a recovery of births that had been wanted but had been postponed. That is, this may be partly a temporary “catch-up” in delayed childbearing. At the same time the ideal family size definitely shifted in the last five years toward somewhat more children (see later section on the ideal number of children).

**Figure 2.1. Trends in Age-Specific Fertility Rates, 1999 to 2010**





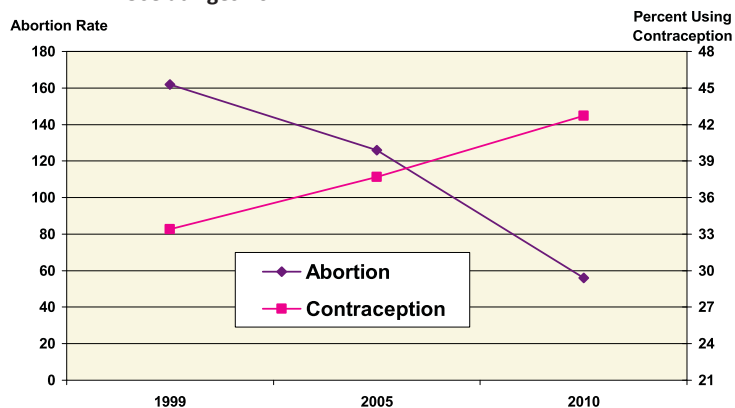
During these changes the abortion rate fell noticeably (abortions/year/1000 women). It was driven down largely by increasing contraceptive use. **Figure 2.2** shows abortions declining from 162 abortions per 1000 women in the 1999 survey to only 56 in the 2010 survey, a full 65% decline. Meanwhile contraceptive use rose sharply, so there were fewer abortions partly because there were fewer pregnancies. In addition, more of the remaining pregnancies were carried to term because more were actively wanted. Further, some couples may have deliberately sought to become pregnant for a second or later birth. All this raised the fertility rate at ages 20-24.

A similar pattern exists among women of all ages, 15-44.

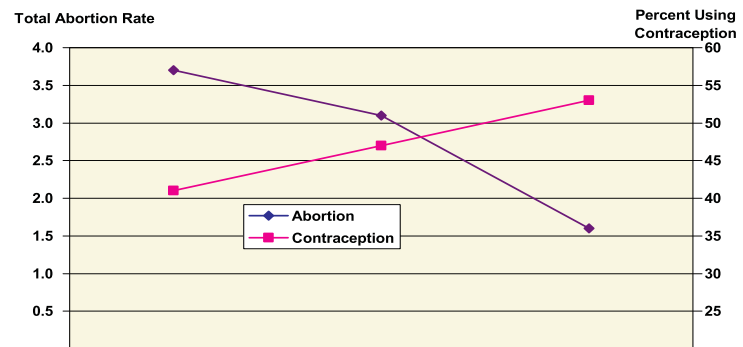
**Figure 2.3** shows the contraceptive use numbers at the right. At the left is the total abortion rate, the measure of how many abortions a woman would have in her lifetime according to current age-specific rates. It was extremely high in the 1999 survey, at 3.7 abortions per woman, but fell sharply to 3.1 and then to 1.6. That is a 57% decline, over half.

During this 11 year period the overall fertility rate rose even though contraceptive use increased, as explained above. If contraception can be made more available, with more method choices, abortions can continue to decline while the fertility rate rises and there are more wanted births.

**Figure 2.2** Concurrent Changes in Abortions and Contraceptive Use at Ages 20-24



**Figure 2.3** Concurrent Changes in Abortions and Contraceptive Use, at all ages 15-44



### Coming Declines in the Numbers of Youth

Population projections show that the total number of reproductive aged women, 15-44, will remain steady to 2025, declining only modestly to 94% of its size in 2010, from about 800,000 to about 750,000 women.

However, the future age mix will change greatly (**Figure 2.7**), due to the very irregular fertility levels in the past. Especially, there are decided declines in the youngest women who are coming of age. Notice at the bottom of the figure that ages 15-19 will decline by about 14,000 between 2010 and 2015, from 127,000 to 113,000, and then by another 5,000, to 108,000 by 2020. Only in the final period, to 2025, do they recover, rising to 129,000 (due to the rise in births in 2005-2010).

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.

Therefore, the numbers of young females in the population will decline. Combining ages 15-19 and 20-24, the group will diminish by 27,000 before 2015 and by another 19,000 by 2020. The starting number in 2010, of 267,000, will fall to 240,000 and then to 221,000. It will then rise, to 237,000 in 2025, reflecting the larger cohort born in 2005-2010.

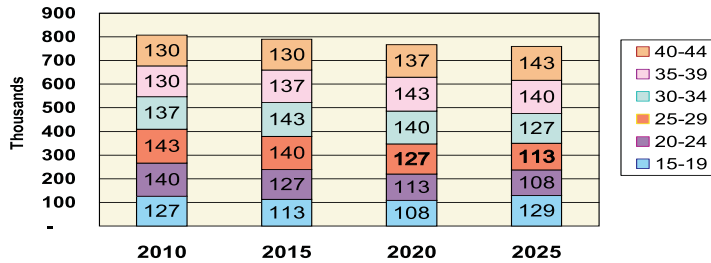
If the percentage married/in union in each group in the 2010 survey remains constant, the numbers of young married women aged 15-24 will decline from 2010 to 2025 as follows (see **Figure 2.5**):

2010	82,000
2015	74,000
2020	67,000
2025	67,000

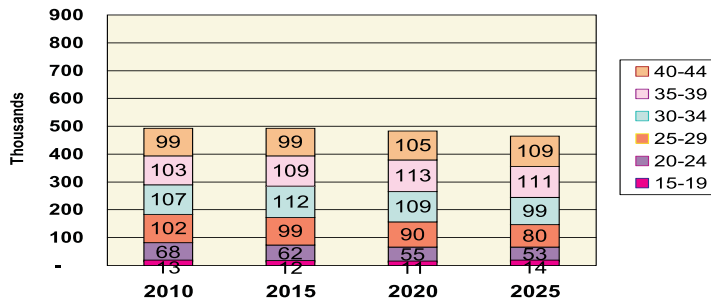
Because young married women will be fewer as the years go by, that also tends to diminish the number of abortions in the population. It reinforces the downward trend of abortions found in the 2010 survey. It also means fewer marriages, and fewer first births. However the numbers of second and higher births might still increase, or at least not decline, if the desired family size rises under improved economic conditions. A counter tendency may be an increasing inclination of young married women to work in the paid labor force, which can compete with the desire for more children.

The changing age mix will affect the mix of services needed, tilting them toward older women. This has implications for the types of medical personnel needed, for age-related activities such as cancer screening, and also for costs.

**Figure 2.4. Number of Females by Age, Projected to 2025**



**Figure 2.5. Number of Married Females by Age, Projected to 2025**

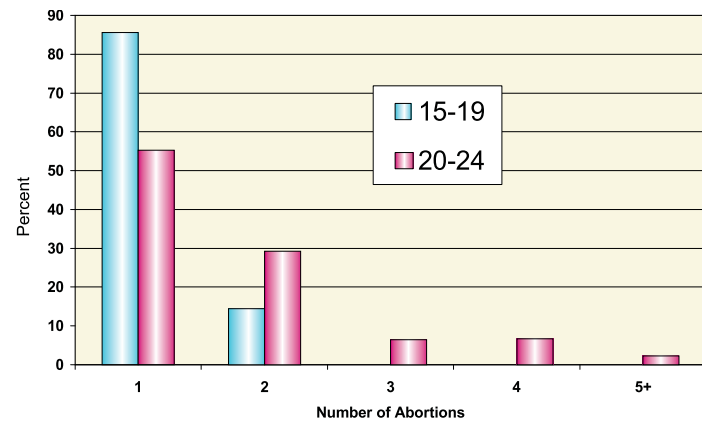


### Abortion Patterns

Abortions occur primarily among married women who already have one child. Therefore few abortions occur at ages 15-19, while the percentage ever having had an abortion increases with age and the number of children. Among those with abortion experience, nearly all at ages 15-19 have had only one (86%); the rest have had only two (**Figure 2.6**). At this early age few women have had abortions and if they have done so they have had only one.

However at ages 20-24 the distribution is broader, as the figure shows. Only about half (55%) report only one, but 29% report two. Another 15% report three or more. At higher ages the distributions show even greater numbers. The data indicate that most Georgian women achieve their desired family size before age 30. After that, in the event of having unplanned pregnancies, they are more likely to resort to an induced abortion.

**Figure 2.6 Percent Distribution of Women by Number of Abortions, Among Those Ever Having Any**



Most abortions occur within the first nine weeks of pregnancy (86% do so). Nearly all of the rest occur within the first 12 weeks. This early pattern occurs partly because nearly three-fourths (71%) are mini-abortions, with only 29% reported as induced abortions. About two-thirds of all abortions occur at hospital/maternity wards, with about a third at ambulatory clinics. (For abortions at all ages 15-44 the percentage at ambulatory clinics is much higher in urban areas and it rises sharply according to the more prosperous wealth quintiles.)

