

# ATTITUDES OF DOCTORS TOWARDS FAMILY PLANNING ISSUES



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Georgia, 2013

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## FOREWORD

In Georgia historically, reliance on abortions has predominated over the use of contraception. At one time the abortion rate was among the highest in the world, but it declined from a peak in the late 1990s to a lower level in 2002-2005 and to a yet lower level in 2005-2010. Meantime contraceptive use has risen: in the same time periods use of any method by married women increased from 41% to 47% to 53%. However some use was of the traditional methods of withdrawal and rhythm, which carry high failure rates and consequent abortions. This information comes from the nationally representative surveys of 2000, 2005, and 2010<sup>1</sup>. (The official reporting of numbers of abortions falls well below the numbers indicated by the surveys.)

Since the nation's doctors provide essentially all abortions and much of the contraception, their knowledge, attitudes, and practices are of great interest. Therefore, in 2010 a special survey of family doctors and Ob-Gyn practitioners was conducted<sup>2</sup> that revealed both strengths and deficiencies among doctors regarding abortion and contraceptive information and procedures. That study is repeated in this publication, to update the 2010 report with selected time trends, and to clarify the current situation.

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1 Serbanescu F., Morris L., Nutsubidze N., Imnadze P., Shaknazarova J., (2001). *Reproductive Health Survey, Georgia, 1999-2000. Final Report*. Atlanta, GA (USA). Georgian National Center for Disease Control and Centers for Disease Control and Prevention.

Serbanescu F., Imnadze P., Bokhua Z., Nutsubidze N., Jackson DB., Morris L. (2005). *Reproductive Health Survey Georgia 2005: Preliminary Report*. Atlanta, GA (USA)

National Center for Disease Control and Public Health (NCDC), Georgia; and Division of Reproductive Health, CDC/Atlanta USA. (2012). *Reproductive Health Survey Georgia 2010*. Tbilisi: National Center for Disease Control and Public Health (NCDC).

2 Tsertsvadze G., Bokhua Z., and Tsuladze, G. (2010). *Attitudes of Doctors Towards Family Planning Issues*. Tbilisi: United Nations Population Fund (UNFPA).



# 1 METHODOLOGY

## **Current state of affairs in researching this topic**

Considerable experience has been accumulated globally as a result of surveys conducted throughout the world on the issues of abortion and contraception. In Georgia also, despite its relative size, several important studies can be named. These include the three national surveys above, as well as a survey on the reproductive health of men in 2005<sup>3</sup>, a special “gap analysis” of family planning services<sup>4</sup>, as well as surveys on adolescent reproductive health in 2002 and 2008, and the 2010 study above on doctor’s attitudes towards family planning Issues in 2010.

## **Goal and objectives of the survey**

The goal of the survey was to identify attitudes of doctors towards family planning and abortion methods. Stemming from this goal, the specific objectives were as follows:

1. Identifying the awareness level of doctors regarding family planning methods;
2. Identifying the attitudes of doctors towards family planning methods;
3. Identifying the awareness level of doctors regarding abortions;
4. Identifying the attitudes of doctors towards abortions;
5. Studying the influence of social, religious and cultural factors on family planning methods, abortions, and related behaviours.

## **Research design**

The survey was conducted among 600 doctors (gynaecologists and obstetricians, reproductologists, and family doctors) in four regions of Georgia.

The survey moved through the following stages:

- Development of a special questionnaire (similar to the 2010 one);
- Administration of a pilot survey;
- Selection of field work areas using a representative random sampling method;

<sup>3</sup> Khomasuridze A., Kristesashvili J., and Tsuladze G. (2005). *Male Reproductive Health Survey*. Tbilisi: United Nations Population Fund (UNFPA).

<sup>4</sup> UNFPA (2013). *Gap Analysis of Family Planning Services in Georgia, Final Report*. Tbilisi: United Nations Population Fund (UNFPA).

- Execution of the interviews;
- Production of data tables using SPSS software;
- Generation of single, dual, and conditional distributions;
- Preparation of the draft report;
- Expert examination of the draft report<sup>5</sup>;
- Translation of the final draft into English;
- Printing the Georgian and English versions of the report.

## **Procedures and criteria for selecting doctors**

The survey covered gynaecologists/obstetricians as well as reproductologists and family doctors. Basic health care statistics provided the total numbers of gynaecologists/obstetricians and family doctors in Georgia in each of the 11 regions (including Tbilisi). For this survey, four of these regions were chosen based on the following guidelines: Tbilisi as the capital of Georgia and the largest region, Ajara as a western region, Kakheti as an eastern region, and Imereti as the second largest region after Tbilisi, located in a somewhat middle position between the eastern and western parts of Georgia. Another criterion was that these regions contain populations of various ethnic backgrounds.

According to data held by the Ministry of Labour, Health and Social Affairs, there are up to 1600 gynaecologists/obstetricians and 800 family doctors in all of Georgia. Respondents were chosen from these lists to produce the numbers that follow, with procedures that balanced representative sampling methods with the necessity of having at least a minimum number of respondents in each region/doctor type. The design, in each region separately, was to give each doctor the same probability of selection. Overall 600 doctors were chosen, the same number as in the 2010 survey.

### Gynaecologists/obstetricians

Tbilisi	246
Imereti	66
Ajara	51
Kakheti	37
<b>Total:</b>	<b>40</b>

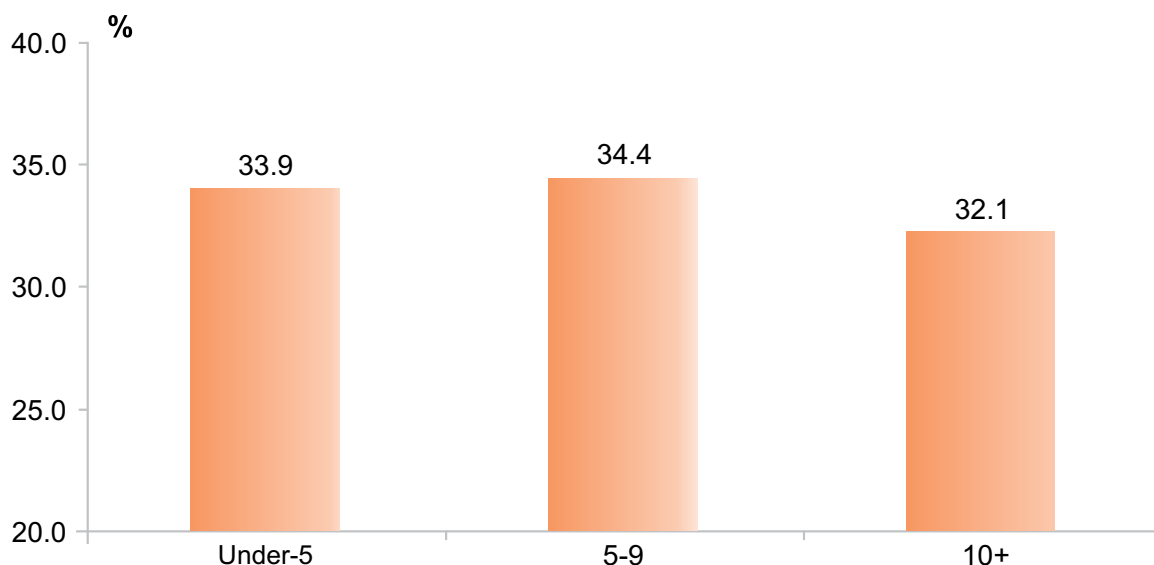
### Family doctors,

Tbilisi	80
Imereti	40

<sup>5</sup> The designated experts returned a positive evaluation of the survey report.



Figure 1. Share of doctors (%) using family planning methods according to the length of use.



Ajara 40  
Kakheti 40

**Total: 200**

Thus the total number of doctors covered by the survey came to:

Tbilisi 326  
Imereti 106  
Ajara 91  
Kakheti 77

**Total: 600**

When a selected doctor was not available on site on the first attempt, the interviewer paid a second visit after several days. If the doctor was again unavailable, or if the selected doctor refused to participate, the next doctor from the list was invited for an interview.

Nine of ten doctors surveyed are female, average age 35-49. Two thirds of all doctors are reproductologists and gynaecologists/obstetricians; the rest are family doctors. The majority (73.8%) have received some training on family planning issues, mostly before 2009. The duration of using family planning in their practices has been nearly the same over the years: about 32% to 34% for up to 5 years, 5-9 years, and 10 and more years (Figure 1 and Table 1).

**Selection of the interviewers and training**

Ten doctors were selected as interviewers and were trained in family planning and abortion methods, as well as in the questionnaire and in interviewing techniques.

**Experts**

Two experts were identified as noted above to review the study and the research report.

## 2 AWARENESS AND ATTITUDES TOWARDS CONTRACEPTIVE METHODS

**Hearing, knowing, and using:** The vast majority of doctors (over 90%) have heard about every contraceptive method listed in Figure 2. This remains true for every subgroup of doctors according to gender, age, specialization, region, or training experience (Table 2).

However fewer know how to use the methods. See Table 2 for the reduced percentages, which vary both by method and by subgroup. Vasectomy is least known, and only half know female sterilization or the implant. Quite high percentages appear for the pill, IUD, and the traditional methods of calendar (rhythm) and withdrawal. In general male doctors score higher than females, and the Ob-Gyns/Reproductiveologists know more than the family doctors. Especially note that Imereti scores are remarkably high; the other three regions show irregular patterns.

As to actual use of contraceptive methods, scores drop off in Figure 2 much more than they do from hearing to knowing. In fact most methods are used by nearly no doctors, or few, in Figure 2. Most used are the pill, IUD, male condom, and the calendar method. Sterilization is quite neglected, as is the in-

jectable. Oddly, Imereti does not stand out for use as it did for knowledge. In fact each region seems to have its own favourite method(s) to use: the IUD in Tbilisi, the pill in Tbilisi and Kakheti, the condom in Imereti and Kakheti, the calendar in Kakheti (Table 2).

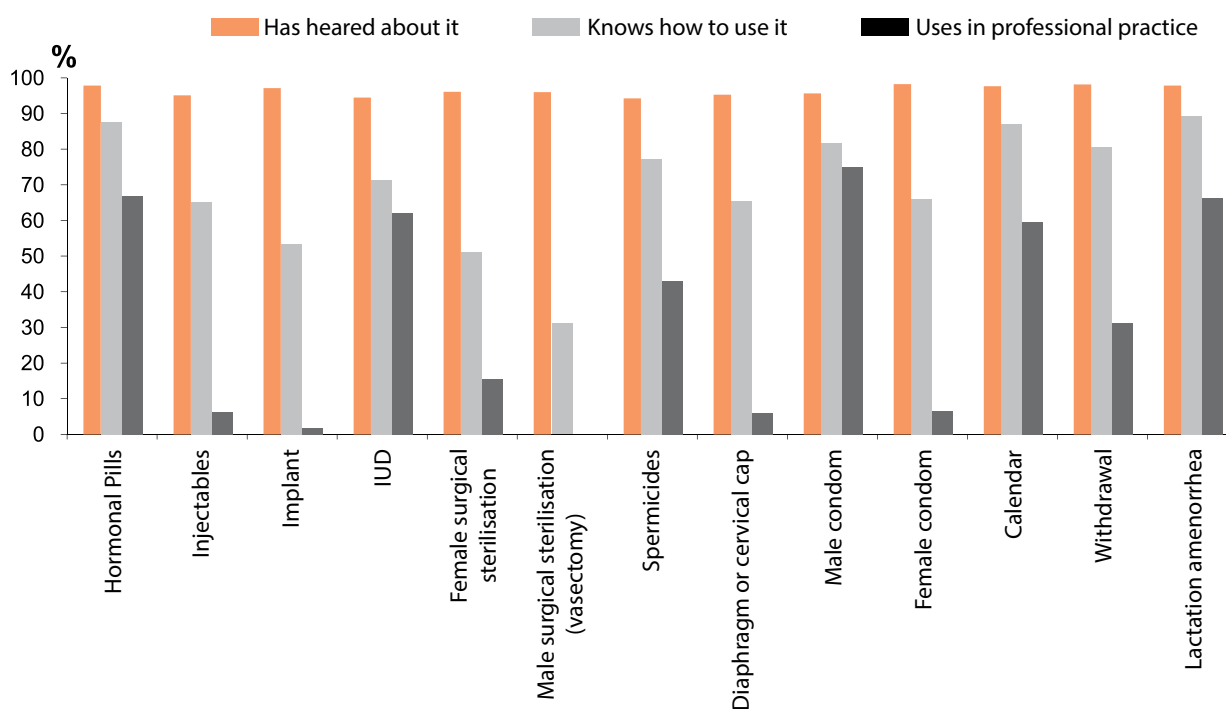
Note that family doctors are only entitled to use the pill, male condom, and spermicide, not the IUD or sterilization. This naturally affects the patterns for which methods the various specialties use.