The main reason given for choosing an abortion was quite different among young women compared to older ones. At ages 15-24 only 34% said it was due to wanting no more children, vs. 55% saying so at older ages 25-34. Instead, the primary reason among young women was to postpone childbearing, apparently because many had recently had their first birth and did not want the next pregnancy quickly. The “postpone-ment” reason was cited by 38% at ages 15-24 but only by 14% at ages 25-34.

Those unplanned pregnancies would not have occurred so frequently if more women had used contraception after the last birth. Fully three-fourths had used no contraception before the conception that ended in abortion. The rest, who were using a method, were about evenly divided among those using a traditional method and those using a modern method. High failure rates are characteristic of traditional methods, but also among condom users, who are included under modern methods. Fewer accidental pregnancies would occur if more users switched to the IUD, pill, or sterilization.

Counseling for contraception is clearly deficient. It was provided to only a third (34%) of young women aged 15-24 having an abortion. About half received the counseling prior to the procedure and about half afterwards, with smaller proportions receiving it at both times. Actions taken were also deficient. They included provision of an actual method (to 8%), a prescription for a method (to 8%), and a referral for a method (to 3%). The result is that many of the young women having an abortion went forward without protection against another unwanted conception.

Ultrasound to assess gestational age occurred in half (52%) of abortion cases but only rarely (3%) to assess the gender of the fetus, implying that son preference is not strong enough to use abortion selectively by gender.

Clinical procedures were also reported in the 2010 survey. At ages 15-24 anesthesia was used in 60% of abortion cases, and antibiotics were applied in 43% of cases. These proportions were about the same at older ages as well. Complications were classified as early or late; at ages 15-24 five percent of cases experienced early ones and 3% experienced late ones. Hospitalizations of one or more nights were rare, about one per thousand cases.

In summary, unintended pregnancy has long been acknowledged as an important health, social and economic problem that creates hardships for women. 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. The 2010 survey demonstrates that 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.

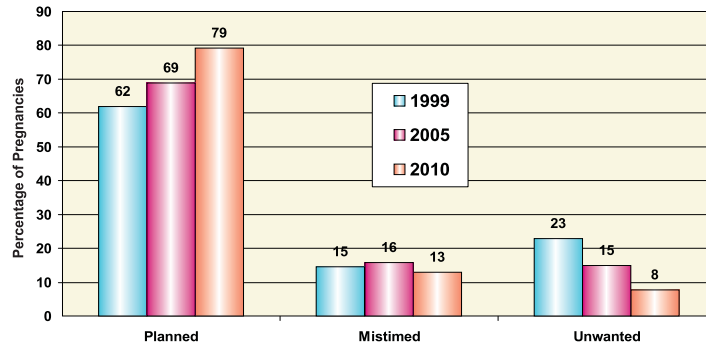
### **Sexual Activity, Pregnancy Intentions, and Future Fertility Preferences**

**Sexual activity** before marriage is rare; 99.7% of never married women report never having had intercourse. Separate data for ages 15-24 are not tabulated, but among all currently married women, 80% report sex within the last month; another 5% had sex within 3 to 12 months, and the rest over a year ago. In addition, 13% are pregnant or postpartum. The overall picture is one of fairly regular sexual activity among cohabiting couples.

**Pregnancy Intentions** exhibit a very favorable trend emerging over the eleven year period covered by the surveys. Several features are significant:

- A sharp upward trend appears in the proportion of pregnancies that were wanted. **Figure 2.7** shows, for young women aged 15-24, an increase from 62% of pregnancies that were planned in 1999, to 69% in 2005, and to a high 79% in 2010.
- At the same time, the percentages reported as unwanted fell from 23% to 15% and then to 8%. The percentage that was ill-timed but still wanted remained about constant over the 11 years.
- As a result of these changes, fewer pregnancies have been aborted, and one reason is the increase in contraceptive use. However the upward trend in the percentage planned is still incomplete, with 21% of pregnancies in 2010 still either ill-timed or unwanted. Reliable contraception is not used by many women at risk, resulting in accidental pregnancies.

Figure 2.7. Planning Status of the Latest Pregnancy, 1999, 2005, and 2010



The improved economic conditions by 2010 probably meant that more pregnancies were sought, or were continued once they occurred. With more contraceptive use 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.

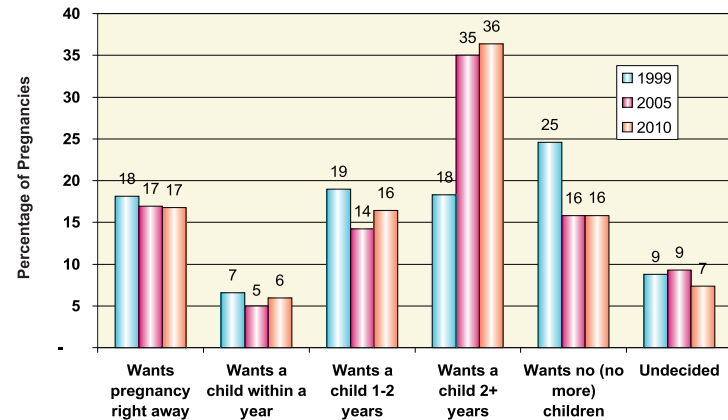
### Future Fertility Preferences:

The three surveys also tell how soon women want to have another child. **Figure 2.8** shows the 11 year trend for several timing desires. Here are the main results:

- About one in six young married women want to become pregnant right away.
- Only about 5% want a child within the next year.
- About one in six prefer one to two years from now.
- Most, about a third in 2005 and 2010, say they wish to wait for 2-plus years. That is up sharply from only 18% in 1999.
- Many more in 1999 wanted no more children at all: a fourth (25%), compared to only one in six (16%) in 2005 and 2010. Most of these are probably in the 20-24 subgroup, with one or two children already.

- That left about 7% to 9% as undecided in all three years.
- Finally note that married women aged 20-24 dominate these results because they are much more numerous than those in the 15-19 age group.

Figure 2.8 Intentions to Have Children, Married Women Aged 15-24, for 1999, 2005, 2010



Of course whether a married woman intends to have another child depends upon the number she already has. Tabulations for all married women aged 15-44 show that 70% of those with no child want to have one or more; this would be higher except that nearly all the others say they are subfecund or infecund. Among those with one child 71% want to have another. Even 21% of those with two children want to have another. The time trend since 1999 shows an increase percentage wanting more, regardless of the current number.

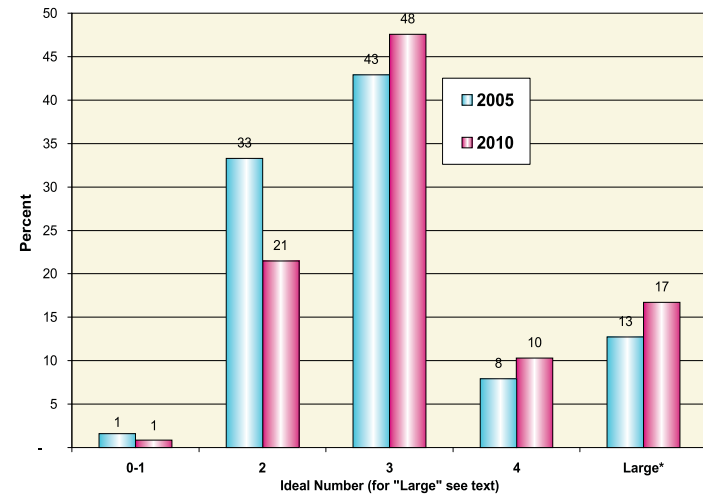
**Ideal Number of Children.** In the context of Georgia's low fertility rates it is quite interesting to consider opinions regarding the ideal number of children. It provides another way to reveal the surprising changes in the last five years. Two remarkable findings emerged: a decided increase in the ideal since 2005, and a wide spread in the ideal.

In 2005 a third (33%) of all young women aged 15-24 gave two children as their ideal, and 43% said three (**Figure 2.9**). But in 2010, by which time economic conditions had eased and fertility had risen, there was a shift upward: only 21% preferred 2 children and a 48% preferred three. There was also

an increase in those favoring large families: in 2005 a total of 13% emerged for “Large” in the figure, composed of “five or more,” “as many as God gives,” and “as many as possible.” Between 2005 and 2010 this 13% rose to 17% favoring large families.

The combination of a rise in the ideal family size together with the wide spread indicates that the ideal is subject to change, and that while most favor either two or three, there a marked diversity of opinion about the ideal.

Figure 2.9 Ideal Number of Children Among Young Adults



## Chapter 3. Contraception

**Contraceptive Knowledge:** Young women lack the knowledge that they need concerning contraceptive methods and the pros and cons of each one. Here are the salient findings from questions related to their information:

**Ever Heard of a Method:** Some young women (ages 15-24) have never heard of the main methods currently in use in Georgia. One fourth (26%) have not heard of the IUD, one third (34%) have not heard of the pill, and even 8% have not heard of the condom. The figures are nearly the same for unmarried young women as for the entire group.

- **Know How Methods are Used:** Fewer know how each method is used than those who have heard of it. About half say they do not even know how the condom is used, and about two-thirds do not know how the IUD or the pill is used. Again, the reports are similar for the entire age 15-24 group as for those never married.
- **Know Where to Get the Method:** Nearly a third (30%) of the age 15-24 group do not know where to obtain a condom, and half do not know where to obtain the IUD or the pill.
- **Sources of Information** are defective: those saying they had heard of at least one contraceptive method were asked for their most important source of information. Most (38%) of young women aged 15-24 named “friends, boyfriends.” Another 16% mentioned a relative, and 6% mentioned a partner/husband. A second type of source, of unknown reliability, was TV/Radio/Internet (15%). A doctor was mentioned by only 9%, a teacher only 2%, and parents only 5%. For the never married group the figures were much the same; more (42%) named “friends, boyfriends” as the most important source. Note that no source whatever is known among those who in the first place were not asked since they said they had never heard of any contraceptive method.

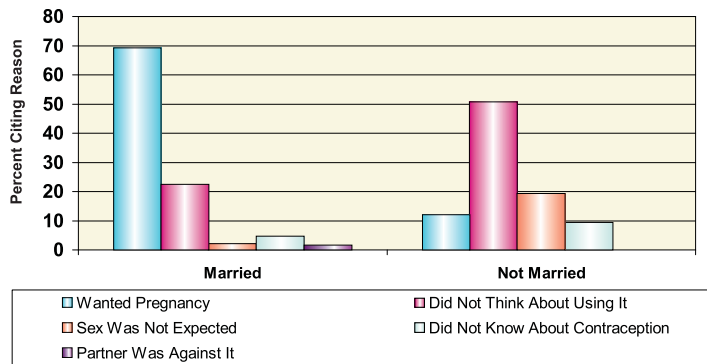
In summary, much remains to be done to provide reliable information to both married and unmarried young women. Substantial numbers of couples come to marriage with defective information about the methods, how they are used, and where to obtain them. Knowledge about the reliability of each method -- its risk of failure, with an unplanned conception -- is very inadequate. (See “Opinions About Contraceptive Methods” below.)

### Contraceptive Use

Contraceptive use at first sexual intercourse is uncommon in Georgia, regardless of marital status. Most young married couples are eager to have their first child relatively soon; for that and other reasons most did not use contraception at their first sexual intercourse. Over two-thirds (69%) in **Figure 3.1** used no method since they wanted to become pregnant. Another 22% did not know about contraception, which reflects the continuing lack of information about particular methods and where to obtain them.

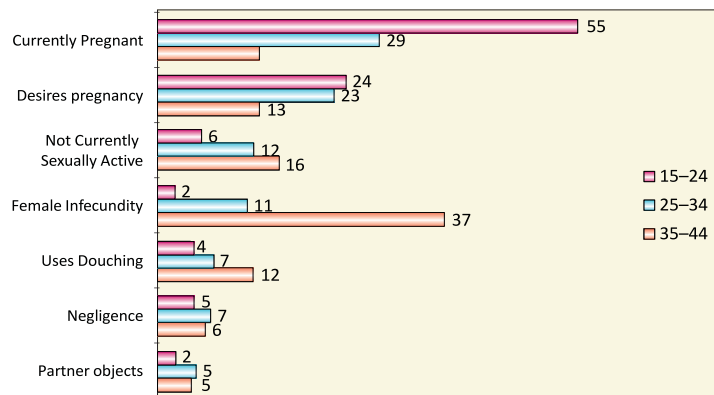
Among unmarried women in the figure half simply did not think about using a method; for another fifth (19%) sex was not expected at the time. (This group is numerically small since premarital sex is uncommon.)

**Figure 3.1 Reasons for Not Using Contraception at First Sexual Intercourse, by Marital Status at the Time, Ages 15-24**



**Use in general.** The above concerns the first sexual intercourse experiences while the following concerns use and non-use in general. Among married non-users in the overall age group 15-24, 55% said “currently pregnant” as their reason for non-use; also 24% said “desire pregnancy” (**Figure 3.2**).

**Figure 3.2 Most Commonly Cited Reasons for Not Currently Using Contraception, by Age Group Among Married Women Aged 15-44**



Thus many young married women were pregnant or desiring to become pregnant. Some may have tried contraception before and stopped, and were between pregnancies or not using contraception for other reasons.

Most married women aged 15-24 did not use any method at their most recent sexual intercourse, but this varied by age:

80% at ages 15-19 used no method, vs. 61% at ages 20-24. This difference partly reflects more knowledge of methods in the older group; also more of them now already have their first child and are starting to use some method. Those who used a method favored the condom (11% used it in the combined age 15-24 group), next the IUD (9%) and next withdrawal (7%). The pill (4%) and the rhythm method (3%) came next.

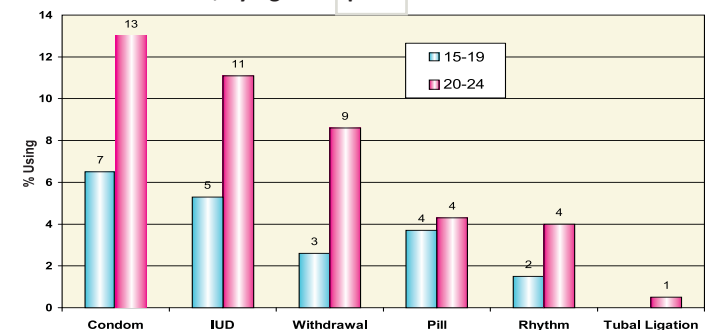
**Current Use by Method**

Contraceptive use increases sharply among married young women and their spouses as they age and build their families. About one-fifth (20%) of those aged 15-19 were currently using some method in 2010, but twice that (43%) at ages 20-24 were doing so. That doubling is remarkable, considering that many were currently pregnant or postpartum and others were actively seeking a pregnancy.

Every method showed more use at ages 20-24 than at ages 15-19, but unevenly. **Figure 3.3** reveals which methods women favor as they age. For modern methods the main increases are for the condom and IUD, doubling for each: from 7% to 13% for the condom and from 5% to 11% for the IUD. For traditional methods withdrawal increases the most, from 3% to 9%, compared to rhythm, which rises only to 4%. The pill and tubal ligation are neglected, showing little increase.

Young couples probably turn to the methods they know after they have the first child, even though two of the primary methods, the condom and withdrawal, suffer from high failure rates that produce ill-timed or unwanted conceptions.

**Figure 3.3 Percent of Young Married Women Currently Using Each Method, by Age Group**

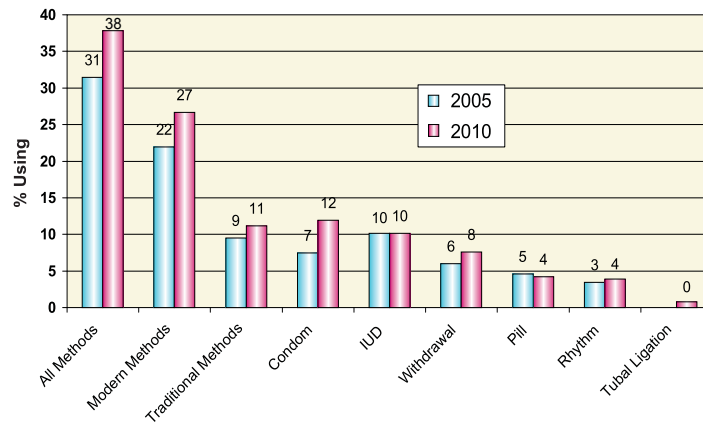


Young couples probably turn to the methods they know after they have the first child, even though two of the primary methods, the condom and withdrawal, suffer from high failure rates that produce ill-timed or unwanted conceptions.

**Time Trends:** The percentage of young couples who were using each contraceptive method rose from 2005 to 2010 for nearly every method (**Figure 3.4**). (The two age groups are merged to show results for ages 15-24, due to the small sample numbers in the 15-19 group.) For all methods (left bars) the increase was from 31% to 38%, or 7 points. This came from a 5 point rise for modern methods and a 2 point rise in traditional methods. As the figure shows, the condom gained most, followed by withdrawal. Only the pill lost, to remain at a low level similar to that of rhythm. Tubal ligation was nearly negligible in both surveys.

The condom and IUD are used more than any other methods. The condom is easily available and widely known. The IUD has been favored in the health systems of the former USSR countries, whereas the pill has been downplayed. Tubal ligation has not been a factor especially among young couples.