Sampling error should be remembered throughout the report especially for Ajara and Kakheti since they have only 51 and 37 Ob-Gyn respondents respectively; also the three regions other than Tbilisi have only 40 family doctors each. Thus a shift of replies by 4 respondents shifts the result by 10%. Therefore it is best to focus on just the major differences and trends rather than on details.

The trends from 2010 to 2013 (Figure 3) show a similar spectrum of contraceptive methods used by doctors (2013 data come from Figure 2). Over the past three years doctors have increased their inclusion of the pill, IUD, and condom, along with withdrawal and lactation amenorrhea.

Those results can be compared to use levels reported by women in the 2010 national reproductive health survey of women cited in the Foreword. It shows that

**Figure 2.** Percentage of doctors according to their awareness, knowledge and use of each contraceptive method.



the condom, IUD, and withdrawal are used about equally, with 13.6%, 12.5%, and 11.1% of married couples using them respectively. Next comes the calendar method (7.4%) and the pill (4.1%). The national survey shows that nearly all condom users and over half of pill users obtain their supplies from pharmacies, not doctors, while the Ob-Gyns provide essentially all IUDs.

**Preferences.** All doctors were also asked which methods they “give preference to (more priority)” and which methods they “do not give preference to (less priority)”. The patterns parallel those for their reports for which methods they actually use (above). Especially stressed are the pill, IUD, and condom, as well as lactation amenorrhea. Very low priority is given to sterilization, and relatively little to withdrawal (Figure 4 and Table 2).

**Ideal features of methods.** Respondents were asked to name the key feature of an ideal contraceptive method. Effectiveness of the method stood out as by far the most important feature, named by 61.2% of doctors (Figure 5 and Table 3). Well below at 25.0% was the absence of side effects. All other features including cost ranked very low since the overall total was 100%. (If multiple replies were permitted some of the other reasons would be named more frequently.)

These replies are in agreement with results for many other surveys, that great importance is given to high effectiveness and low frequency of side effects, along with easy use in the long term.

**Figure 3.** Percentage of doctors using each contraceptive method in their professional practice: 2010 and 2013 survey data

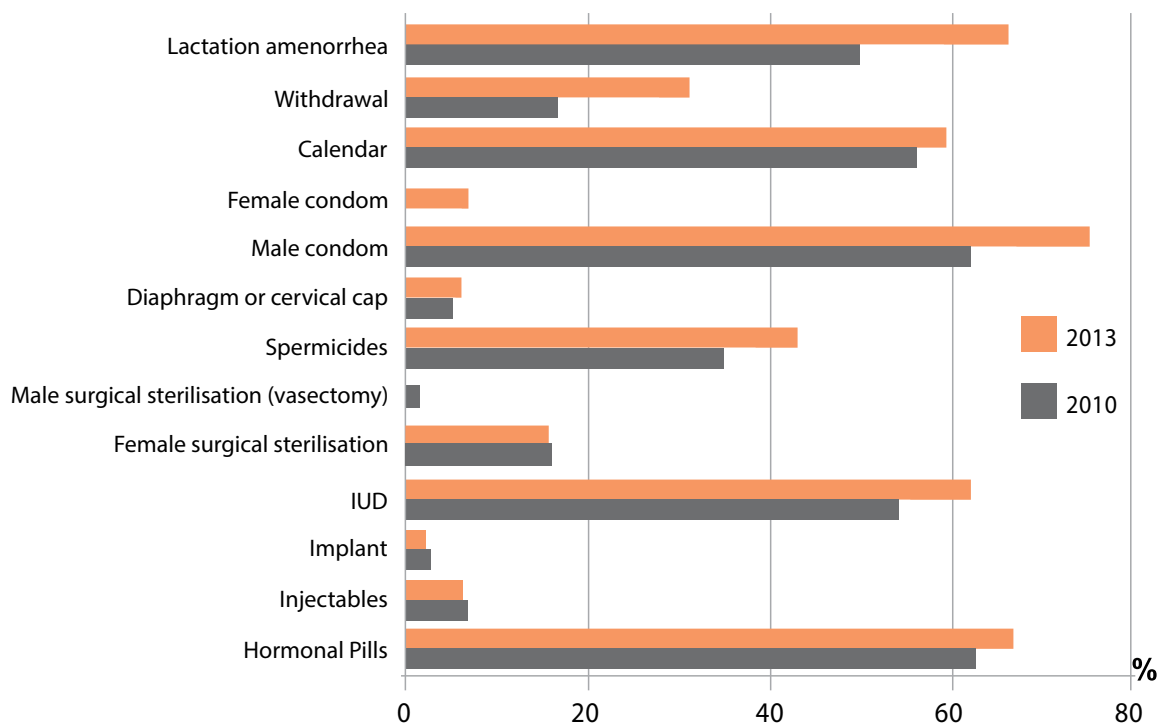


Figure 4. Share (%) of doctors that give more or less priority to the contraceptive methods.

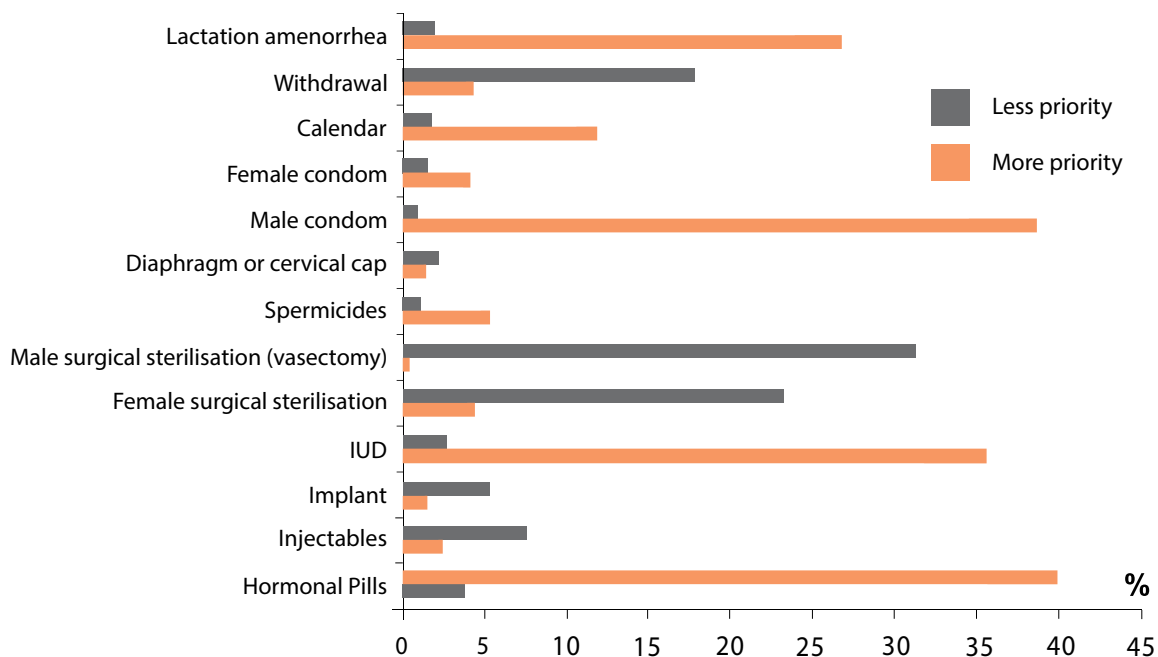
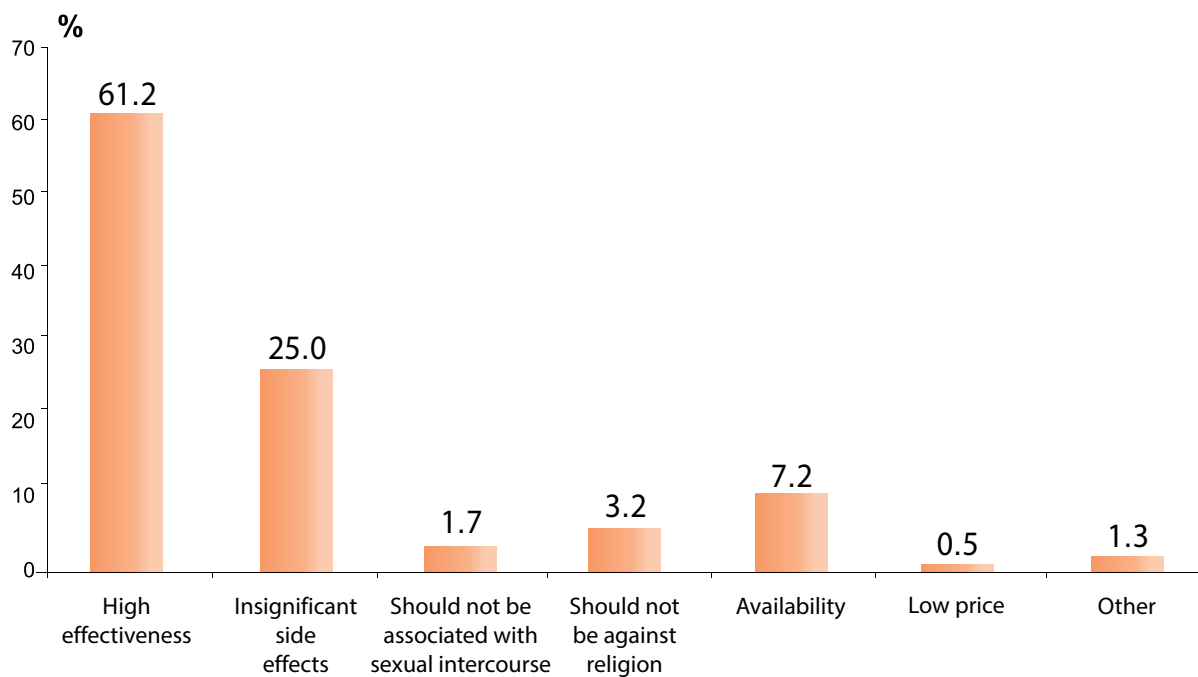


Figure 5. Percentage of doctors naming key features of the ideal contraception method



### 3 AWARENESS AND ATTITUDES TOWARDS INDUCED ABORTION

**Awareness:** About two-thirds of obstetricians-gynaecologists say they are aware of the various methods of induced abortion. (Question not asked of family doctors, who are not authorized to do abortions.) Table 4 shows similar percentages of Ob-Gyns, from 67% to 72%, saying they are aware of each of the five methods. However regions differ greatly: the percentages are very high in Imereti, about average in Tbilisi, and much lower in both Ajara and Kakheti. Also older doctors, past age 50, score lower than the younger doctors do.

**Actual use** of the various abortion methods is much lower than awareness. It also follows very irregular patterns (Figure 6). Clearly, the Ob-Gyns are quite selective in which methods they employ, and that holds true within each region. Dilatation and curettage usually scores low, used by only about 10% to 15% of the Ob-Gyns (Table 4). Electronic vacuum-aspiration is neglected in Tbilisi and is nearly absent in Ajara, but it scores very high in Imereti (46%) and somewhat in Kakheti (23.5%). Next, manual vacuum-aspiration is used by only 15% to 19% of Ob-Gyns in all regions except Ajara, where it scores 28.9%. Ajara continues to be exceptional: for mini-abortions (prior to 5th week of pregnancy) it scores relatively low compared to the other regions. Finally, medical abortion is used mainly in Imereti and Kakheti. These strange patterns are difficult to explain.