**Figure 3.4** Trend for Contraceptive Use by Method, 2005 to 2010 for Merged Age Group 15-24

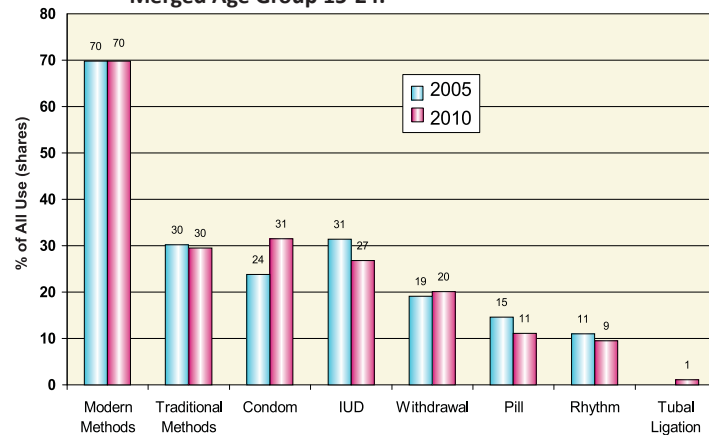


A different perspective appears in **Figure 3.5**, for the method mix. This pertains to all current users rather than to married women, and shows the share of all use due to each method. The two age groups are merged, as in the previous figure. The first two sets of bars, for modern and traditional methods, add to the total of 100% in each year.

(So among all users, the condom and IUD were dominant in both years, and withdrawal was next. Most use is for those, plus withdrawal. The overall pattern did not change much over the five years, although the condom gained share and the IUD lost share. Meanwhile, the absolute levels were rising for nearly all methods, as shown in **Figure 3.4**.)

The 2010 data also show that in the next higher age group, 25-29, the method mix was essentially identical to that shown in **Figure 3.5**, so the women who had moved into the next older group had method preferences close to those of the younger women.)

**Figure 3.5** Trend for Method Mix for 2005 and 2010, Merged Age Group 15-24.



### Unmet Need for Contraception

“Unmet Need” pertains to those women who do not want another child within the next two years, or ever, but who are exposed to pregnancy and yet are not using any method. This group is relatively small among young women because many are not yet married and are sexually inactive; also many of the married group desire their first child soon or are already pregnant. The 2010 survey found 3% at ages 15-24 to have unmet need (all marital statuses). However some were using the traditional methods of rhythm or withdrawal, which risk failures, and if these are added then 7% of the group has unmet need.

For married women aged 15-24 the figures are higher: 10% have unmet need, or 21% have unmet need when traditional



method users are included. That is one in five of all young married couples, pointing to the need for more use of modern, more reliable methods. Note however that condoms are included among modern methods, and they too have high failure rates. The IUD and pill perform best, along with sterilization which however is less used by the young.

Policies to reduce unmet need must primarily consider **contraception**, since unmet need declines mainly as contraceptive use increases. Without that the unfortunate numbers of ill-timed or unwanted conceptions will persist with the abortions that often follow.

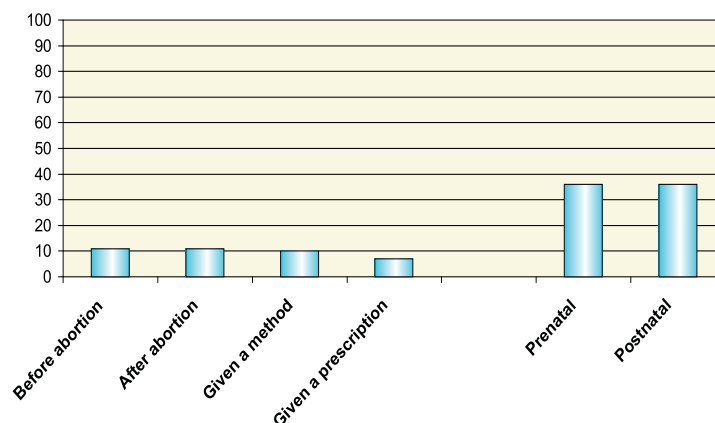
### Counseling for Contraception

The women who had received counseling about contraception were asked about their satisfaction with the service provider. Most (82%) said they were either very satisfied or satisfied; the other 18% were only somewhat satisfied or not satisfied. This is generally favorable, but allowing for courtesy replies the true level of satisfaction is probably somewhat lower. Also, since young women have inadequate information in the first place they may have little basis to judge the value of the counseling received. For all women (all ages 15-44) only half said their counseling was “comprehensive” and only 59% reported receiving information about the effectiveness of alternative methods.

Abortions give an occasion for counseling on contraception, and for providing a method. All those having an abortion in the past five years were asked if they had received counseling. Among young women aged 15-24, 11% reported counseling before the abortion and another 10% afterward, or one if five total. Nearly a tenth (9%) received a contraceptive method, and 7% were given a prescription for one. **Figure 3.6** shows the great shortfalls from 100% coverage.

Pregnancy also gives an occasion for contraceptive counseling. All those giving birth in the last five years were asked about their experience, and 36% reported some counseling during prenatal care; 36% also reported counseling during postnatal care. These figures seem unfortunately low, since so many women giving birth consider it their final one, or wish to postpone the next pregnancy for at least two years. Clearly, counseling is lacking, both before and after pregnancy.

**Figure 3.6 Percent Receiving Counseling for Contraception at time of Abortion or Pregnancy**



### Opinions About Contraceptive Methods

**Effectiveness of Methods.** The women were asked which contraceptive method is the most effective (has the lowest failure rate). Not surprisingly, 42% of those in the 15-19 age group (90% of whom were not yet married) said they did not know. However only 2% chose sterilization as the most effective method while 29% chose the condom, an unfortunate reversal of the truth that can easily lead to accidental pregnancies. Only 17% chose the IUD and only 9% the pill, revealing additional misinformation. In fact the IUD rates next to sterilization as the most effective method and the pill is next, for which failures are due primarily to inconsistent pill taking.

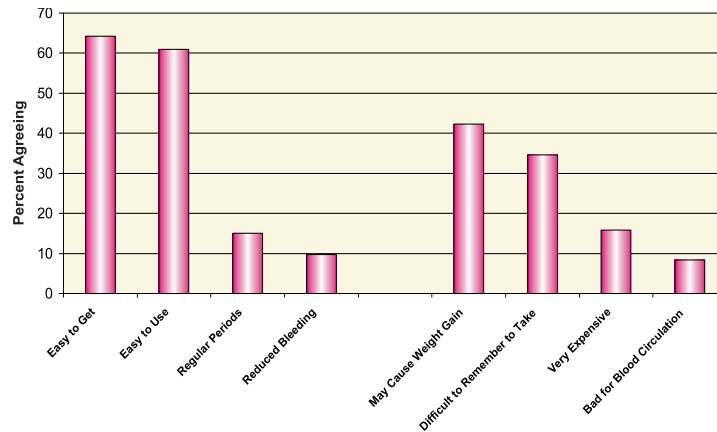
The next higher age group, 20-24 also suffered from much misinformation. Fewer (21%) said they did not know which method is the most effective, but 22% chose the condom. Only 4% chose sterilization. The IUD was named by 33%, an improvement over ages 15-19 that suggests a learning process as women age and marry. The pill was chosen by 14%, slightly above the figure for the younger women.

Here are the opinions of young women ages 15-24 concerning the pros and cons of using the pill and the IUD, among those who had every heard of each method. They were asked to

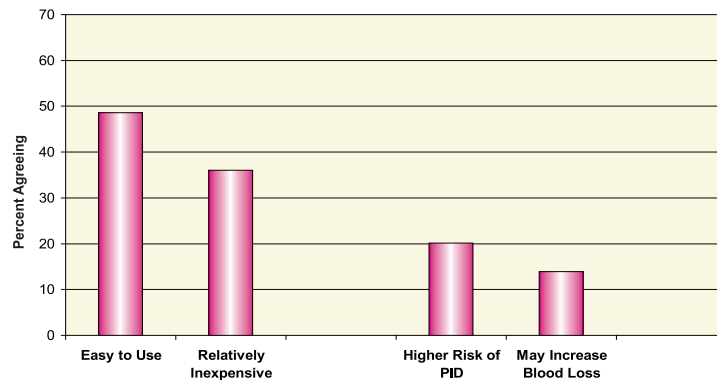
agree or disagree with a series of statements regarding the advantages and disadvantages of certain methods. The bars in **Figures 3.7** and **3.8** show the percentage agreeing with each statement. The pill is regarded as easy to get and easy to use, but some regard it as very expensive. Small percentages agreed with the other statements shown.

The IUD is seen as easy to use and relatively inexpensive by 35% to about half of respondents, with 20% regarding it as raising the risk of PID and 13% as perhaps increasing blood loss.

**Figure 3.7** Opinions Regarding Pros and Cons of the Pill, Among Those Who Have Heard of It



**Figure 3.8** Opinions Regarding Pros and Cons of the IUD, Among Those Who Have Heard of It



## Condom Issues

In an era of HIV, condom use becomes very important to anyone possibly exposed to either HIV or to other STDs. While HIV prevalence in Georgia is relatively low it is thought to be rising, due partly to drug usage. The typical pattern is for HIV and AIDs to start in such special subgroups as drug users and highly mobile male workers, and then later to spread into the general population, first in cities and then outward.

Condom use is the only method that offers dual protection against both pregnancy and STD infection. It is fairly well established in Georgian culture and is generally accessible in pharmacies. Ever-use of the condom is limited because many couples prefer some other method, such as the IUD. Many use withdrawal or rhythm, even though they have a high failure rate and give no protection against an STD.