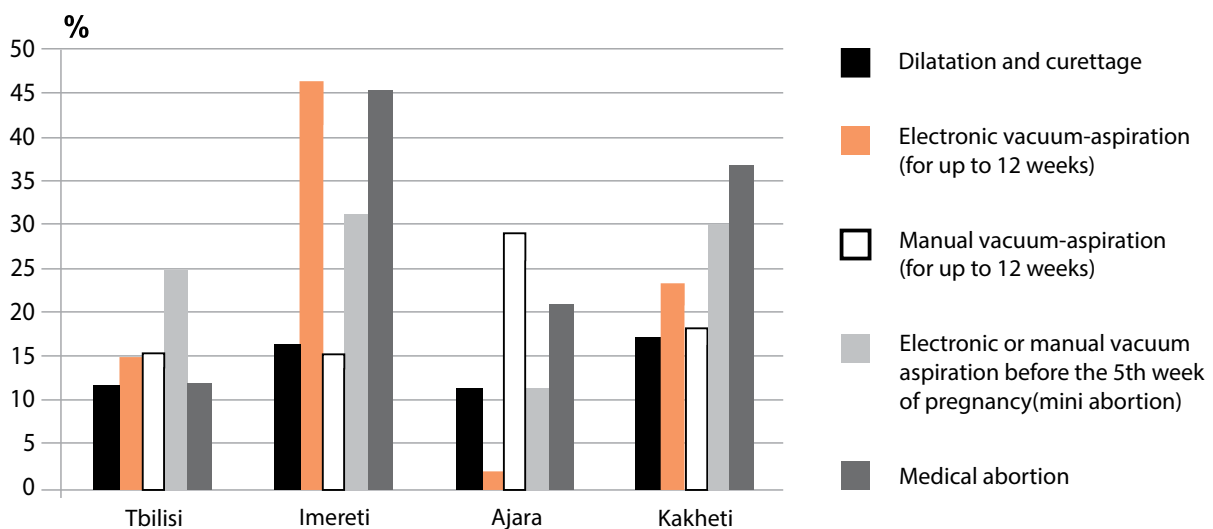
Differences also exist by personal characteristics: female Ob-Gyns use medical abortion, mini-abortion, and early vacuum aspiration more than the males do (Table 4). Older doctors, above age 50, use every method except medical abortion more than the younger doctors do, even though they scored lower on awareness (above).

**Preferences and Use for Each Abortion Method** (all regions merged) appears in Figure 7 and Table 4. The least preferred method by far, and the one least used, is dilatation and curettage perhaps because simpler technical methods have emerged. Medical abortion is clearly the most preferred, but mini-abortion is actually used more. Past experience is fairly broad across the various methods (around 40%) except for medical abortion, which has a special character.

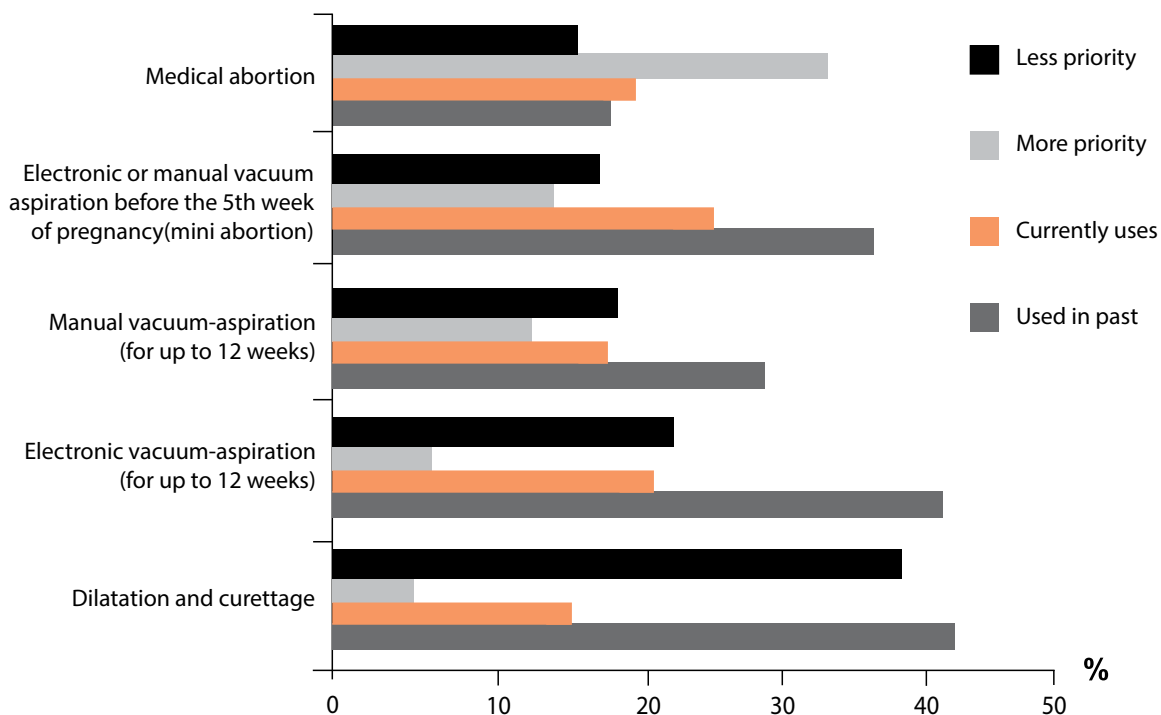
To repeat, the respondents clearly gave less preference to dilatation and curettage than to the other methods. Figure 8 highlights the responses for this, taken from Figure 7. The other three methods scored from 16.4% to 23.9%, well below the peak of 38.4%. The other methods are in fact superior, with less trauma and fewer side effects than the “D&C” method.

**Preference Trends** show a remarkable rise for medical abortion in the past three years, from 7.0% up to 35.7% of the Ob-Gyns preferring it. The other three methods also gained in their scores, but at far lower levels and with tinier increments (Figure 9). The dramatic increase for medical abortion implies further gains in the future.

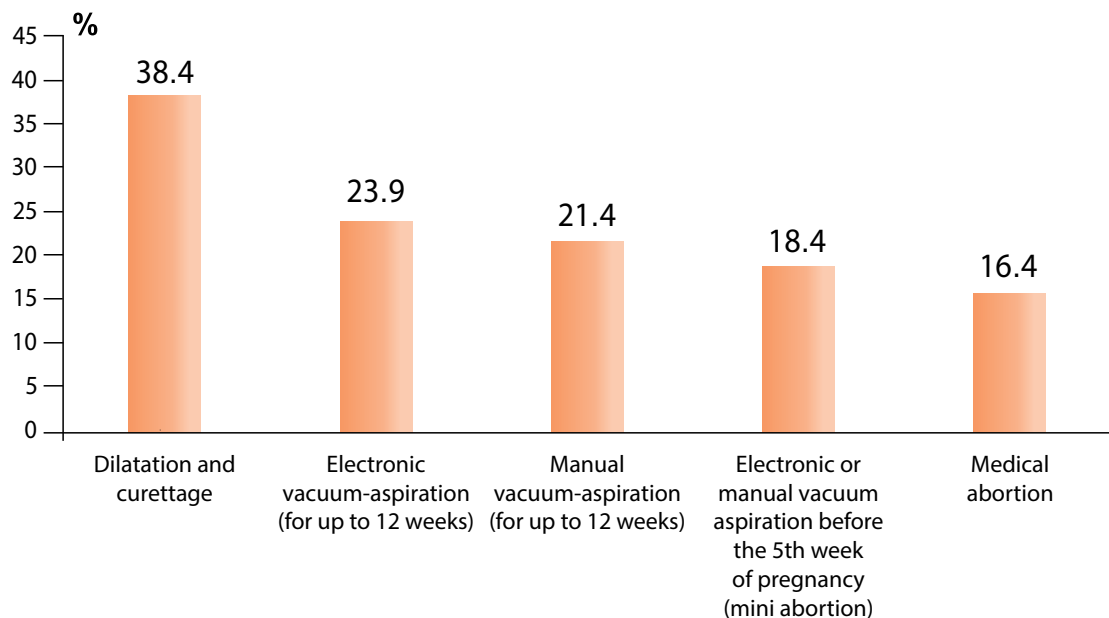
**Figure 6.** Percentage of Ob-Gyn’s currently using abortion in their practices, by method and region.



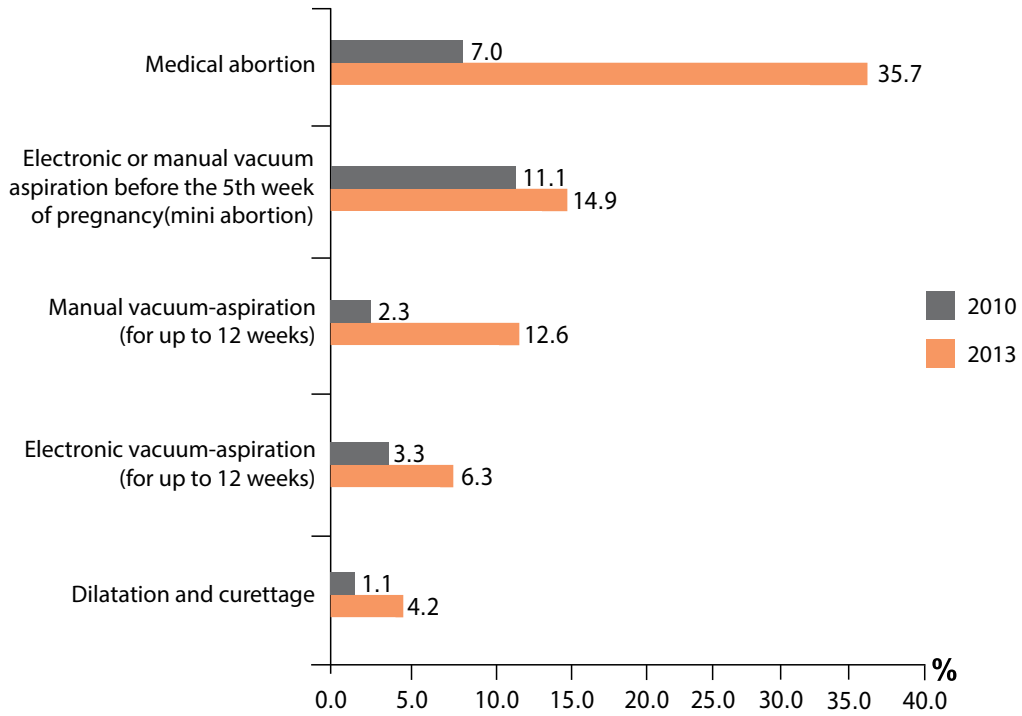
**Figure 7.** Percentage of Ob-Gyn’s according to their assessment and use of induced abortion methods



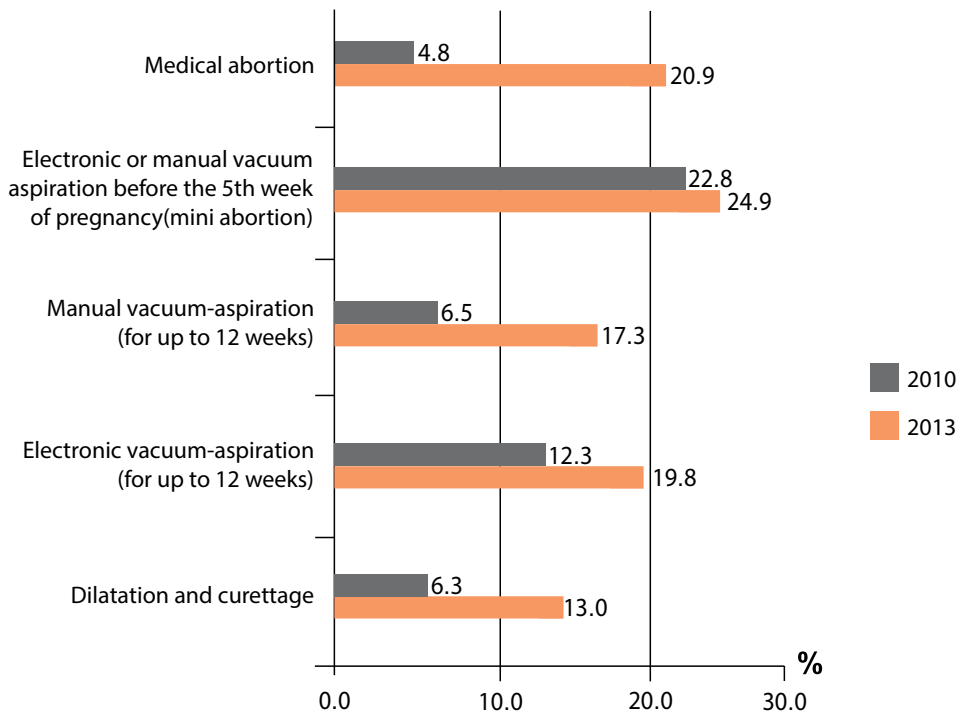
**Figure 8.** Percent of Ob-Gyns giving less preference to each abortion method.