Therefore it is important to measure the attitudes of young women aged 15-24 toward condom use. When “ever-users” of condoms were asked a variety of questions, most agreed that using a condom with a new partner is “a smart idea,” and that women should ask their partners to use condoms. Less than half agreed that it is easy to discuss using a condom with a prospective partner, or that using condoms is unnecessary if you know your partner, or that condoms diminish sexual enjoyment. In contrast, “never-users” frequently gave “don’t know” answers, so the “agree” percentages were lower than those for the “ever-users.” Both groups disagreed strongly that it is embarrassing to ask for condoms in FP clinics or pharmacies, that people who use condoms sleep around a lot, or that the same condom can be used more than once.

## Health Risks from Using Contraceptives

All young women whether married or not were asked to judge the risk from using each contraceptive method, whether the risk is low, medium, high, or don’t know. Five methods were assessed: pill, IUD, condom, sterilization, and abortion (also the injectable, but very few had heard of it). Table 1 contains the results.

First, those saying “don’t know” must be separated out (column 1 in Table 1), so the “know” replies can be distributed among those with an opinion (remaining columns add to 100%). The main results are:

- The 15-19 age group reported “don’t know” for each method much more than the 20-24 age group did, again showing the advance of opinions as women age and marry.
- “Don’t know” replies were greatest for sterilization, and least for the condom and abortion, with the pill and IUD in between.
- Among those with an opinion, the risk to the woman’s health was judged to be greatest by far for abortion, at over 80% in the “high risk” column. At the other extreme, nearly no-one rated the condom as high risk. For the other methods the IUD was seen as least risky and the pill was only somewhat higher, with sterilization rated above the pill.
- The two age groups gave similar replies for every method, among those having an opinion. Therefore two dynamics are underway as women age: they gain some information in the first place, and then they form an opinion about the risk to their health. In general, those with an opinion made reasonably accurate judgments as to the relative risks of the methods.

**Table 1. Perceived Level of Health Risks from Contraception**

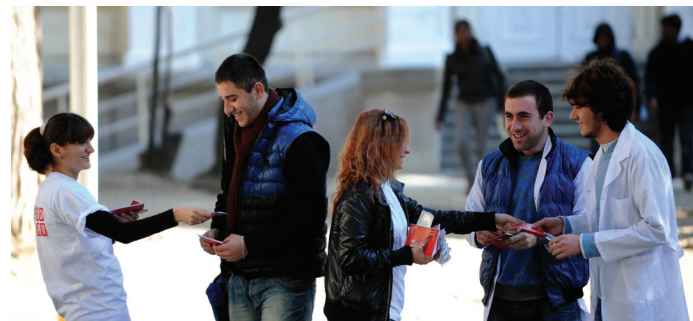
	Does Not Know	Low Risk	Medium Risk	High Risk	Total
<b>PILL</b>					
15-19	69.9	19.3	59.5	20.9	100
20-24	38.9	16.5	59.9	23.6	100
<b>IUD</b>					
15-19	65.0	30.0	53.4	16.3	100
20-24	33.1	28.1	56.7	15.2	100
<b>CONDOM</b>					
15-19	38.4	83.8	15.3	1.0	100
20-24	22.2	84.2	15.4	0.4	100
<b>STERILIZATION</b>					
15-19	94.3	19.3	42.1	36.8	100
20-24	79.3	20.8	47.3	31.9	100
<b>ABORTION</b>					
15-19	40.0	0.8	17.3	81.8	100
20-24	22.7	1.0	15.4	83.6	100

## Desire for More Information

The 2010 survey confirms that young women want more information about contraception. Also, they have decided views about their preferred sources of such information.

- In the two age groups, 15-19 and 20-24, 62% and 67% respectively desired more information about contraceptive methods. These figures are actually higher than those in the older age groups (who already knew more).
- When women were asked about the “best source” of information, gynecologists won out, with 37% and 52% of the two age groups naming them. Most others named impersonal sources: the mass media for radio/TV (27% and 20%) plus newspapers/magazines at 10% in each age group, and then books, with 9% and 9% respectively, as well as the internet (4% in each group). Few mentioned friends or mothers, or contraceptive users as the best source. One implication of these results is that gynecologists should pay close attention to their roles as educational sources for young women; also the mass media should remember that about a third of young women regard them as key sources for reliable information on contraception.
- Sensitivity to the mass media containing contraceptive information can be an issue to some people, but the survey found that over two-thirds of young women favored such broadcasts on TV or radio.

Overall, the bulk of the young population desires more contraceptive information than they now possess. They look to gynecologists and the media as good sources, and they are comfortable with media inclusion of such information.



## Chapter 4. Maternal and Child Health

Several factors related to pregnancy and birth can impact the health of a woman, including prenatal care, the location and type of assistance at delivery, and postpartum behaviors, including breastfeeding. Information on these and related determinants of maternal health for young women is reviewed below, along with infant and child mortality rates.

**Prenatal Care.** Nearly all young women receive prenatal care in Georgia, and most (58%) receive 4 to 6 visits with another 23% receiving 7 to 9 visits. Also most (89%) women have the first visit within the first trimester of pregnancy. All this is nearly the same for both age groups 15-19 and 20-24 and applies to births in the last five years.

**Care Received.** Nearly 100% of women receiving prenatal care were measured on numerous items: basic blood and urine tests, height and weight, and blood pressure, as well as an ultrasound exam, but only 61% were tested for HIV.

**Delivery Place and Delays.** Roughly half of women were delivered in the city maternity hospitals and the rest in regional maternity hospitals. Home deliveries were rare, less than 2%. On average, four hours elapsed between admission and delivery. Delays before departure varied considerably: over half (58%) spent four or fewer nights in the facility, 26% spent 5 nights, and 13% spent 6-7 nights.

**Cesarean Deliveries** accounted for 15% of all deliveries at ages 15-19 and 19% at ages 20-24. Both percentages were below the average of 24% for all ages 15-44.

**Postpartum Care** was not received by most women. Only 21% reported receiving it. For those the main information given (to 70% - 80% of those seen) concerned breastfeeding and breast care, child care, immunization, and nutrition. However only 39% of those seen received family planning information, and that is a mere 8% of all delivering women (39% of 21%). The result is the occurrence of some unplanned conceptions after the current birth.

**Well-Baby Visits** were made by 84% of new mothers. About half of visits were made within one or two weeks, with the rest evenly divided between less than a week and over two weeks.

**Complications:** One in seven (14%) of women had at least one pregnancy complication, and one in ten (10%) had at least one postpartum complication. The types of complications varied widely, with only a small percent experiencing each one. Pregnancy complications included the risk of preterm delivery, anemia, edema, high blood pressure, and others. Postpartum complications included severe bleeding, a painful uterus, high fever, breast infection, and others.

**Breastfeeding** is quite common; 90% of women used it and of those a fifth began within the first hour and over half within 24 hours. Some supplementary food is given relatively soon to most infants, since “exclusive” breastfeeding (only breast milk) lasted on average

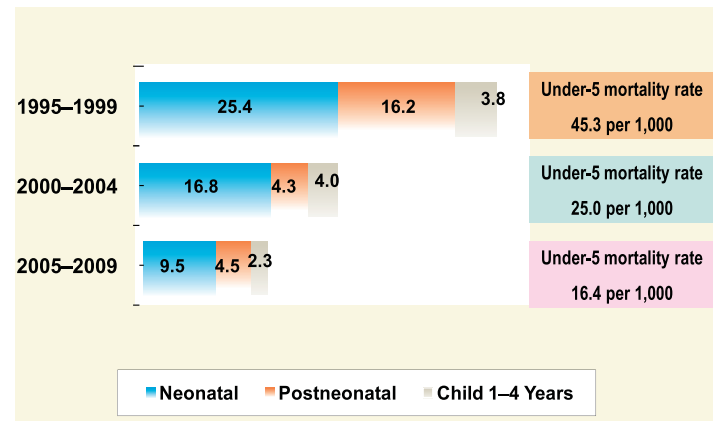
three months and “full” breastfeeding (either “exclusive” or with slight addition of other liquids or food) lasted only 4.1 months. However some type of breastfeeding lasted on average 12.2 months.

**Infant and Child Mortality.** Due to the sample size and the relatively low rates of infant and child mortality, the only estimates available for women aged 15-24 are for the ten-year average prior to the survey. These rates follow:

Neonatal mortality	12.9
Postnatal mortality	5.3
Infant mortality (sum of neonatal and postnatal mortality)	18.2
Child mortality (1.0 - 4.9 years)	1.5
Under-5 mortality (0 - 4.9 years) (sum of infant and child mortality)	19.7

A most remarkable decline in the risk of dying before age 5 has occurred. Rates for five year periods prior to the survey are available for all women aged 15-44, and they show an encouraging time trend from 1995-1999 onward (**Figure 4.1**). Each of the three parts of mortality declined between 1995-1999 and 2005-2009. Overall, the Under-5 Mortality Rate fell from 45.3 to 16.4, a two-thirds (64%) drop in ten years.

**Figure 4.1** Mortality Rates Under Age five in the 5 Years Prior to GERHS: 1999, 2005, 2010



## Chapter 5. Health Behaviors and Knowledge

All youth were asked a range of questions about reproductive issues and behavior. Here is a digest of the results.

### **Pregnancy, Breastfeeding, Abortion.**

When is a woman most likely to become pregnant? Of those aged 15-19 two thirds (68%) said they did not know, as did 37% of those aged 20-24. Otherwise responses varied widely:

- Right after her period ends (9% and 20% for the two age groups respectively)
- Halfway between her periods (9% and 31%)
- Anytime (10% and 9%).

How does breastfeeding affect a woman's chance of getting pregnant? Again, 63% and 29% of the two age groups said they did not know. Other replies:

- Decreases the chance: 22% and 54%
- Has no effect: 15% and 17%
- Increases the chance: 1% and 1%.

Should a woman always have the right to decide about her pregnancy, including whether to have an abortion? Virtually no respondents said "don't know."

- Always acceptable was the reply chosen by 65% and 71% of the two age groups respectively.
- Acceptable under certain circumstances was chosen by 31% and 24%.
- Never acceptable was chosen by only 3% and 4%.

A follow-up question was asked of those with the more conservative opinion that specified only certain circumstances. For the merged group aged 15-24 most (77%) agreed if the woman's life was endangered, about half (55%) agreed if her health was endangered or if the fetus was deformed, but only 29% agreed if the pregnancy resulted from rape. Less than 10% agreed if the woman could not afford a child, was unmarried, or desired no more children.

What should a woman do if she has an unwanted pregnancy? Even though most (above) said that abortion was always acceptable, in this query most favored keeping the baby rather than having an abortion.

Give birth and keep the baby: 73% and 69% agreed in the two age groups, respectively.

- Have an abortion: 20% and 26%
- Give birth and give it up for adoption: 2% and 2%.

**Trends:** Remarkably, far more young women opposed an abortion in 2010 than in 2005, when 43% chose the “have abortion” response and only 52% favored keeping the baby. The difference, 43% vs. 23% signals a fundamental change that may be occurring in Georgia toward the choice between abortion and contraception. It is also consistent with the fall in the abortion rate for all ages.

A much larger drop occurred during the longer period from 1999 to 2010, for all women and all ages 15-44. In 1999 a full two-thirds of women favored aborting an unwanted pregnancy, down to only 55% in 2005 and only 30% in 2010.

#### **Patronizing Health Facilities:**

- About a fourth of all young women aged 15-24 reported having no “usual place of care” for medical services.
- About a third have obtained medical care in the last year. Among these one-sixth did so for a chronic condition. An interesting difference existed by age: 61% of visits were for acute care in the 15-19 age group vs. only 46% in the 20-24 age group. That balanced the results for preventive care: 27% in the 15-19 age group vs. 48% in the older group. This may partly be because more of the older group are married and visiting for pregnancy-related reasons, classified as preventive care.
- Routine gynecological examinations were too infrequent among those with experience of sexual intercourse (primarily those married); only 45% reported ever having had such an examination.
- Delays in obtaining needed care were predominantly due to cost (nearly 80% of all reasons). Only one in six carried any health insurance.

Regarding health insurance, since September 2012 the government, particularly the Ministry of Labour, Health and Social Affairs, has expanded coverage of state funded health insurance. The new State Insurance Programme aims to cover the following target groups: children under age six, pensioners, students, and persons with disabilities. The government has also been providing medical insurance to the population below poverty level, teachers, and Internally Displaced People (IDPs). As of October, 900,000 persons were insured by Government

Ordinance N165 and 800,000 persons by Government Ordinance N218. There are 37,358 women and 27,238 men of reproductive age insured by the State Insurance Programme by Government Ordinance N165, and 172,732 women and 143,164 men by Government Ordinance N218. Reproductive health services covered by the State Insurance Programme include:

- Services related to pregnancy (ANC), delivery, and associated complications,
- Services provided by family doctors, including pregnancy tests and family planning counseling (but contraceptive methods are not provided),
- Services provided by doctors of various specialties, including OB/GYNs and reproductologists, if referred by family doctors.

#### **Cancer Examinations**

- Self-Breast-Examination (BSE) had never been used by 84% of the 15-19 age group and 73% of the 20-24 age group (among all those with sexual experience, i.e. primarily married youth). Only about 10% in each age group used it every month.
- Breast Examination ever by a health professional (CBE) was uncommon, reported by only 7% and 11% of sexually experienced women in the two age groups respectively.
- The mammogram picture was considerably worse, with essentially none of the 15-19 age group and only 3% of the 20-24 age group reporting ever having had it. Actually mammograms are especially recommended for older women. Nearly half (46%) of the combined age 15-24 group said they had never heard of the exam, a third (33%) regarded as “not unnecessary/too young” and a fifth (19%) said a doctor had never recommended it.
- Cervical cancer screening had never been obtained by 89% of the combined group aged 15-24. Seven percent had an examination within the past 12 months, and 3% within one to three years. These figures were higher for those having had a routine gynecological exam.

**HPV Infection and Virus.** A major risk factor for cervical cancer is infection with “human papilloma virus” (HPV). A vaccine against HPV is available to help prevent cervical cancer, but many young women do not know about either the infection or the vaccine. Among all women aged 15-24 only 11% had ever heard of the infection, and only 12% had ever heard of the vaccine for it. However when respondents were informed about it, one third (31%) said they would like to obtain it. That was more than for other age groups; in fact the vaccine is especially recommended for young women, who are less likely to be infected yet.

**Tuberculosis (TB)** was known of by most women aged 15-24 (91%), but only 58% correctly indicated that it is transmitted through the air by coughing, and about a fifth (19%) said they did not know how it is spread. Others gave erroneous answers. About one in ten (12%) said they had been exposed to TB from a family member who had TB and 10% said from frequent contact with someone else who had TB.

Only two-thirds (65%) of women were aware that TB can be completely cured. When asked the most appropriate treatment for TB-infected people, the majority (74%) said they should be hospitalized, 11% said they should be hospitalized initially and then treated at home, and 2% said they should be treated entirely at home. One in eight (13%) said they did not know.

**Smoking** among young women is not common: 3% of those aged 15-19 have ever smoked and 7% of those aged 20-24. Nevertheless, 7% is one in 14, and this is probably more in the cities and in the higher quintiles. Reports of “current” smoking are less: 2% and 5% in the two groups respectively.



Secondary smoke is a more serious problem: half (51%) of the combined group aged 15-24 are exposed to tobacco smoke at home. Also, half (47%) are exposed to it at work. The figures are not much lower among non-smokers: 50% and 44% at home and at work.

Drinking is much more frequent than smoking among these young women aged 15-24. Concerning the last three months 29% “ever drank” and 14% are “current drinkers.” Falling into the more extreme category of “binger” are 9%, or nearly one in ten.

A final measure of health status for young women comes from a question that asked whether the respondent had ever been told by a doctor that she had any of five health problems. The following percentages, for the combined group aged 15-24 are all low, but they are probably under-estimates since many people do not see doctors for their symptoms due to costs; also the group includes the youngest women within the 15-19 age range, who would not normally develop symptoms so early.

PID: 7%  
 High blood pressure 2%  
 Anemia 3%  
 Heart disease 1%  
 Diabetes 1%

PID (pelvic inflammatory disease) is the primary symptom since it can often appear at early ages. Anemia can also, but it is reported at only 3%.





## Chapter 6. Family Life Education (Sex Education)

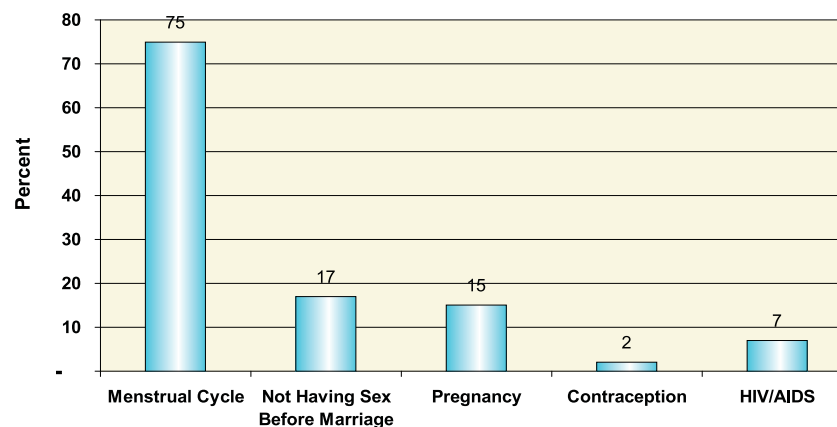
Interests in teenage sexuality, adolescent pregnancy, and sexual health have been increasing worldwide in recent years. Complex approaches are required to prevent, or reduce the rates of sexually transmitted infections and early pregnancies among adolescents. School-based sex education can be part of a wider effort, along with family-based activities and use of the media. Studies from different countries show that high-quality sex education programs in school can lead to enhanced understanding of personal hygiene, health, and reproductive issues. Recently, in Georgia, elements of reproductive biology have been incorporated in high school biology and human anatomy classes, but the curriculum still needs improvement and enhancement.