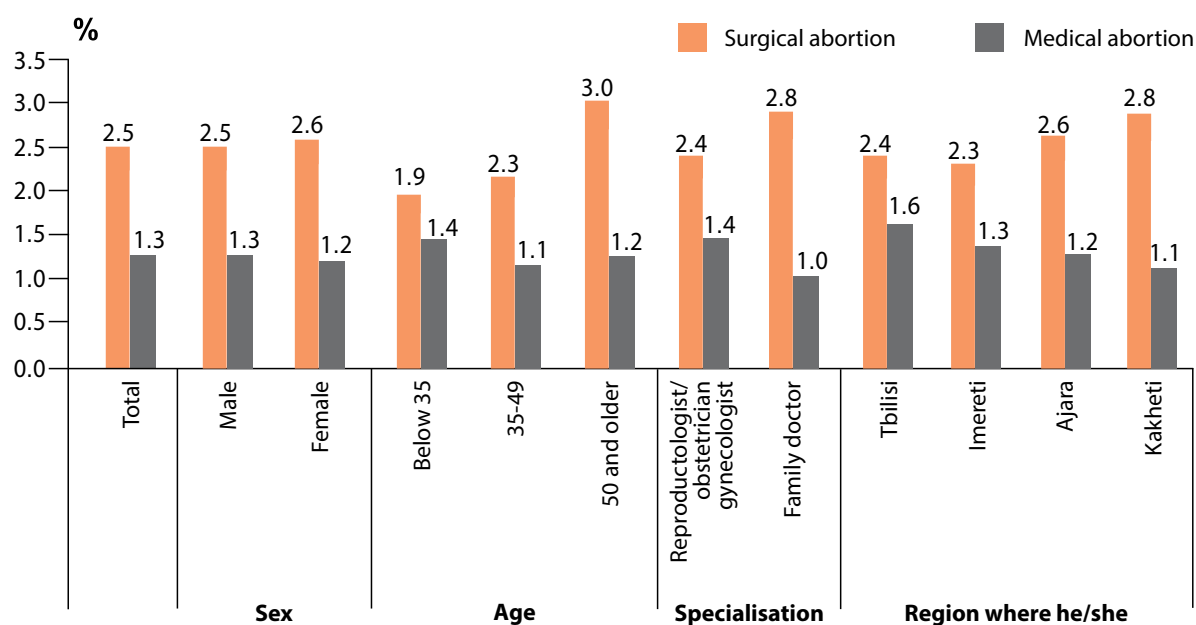


**Figure 9.** Percentage of Ob-Gyns expressing a preference for each method, comparing the 2010 and 2013 surveys



**Figure 10.** Percentage of Ob-Gyns using each abortion method, comparing the 2010 and 2013 surveys



**Figure 11.** Average number of induced abortions undergone by doctors (or their partners)

**Use Trends** agree regarding the rising popularity of medical abortion. In Figure 10 the increase was from only 4.8% of Ob-Gyns using it in 2010 to a high 20.9% in 2013, a level nearly matching that of mini-abortion. Each other method also showed an increase for use, larger than the increases for preferences in Figure 9. This suggests that each abortion method is becoming better known even while the overall abortion rate has been declining.

**Personal Abortion use by doctors.** All doctors were asked about their own personal use of abortions, either by them or by their partners (although 89% of respondents were female). The questionnaire asked about use of both surgical abortion and medical abortion, as to whether the frequency was 1, 2-5, 6-9, or 10+ times. The results appear in Figure 11 and Table 5, showing a substantial personal use of abortion by the doctors. (These are not full lifetime numbers since some doctors are relatively young.)

**Reasons for Abortions.** All doctors were asked the chief reason why women undergo induced abortion, and half of them chose socio-economic reasons (50.7% in Table 6). It ranked first when the respondent was asked for just the single most significant reason. Almost all other doctors said the reason was that the women did not want to have any more children (42.3%). Only 3.2% said the reason was to postpone the next birth, and a mere 1.7% said it was for sex selection of the foetus. Note however that if multiple reasons had been permitted every cate-

gory would have been mentioned more often. Nevertheless these results show the impact of financial pressures on women and families, which reduce the numbers of births annually.

**Sex-Selection abortions** were uncommon among the Ob-Gyns. Four-fifths (79.4%) said they had never done an abortion due to the unwanted sex of the foetus. Another 15.2% said they had done so “very seldom” (Table 7). Other replies were “quite seldom”, “quite often”, and “very often” registering only 2.6%, 2.3%, and 0.5% respectively. The age of the obstetrician mattered however: the percentage saying “never” fell from 97% for those below age 35 to 79.5% at ages 35-49 and to only 69.0% at ages 50 and above. The lowest “never” figure, 44.8%, was in Imereti but another 50.7% said “very seldom, whereas in Table 7 for Ajara 15.6% fell into the more active categories for doing sex-selective abortions. The highest “never” figure, 90.3%, was for doctors who had received no training on family planning issues.



# 4 FAMILY PLANNING METHODS

The doctors in the study were asked a variety of questions about their views toward family planning and particular contraceptive methods.

**Fertility and Abortion Effects.** When asked whether the use of family planning methods affects the national birth rate, only half (47.2%) thought it does so; among them about two-thirds (64.7%) felt that it reduces the birth rate; the others felt that it increases it (Table 8). It is unclear why they believed it might increase it.

On the other hand, when asked whether family planning influences abortion indicators there was near unanimity, with 94.7% saying it does have an effect (Table 10). The doctors were also very firm that abortion is not an acceptable family planning method, with 86.8% saying it is not (Table 9). And nearly every doctor interviewed (99.5%) said that contraception is better for family planning than abortion is.

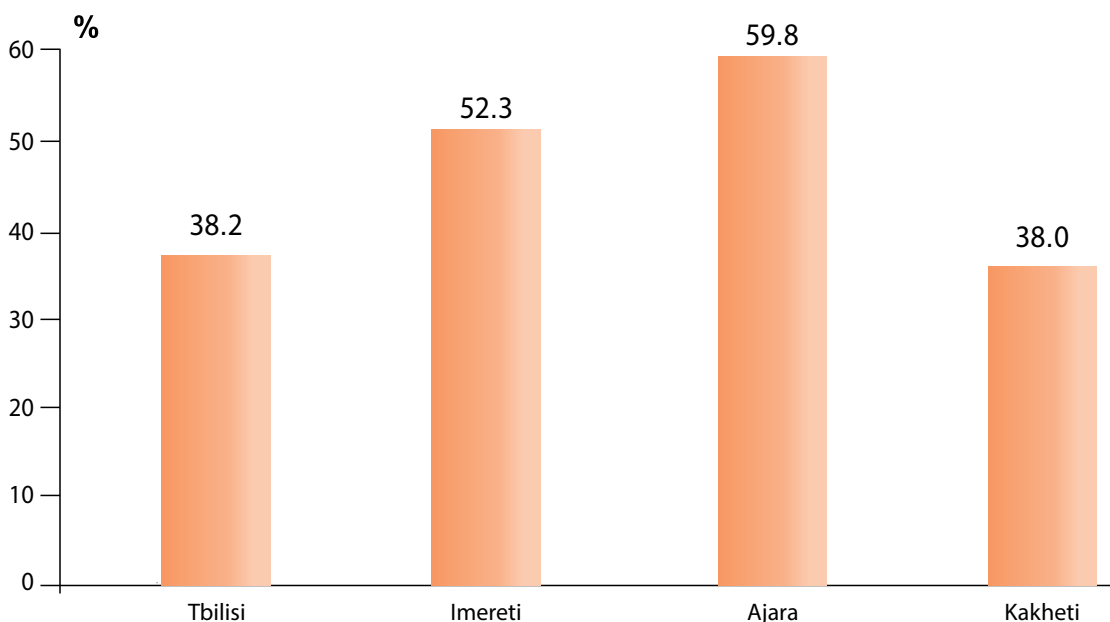
The views were much more mixed regarding the profitability of abortions and contraceptives (Figure 12 and Table 11). Roughly half (44.0%) said that abortion is more profitable, only a third (31.1%) said that family planning methods are more profitable, and a fourth (24.9%) said it makes no difference. The regions differed substantially in this regard: 59.8% in

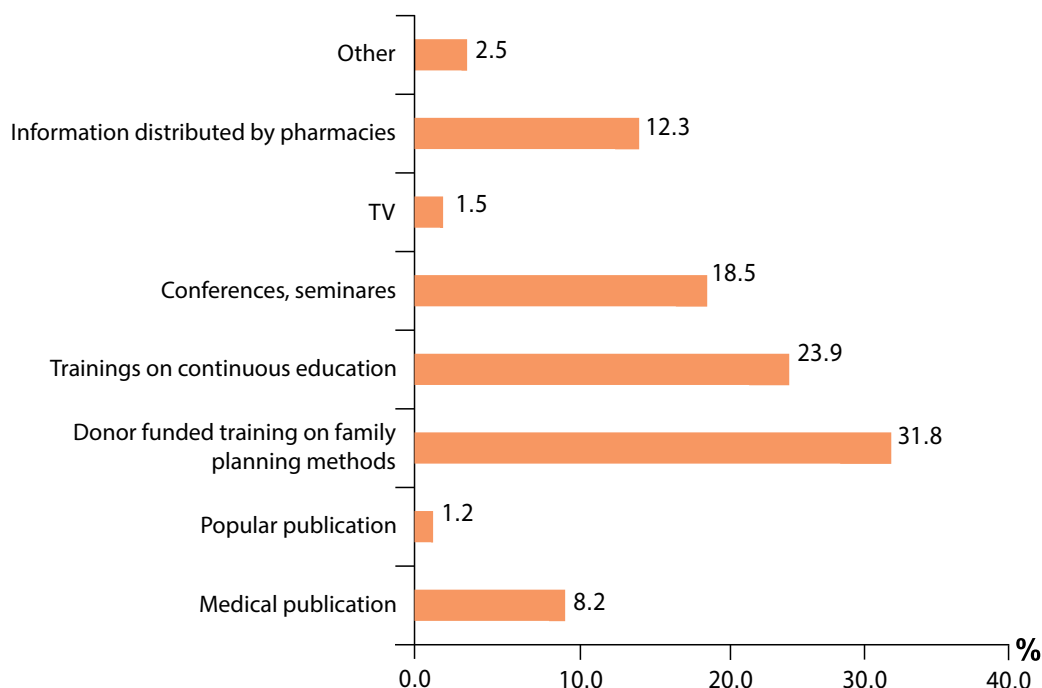
Ajara viewed abortion as more profitable vs. only 38% in Tbilisi and Kakheti. Age also mattered: 54.1% of doctors aged 50 and over saw abortion as more profitable vs. only 24.4% at ages below 35.

**Reasons for Non-Use of Contraception.** All doctors were asked the single most important reason why people do not use contraception. When offered six possible reasons, most (69.4%) chose “low awareness of family planning” as the principal reason. Another 11.4% chose the option of “poor quality of family planning services”, and 6.5% chose “prefers abortion.” Only 4% chose “expensive.” Regions differed somewhat: in Tbilisi 16.5% of doctors chose “poor quality,” and in Kakheti only 60.3% chose “poor awareness” (Table 12).

**Doctors own source of information on contraception.** When asked where they generally get their information on family planning methods and offered eight possible choices, over half (55.7%) chose either donor funded training or continuous training (Figure 13 and Table 13). Also important were conferences and seminars at 18.5%, and information from pharmacies (12.3%). Only 8.2% chose medical publications. In actual practice there are multiple sources, but this shows the importance of training sessions that are deliberately planned and focused on doctors. In reply to two other questions most doctors (91.9%) said it is not difficult to obtain clinical information on family planning methods, although fewer said so in Ajara and Kakheti (84.4% and 81.3% respectively)

**Figure 12.** Percentage of doctors who think that doing abortions is more profitable to the doctor than (a) family planning or (b) it doesn't matter.



**Figure 13.** Distribution of doctors (%) according to the key sources of information on contraception

(Table 14). Most doctors (81.5%) said that they need more clinical information. This varied primarily by the doctor's age, at a high 92.0% for those below age 35 falling to 82.5% at ages 35-49, and 75.4% at ages 50 and above. Thus training plans might especially focus on younger doctors.

**When should family planning instruction be given, and by whom?** All doctors were asked where information on family planning is best given, and asked to select the single most important choice among the options shown in Figure 14 and Table 15. The school was chosen by 38.3%, and another 18.9% chose a higher education institution for a total of 57.2%. Another cluster of choices was also significant: the sum of premarital and postmarital consultation with a doctor, plus discussion after the first birth or abortion, came to 36.4%. The family as a source received very low priority, perhaps reflecting the common embarrassment between parents and teenagers in discussing sexual matters.