The surveys covered only women, but sex education is very important for young men as well, and the school programs underway cover both men and women. In 2010 all women aged 15-24 were asked whether they supported some form of sex education in the schools. High and consistent levels of approval resulted. Approximately 80% responded favorably to the following topics: how pregnancy occurs, sexually transmitted infections (STIs), and contraception.

Regarding the age at which education on these topics should begin, respondents were evenly split between ages 14-15 (48%) vs. ages 16 or higher (44%). These results closely parallel those for the entire age group 15-44.

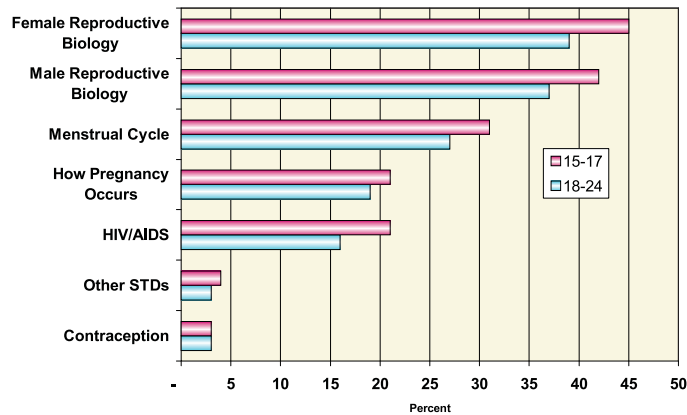
Many young women (75%) recalled discussions on menstruation with a parent before reaching age 18 (**Figure 6.1**). Much smaller percentages, 17% and 15%, recalled discussions on not having sex before marriage and on pregnancy. Exchanges about contraception were rare, and little was said about HIV/AIDS. There is some suggestion in the data that the youngest women, aged 15-17, are having more parental discussions, perhaps because the schools recently have added more sex education courses.

**Figure 6.1** Percent of Women Aged 15-24 Who Discussed Topics with a Parent Before Reaching Age 18



Indeed, that was indicated by a further question on whether the youth had been taught various topics before age 18 in the schools. More of those aged 15-17 than those aged 18-24 reported such experience on seven different topics (**Figure 6.2**). This trend is encouraging; yet all the results are below 50% for both age groups. Contraception is especially neglected, as well as STDs.

**Figure 6.2** Percent Taught Topics in School Before Reaching Age 18, by Current Age



Where do young women get information on sexual matters? Respondents aged 15-24 were asked for their “most important” source of information, and again, the youngest ones were most likely to refer to the schools, naming a teacher. The combined group aged 15-24 gave first place to friends (32%), and another mentioned a parent (23%). Thirteen percent said radio/TV and 9% books. Only 5% mentioned doctors.

These results pertain strictly to the “most important” source. In practice most youth receive information from multiple sources



## Chapter 7. Sexually Transmitted Infections (STIs) and HIV/AIDS

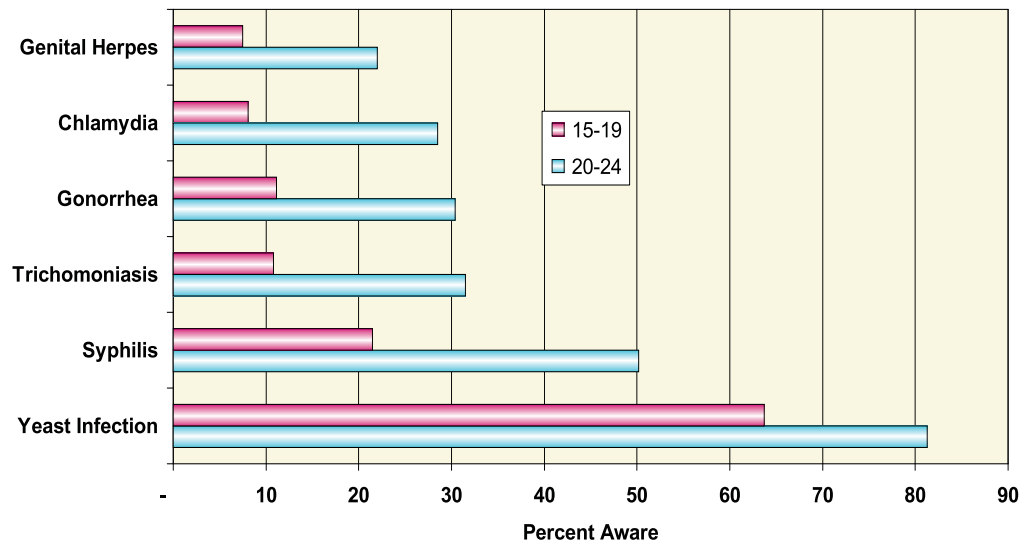
### Sexually Transmitted Infections (STIs)

STIs differ in their prevalence, and in public knowledge about them and their prevention. Both knowledge and testing for STI's are inadequate, and rates of HIV and AIDS are low but increasing. Early action is vital to limit their spread into the heterosexual population.

In general, 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 the World Health Organization. In addition, STIs increase the susceptibility to and the spread of HIV infection.

**Awareness of STDs.** All respondents were asked if they had ever heard of the most common STIs in Georgia, other than HIV/AIDS. For each STI the older women, at ages 20-24, knew more about each type of STD than the younger women did (**Figure 7.1**). Both groups were best acquainted with yeast infections, which appear to be the most common complaint at well. Next came familiarity with syphilis, and then next a group of three at similar levels, with genital herpes least well known. Overall there are clear deficiencies, and especially for the younger group the schools can help to address these.

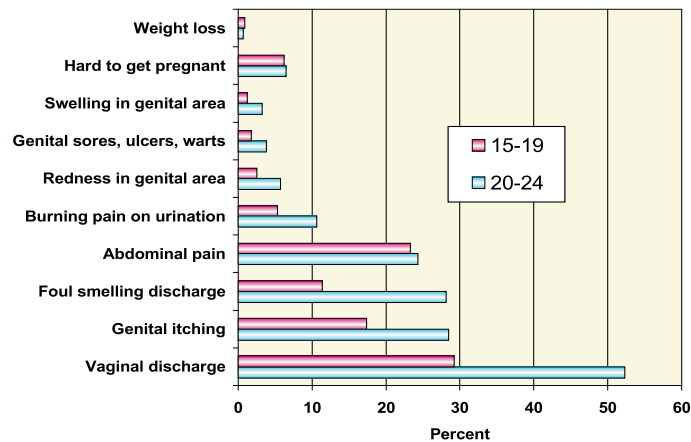
Figure 7.1 Awareness of STDs, by Women Aged 15-24



**Awareness of symptoms.** All young women were asked to spontaneously name symptoms of STIs, however many respondents could not name any at all: 42% at ages 15-19 and 22% at ages 20-24. About 30% in both groups could name only one.

The symptoms actually named are shown in **Figure 7.2**. Clearly, women at ages 20-24 are better informed, but equally clearly their information is quite deficient, demonstrating again the need for more effective public information efforts and better counseling wherever young women are seen by the health services.

**Figure 7.2** Percentage Spontaneously Mentioning STI Symptoms



**Personal Perception of Risk.** Respondents who were aware of at least one STI symptom were asked to rate their own risk of contracting an STI. High percentages considered themselves at no risk at all: 68% and 56% in the two age groups 15-19 and 20-24 respectively; and another 25% and 37% felt at low risk. In fact risk is probably quite low among unmarried young women since few are sexually active. However those who are active carry a definite risk of an STI infection.

**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. About one-fifth in both age groups reported having had at least one STI, and nearly all of them had been tested for yeast infection. Tests for any other STIs were quite uncommon in both groups, with only 1% to 6% ever tested for any of the STIs shown in Figure 7.1 above for awareness, in which yeast infection was also prominent.

**Recent Symptoms.** For the last 12 months, among sexually experienced women (nearly all married) 28% at ages 15-19 and 19% at ages 20-24 reported “vaginal discharge with a bad smell” and 15% and 11% reported “itching or burning

in the genital area.” Some, 13% and 8%, reported “burning pain on urination;” some, 8% and 7%, had “pain during sexual intercourse,” and some, 7% and 2%, had “sores, ulcers, or warts in the genital area.” Note that some symptoms can occur without being due to sexual contacts; that may help explain the rather high percentages who reported a recent symptom.

**Treatments** were sought in most cases: by 79% in the 15-19 age group and by 70% in the 20-24 age group among those with one or more symptoms. By far, most went to an Ob-Gyn doctor (87%) and another 5% went to some other doctor. Cost was listed as the primary reason for not seeking treatment.

**Information Sources.** How do women learn about STIs? Women who were aware of at least one STI were asked for their most important single source of information about STIs, including HIV/AIDS. Television was dominant by far, at 40%. It was followed by friends/colleagues (18%). Health care workers were a less common source at 9%. Minor sources included specialty books and print media. Less than 1% mentioned a husband or a partner. Other minor sources were parents, other relatives, teachers, and the internet; however all these sum to an important one-third of all who responded. It must be remembered that these are primary sources. In reality many women are affected by multiple sources of information.