**Regarding the timing** of when to start giving youth some information on family planning, the general preference was to start at either age 15-17 (46.3%) or even later, at 18 and older (38.9%). Only 14.8% said "up to 15 years." An interesting age gradient emerged for those favouring early instruction (up to 15 years): from 25.9% down to 15.3% and to 9.7% across the doctors' age groups from youngest to oldest. Thus the younger doctors are less conservative

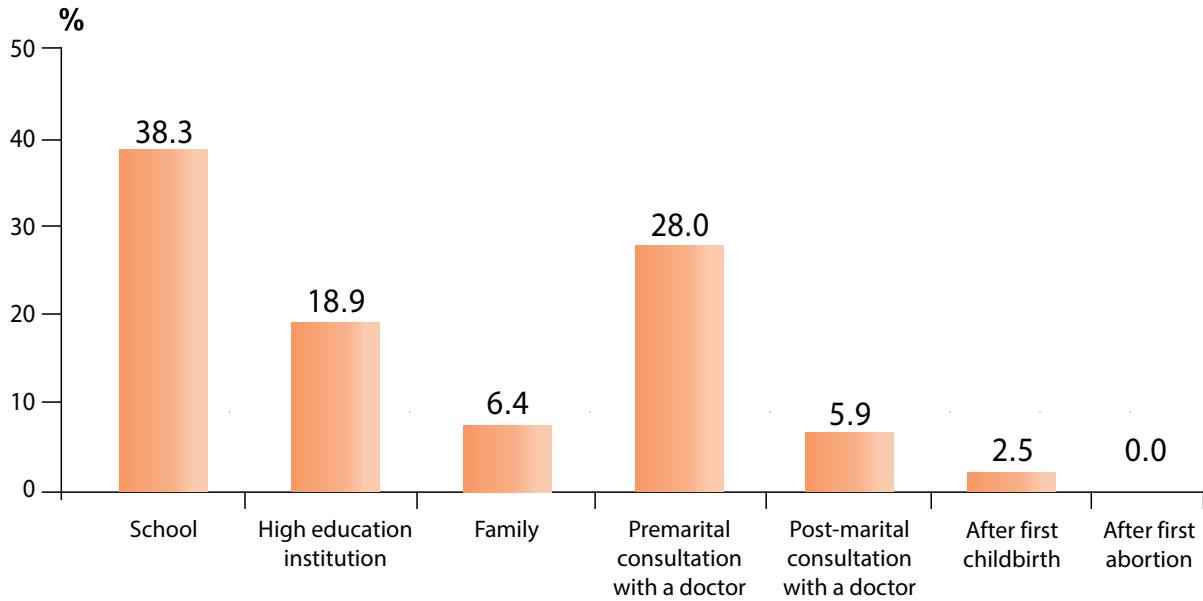
regarding early information for youth. The Kakheti region was also least conservative, with 23.4% favouring early information provision (Table 15).

**Then who should give information to youth?** Respondents were asked to choose the single best option among six possibilities (Table 16). Two sources stood out: a "specially trained person" and "doctor" received 50.8% and 44.6% of the replies, respectively. The "parent" was chosen by only 3.5%, again a reflection of the usual awkwardness between parents and youth on family planning matters. The male respondents were prone to prefer a doctor as the main source (59.1%) compared to the female respondents (42.7%). More females preferred a specially trained person.

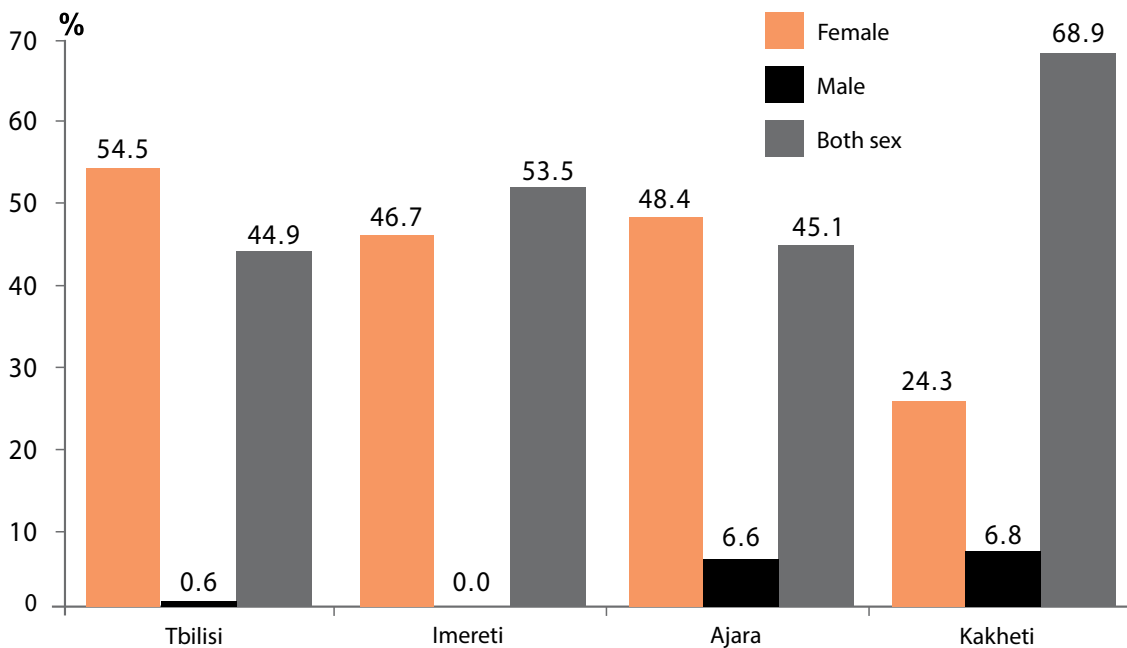
For unmarried youth (aged 15-24) most (73.2%) doctors felt that reproductive services (consultations, clinical services) should be different from normal services (Table 22). Many also felt that these services should be anonymous, with considerable variation among the subgroups of doctors (Table 23).

A surprisingly high percentage (58.9%) of doctors say that they have had actual experience in providing reproductive health services to unmarried youth. Nearly all (98.3%) believe that special training for doctors for such services is necessary (Tables 24 and 25).

**Figure 14.** Opinions of doctors on the provision of information on family planning methods (%)



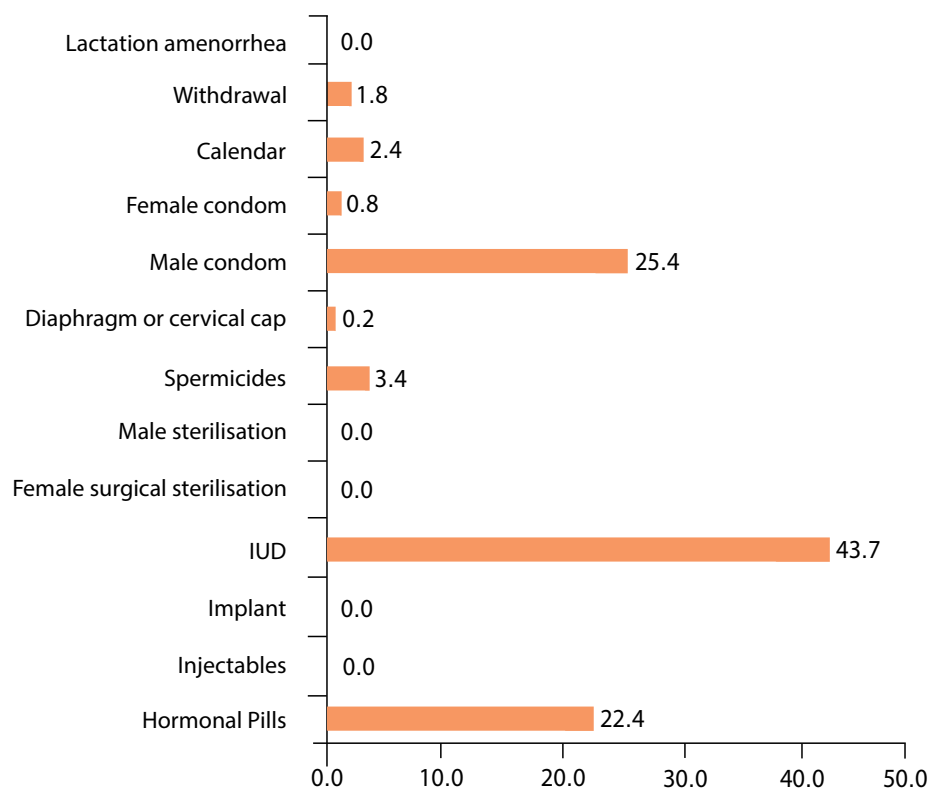
**Figure 15.** Percentage of doctors concerning who takes decisions on family planning methods among couples



**Which spouse decides about contraception?** Doctors were asked whether couples disagree in their family planning attitudes and who is dominant in decision making about the use of family planning methods (Figure 15 and Tables 17 and 18). Interestingly, 81.0% of all doctors say the attitudes do differ, but fully half (49.4%) also say that the couple makes joint decisions on the use of family planning methods. Figure 15 displays the patterns by region. Overall, more doctors believe that couples' decisions on the use of family planning methods are taken by women, or both women and men jointly

**Which contraceptive methods are most used?** Doctors were asked what percentage of women of reproductive age currently use contraception. About half (Table 19) said 20% to 40% , a fifth said up to 20%, and nearly a third said 41% to 60%. Actually, the 2010 national reproductive health survey showed 32% of all women aged 15-44 using some method, equal to 53.4% among married women.

The doctors were asked for the single method most used in Georgia. The IUD was mentioned most often (43.7%), followed by the male condom (25.4%)

**Figure 16.** Contraceptive methods most frequently used in Georgia according to doctors' opinion

and the pill (22.4%). No other methods received significant attention (Figure 16 and Table 20). In fact, the 2010 national survey partly agreed: the IUD and condom stood out; however the pill ranked well below. Withdrawal was nearly as popular as the IUD and condom. In Georgia by far most use is among married women; the actual percentages using each method in the national 2010 survey for them were:

Condom	13.6%
IUD	12.5%
Withdrawal	11.1%
Calendar/rhythm	7.4%
Pill	4.1%
Female sterilization	2.9%
Others	1.8%
Total	53.4

These figures represent only the percentages of doctors who have seen such cases, not their numbers of patients nor the frequency of such cases in the general population, many of which do not come to doctors' attention.

**Violence experience.** The survey also asked doctors whether patients had come to them for help with family violence issues. The three panels of Table 26, for "often," "seldom," and "never" give the results. Nearly no doctors said "often;" most said "never." But from 4.4% to 19.9% said they had been consulted for the following:

Beating a pregnant woman	14.3%
Beating a woman	19.9%
Raped by known or unknown man	12.9%
Raped by spouse	4.4%

## 5 LEVEL OF KNOWLEDGE ON CONTRACEPTION

During the survey the doctors were provided with a test on 25 points of their knowledge regarding various contraceptive methods. Each doctor answered either “yes” or “no” to indicate whether he/she agreed or disagreed with the statement (see Annex 1, Questionnaire). Figure 17 shows the percentage who answered each question correctly (see also Table 21).

### Question Number

Here are the 25 statements in the same sequence as in Figure 17.

1. The doctor has to convince the patient to use the contraceptive method that the doctor deems necessary
2. Implanting an intrauterine device is possible within 48 hours after a childbirth
3. Intrauterine device is a more effective contraception method than spermicides
4. Intrauterine device protects from sexually transmitted infections
5. Use of intrauterine device increases the risk of ectopic pregnancy
6. After removing the intrauterine device fertility does not return for a long time
7. Intrauterine device can be implanted after an abortion
8. Combined oral contraceptives (COC) increase bleeding during menstruation
9. Use of COC reduce the risk of endometrial cancer
10. Use of COC reduce the risk of cervical cancer
11. Use of COC reduce the risk of ovarian cancer
12. Use of COC cause hirsutism
13. Use of COC mostly cause weight increase
14. Use of COC reduce the risk of pelvic inflammatory diseases.
15. Use of COC reduce the risk of STI
16. Use of COC for lactating mothers is possible after 42 days from childbirth
17. Use of COC by non-lactating mothers is possible after 21 days from childbirth
18. Use of COC is possible after abortion
19. Use of pure progestagens for lactating mothers is possible after 42 days from childbirth
20. Ejaculate contains sperm within one week from vasectomy
21. Surgical sterilization of a woman is a reversible contraceptive method
22. An effect of spermicides contraception is a thickening of the cervical mucus
23. Lactation amenorrhea protects women from undesired pregnancy in 98-99% of the cases
24. Effectiveness of calendar contraceptive method is 98%
25. Condom protects from STIs and HIV/AIDS.

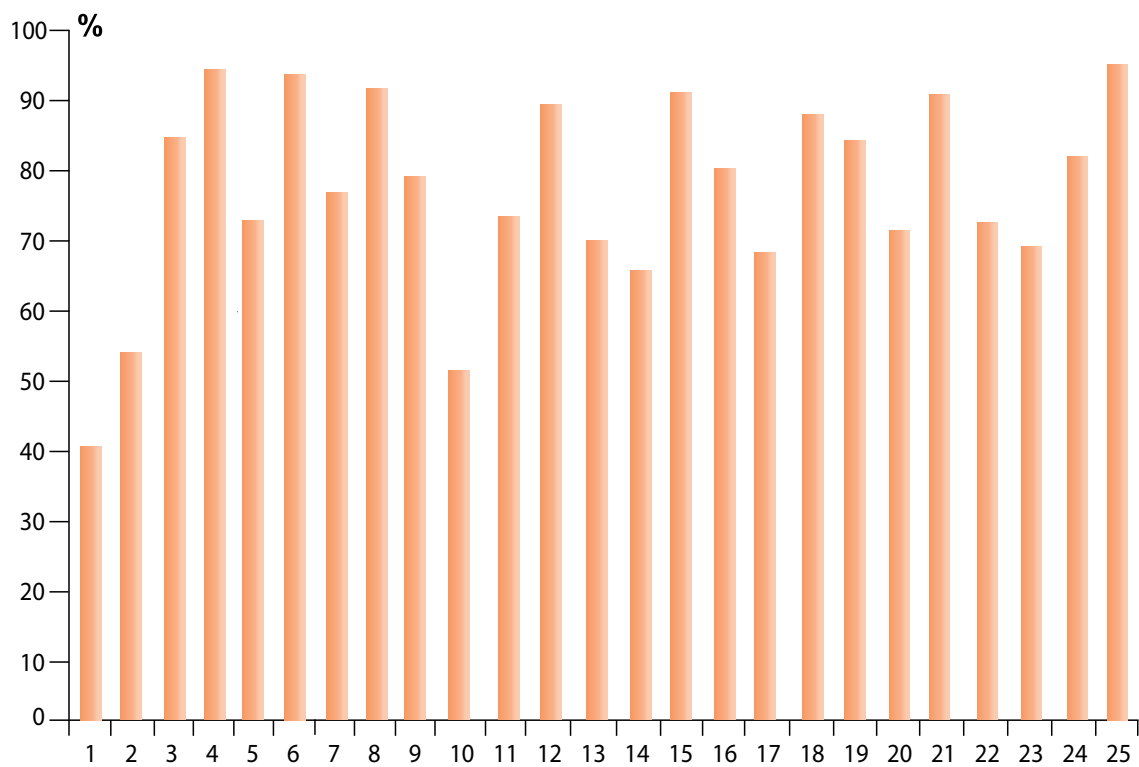
Considerable inaccuracy emerges for the doctors' knowledge on numerous topics. The lowest share of correct responses was received on the statement “The doctor has to convince the patient to use the contraceptive method that the doctor deems necessary”, while the highest share of correct answers was to the statement “Condom protects from STIs and HIV/AIDS”. In between these two extremes there was considerable variation, depending upon the topic. Male doctors outscored female doctors on 20 of the 25 questions, and the Ob-Gyns/Reproductologists outscored family doctors on 15 of the 25 questions. These differences may reflect differences in the ages or training experience of the individuals.

The four regions showed erratic patterns regarding correct answers among the 25 topics. That may reflect differential training partly through donor involvement, as well as the particular topics stressed in the training. It should be noted that questions regarding the intrauterine device were answered correctly by more doctors than questions regarding oral contraceptives.

Training sessions for family planning were most frequently held in Imereti, and doctors who had been through the family planning training gave more correct answers than the doctors without the same training, indicating that it is desirable to provide training on regular basis.

The trend is somewhat encouraging notwithstanding the deficiencies. The 2013 survey showed that the share of doctors who correctly answered questions regarding family planning methods increased compared to the 2010 survey. That also indicates that conducting regular training on these issues is useful and is needed.

**Figure 17.** Percentage of doctors giving correct answers on contraception methods.



## CONCLUSIONS

- Most of the doctors are aware of, and use, a wide range of family planning methods in their practices.
- Doctors believe that some of the key characteristics of contraceptives should be high effectiveness, few side effects, and easy availability.
- Most doctors wish to have more clinical information on family planning methods.
- Doctors believe that provision of information about family planning methods is best to be given from the age of 15-17 starting from school and college.
- Most doctors believe that teenagers should be provided with information on contraception by appropriately trained professionals.
- Greater involvement of family doctors in family planning facilitates the promotion of modern contraceptive methods.
- Most doctors are well aware of the negative consequences of abortion and the advantages of family planning methods. However, due to financial considerations they may sometimes be focused on abortions.
- Most doctors recognize that use of family planning methods reduces the birth rate.
- Doctors' level of knowledge on family planning issues has improved but needs further advance.
- Information on practical and theoretical aspects of family planning methods is usually received at special training sessions.
- Doctors believe that special training is necessary on the provision of youth-friendly reproductive health services to unmarried youth.
- Regarding violence, 20 percent of doctors have had patients who reported beatings and 13 percent reporting rapes.
- The majority of doctors report very few abortions for sex selection.

## RECOMMENDATIONS

- It is important to conduct training sessions for doctors on family planning methods on a regular, continuing basis.
- It is important to broaden the choice of family planning methods that can be used by doctors in their practices.
- It is important for the doctors and donors to provide more information to the public on the advantages of family planning methods.
- It is important for the doctors to periodically receive new clinical data regarding family planning methods.
- It is important to conduct training sessions on the provision of youth friendly reproductive health services for unmarried couples.





**9. What do you think should be the key feature of an ideal contraceptive method?**

*(circle only one, the most important to you)*

1. High effectiveness
2. Insignificant side effects
3. Should not be associated with sexual intercourse
4. Should not be against religion
5. Availability
6. Low price
7. Other (please indicate).....

**10. Which methods of induced abortion do you know and have you used in your practice?**

(To interviewer: Ask this question only to obstetrician- gynaecologists)

		I am aware of it	Have used it in my medical practice	Am currently using it in my medical practice	I give preference to it	I give least preference to it
10.1.	Dilatation and curettage	1	2	3	4	5
10.2	Electronic vacuum-aspiration (for up to 12 weeks)	1	2	3	4	5
10.3	Manual vacuum-aspiration (for up to 12 weeks)	1	2	3	4	5
10.4	Electronic or manual vacuum aspiration before the 5th week of pregnancy (mini-abortion)	1	2	3	4	5
10.5	Medical abortion	1	2	3	4	5
10.6	Other (please indicate).....	1	2	3	4	5

**11. Have you or your partner used any methods of abortion? (if yes, how many times?)**

		Used				Have not used it
		1	2-5	6-9	10+	
11.1.	Surgical abortion	1	2	3	4	5
11.2.	Medical abortion	1	2	3	4	5

**12. What do you think is the main reason for women undergoing induced abortions?**

*(please indicate only the most significant reason)*

1. Do not want to have any more children
2. Socio-economic reasons
3. Desire to postpone childbirth
4. Risk to mother's or foetus's health
5. Partner is against pregnancy
6. Foetus sex
7. Other – please indicate

**13. Have you ever performed abortions due to the undesired sex of the foetus?**

(Interviewer: ask only obstetricians)

1. Yes, very often
2. Yes, quite often
3. Yes, quite seldom
4. Yes, very seldom
5. Never

**14. Does the use of family planning methods affect the birth rate in Georgia?**

1. Yes, it does
2. No, it does not (skip to question 16)
3. I do not know (skip to question 16)

**15. In case you think that the use of family planning methods does affect the birth date, please indicate whether it:**

1. Reduces birth rate
2. Increases birth rate

**16. Do you think abortion is an acceptable family planning method?**

1. It is an acceptable method
2. It is not an acceptable method

**17. For family planning purposes which of the following is preferable?**

1. Abortion
2. Methods of contraception

**18. Do you think that family planning methods influence abortion indicators?**

1. Yes
2. No

**19. Which of the following are the most profitable for the doctor?**

1. Abortion
2. Use of family planning methods
3. Does not matter

**20. What, do you think is the main reason for the population not using family planning methods? (circle only the most important reason)?**

1. It's expensive
2. Level of awareness is low
3. It's forbidden by religion
4. Low quality of family planning service
5. Doctors do not recommend it
6. Abortion is preferred by women
7. Other (please indicate).....

**21. Where do you generally get information on contraceptive methods? (please circle only one answer)?**

1. Professional medical magazine
2. Popular magazine
3. Family planning trainings held by donor organizations
4. Continuous education training
5. Conferences, seminars
6. TV
7. Information distributed by pharmaceutical companies
8. Other (please indicate).....

**22. Is it difficult for you to receive clinical information regarding family planning methods?**

1. Yes, it is
2. No, it is not





**60. Have patients consulted you who were victims of violence, and if yes, how often?**

	TYPES OF VIOLENCE	Frequently	Seldom	Has not
60.1	Beating pregnant women	1	2	3
60.2	Beating women	1	2	3
60.3	Raped by unknown or known man	1	2	3
60.4	Raped by a spouse	1	2	3

*Thank you for your assistance!*

## ANNEX 2.

	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		Includes family planning methods in professional practice		
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologists	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	Up to 5 years	5-9 years	10 and more years
2010																			
Number	600	78	522	101	304	195	398	202	326	106	91	77	463	137	185	287	209	183	175
%	100	13.0	87.0	16.8	50.7	32.5	66.3	33.7	54.3	17.7	15.2	12.8	77.2	22.8	39.2	60.8	36.9	32.3	30.9
2013																			
Number	600	66	534	89	307	204	400	200	324	107	91	78	443	157	271	172	124	152	258
%	100	11.0	89.0	14.8	51.2	34.0	66.7	33.3	54.0	17.8	15.2	13.0	73.8	26.2	61.2	38.8	33.9	34.4	32.1

	<i>Has heard about it</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	
Hormonal Pills	98.7	98.5	98.7	100.0	98.0	99.0	99.0	98.0	99.4	100.0	100.0	92.2	98.6	98.7	97.8	100.0	
Injectables	95.9	92.2	96.4	100.0	95.9	94.0	95.6	96.5	98.0	99.1	89.7	89.7	96.1	95.2	96.3	95.9	
Implant	97.9	95.0	98.3	100.0	97.5	97.6	97.6	98.8	99.3	100.0	92.7	95.1	98.1	97.1	97.7	98.8	
IUD	95.3	97.0	95.1	96.6	95.8	94.0	93.7	98.5	94.1	100.0	96.6	92.2	96.1	92.9	94.4	98.8	
Female surgical sterilisation	96.9	92.2	97.5	97.7	97.4	95.9	95.5	100.0	97.2	100.0	94.3	94.4	98.6	91.8	98.9	98.2	
Male surgical sterilisation (vasectomy)	96.8	95.3	97.0	93.0	96.9	98.4	96.7	97.1	96.8	100.0	98.7	90.0	98.1	92.6	98.1	99.4	
Spermicides	95.1	93.7	95.2	94.4	95.2	95.2	95.6	93.8	95.5	100.0	94.3	85.9	95.2	94.8	94.3	96.5	
Diaphragm or cervical cap	96.1	96.8	96.0	98.8	97.2	93.0	95.2	98.1	95.4	100.0	94.9	94.0	97.2	91.7	97.3	97.0	
Male condom	96.5	97.0	96.4	98.9	95.4	97.0	97.2	94.9	96.6	100.0	96.6	90.8	96.2	97.4	94.8	98.2	
Female condom	99.1	100.0	99.0	98.7	99.6	98.3	99.2	98.8	99.3	100.0	100.0	95.7	98.8	100.0	98.5	99.4	
Calendar	98.5	100.0	98.3	96.6	99.0	98.5	98.2	99.0	99.1	100.0	100.0	92.1	98.4	98.7	98.5	98.2	
Withdrawal	99.0	100.0	98.8	98.8	98.7	99.5	99.0	98.9	99.0	100.0	98.9	97.3	98.6	100.0	98.2	99.4	
Lactation amenorrhea	98.6	100.0	98.5	98.9	98.4	99.0	99.0	97.9	100.0	100.0	97.6	92.2	98.2	100.0	98.2	98.2	