In another query all women aged 15-24 were 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 a full 71% reported none whatever, and another 12% said they could not remember. Otherwise television was nearly the only source given: 14% mentioned it either alone or in combination with radio or print media. These results testify to the neglect of the subject for the population at large, since the pattern of results parallels that reported by all reproductive age women.

Overall, the surveys show the lack of awareness and accurate knowledge about STIs among young women; as well as older women. 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.

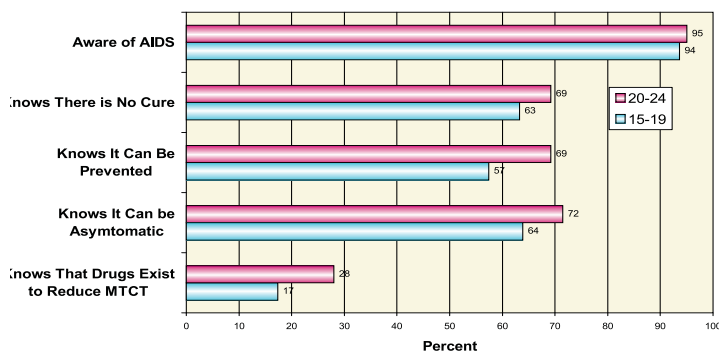
**HIV/AIDS constitute a somewhat separate subject from other STIs, due to their life threatening character, their incurable nature, and their tendency to spread widely throughout large population groups.**

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.

To assess awareness and correct knowledge of HIV/AIDS all women were asked if they had ever heard about HIV/AIDS. Even though the vast majority were aware of it (**Figure 7.3**), much lower percentages knew about the detailed items: 63% to 69% believed that no cure exists for HIV/AIDS. Only 57% to 69% of respondents knew that HIV can be prevented, and only 64% to 72% knew that HIV infection can be asymptomatic. A mere 17% to 28% knew that drugs exist to prevent mother-to-child transmission. Women at ages 15-19 knew much less than those at 20-24.

**Figure 7.3. Awareness and Knowledge of HIV/AIDS, by Age**



Poor knowledge is very important, since women are at special risk of HIV transmission if they have sex with an HIV-positive partner. Informational and educational interventions aimed to improve correct

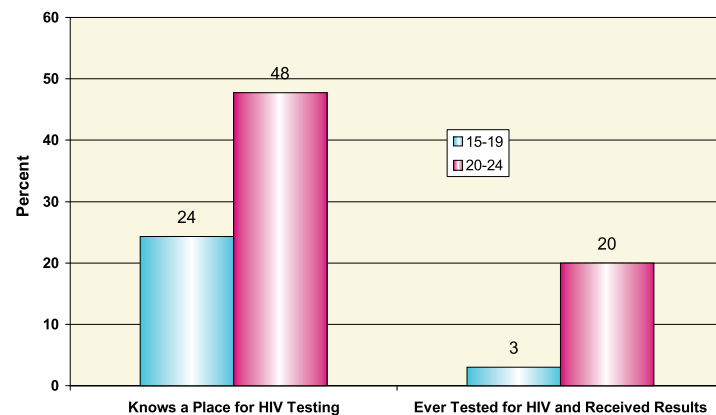


knowledge about HIV/AIDS are needed for the general population, together with special efforts in the subgroups where the level of HIV knowledge is especially low.

Testing locations for HIV were known by only a fourth of the youngest women and about half at ages 20-24 (**Figure 7.4**). Nearly no one in the youngest group had ever been tested in the past (3%), although a fifth (20%) had in the older group.

Of those who were in fact tested, about three-fourths were tested during antenatal care (received by most pregnant women). Most tests occurred at Women's Consultation Centers (62%) with another 26% at Government Hospitals. Most tests were received within the last two years: 39% in the last 12 months and another 35% between 12-24 months.

**Figure 7.4. Knowledge and Experience of HIV Testing, by Age**



Television is clearly the primary source of information about HIV/AIDS. During the last six months it was mentioned as the sole source by 44% of women. Altogether, in combination with radio and print media, it was the primary source for 62% of women. Another 30% said they had not seen or heard any source at all.

Many women are confused about the means of HIV transmission, hence the need for improved public information. All at ages 15-24 were asked to identify which modes of transmission were false, such as witchcraft. Only 80% scored witchcraft as a false mode, so 20% were unsure or claimed it to be a cause. Other modes also showed disappointing results with low rejection percentages: by shaking hands (only 81%), kissing (59%), sharing food plates (67%), or mosquito bites (48%). Only 14% rejected manicures, pedicures, or haircuts as a true mode, and only 5% rejected dental or surgical treatment. The latter may be partly due to the influence of correct knowledge, namely that HIV can indeed be transmitted via contaminated sharp objects, and may be related to the widespread distrust of the general public about the sterilization procedures conducted at health care facilities and beauty salons.

The older women aged 20-24 were somewhat better informed than those aged 15-19 but the school have better access to the younger group and can expand their teaching on HIV/AIDS.

**MTCT: Mother to Child Transmission.** All women were asked to name all possible ways that an infected mother could give HIV to her child. About half of the women (44%) knew about all three means of transmission: during pregnancy, during birth, and through breast milk. Regarding each mode separately, only 49% knew that HIV can be transmitted through breastfeeding, compared to during pregnancy (69%) and during delivery (60%).

Some women thought there is no way to avoid the risk of getting HIV: 11% said there is no way, and another 25% said they did not know. Only two-thirds (64%) believed something can be done to avoid getting HIV.

Then when asked to spontaneously name specific ways to avoid getting HIV, a full third (36%) could not do so. Among those naming methods nearly half (46%) mentioned condoms, a sharp improvement over the 2005 replies (32%). Others mentioned having only one partner, abstaining from sexual

intercourse, avoiding prostitutes, and non-sharing of needles or syringes. The mention of condoms was much more (52%) at ages 20-24 than at ages 15-19 (39%).

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 (57%) considered themselves under no risk at all of getting HIV. Another 35% believed that they were at low risk; only 2% thought they were at moderate risk. Feeling at high risk was reported by less than 1% of respondents. A sense of no risk was higher at ages 15-19 since many more of them are single and not sexually active.

In summary, the 2010 survey established that particular sub-groups lack awareness of and correct knowledge about HIV/AIDS. The survey also showed that the rate of HIV testing still remains a challenge, and that 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. Common misconceptions about HIV transmission need to be addressed. The schools have a special opportunity to educate young women about the risks they may face of acquiring HIV infection. In general, information and education campaigns can be useful in multiple ways: through mass-media, family doctors, and non-medical professionals trained as peer-educators.

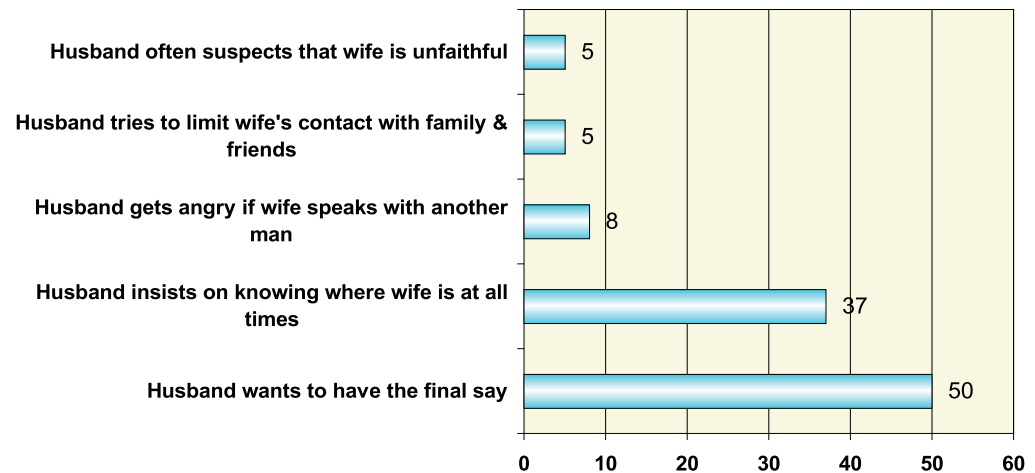


The 2010 survey asked ever-married women aged 15-24 a variety of questions concerning their history of abuse by husbands or partners. Verbal abuse in the last 12 months was reported by 6% of women, and physical abuse by 2%. Reports for lifetime abuse were only slightly higher.

Among ever-married women of all ages 15-44 abuse was somewhat correlated with the equity between the spouses, or “gender norms.” for example about a third of all husbands insist on knowing where his wife is at all times, and “husband wants to have the final say” (50%). Both verbal and sexual abuse were somewhat more common where the wife had poor gender status. **Figure 8.1** displays the 2010 survey results for measures of gender equity.

## Chapter 8. Note on Domestic Violence

Figure 8.1 Gender Equity among Ever-Married Women Aged 15-24



## 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.

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*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.