Continued

<i>Knows how to use it</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Hormonal Pills	87.6	97.0	86.5	88.8	88.6	85.7	94.5	74.0	86.1	100.0	80.2	85.7	92.1	75.2	90.8	94.7
Injectables	65.2	81.3	63.2	59.3	69.6	61.0	77.4	37.8	60.5	95.3	47.1	61.8	71.7	42.9	71.5	74.0
Implant	53.5	75.0	50.7	45.7	56.5	52.1	64.2	28.6	50.9	85.0	29.3	42.6	56.6	40.4	56.9	59.8
IUD	71.5	86.4	69.6	74.2	72.5	68.7	88.2	38.2	65.9	100.0	64.0	63.6	74.5	62.8	71.7	80.1
Female surgical sterilisation	51.1	76.6	48.0	39.8	53.0	53.4	62.5	26.9	45.0	99.1	35.6	25.4	56.5	34.9	56.5	59.5
Male surgical sterilisation (vasectomy)	31.2	48.4	28.9	18.6	34.4	31.9	34.1	24.6	21.0	91.6	7.7	10.0	34.5	20.6	29.3	47.6
Spermicides	77.2	87.3	76.0	60.7	83.4	75.7	81.3	68.4	76.3	100.0	61.4	65.6	83.1	58.2	84.0	84.2
Diaphragm or cervical cap	65.5	81.0	63.5	52.4	67.1	69.2	75.1	42.8	58.1	99.1	63.3	46.3	67.4	58.3	67.3	72.3
Male condom	81.9	90.9	80.8	86.5	81.8	80.0	87.7	70.1	83.3	100.0	65.2	69.7	86.4	68.8	85.2	89.5
Female condom	66.2	79.0	64.5	58.4	67.7	67.0	74.9	46.0	58.7	99.1	56.0	58.0	69.2	54.5	69.0	72.0
Calendar	87.0	86.4	87.1	86.5	89.2	83.9	91.5	78.1	86.0	100.0	84.4	76.3	92.7	70.6	91.5	96.5
Withdrawal	80.8	87.9	79.9	82.6	81.5	79.0	86.7	67.9	83.0	100.0	63.3	65.3	84.6	68.8	83.8	87.1
Lactation amenorrhea	89.3	90.9	89.1	86.4	90.9	88.2	92.7	82.3	88.8	100.0	83.5	83.1	92.3	80.7	89.7	98.2

Continued

<i>Gives preference to</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Hormonal Pills	39.9	40.9	39.8	49.4	40.4	35.0	41.4	37.0	37.3	56.1	28.6	41.6	43.4	29.9	36.2	53.2
Injectables	2.3	3.1	2.2	3.5	2.4	1.6	2.8	1.2	1.0	5.6	0.0	5.9	2.5	1.6	2.6	3.0
Implant	1.5	0.0	1.7	3.7	1.4	0.6	1.6	1.2	0.7	3.7	0.0	3.3	1.9	0.0	2.7	0.6
IUD	35.7	42.4	34.9	39.3	37.6	31.3	44.1	19.1	33.1	56.1	11.2	46.8	36.4	34.0	40.1	32.7
Female surgical sterilisation	4.3	14.1	3.1	6.8	3.3	4.7	6.3	0.0	2.8	12.1	1.1	2.8	3.9	5.5	5.2	2.4
Male surgical sterilisation (vasectomy)	0.4	0.0	0.4	1.2	0.3	0.0	0.5	0.0	0.3	0.9	0.0	0.0	0.2	0.7	0.4	0.0
Spermicides	5.3	4.8	5.4	1.1	5.9	6.3	7.2	1.1	5.8	8.4	2.3	1.6	6.2	2.2	6.9	5.8
Diaphragm or cervical cap	1.3	0.0	1.5	0.0	1.1	2.3	1.1	1.9	0.4	2.8	1.3	3.0	1.4	0.9	0.8	2.4
Male condom	38.8	48.5	37.5	36.0	42.0	35.0	35.6	45.2	32.7	74.8	20.2	35.5	42.8	27.3	39.1	48.5
Female condom	4.1	6.5	3.8	1.3	4.9	3.9	2.6	7.4	1.8	4.7	1.2	15.9	4.7	1.8	6.1	2.4
Calendar	11.8	10.6	11.9	10.1	12.1	12.1	11.6	12.2	5.9	22.4	6.7	27.6	11.3	13.1	10.0	14.0
Withdrawal	4.3	4.5	4.3	3.5	5.6	2.6	5.3	2.2	1.9	14.0	1.1	4.0	5.7	0.0	4.8	6.4
Lactation amenorrhea	26.8	30.3	26.3	28.4	26.7	26.2	20.9	39.1	31.8	29.9	1.2	29.9	27.7	24.0	26.9	27.2

Continued

<i>Uses in professional practice</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Hormonal Pills	66.8	62.7	67.3	61.9	67.9	67.3	68.0	56.5	71.2	63.8	50.4	71.8	76.2	40.3	76.0	72.5
Injectables	6.2	10.9	5.6	7.0	6.5	5.5	8.2	1.7	2.3	4.7	6.9	25.0	6.7	4.8	6.0	7.7
Implant	1.9	3.3	1.7	3.7	1.8	1.2	2.7	0.0	1.1	0.0	1.2	9.8	2.1	1.0	1.5	3.0
IUD	62.1	77.3	60.2	65.2	64.7	56.7	90.2	1.0	68.7	54.2	56.2	51.9	63.2	59.0	69.1	55.6
Female surgical sterilisation	15.4	37.5	12.7	10.2	14.6	19.2	21.9	1.6	14.5	18.7	18.4	11.3	16.9	11.0	21.2	10.7
Male surgical sterilisation (vasectomy)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Spermicides	43.0	39.7	43.5	28.1	43.6	49.2	51.3	24.9	54.9	32.7	26.1	26.6	46.9	30.6	58.4	31.0
Diaphragm or cervical cap	6.0	7.9	5.7	1.2	4.6	10.5	8.2	0.6	8.1	0.9	2.5	9.0	6.3	4.6	8.7	2.4
Male condom	75.2	86.4	73.8	67.4	76.5	76.5	75.7	74.1	70.4	89.7	67.4	84.2	82.4	54.5	83.0	79.5
Female condom	6.7	6.5	6.7	5.2	6.7	7.3	7.4	4.9	3.6	5.6	2.4	26.1	6.5	7.1	8.4	4.8
Calendar	59.6	59.1	59.7	50.6	61.1	61.3	65.6	47.4	53.6	60.7	60.0	82.9	62.4	51.6	67.8	52.6
Withdrawal	31.2	19.7	32.7	32.6	34.4	25.6	32.1	29.3	32.8	33.6	23.3	30.7	31.4	30.5	36.5	22.8
Lactation amenorrhea	66.4	74.2	65.5	69.3	64.2	68.7	70.1	58.9	70.7	66.4	31.8	87.0	73.9	44.7	80.1	60.9

Continued

<i>Gives least preference to</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Hormonal Pills	3.7	1.5	3.9	3.4	5.5	1.0	4.5	2.0	1.9	13.1	0.0	2.6	3.8	3.2	4.4	4.1
Injectables	7.5	6.3	7.6	5.8	7.8	7.7	8.7	4.7	3.0	26.2	2.3	4.4	8.0	5.6	6.4	11.2
Implant	5.3	5.0	5.3	4.9	4.9	5.9	6.2	3.1	2.5	15.9	4.9	0.0	5.8	2.9	5.0	7.7
IUD	2.7	1.5	2.8	0.0	1.6	5.5	0.8	6.5	0.3	11.2	2.2	1.3	3.2	1.3	0.7	7.0
Female surgical sterilisation	23.3	7.8	25.2	28.4	20.5	25.4	18.4	33.9	14.2	43.0	18.4	40.8	20.4	32.2	12.3	31.5
Male surgical sterilisation (vasectomy)	31.3	42.2	29.9	38.4	29.3	31.4	27.9	38.9	21.9	58.9	10.3	54.3	30.3	34.6	25.1	34.9
Spermicides	1.1	3.2	0.8	1.1	1.0	1.1	1.5	0.0	1.0	2.8	0.0	0.0	0.9	1.5	0.4	1.8
Diaphragm or cervical cap	2.0	0.0	2.3	1.2	3.2	0.6	2.4	1.3	2.1	2.8	0.0	3.0	2.1	1.9	1.5	3.0
Male condom	0.8	0.0	0.9	1.1	1.3	0.0	1.3	0.0	0.0	2.8	0.0	2.6	1.1	0.0	0.4	2.3
Female condom	1.5	0.0	1.7	0.0	2.1	1.1	2.1	0.0	1.8	2.8	0.0	0.0	1.6	0.9	1.1	2.4
Calendar	1.7	1.5	1.7	1.1	2.6	0.5	2.3	0.5	0.6	2.8	5.6	0.0	2.0	0.7	1.9	2.3
Withdrawal	17.8	27.3	16.6	15.1	16.6	21.0	18.8	15.8	12.2	20.6	18.9	36.0	16.5	22.0	14.0	18.7
Lactation amenorrhea	1.9	1.5	1.9	1.1	2.6	1.0	2.8	0.0	0.6	2.8	5.9	1.3	2.3	0.7	2.2	2.4





Continued

<i>Applied this method in medical practice in past</i>																	
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	
Dilatation and curettage	42.6	63.2	38.9	20.0	44.3	52.7	42.6	NA	37.5	61.2	38.6	45.7	47.9	25.6	51.1	39.6	
Electronic vacuum-aspiration (for up to 12 weeks)	41.8	60.3	38.4	15.9	46.1	49.1	41.8	NA	38.7	61.2	26.7	44.1	48.4	20.7	50.5	43.9	
Manual vacuum-aspiration (for up to 12 weeks)	26.4	47.3	22.4	13.6	28.0	31.0	26.4	NA	30.4	19.2	17.8	22.2	30.7	12.5	38.7	16.9	
Electronic or manual vacuum aspiration before the 5th week of pregnancy (mini-abortion)	36.9	51.8	34.2	15.6	38.3	46.4	36.9	NA	38.1	43.3	7.0	54.5	42.1	19.0	49.2	28.3	
Medical abortion	19.3	22.0	18.8	4.7	23.6	20.2	19.3	NA	10.7	45.3	20.9	27.3	20.6	15.4	21.9	22.0	

Continued

<i>Currently uses in professional practice</i>																	
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	
Dilatation and curettage	13.0	17.5	12.1	6.2	10.8	20.9	13.0	NA	11.6	16.4	11.4	17.1	12.5	14.4	14.2	8.9	
Electronic vacuum-aspiration (for up to 12 weeks)	19.8	24.1	19.0	4.8	21.8	25.0	19.8	NA	14.9	46.3	2.2	23.5	21.0	16.1	21.3	19.4	
Manual vacuum-aspiration (for up to 12 weeks)	17.3	14.5	17.8	13.6	16.5	21.0	17.3	NA	15.2	15.4	28.9	18.5	20.3	7.5	18.5	23.6	
Electronic or manual vacuum aspiration before the 5th week of pregnancy (mini-abortion)	24.9	21.4	25.6	14.1	23.8	33.0	24.9	NA	24.8	31.3	11.6	30.3	26.7	19.0	28.0	25.3	
Medical abortion	20.9	8.5	23.2	10.9	24.1	21.1	20.9	NA	12.0	45.3	20.9	36.4	22.3	16.5	20.3	28.0	

Continued

<i>Gives preference to</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Dilatation and curettage	4.2	3.5	4.4	0.0	3.0	9.1	4.2	NA	1.7	13.4	2.3	5.7	4.9	2.2	5.3	4.0
Electronic vacuum-aspiration (for up to 12 weeks)	6.3	6.9	6.1	3.2	6.7	7.1	6.3	NA	2.7	20.9	2.2	5.9	6.4	5.7	5.3	9.2
Manual vacuum-aspiration (for up to 12 weeks)	12.6	21.8	10.8	10.2	13.7	12.0	12.6	NA	15.7	5.8	11.1	3.7	15.7	2.5	19.1	9.0
Electronic or manual vacuum aspiration before the 5th week of pregnancy (mini-abortion)	14.9	1.8	17.3	9.4	17.1	14.3	14.9	NA	13.3	11.9	18.6	27.3	17.2	7.1	15.9	19.2
Medical abortion	35.7	35.6	35.7	37.5	37.9	30.7	35.7	NA	32.2	48.4	23.3	51.5	39.0	25.3	39.0	41.0

Continued

<i>Gives least preference to</i>																
	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained	
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Ajara	Kakheti	Has taken	Has not taken	Before 2009	After 2009
Dilatation and curettage	38.4	40.4	38.0	47.7	42.9	24.5	38.4	NA	37.5	43.3	43.2	28.6	44.4	18.9	43.7	44.6
Electronic vacuum-aspiration (for up to 12 weeks)	23.9	22.4	24.2	34.9	26.4	13.4	23.9	NA	23.0	25.4	26.7	23.5	25.3	19.5	22.9	28.6
Manual vacuum-aspiration (for up to 12 weeks)	21.4	14.5	22.7	30.5	24.2	11.0	21.4	NA	18.0	32.7	22.2	25.9	21.8	20.0	19.1	27.0
Electronic or manual vacuum aspiration before the 5th week of pregnancy (mini-abortion)	18.4	12.5	19.5	25.0	21.2	9.8	18.4	NA	17.7	23.9	18.6	12.1	19.3	15.5	16.4	24.2
Medical abortion	16.4	11.9	17.2	23.4	17.4	10.5	16.4	NA	17.2	23.4	7.0	9.1	17.0	14.3	15.0	20.0

<b>Table 5. Average number of abortions undergone personally by doctors (or their partners)</b>		
	Surgical abortion	Medical abortion
Total	2.5	1.3
<b>Sex:</b>		
Male	2.5	1.3
Female	2.6	1.2
<b>Age:</b>		
Below 35	1.9	1.4
35-49	2.3	1.1
50 and older	3.0	1.2
<b>Specialisation</b>		
Reproductologist/obstetrician-gynecologist	2.4	1.4
Family doctor	2.8	1.0
<b>Region where he/she works</b>		
Tbilisi	2.4	1.6
Imereti	2.3	1.3
Ajara	2.6	1.2
Kakheti	2.8	1.1
<b>Training on family planning issues</b>		
Has taken	2.4	1.2
Has not taken	2.6	1.5
<b>Has been trained:</b>		
Before 2009	2.5	1.4
After 2009	2.4	1.2
<b>Uses family planning methods in professional practice</b>		
Up to 5 years	2.5	1.7
5-9 years	2.3	1.2
10 and more years	2.6	0.9























**Table 21. Distribution of doctors (%) according to correct answers to questions on family planning methods**

	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		Uses family planning methods in professional practice		
		Male	Female	Below 35	35-49	50 and older	Reproductive gynecologist	Family doctor	Tbilisi	Imereti	Adjara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	Up to 5 years	5-9 years	10 and more years
The doctor has to convince the patient to use contraceptive method that the doctor thinks is necessary	42.7	48.4	41.9	51.2	39.3	44.4	37.6	52.6	39.2	65.4	24.1	44.3	47.1	30.2	40.8	57.5	35.1	47.6	47.6
Implanting intrauterine device is possible within the 48 hours after the childbirth	55.0	62.5	54.1	66.3	59.5	43.3	61.6	41.9	60.8	42.1	40.0	64.3	60.7	38.3	63.6	52.6	58.2	60.6	53.7
Intrauterine device is a more effective contraception means that spermicides	86.1	92.1	85.3	96.1	84.5	84.6	89.2	80.0	87.8	100.0	57.1	86.2	86.4	85.3	86.4	87.2	88.9	83.0	88.7
Intrauterine device protects from sexually transmitted infections	95.0	100.0	94.4	98.8	93.1	96.3	97.6	89.9	97.8	100.0	84.5	85.7	96.9	89.7	97.3	96.2	92.6	95.8	98.8
Use of intrauterine device increases the risk of ectopic pregnancy	73.2	85.7	71.6	70.0	70.9	78.2	74.5	70.7	82.9	62.6	39.4	80.6	75.2	67.6	78.5	69.9	55.0	79.2	78.1
After removing the intrauterine device fertility does not restore for a long time	94.5	96.8	94.2	90.1	94.5	96.3	94.9	93.8	95.5	93.5	91.8	94.5	96.4	89.0	97.7	93.6	91.7	94.4	98.8
Intrauterine device can be implanted after abortion	77.3	79.7	77.0	73.8	81.3	72.8	77.3	77.5	71.1	94.4	91.0	63.9	84.5	56.8	84.2	84.5	79.5	84.9	80.8
Combined oral contraceptives increase bloodshed during menstruation	90.7	96.8	90.0	97.6	90.8	87.6	93.3	85.6	96.5	84.1	81.6	85.5	89.4	94.5	93.0	83.2	85.0	95.1	91.0
Use of combined oral contraceptives reduce the risk of endometrial cancer	78.8	81.0	78.5	78.8	77.3	81.1	81.8	72.6	83.2	65.4	80.5	77.6	82.6	67.8	85.7	76.1	72.7	81.5	85.1

Continued

	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		Uses family planning methods in professional practice		
		Male	Female	Below 35	35-49	50 and older	Reproductive/obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Adjara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	Up to 5 years	5-9 years	10 and more years
Use of combined oral contraceptives reduce the risk of vaginal cancer	51.2	54.7	50.7	60.0	48.3	51.9	52.7	48.1	47.7	76.6	51.3	25.8	47.9	60.4	43.2	56.3	59.8	37.1	53.0
Use of combined oral contraceptives reduce the risk of ovarian cancer	76.9	78.1	76.8	76.5	74.2	81.3	77.9	75.0	78.9	68.2	73.4	85.5	80.9	65.5	84.6	73.9	73.1	76.4	84.4
Use of combined oral contraceptives cause hirsutism	89.9	95.2	89.2	89.0	89.2	91.3	91.7	86.3	95.1	91.6	79.2	76.1	89.0	92.3	91.0	87.8	87.3	87.0	93.1
Use of combined oral contraceptives mostly cause weight increase	67.7	67.7	67.7	65.9	67.0	69.6	66.0	70.9	74.9	63.6	48.6	62.5	72.2	54.2	71.6	74.5	66.4	75.7	64.9
Use of COC reduces the risk of inflammatory diseases of organs in pelvis minor	62.8	74.6	61.3	63.0	60.0	67.2	64.6	59.1	72.8	51.2	88.9	67.7	66.7	51.4	74.4	51.8	66.1	65.8	63.5
Use of combined oral contraceptives reduces the risk of transferring STI	91.3	95.2	90.7	91.3	93.9	87.2	91.2	91.4	93.8	94.4	83.5	83.3	90.8	92.5	92.9	88.3	93.8	93.2	89.7
Use of combined oral contraceptives for breast-feeding mothers is possible after 42 days from childbirth	81.7	79.4	81.9	73.4	82.4	84.0	81.3	82.4	87.6	94.4	70.1	47.0	82.2	80.1	82.2	83.5	67.6	85.1	87.9
Use of combined oral contraceptives by non-lactating mothers is possible after 21 days from childbirth	64.9	84.1	62.5	70.4	66.0	61.0	75.4	44.1	60.8	81.3	59.0	64.7	67.2	58.3	66.2	70.0	72.5	53.5	73.9
Use of combined oral contraceptives is possible from the moment of abortion	88.0	91.9	87.6	81.9	91.7	85.0	93.6	76.9	87.3	97.2	88.6	76.1	91.4	77.9	92.6	90.3	81.8	92.4	92.3



Continued

	Total	Sex		Age			Specialisa- tion		Region where he/she works				Training on family planning issues		Has been trained		Uses family planning methods in professional practice		
		Male	Female	Below 35	35-49	50 and older	Reproductologist /obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Adjara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	Up to 5 years	5-9 years	10 and more years
Use of clean progestagens for breast-feeding mothers is possible after 42 days from childbirth	84.1	91.2	83.3	74.0	83.5	89.3	86.8	78.9	83.7	91.6	81.1	76.7	88.1	72.7	88.4	87.8	72.4	88.6	91.0
Ejaculate contains sperm within one week from vasectomy	68.4	66.7	68.7	64.9	66.7	72.9	65.5	74.3	73.0	74.8	53.4	47.8	72.7	56.0	71.4	74.7	62.5	73.0	71.8
Surgical sterilization of a woman is a reversible contraceptive method	88.7	90.6	88.4	80.8	90.0	90.0	88.7	88.7	90.5	97.2	71.8	86.8	88.9	87.9	91.1	86.3	80.6	88.0	92.8
Contraceptive effect of spermicides is thickening the cervical mucus	67.9	83.9	65.9	68.8	65.9	70.9	65.2	73.6	79.4	82.2	21.1	42.1	66.8	71.3	70.0	63.5	52.3	70.0	71.7
Lactation amenorrhea protects women from undesired pregnancy in 98-99% of the cases	61.6	60.9	61.7	50.0	64.3	62.5	59.6	65.4	59.2	98.1	37.5	44.4	66.5	47.3	64.2	71.1	46.5	63.7	71.8
Effectiveness of calendar contraceptive method is 98%	82.3	87.5	81.7	95.0	80.1	80.5	84.4	78.3	84.1	89.7	75.6	70.8	82.9	80.8	80.2	86.6	84.7	81.4	82.3
Condom protects from STIs and HIV/AIDS.	98.3	96.9	98.4	98.8	98.0	98.4	98.2	98.4	97.8	100.0	97.6	98.6	100.0	97.7	97.7	97.6	98.2	99.3	97.2
Combined oral contraceptives increase bloodshed during menstruation	90.7	96.8	90.0	97.6	90.8	87.6	93.3	85.6	96.5	84.1	81.6	85.5	89.4	94.5	93.0	83.2	85.0	95.1	91.0
Use of combined oral contraceptives reduce the risk of endometrial cancer	78.8	81.0	78.5	78.8	77.3	81.1	81.8	72.6	83.2	65.4	80.5	77.6	82.6	67.8	85.7	76.1	72.7	81.5	85.1



**Table 25. Percentage of doctors who think that training of doctors is needed for introducing reproductive services to youth**

	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		Uses family planning methods in professional practice		
		Male	Female	Below 35	35-49	50 and older	Reproductiveologist /obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Adjara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	Up to 5 years	5-9 years	10 and more years
Training required	98.3	100.0	98.1	100.0	99.3	96.0	99.2	96.4	98.4	100.0	100.0	93.5	100.0	93.4	100.0	100.0	98.4	99.3	99.6
Training not required	1.7	0.0	1.9	0.0	0.7	4.0	0.8	3.6	1.6	0.0	0.0	6.5	0.0	6.6	0.0	0.0	1.6	0.7	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

**Table 26. Percentage of doctors who have been consulted by victims of violence, by type of violence**

	Total	Sex		Age			Specialisation		Region where he/she works				Training on family planning issues		Has been trained		
		Male	Female	Below 35	35-49	50 and older	Reproductiveologist /obstetrician-gynecologist	Family doctor	Tbilisi	Imereti	Adjara	Kakheti	Has taken	Has not taken	Before 2009	After 2009	
<b>Often</b>																	
Beating pregnant women	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Beating women	1.4	1.6	1.4	3.4	0.3	2.1	1.6	1.0	0.3	0.0	5.7	2.7	1.7	0.7	1.2	2.4	
Raped by unknown or known man	1.0	0.0	1.2	0.0	0.7	2.1	1.6	0.0	1.6	0.0	1.2	0.0	0.7	2.0	0.8	0.6	
Raped by spouse	0.3	0.0	0.4	0.0	0.3	0.5	0.3	0.5	0.3	0.0	0.0	1.4	0.5	0.0	0.4	0.6	
<b>Seldom</b>																	
Beating pregnant women	14.3	23.4	13.1	15.3	10.8	19.1	17.3	8.3	12.1	1.9	18.6	35.1	14.0	15.0	13.0	14.3	
Beating women	19.9	32.8	18.2	17.0	18.3	23.6	22.2	15.2	21.5	1.9	29.5	27.4	18.2	24.5	18.5	16.6	
Raped by unknown or known man	12.9	26.6	11.2	2.4	10.7	20.8	17.0	4.7	14.1	13.1	7.1	14.1	13.2	12.0	16.6	7.9	
Raped by spouse	4.4	4.7	4.3	1.2	5.1	4.7	4.5	4.2	5.5	0.0	4.7	5.5	3.3	7.3	3.1	3.6	
<b>Never</b>																	
Beating pregnant women	85.7	76.6	86.9	84.7	89.2	80.9	82.7	91.7	87.9	98.1	81.4	64.9	86.0	85.0	87.0	85.7	
Beating women	78.7	65.6	80.4	79.5	81.4	74.3	76.2	83.8	78.2	98.1	64.8	69.9	80.1	74.8	80.3	81.1	
Raped by unknown or known man	86.1	73.4	87.6	97.6	88.6	77.1	81.5	95.3	84.2	86.9	91.8	85.9	86.1	86.0	82.6	91.5	
Raped by spouse	95.3	95.3	95.3	98.8	94.6	94.7	95.3	95.3	94.1	100.0	95.3	93.2	96.2	92.7	96.5	95.8	